

Bioethical Issues and Secondary Prevention for Nonoffending Individuals with Pedophilia

AINSLIE HEASMAN and THOMAS FOREMAN

Abstract: Child sexual abuse is a global problem with significant emotional, psychological, and financial implications to victims, perpetrators, and society. Most child sexual abuse prevention programs target young children or those who have already engaged in abusive behavior, in order to prevent further offending. There are numerous secondary prevention programs targeting individuals at-risk of various health conditions in an effort to reduce the likelihood they will go on to experience a particular illness or disease. Considerable research exists regarding the risk factors for engaging in child sexual abuse and more specifically the factors contributing to reoffense. We argue that engaging in secondary prevention programs for people with pedophilia, in order to prevent child sexual abuse, is an ethically responsible and necessary practice. Secondary prevention programs with this focus are reviewed, along with the implications of mandatory reporting in doing this work.

Keywords: pedophilia; sexual abuse; secondary prevention programs; reoffense; treatment

Child sexual abuse (CSA) is a complex and sensitive issue that often generates significant emotional response. Individuals with pedophilia, some of whom will engage in CSA, are arguably some of the most stigmatized and judged people in society. This paper discusses a harm reduction approach to CSA through the treatment of nonoffending people with pedophilia.

The World Health Organization defines child sexual abuse as “the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared, or else that violates the laws or social taboos of society.”¹ A recent meta-analysis estimated that 6 percent of males and 13 percent of females experience contact sexual abuse (e.g. touching) during their childhood, with higher rates for noncontact sexual abuse (e.g. being exposed to).² The most common approaches to addressing CSA involve teaching children how to prevent abuse, educating parents on how to recognize signs of abuse, and using the criminal justice system (CJS) to deal with child sexual abusers. What has largely been absent in the prevention of CSA is an attempt to reach the individuals who are responsible for perpetrating CSA *prior to* the behavior occurring. To date, the societal response to this group has been post-offense, and through criminal justice sanctions.

Experiencing child sexual abuse (CSA) has long-standing and far-reaching effects for a significant number of children annually. CSA has been linked with a number of negative experiences and outcomes for victims, including: increased mental health problems, reduced self-esteem, earlier age of onset of sexual activity, more unplanned pregnancies, higher rates of suicide attempts, more medical contacts, and lower gross personal income.^{3,4}

While the emotional and psychological impact to victims is of vital importance in preventing CSA, the financial implications of investigating, prosecuting, detaining, and monitoring individuals convicted of sexual offenses, in addition to the

Acknowledgment: We thank Sarah Moss for a review of an earlier version of this paper

financial costs for victims via mental health and victim agency support and lost wages, is not insignificant. The Vera Institute of Justice determined the average per inmate cost of incarceration was \$33,274.⁵ California's cost for a prison inmate in 2016-2017 was \$70,812.⁶ Recent research estimates a \$9.3 billion lifetime economic impact for CSA that occurred in the US in 2015, while the lifetime cost for each nonfatal CSA female victim is \$282,734.⁷

Given the aforementioned, and significant, costs associated with CSA, there is a need to refine the approaches used to prevent this global problem. We argue that to successfully reduce the occurrence of CSA, it is essential to target CSA through the lens of a preventable public health problem, and with those at -risk of engaging in CSA, namely, people with pedophilia (PWP).

Prevention of Child Sexual Abuse through a Public Health Model

The World Health Organization adopts a position that child maltreatment (which would include CSA) is preventable and that there exists a responsibility to engage in prevention efforts.⁸ The WHO views a public, multisectoral model (also referred to as a public health model) as necessary to combat the occurrence of child maltreatment. Approaches to the prevention of illness or disease occurs on three levels: primary, secondary, and tertiary. Each level targets different aspects and stakeholders in the prevention of a particular outcome. Specific to CSA, primary prevention efforts target whole populations (i.e., parents, primary-school children), and involve education and knowledge-building regarding risk and protective factors for CSA. This is done in an effort to reduce the likelihood that children will experience CSA. Secondary prevention efforts target specific groups thought to be at greater risk of engaging in, or experiencing, CSA. Tertiary prevention strategies occur after abuse has transpired and focuses on individuals who have engaged in or experienced CSA to prevent them from engaging in, or experiencing, CSA in the future.⁹ By definition, tertiary responses target those convicted of CSA. Given CSA is often unreported, there are a substantial number of individuals who are never convicted or reported to the criminal justice system (CJS), and thus no intervention (in order to prevent future offending) is offered.

A significant focus in the prevention of CSA has been on primary prevention, namely through programs for children and those involved with children. Geoffrey Nelson, Marie-Claire Laurendeau and Claire Chamberland¹⁰ summarize the types of information discussed in these programs, including; understanding the nature of sexual abuse, who in the child's life could be abusive, building skills to resist inappropriate advances, and how to report attempted or actual abuse. Primary prevention programs have also been shown to improve the knowledge, attitudes, and behaviors regarding CSA for community adults involved with children¹¹, and school-based CSA prevention is supported by parents.¹² An extensive review of school-based education programs in seven countries for the prevention of CSA demonstrated that children involved in school-based education of this type showed an increase in protective behaviors and knowledge of sexual abuse prevention. The review noted, however, that there are no adequate long-term follow-up studies to determine the extent to which these programs assisted in reducing the incidents of CSA.¹³

In addition to primary prevention efforts aimed at children, there is substantial tertiary intervention for individuals convicted of sexual offenses against children—in

an effort to prevent further victimization. There are many legislative efforts to curtail sexual abuse through the restriction, monitoring, and detention of individuals convicted of CSA. Residency restrictions, electronic monitoring, community notification, registration with police, and civil commitment strategies have been employed, to varying degrees, in North America, Europe, Asia, South America, the Caribbean, Australia, New Zealand, and Africa.^{14,15} Research has shown that many of these post-conviction strategies do little to reduce recidivism and may in fact increase the likelihood of offending by destabilizing the offender and removing their ability to secure employment, maintain social supports, and reintegrate effectively.^{16,17}

The vast majority of the response to CSA is primary and tertiary, with the allocation of significant financial, legislative, and mental health resources occurring after the abuse. Secondary prevention includes prevention strategies targeted at individuals with an increased risk of engaging in CSA. This could translate into the provision of mental health support and education to individuals prior to their potential involvement with the CJS as a result of committing CSA. To be clear, the goal is not to support or condone CSA, but to intervene and support individuals who have been identified (or self-identify) as being at greater risk for engaging in CSA, in order to prevent offending.

Secondary Prevention for Nonjustice Involved Individuals with Pedophilia and/or Hebephilia

Pedophilia is the sexual preference for prepubescent children (generally before age 11), and hebephilia is the sexual preference for pubescent children (generally between 11-12 and 14).¹⁸ Pedophilia, in and of itself, is no longer classified as a mental health condition in the Diagnostic & Statistical Manual – V (DSM-V)¹⁹, the main guidebook for clinicians in North American on the diagnosis of mental health conditions. What is now included in the DSM-V is Pedophilic Disorder, which requires the individual's prepubescent sexual interest to have interfered in their functioning (i.e., legal consequences) and/or that the individual experiences distress regarding their sexual interests. Pedophilic Disorder cannot be diagnosed in someone younger than 16.

Research suggests that individuals with pedophilia first become aware of their sexual preference at a young age.^{20,21} Investigation is ongoing to understand the causes and development of pedophilia. However, there are indications that the neuroanatomy and neurodevelopment of individuals with pedophilia are different than those with a sexual preference in physically mature individuals.²²⁻²⁵ What has become increasingly clear in the sex offense literature is that PWP do not choose this interest, but are, without question, responsible for their actions as a result. A common public misconception is that all people with pedophilia have, or will, sexually abuse a child. It cannot be underscored enough that not all individuals with a pedophilic preference go on to commit CSA. Approximately 40-50% of adults who sexually offend against children would be considered to have a pedophilic preference.²⁶ Online and anonymous research suggests that between 1.8% and 4.1% of community samples report sexual fantasies involving children.^{27,28} There are a variety of evidence-based factors that contribute to sexual offending, which will be expanded on below, and do not relate to having a sexual interest in prepubescent or pubescent children.

In recent years, there has been an increased focus on providing therapeutic intervention to individuals prior to a sexual offense, with the aim of reducing the likelihood of offending, and in turn preventing significant psychological and physical consequences to victims. This is due, in part, to the increased understanding of individuals who have already sexually offended. Researchers and clinicians now have a depth and breadth of knowledge regarding the risk and protective factors that contribute to sexual reoffending. Empirically supported risk factors include; sexual preoccupation, emotional identification with children, conflicts in intimate relationships, deficits in general self-regulation, and poor cognitive problem solving. What continues to hold as one of the main features associated with sexual recidivism is sexual interest in children.^{29,30} Attending to these factors is a reasonable first step in providing treatment to nonoffenders, to assist in reducing the likelihood of engaging in CSA.

Reaching individuals prior to an offense is no easy task. There are numerous external and internal barriers to engaging in help-seeking behaviors. External barriers identified by individuals who seek support prior to offending or who are canvassed after an offense include: a lack of awareness of who or where to turn to for assistance, concerns about confidentiality, shame and guilt regarding their interests and/or behaviors, and denial and minimization of the risk of harm to children.^{31,32}

A number of mental health professionals experienced in treating individuals who have been convicted of a sexual offense also offer therapy to those concerned about their sexual interests in children and who have not had involvement in the CJS. This therapy is often not within a public health system and is a fee-for-service arrangement—which can be cost-prohibitive for many. The first author works at the Sexual Behaviours Clinic (SBC) at the Centre for Addiction & Mental Health (CAMH); a publicly funded mental health hospital in Toronto, Canada. The SBC offers treatment to individuals post-conviction, as well as to PWP without criminal justice involvement. Treatment is currently offered at the SBC in individual or group format, depending on the nature of the individual's interests and/or behavior.³³

The most comprehensive prevention program for PWP (who have not offended, who have not been detected by the CJS or who are no longer involved with the CJS) is the Prevention Project Dunkelfeld (PPD) in Germany.³⁴ This program was launched in 2005, for individuals 18+, alongside an extensive media campaign, and has expanded to multiple sites throughout the country. Beginning in 2014, the Prevention Project Juveniles (PPJ) began in Germany with a focus on providing much of the same prevention focus as PPD, but for individuals under 18. The program was financed initially by the German federal government and in the first year, 49 youth contacted the program. Germany, unlike many other countries, does not have mandatory reporting requirements for mental health professionals. More specifically, confidentiality with a medical professional can be broken only if the provider believes the client will engage in a sexual offense. There is clear demand for PPD given 9,515 people contacted the program between the launch in 2005 until March 2018, with 2,894 of those attending one of the program's offices for diagnosis and information.³⁵ The existence of mandatory reporting legislation in many other countries, including in Canada and the United States, has significantly contributed to the complexities in developing and offering secondary prevention programs similar to PPD and PPJ.

Stop It Now! is a sexual abuse prevention program, started in the United States in 1992, by Fran Henry who is a survivor of CSA. The program has been offered in the US, UK, and the Netherlands. These programs typically offer free and anonymous online resources and/or a telephone line for individuals to call if they are concerned about their sexual interest in children. Opportunities also exist for individuals (i.e. family, friends, or other professionals) who are concerned about someone else's sexual interests to call the phone line for information. The program was implemented in the UK and Ireland in 2002 and in the Netherlands in 2012. A helpline is offered as an initial resource, and brief in-person intervention is offered as a follow-up to those who are interested and qualify. Research on the UK and Netherlands program revealed approximately half of the helpline callers were individuals concerned about their own sexual behaviors and/or interests. Stop It Now! UK received 3,451 phone calls in March 2013 alone, suggesting there is a significant demand for these services.³⁶

The success of interventions for individuals contacting helplines and/or seeking in-person therapeutic support is difficult to quantify, as many of the services are offered anonymously with no way to accurately determine if CSA was prevented. Some research has identified that individuals who have sought out secondary prevention programs have engaged in strategies to reduce their risk for offending, developed an understanding of warning signs that could lead to viewing child abuse images, identified social supports, were less lonely, were less sexually pre-occupied and knew how to better cope with sexual urges toward children.³⁷⁻³⁹ Initial research from the PPD program in Germany demonstrated that PWP are interested in receiving treatment outside the criminal justice system. Additionally, there was no self-reported first CSA offense for individuals involved in their treatment program.⁴⁰

Implications of Mandatory Reporting for Treatment of Nonjustice Involved Individuals with Pedophilia

Mical Raz provides a summary of the development of mandatory reporting in the United States beginning in the 1960's.⁴¹ Mandatory reporting legislation varies depending on the country and/or jurisdiction, and typically speaks to the requirement to report reasonable suspicions that abuse to a child has occurred and/or that a child is likely to be, or is at-risk of being, abused.^{42,43} Guidance as to how to interpret this legislation is often lacking and remains subjective.⁴⁴ Healthcare professionals who gain information regarding CSA, or risk of CSA, during the course of their professional work are not exempt from reporting. Providing mental health treatment to PWP (when the preference is known) who have unsupervised access to a child, may satisfy the legislative requirements for a mandated report in some jurisdictions.

A relevant comparison to draw exists in the privilege between solicitors and clients. In some US States, a report to child protective services is discretionary for attorneys, while it is mandatory for mental health professionals.⁴⁵ In Ontario, Canada, The Child & Youth Services Act⁴⁶ expressly indicates that mandatory reporting is not required by a solicitor when privilege exists between the solicitor and the client. The principles underlying solicitor-client privilege are highlighted in *Smith v. Jones*,⁴⁷ a Supreme Court of Canada judgment. This particular case assessed whether the solicitor-client privilege extended to a psychiatrist retained

by the client's attorney to perform an assessment, when the client reported a plan to kidnap, sexually assault, and kill sex trade workers. The ruling noted that the need for public safety could outweigh the solicitor-client privilege if there was "clear, serious, and imminent" risk. The aim of solicitor-client privilege relates to ensuring that an individual can be suitably represented and can rely on their solicitor, who is duly qualified, to guide them appropriately through the judicial process. We argue that a client should be able to rely on a mental health professional, many of whom are duly qualified in treating PWP, to guide them appropriately through treatment in order to mitigate risk, without the mental health professional having to make a mandatory report. A public safety exception for risk that is "clear, serious, and imminent," akin to the solicitor-client privilege exception, may be a more suitable standard relating to mandatory reporting.

There is arguably a difference between the need for a mandatory report for a child who is at 'imminent' risk in the context of a clear intention and motivation to abuse on the part of the would-be-offender; and the potential risk to a child based on the sexual preferences of someone in contact with that child who is actively seeking treatment to ensure they do not offend and who states no intention to offend. In most jurisdictions, particularly in North America, there is no exception for mental health professionals regarding the requirement to report to child protective services. This, in turn, can serve as a significant barrier for PWP to seek treatment for their sexual interest or for any issue that may contribute to an increased risk of offending, out of fear of a breach in confidentiality by the provider.

Little research has been done to determine the impact of implementing mandatory reporting on CSA. David Lamond⁴⁸ noted an increase in the number of reports from teachers regarding suspected sexual abuse once mandatory reporting requirements were introduced for teachers in Australia. There are indications that the system was unable to keep up with the investigation of the increased numbers.⁴⁹ Mandatory reporting may serve to overburden the child protection system in such a way as to limit the amount of resources available for the most at-risk or serious cases. A systematic review of the studies on the effectiveness of mandatory reporting was undertaken⁵⁰; however the authors were unable to find relevant prospective control groups, cohorts, or case-control studies. The authors highlighted their inability to locate any high-quality research that demonstrated that mandatory reporting and the relevant follow-up produced more positive than negative outcomes. Although modern ethics restrictions may certainly prevent this type of prospective study from being implemented, we should not take for granted that the intended effect of mandatory reporting (by mental health professionals in order to prevent CSA) has been fulsomely achieved.

Bioethical Considerations in the Treatment of Nonjustice Involved Individuals with Pedophilia and/or Hebephilia

There are several key ethical issues that require consideration in evaluating secondary prevention strategies for nonjustice involved individuals with pedophilia and/or hebephilia. These include: whether clinicians should apply a harm reduction/harm minimization approach as a secondary prevention strategy to this population; the impact of mandatory reporting legislation on clients, clinicians and the community at large; and the ethical obligations of systems that provide care to PWP.

Healthcare professionals are typically exempt from civil litigation if they make a report to child protective services in good faith. Professionals may also choose to report so as to avoid complaints, to their registration body, about unethical practice. However, there appear to be few complaints of professional misconduct against psychologists in Canada regarding having made, or failed to make, a mandatory report regarding CSA.⁵¹

Traditional definitions of harm reduction have focused on substance use/misuse and historically, harm reduction strategies have concentrated their efforts on minimizing the negative impact of such use/misuse.^{52,53} The Harm Reduction Coalition defines harm reduction in the following way:

Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm Reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs. Harm reduction incorporates a spectrum of strategies from safer use, to managed use to abstinence to meet drug users "where they're at," addressing conditions of use along with the use itself. Because harm reduction demands that interventions and policies designed to serve drug users reflect specific individual and community needs, there is no universal definition of or formula for implementing harm reduction.⁵⁴

The Canadian Mental Health Association defines harm reduction as:

...an evidence-based, client-centered approach that seeks to reduce the health and social harms associated with addiction and substance use, without necessarily requiring people who use substances from abstaining or stopping. Included in the harm reduction approach to substance use is a series of programs, services and practices. Essential to a harm reduction approach is that it provides people who use substances a choice of how they will minimize harms through non-judgmental and non-coercive strategies in order to enhance skills and knowledge to live safer and healthier lives.⁵⁵

Therapeutic intervention for PWP could be seen to follow a harm reduction approach based on the aforementioned definitions. An evidence-based approach to reducing negative personal and social consequences (i.e., offending) potentially associated with pedophilia could assist in allowing individuals to augment their knowledge and skills in order to live a safer, and offense-free, lifestyle.

There is a general consensus among ethicists of the legitimacy of harm reduction or harm minimization strategies in the context of public health and public health crises. Secondary prevention programming has demonstrated effectiveness with a wide range of physical health issues, including coronary heart disease,⁵⁶ cardiovascular disease events,⁵⁷ and HIV⁵⁸ as well as mental health prevention programs for at-risk post-secondary students.⁵⁹ However, pedophilia is one of the most stigmatized mental health conditions.⁶⁰ Kelly Richards⁶¹ described how the public engages in "etiological othering," which allows the public's response to people who engage in CSA (as people who should be killed or excluded from society) seem plausible. This stigmatization may contribute to resistance in the development of prevention programs that seek to assist individuals prior to offending, and instead

has resulted in primarily CJS based interventions. De-stigmatizing PWP (while still denouncing CSA), among healthcare professionals in particular, can contribute to the prevention of child sexual abuse by increasing the numbers of providers willing to provide service to this population.⁶²

The principles-based approach to ethics, as detailed by Tom Beauchamp and James Childress, is comprised of four principles; autonomy, beneficence, nonmaleficence and justice.⁶³ We would advocate that in the case of seeking to support and care for nonjustice involved PWP, who are desirous of support and care in order to not become offenders, harm reduction itself could be a relevant principle. Such an approach aligns well with the four traditional principles. By taking a harm reduction approach, clinicians are promoting client autonomy and seeking to do good by preventing nonoffenders from becoming offenders with the goal of reducing the incidence of CSA. If successful, the benefits of such an approach extend to potential victims of CSA and to the society at large. Indeed, an argument can be made that in the face of evidence that shows the effectiveness of harm reduction strategies at-large, to not apply them in this instance would be ethically negligent. If we know we have the ability to reduce or prevent harm to clients, potential victims and society at large, how could we defend not acting to do so?

Sabine Muller, Henrik Walter and Markus Christen examined the issue of providing Deep Brain Stimulation (DBS) to patients with pedophilia and Parkinson's disease where some patients undergoing the procedure experience hypersexuality, hypomania, disinhibition and other symptoms that could, in some cases, lead to problematic sexual behaviors—which could include CSA. They applied a principles-based approach for considering the ethical appropriateness of providing DBS in light of the reality that it may result in personality changes that could lead to CSA. They concluded that with the right oversight and a robust and clinically driven risk-benefit analysis, the application of DBS to Parkinson's patients with pedophilia is ethically defensible.⁶⁴ We would argue that applying the same principles-based lens to the question of utilizing harm reduction strategies to PWP is equally defensible.

Clinical dilemmas can develop in the context of mandatory reporting environments. First, is the negative effect that mandatory reporting may have on PWP who have not offended and who actively desire to not become offenders. Mandatory reporting can be a significant barrier to accessing preventative (harm reduction) support. Under current legislation, if nonjustice involved PWP seek out help and support from clinicians they may risk being exposed to their family, friends, and employer, become involved in the child protective services system, and experience stigmatization both within and outside of the clinical environment. There is an understandable level of moral distress among clinicians who believe their primary obligation is to their client on the one hand, yet function in a mandatory reporting environment where they may need to make a mandatory report and thereby cause harm to that client. This moral distress can be exacerbated in the context of a clinical encounter with a PWP who is seeking support in order to control their behaviors and where the clinician may be required to report them and thus risk alienating the patient from the very support that is enabling them to control their inclinations. The very real ethical quandary then becomes: which is the greater harm, and how do clinicians strike an appropriate balance?

As Klaus Beier highlights, the ethical dilemma regarding mandatory reporting flows not from whether or not to engage in a report to child protective services

about one client and/or one child, but, “whether a society creates or obstructs circumstances, which allow a higher number of individuals to face their problem, granting professionals the opportunity of protecting a greater number of children.”⁶⁵

Conclusion and Recommendations

As we know, the impact of CSA is significant with considerable consequences for victims and offenders. To-date we have employed a host of interventions, through the CJS and/or therapeutically, to reduce the likelihood that someone apprehended for CSA goes on to reoffend and create additional victims. However, there are programs that exist to reach PWP prior to their involvement in the CJS, and, ideally, prior to a sexual offense. These programs exist in both mandatory and nonmandatory reporting environments. However, the scope of services, coupled with the willingness for PWP to access services, appears more significant in nonmandatory reporting environments. As can be seen from the number of contacts to already established prevention programs, there is a need, and demand, for service.

There are unintended, and significant, consequences of mandatory reporting that perhaps have not been fulsomely debated prior to the implementation of mandatory reporting requirements for healthcare professionals. This paper is not intended to discount the innumerable children who have been protected from sexual abuse, or other maltreatment, through a mandatory reporting framework. According to the World Health Organization (WHO), prevention of CSA requires a multisystem public health approach that allows for intervention on multiple levels. Much of the focus on CSA prevention (prior to an offense) has been directed toward children, the youngest and most vulnerable group, in an effort to build the skills necessary to resist abusive behavior. It stands to reason that the individuals who are most at risk for engaging in CSA, those with a sexual preference for prepubescent and/or pubescent children, be the recipients of targeted, funded, comprehensive, and confidential strategies to reduce the risk of CSA.

Available evidence indicates that harm reduction and secondary prevention strategies can be effective for a number of physical and mental health issues, as well as substance abuse. In light of this evidence, it is reasonable to expect that such approaches, when oriented toward nonoffending PWP, could be equally as effective. As such it is ethically justifiable, some might say ethically obligatory, to apply such strategies. In the face of evidence, and in an “evidence-based” clinical environment, to not apply these strategies and interventions to nonoffending PWP would be to abandon the principles of evidence based medicine. It would also call into question the motivations for not applying these strategies to this population.

There is a significant, and arguably urgent, need for more research and intervention for PWP who are not involved with the CJS. Awareness-building is required to educate the general public about the ability to prevent CSA through positive, proactive and therapeutic services for PWP. The stigma associated with pedophilia is a significant barrier that may inhibit help-seeking when it may be needed most. Policy makers, researchers, health professionals, and victim advocates will need to work together to explore the difficult questions related to the added barriers to help-seeking for PWP in a mandatory reporting environment.

Individuals with pedophilia and/or hebephilia are currently presenting to mental health professionals in need of, and requesting, therapeutic intervention. Ian McPhail,

Skye Stephens, and Ainslie Heasman⁶⁶ offer recommendations for working in a mandatory reporting context when providing treatment to PWP who are not involved with the CJS. While we do not advocate for a complete abandonment of mandatory reporting, benefits (and potentially a reduction in CSA) could be achieved through an evaluation of the ways in which mandatory reporting requirements for healthcare professionals could be modified to allow for greater ease of access to treatment for those at-risk of engaging in CSA.

Notes

1. World Health Organization. *Preventing Child Maltreatment: A Guide to Taking Action and Generating Evidence* [Internet]. Geneva: World Health Organization; 2006; available at http://apps.who.int/iris/bitstream/handle/10665/43499/9241594365_eng.pdf;jsessionid=55060734A3F698280E7A408E2596E7BE?sequence=1 (last accessed 22 Aug 2018).
2. Barth J, Bermetz L, Heim E, Trelle S, Tonia T. The current prevalence of child sexual abuse worldwide: A systematic review and meta-analysis. *International Journal of Public Health* 2012;58(3):469–83.
3. Fergusson D, McLeod G, Horwood L. Childhood sexual abuse and adult developmental outcomes: Findings from a 30-year longitudinal study in New Zealand. *Child Abuse & Neglect* 2013;37(9):664–74.
4. Turner S, Taillieu T, Cheung K, Afifi T. The relationship between childhood sexual abuse and mental health outcomes among males: Results from a nationally representative United States sample. *Child Abuse & Neglect* 2017;66:64–72.
5. Mai C, Subramanian R. Price of prisons 2015: Examining state spending trends, 2010-2015. [Internet]. New York: Vera Institute of Justice; 2017; available at https://storage.googleapis.com/vera-web-assets/downloads/Publications/price-of-prisons-2015-state-spending-trends/legacy_downloads/the-price-of-prisons-2015-state-spending-trends.pdf (last accessed 22 Aug 2018).
6. *California's Annual Cost to Incarcerate an Inmate in Prison* [Internet]. Legislative Analyst's Office. 2017 [cited 15 Aug 2018]; available at https://lao.ca.gov/policyareas/CJ/6_cj_inmatecost (last accessed 22 Aug 2018).
7. Letourneau E, Brown D, Fang X, Hassan A, Mercy J. The economic burden of child sexual abuse in the United States. *Child Abuse & Neglect* 2018;79:413–22.
8. See note 1, World Health Organization 2006.
9. Van Horn J, Eisenberg M, Nicholls C, Mulder J, Webster S, Paskell C et al. Stop It Now! A pilot study into the limits and benefits of a free helpline preventing child sexual abuse. *Journal of Child Sexual Abuse* 2015;24(8):853–872.
10. Nelson G, Laurendeau M, Chamberland C. A review of programs to promote family wellness and prevent the maltreatment of children. *Canadian Journal of Behavioural Science/Revue Canadienne des Sciences du Comportement* 2001;33(1):1–13.
11. Martin E, Silverstone P. An evidence-based education program for adults about child sexual abuse ("Prevent It!") that significantly improves attitudes, knowledge, and behavior. *Frontiers in Psychology* 2016;7.
12. Chen J, Dunne M, Han P. Prevention of child sexual abuse in China: Knowledge, attitudes, and communication practices of parents of elementary school children. *Child Abuse & Neglect* 2007;31(7):747–55.
13. Walsh K, Zwi K, Woolfenden S, Shlonsky A. *School-Based Education Programmes for the Prevention of Child Sexual Abuse*. Cochrane Database of Systematic Reviews. 2015;4.
14. Kemshall H, Wood J. Risk and public protection: Responding to involuntary and 'taboo' risk. *Social Policy & Administration* 2008;42(6):611–29.
15. Smart summary 2016. Global survey of sex offender registration and notification systems [Internet]. U.S. Department of Justice; 2018 [cited 16 Aug 2018]; available at <https://smart.gov/pdfs/global-survey-2016-final.pdf> (last accessed 22 Aug 2018).
16. Lasher M, McGrath R. The impact of community notification on sex offender reintegration. *International Journal of Offender Therapy and Comparative Criminology* 2010;56(1):6–28.
17. Nobles M, Levenson J, Youstin T. Effectiveness of residence restrictions in preventing sex offense recidivism. *Crime & Delinquency* 2012;58(4):491–513.
18. Blanchard R, Lykins A, Wherrett D, Kuban M, Cantor J, Blak T et al. Pedophilia, hebephilia, and the DSM-V. *Archives of Sexual Behavior* 2008;38(3):335–50.

19. *Diagnostic and Statistical Manual of Mental Disorders*. 5th ed. Washington, D.C.: American Psychiatric Association; 2013.
20. Grundmann D, Krupp J, Scherner G, Amelung T, Beier K. Stability of self-reported arousal to sexual fantasies involving children in a clinical sample of pedophiles and hebephiles. *Archives of Sexual Behavior* 2016;45(5):1153–62.
21. Levenson J, Willis G, Vicencio C. Obstacles to help-seeking for sexual offenders: Implications for prevention of sexual abuse. *Journal of Child Sexual Abuse* 2017;26(2):99–120.
22. Cantor J, Blanchard R, Christensen B, Dickey R, Klassen P, Beckstead A et al. Intelligence, memory, and handedness in pedophilia. *Neuropsychology* 2004;18(1):3–14.
23. Cantor J, Blanchard R. White matter volumes in pedophiles, hebephiles, and teleiophiles. *Archives of Sexual Behavior* 2012;41(4):749–52.
24. Poepl T, Nitschke J, Santtila P, Schecklmann M, Langguth B, Greenlee M et al. Association between brain structure and phenotypic characteristics in pedophilia. *Journal of Psychiatric Research* 2013; 47(5):678–85.
25. Fazio R, Lykins A, Cantor J. Elevated rates of atypical handedness in paedophilia: Theory and implications. *Laterality: Asymmetries of Body, Brain and Cognition* 2014;19(6):690–704.
26. Seto M. Pedophilia and sexual offenses against children. *Annual Review of Sex Research* 2018; 15(1):321–61.
27. Dombert B, Schmidt A, Banse R, Briken P, Hoyer J, Neutze J et al. How common is men's self-reported sexual interest in prepubescent children? *The Journal of Sex Research* 2015;53(2):214–23.
28. Joyal C, Cossette A, Lapierre V. What exactly is an unusual sexual fantasy? *The Journal of Sexual Medicine* 2015;12(2):328–40.
29. Mann R, Hanson R, Thornton D. Assessing risk for sexual recidivism: Some proposals on the nature of psychologically meaningful risk factors. *Sexual Abuse: A Journal of Research and Treatment* 2010;22(2):191–217.
30. Hanson R, Morton-Bourgon K. The characteristics of persistent sexual offenders: A meta-analysis of recidivism studies. *Journal of Consulting and Clinical Psychology* 2005;73(6):1154–63.
31. See note 9, Van Horn et al. 2015.
32. See note 21, Levenson et al. 2017.
33. Sexual Behaviours Clinic [Internet]. CAMH. 2018 [cited 16 Aug 2018]; available at <https://www.camh.ca/en/your-care/programs-and-services/sexual-behaviours-clinic> (last accessed 22 Aug 2018)
34. Beier K. Proactive strategies to prevent child sexual abuse and the use of child abuse images: The German Dunkelfeld-Project for Adults (PPD) and Juveniles (PPJ). In: Jeglic E, Calkins C, ed. *Sexual Violence: Evidence Based Policy and Treatment*. New York: Springer; 2016. p. 249–272.
35. More than 9,500 people asked for help [Internet]. Dont-offend.org. 2018 [cited 17 Aug 2018]; available at <https://www.dont-offend.org/story/more-than-9-500-people-asked-for-help.html> (last accessed 22 Aug 2018).
36. See note 9, Van Horn et al. 2015.
37. Beier K, Grundmann D, Kuhle L, Scherner G, Konrad A, Amelung T. The German Dunkelfeld Project: A pilot study to prevent child sexual abuse and the use of child abusive images. *The Journal of Sexual Medicine*. 2015;12(2):529–42.
38. See note 9, Van Horn et al. 2015.
39. See note 34, Beier 2016.
40. See note 34, Beier 2016.
41. Raz M. Unintended consequences of expanded mandatory reporting laws. *Pediatrics* 2017;139(4): e20163511.
42. Hendricks M. Mandatory reporting of child abuse in South Africa: Legislation explored. *South African Medical Journal* 2014;104(8):550.
43. McPhail I, Stephens S, Heasman A. Legal and ethical issues in treating clients with pedohebephilic interests. *Canadian Psychology/Psychologie canadienne* 2018;59(4):369–381.
44. Levi B, Crowell K. Child abuse experts disagree about the threshold for mandated reporting. *Clinical Pediatrics* 2010;50(4):321–29.
45. Lareau C. Attorney work product privilege trumps mandated child abuse reporting law: The case of Elijah W. v. Superior Court. *International Journal of Law and Psychiatry* 2015;42–3:43–8.
46. Ontario.ca. (2018). *Child, Youth and Family Services Act, 2017, S.O. 2017, c. 14, Sched. 1*; available at <https://www.ontario.ca/laws/statute/17c14#BK167> [last accessed 19 Aug. 2018].
47. *Smith v. Jones*, 1999, S.C.C. 455; available at <https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/1689/index.do> (last accessed 22 Aug 2018).

48. Lamond D. The impact of mandatory reporting legislation on reporting behavior. *Child Abuse & Neglect* 1989;13(4):471–80.
49. Mathews B, Lee X, Norman R. Impact of a new mandatory reporting law on reporting and identification of child sexual abuse: A seven year time trend analysis. *Child Abuse & Neglect* 2016;56:62–79.
50. McTavish J, Kimber M, Devries K, Colombini M, MacGregor J, Wathen C et al. Mandated reporters' experiences with reporting child maltreatment: a meta-synthesis of qualitative studies. *BMJ Open* 2017;7(10):e013942.
51. See note 43, McPhail et al. 2018.
52. Fischer B, Blanken P, Da Silveira D, Gallassi A, Goldner E, Rehm J et al. Effectiveness of secondary prevention and treatment interventions for crack-cocaine abuse: A comprehensive narrative overview of English-language studies. *International Journal of Drug Policy* 2015;26(4):352–63.
53. Kolodny A, Courtwright D, Hwang C, Kreiner P, Eadie J, Clark T et al. The prescription opioid and heroin crisis: A public health approach to an epidemic of addiction. *Annual Review of Public Health* 2015;36(1):559–74.
54. Principles of harm reduction–Harm Reduction Coalition [Internet]. Harmreduction.org. 2018 [cited 17 Aug 2018]; available at <http://harmreduction.org/about-us/principles-of-harm-reduction/> (last accessed 22 Aug 2018).
55. Harm reduction | CMHA Ontario [Internet]. Ontario.cmha.ca. 2018 [cited 17 Aug 2018]. available at <https://ontario.cmha.ca/harm-reduction/> (last accessed 22 Aug 2018).
56. Critchley J, Capewell S. Smoking cessation for the secondary prevention of coronary heart disease. *Cochrane Database of Systematic Reviews*; 2012.
57. Thompson A. Antihypertensive treatment and secondary prevention of cardiovascular disease events among persons without hypertension. *JAMA* 2011;305(9):913.
58. Kelly J, Kalichman S. Behavioral research in HIV/AIDS primary and secondary prevention: Recent advances and future directions. *Journal of Consulting and Clinical Psychology* 2002;70(3):626–39.
59. Conley C, Shapiro J, Kirsch A, Durlak J. A meta-analysis of indicated mental health prevention programs for at-risk higher education students. *Journal of Counseling Psychology* 2017;64(2):121–40.
60. Feldman D, Crandall C. Dimensions of mental illness stigma: What about mental illness causes social rejection? *Journal of Social and Clinical Psychology* 2007;26(2):137–54.
61. Richards K. Born this way? A qualitative examination of public perceptions of the causes of pedophilia and sexual offending against children. *Deviant Behavior* 2017;39(7):835–51.
62. Jahnke S, Philipp K, Hoyer J. Stigmatizing attitudes towards people with pedophilia and their malleability among psychotherapists in training. *Child Abuse & Neglect* 2015;40:93–102.
63. Beauchamp T, Childress J. *Principles of Biomedical Ethics*. 7th ed. New York: Oxford University Press; 2012.
64. Müller S, Walter H, Christen M. When benefitting a patient increases the risk for harm for third persons — The case of treating pedophilic Parkinsonian patients with deep brain stimulation. *International Journal of Law and Psychiatry* 2014;37(3):295–303.
65. See note 34, Beier 2016, at 258.
66. See note 43, McPhail et al. 2018, at 381.