Sexual Offences Against Children

Volume 2

Report of the Committee on Sexual Offences
Against Children and Youths

appointed by

The Minister of Justice and Attorney General of Canada
The Minister of National Health and Welfare

Canada

Available in Canada through

Authorized Bookstore Agents
and other bookstores

or by mail from

Canadian Government Publishing Centre
Supply and Services Canada
Ottawa, Canada K1A 0S9

Catalogue No. J2-50/1984E Canada: $40.00 (set)
ISBN 0-660-11639-1 (set) Other Countries: $48.00 (set)

Price subject to change without notice

reprinted 1986

Committee on Sexual Offences Against Children and Youths

August, 1984

The Honourable Donald J. Johnston
P.C., M.P.
Minister of Justice and
Attorney General of Canada

The Honourable Monique Bégin
P.C., M.P.,
Minister of National Health
and Welfare

Dear Mr. Johnston and Madame Bégin:

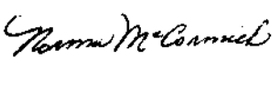
In accordance with the Terms of Reference assigned on February 16, 1981, we have inquired into and report upon the "prevalence in Canada of sexual offences against children and youths" and "the problems of juvenile prostitution and the exploitation of young persons for pornographic purposes".

In undertaking our mandate, we have received valuable assistance and support across Canada from all levels of government, the helping professions and many community and voluntary associations. Our findings show that vital changes must be made in order to afford Canadian children and youths better protection from all forms of child sexual abuse and exploitation.

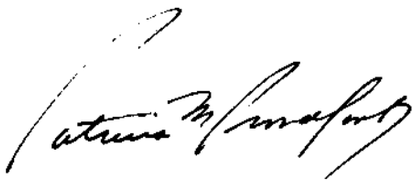
The actions we propose provide a rational and co-ordinated framework whose implementation would assure a level of protection that is essential for young persons to have against sexual offences. In recognition of the child's vulnerabilities and special needs, efforts to provide better assistance and protection for sexually abused children and youths must be assigned high priority by the Government of Canada. These activities must be undertaken on a co-operative basis with the provinces and non-governmental organizations, and must be strongly co-ordinated.

We respectfully submit our recommendations. We do so unanimously.

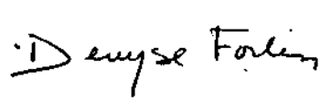
Herbert A. Allard



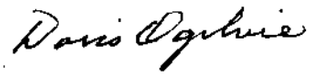
Norma McCormick



Patricia M. Proudfoot



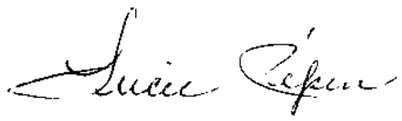
Denyse Fortin



Doris Ogilvie

Quentin Rae-Grant

Paul-Marcel Gélinas



Lucie Pépin

Sylvia Sutherland

Robin F. Badgley
Chairman

Table of Contents

Volume II

Volume I

Part VI

Health Services

Chapter 30

Research and Treatment Programs

In its Terms of Reference the Committee was asked to consider: "the elements of the offences"; means other than legal ones which are used "to protect children and youths from sexual abuse"; and the measures required to improve the protection afforded victims of these offences. Implicit in the Committee's mandate was a recognition of the fact that health services have an essential contribution to make in the treatment and protection of sexually abused children, a recognition acknowledged by the joint appointment of the Committee by the Department of Justice and the Department of National Health and Welfare and reflected in the Committee's interdisciplinary membership.

The information obtained by the Committee on sexually assaulted children who were injured and the medical care they received is presented in the chapters in this section of the Report. In this chapter, an overview is given of the issues identified by the Committee. This summary is followed by a synopsis of the Canadian medical research dealing with these matters and by a description of developments in the establishment and operation of specialized units for the identification and treatment of sexually abused children.

In the chapters that follow in this section, an analysis is given of: the findings of the National Hospital Survey (Chapter 31); the classification, for purposes of hospital and medical care statistics, of the diseases, injuries and conditions which were treated in relation to child sexual abuse (Chapter 32); the health risks associated with child sexual abuse in relation to live births, therapeutic abortions and the contracting of sexually transmitted diseases (Chapter 33;) a review of the genetic implications of incest (Chapter 34); and an overview of the practices of criminal injuries compensation boards (Chapter 35).

Sexual Abuse and Health-related Issues

A central concern of the Committee was the documentation of the nature and extent of the harms associated with the sexual abuse of children. The documentation of these injuries is a prerequisite to considering the nature and

gravity of the long-term harms experienced by these children, whether the medical care provided is adequate or might be improved, whether the harms incurred may constitute sufficient grounds to take custody of a child or serve as the basis for the laying of charges against an assailant by the police, and the nature, collection and preservation of evidence with respect to these injuries.

The classification of the elements of the sexual offences set out in the *Criminal Code* by the 1983 amendments which were proclaimed in January, 1983 underscores the need for having reasonably firm documentation of the nature and extent of injuries associated with sexual assaults. These amendments introduced the provision that made the causing of bodily harm an element of one form of the sexual assault offences; it also specified the wounding, maiming or disfiguring of a person by an assailant as elements of the offence of aggravated sexual assault. To the extent that the elements of these offences occur with respect to sexually assaulted children, their assailants may be charged. Conversely, to the extent that these elements are found not to occur, or in instances in which there is insufficient documentation of evidence, the more serious forms of the sexual assault offence will be inapplicable in the prosecution of these cases.

In its review of *Advisory Reports and Previous Research*, (Chapter 4), the Committee found that there was limited and largely inconclusive documentation concerning the injuries that were known to have resulted from incidents of sexual assault, whether the victims were children or adults. While in some reports dealing with these matters, it was concluded that a majority of sexually assaulted victims had been injured, in some instances seriously, the documentation upon which these observations were based either was fragmentary or was derived from the experience of a small number of victims who had been seen at a hospital clinic or a voluntary community referral agency. The assumption was made in some of these reports that the experiences of sexually assaulted children were similar to those of adult victims.

Little of the general community and social survey research for Canada available on these matters appears to have considered directly the extent and nature of the injuries sustained by sexually assaulted children. For these reasons, these sources cannot be drawn upon as a basis upon which to determine the extent of this problem, to assess the measures taken or those steps that might be effective in improving medical care, or to evaluate the potential utility of the provisions regarding injuries introduced by the 1983 amendments, as these pertain to sexually assaulted children.

In order to obtain documentation about the nature of the physical and emotional harms incurred by children who had been sexually assaulted, the Committee sought this information in each of its national surveys. Following a review of available medical research concerning the issues identified by the Committee, it undertook a separate study in which a number of major regional hospitals participated. These surveys, and in particular the National Hospital Survey, not only assembled extensive findings on injuries associated with sexual assaults, but also served as the basis for a review of the health services provided

for these children, of the extent to which other services were notified of these cases, and of ways in which medical services might be improved to afford better protection.

As the Committee undertook its review of sexually assaulted children who had been injured and of the medical services provided for them, it learned that in some quarters there were mixed reactions about the provision of existing health services. In some instances, sharp criticism was levelled at the medical profession and hospitals for their alleged indifference to these problems and the insensitive care that they provided for patients who had been sexually assaulted. At meetings which the Committee held with some non-medical child care specialists, it was reported: that some hospitals routinely turned away or gave a "brush off" to these patients; that the hospitals did not have adequate facilities; that their personnel were often inexperienced or poorly trained to deal with these problems; and that, of the sexually abused children who had been treated, few of these cases were reported to child protection services and the police. While such allegations were often voiced, they were seldom supported by reasonable evidence to document their validity. While the Committee neither accepts nor rejects these premises, in order to fulfill its Terms of Reference, it deemed it essential to obtain information on these issues, and in particular, on the medical assessment of injuries sustained by patients in incidents of child sexual abuse, and on the procedures taken in providing care for these children.

Counterbalancing the criticism directed at the provision of medical care for sexually assaulted patients, the Committee also learned of the operation of a number of specialized units across Canada which were seeking to provide exemplary and comprehensive care for sexually abused children. Several of these programs had evolved out of special units for physical child abuse established in the late 1960s and early 1970s. These programs were initially set up as a result of the growing recognition of the problem of physical child abuse, of which sexual abuse was known to be a component, but one that in relative terms, had received comparatively little medical attention. The available statistics on cases of child sexual abuse treated at some of these programs during this early period ranged between 7.7 and 13.6 per cent of the caseloads of child physical abuse.

Towards the end of the 1970s, there was a sharp increase in the number of sexually abused children referred for medical assessment and treatment. In several hospitals across Canada, either sub-units specializing in child sexual abuse evolved out of established programs for physical child abuse, or new, autonomous units for this purpose were created. In some instances, these services operated under the aegis of a hospital or a community-based co-ordinating committee having an interdisciplinary membership.

When the Committee undertook its review, apart from a number of in-house reports describing the work of these special hospital units, there was no listing or comprehensive review of the objectives of these programs, of the types

of services routinely provided, and of the experience of sexually abused children who had been assessed and treated. In the *1978 Child Abuse Study* sponsored by the Department of National Health and Welfare, a description was given of eight hospital-based child abuse and/or protection programs, but no information was provided about the procedures followed with respect to sexually abused children.[1] With the co-operation of a number of major hospitals across the country, the Committee assembled a profile of the services being provided for sexually abused children. A summary of the operation of some of these programs is given later in this chapter.

With respect to its mandate, the Committee identified four additional medical issues warranting special consideration. These concerns were with: the means used to classify sexual assaults and related injuries for purposes of hospital and medical care statistics; the extent to which children who had been sexually assaulted had become pregnant, had had a therapeutic abortion, or contracted a sexually transmitted disease; the genetic implications of incest for offspring of such unions; and the provision of compensation for sexually assaulted young persons.

In relation to the diagnostic identification of sexual assaults of children, the statistical system developed for the classification of diseases, injuries and causes of death that is used widely across Canada adheres to the concept of illness as pertaining to the individual. Thus, it permits the identification of only a limited number of the sexual acts that may be committed against a person (child or adult). This classification system, for instance, identifies the sexual deviation of *exhibitionism*, but not acts between individuals such as incest or sexual assault. The Committee's review of the system of disease classification, given in Chapter 32, was undertaken to assess how the diagnoses of sexually assaulted children were being classified and to determine the effectiveness of this system as a means of identifying these conditions.

The Committee reviewed national statistics in relation to child births and therapeutic abortions involving young girls. The Committee also considered the issue of sexually transmitted diseases that may have been contracted by children as a result of sexual assaults. Because of the stigma associated with venereal disease, it is generally believed that, despite regulations requiring the reporting of these diseases, few of these cases are brought to the attention of notifiable disease control programs. In the research on child sexual abuse, it appears that only a handful of studies has dealt with the associated risk of a child contracting a venereal disease. It is generally believed that few such cases occur.

An alternative approach is to consider cases of sexually transmitted diseases in which children have been treated for this condition, regardless of whether they may have been otherwise sexually assaulted. In this respect, the Committee was fortunate to be able to work in co-operation with a provincial communicable disease control program. Drawing upon its records of notified cases of sexually transmitted disease, the Committee reviewed the experience

of several hundred children who had contracted these conditions. The results of this review are given in Chapter 33.

With respect to the genetic implications of incest, it has been concluded in some quarters that since these risks are believed to be minimal or do not exist, there is no justification on these grounds for the retention of a special provision dealing with this offence in the *Criminal Code*. A number of research studies involving the discipline of genetics have dealt with these issues and a few reports have documented results in relation to children who were born as a result of incest. The Committee undertook a review to clarify this issue, with the findings given in Chapter 34.

In virtually all jurisdictions, an administrative board has been established whose function is to provide compensation to the innocent victims of crime. In recent years, a small but growing proportion of these awards has been made to the victims of sexual assault, including those who were children and youths. The practices of these boards and case studies of young victims are reviewed in Chapter 35, *Criminal Injuries Compensation Boards*.

Medical Research

In its review of medical research on child sexual abuse in Canada, the Committee identified five types of reports. These studies included:

1. *General Reviews*. These reports provided an overview of the general research literature. Their focus is variously on the etiology, classification and discussion of treatment procedures.

2. *Physical Child Abuse*. Several Canadian clinical research reports have documented the experience of physically abused children, of whom some were sexually abused children.

3. *Child Sexual Abuse*. The mounting of studies on this problem gained momentum during the 1970s; research along these lines had been undertaken at about half a dozen medical centres across Canada. The most extensive longitudinal studies on child sexual abuse for Canada have been carried out at the Centre Hospitalier Saint-Justine in Montreal.

4. *Incest*. The initial reports on incest involved the presentation of case reports on victims and/or offenders. In recent years, the experience of small groups of patients has been documented, most notably, at the Forensic Psychiatry Clinic of McGill University. A majority of the cases of incest reported in clinical research had been referred to psychiatric services by the police or remanded for assessment by the courts.

5. *Pedophilia and Exhibitionism*. Extensive research was undertaken on a small number of pedophiles and exhibitionists with the information on these sexual offenders having been obtained from police records or assessments of these patients made at forensic psychiatric clinics. The most complete reports have come from the Toronto Psychiatric Clinic (more recently retitled, the Metropolitan Toronto Forensic Service [Metfors]).

The findings of the fourth and fifth categories of clinical medical research are considered elsewhere in the Report. In the instance of the clinical results on incest, no information was available on the findings for patients in relation to their physical examinations and their physical injuries. Most of the studies on incest have dealt with the experience of suspected offenders and these reports have not provided a detailed description of the young victims of this offence. This approach also characterizes the research on pedophilia and exhibitionism in which the focus of attention has primarily been on providing an assessment of assailants. The limited information given about victims of these offences in these research studies is typically gleaned from reports about them provided by their suspected offenders.

In the following parts of this chapter, the conclusions and findings of the first three categories of clinical reports are summarized in relation to: the procedures followed in the identification and treatment of sexually abused children; the listing of findings based on the medical histories and physical examination of these patients; and information on the clinical assessment of the injuries which sexually abused children may have suffered in relation to these incidents.

General Medical Reviews

Canadian medical reports on physical child abuse which began appearing in the 1970s provided an overview of these problems and in a few instances the results of clinical research describing the experience of young children who had been treated. The Canadian reports in the former category acknowledged the work of Henry Kempe of Colorado, whose findings served as a catalyst in initiating the establishment of several comparable programs in this country.

In his research on the *Battered-Child Syndrome*, Kempe gave findings on 302 cases from a national survey of 71 hospitals across the United States. This 1961 survey found that 33 of the children had died and 85 had suffered permanent brain damage. Legal action had been taken in about a third of the cases for which a "proper medical diagnosis" had been given. For a majority of these cases, it was reported that charges had not been laid because there was insufficient evidence; the requisite medical examination procedures had not been performed; the injuries sustained by patients were deemed to be minor; or attending physicians were reluctant to initiate legal action. In commenting on these findings, Kempe noted:

> "... physicians have great difficulty both in believing that parents could have attacked their children and in undertaking the essential questioning of parents on this subject. Many physicians find it hard to believe that such an attack could have occurred and they attempt to obliterate such suspicions from their minds, even in the face of obvious circumstantial evidence. The reason for this is not clearly understood. One possibility is that the arousal of the physician's antipathy in response to such situations is so great that it is easier for the physicians to deny the possibility of such an attack than to have to deal with the excessive anger which surges up in him when he realizes the

truth of the situation. Furthermore, the physician's training and personality usually make it quite difficult for him to assume the role of a policeman or district attorney and start questioning patients as if he were investigating a crime."[2]

Drawing heavily on the reports by Kempe, Gil and other researchers who had studied these problems in the United Kingdom and the United States, a number of Canadian general review articles were written during the 1970s by physicians who identified issues and programs related to child abuse. The major themes dealt with in these review papers included:

1. *Physical Child Abuse.* All of these reports focussed on physical child abuse. The sexual abuse of children either was not dealt with or was listed only in passing as a component of physical abuse.

2. *Inadequate Statistical Information.* Most of the reports recognized that there was insufficient information on child abuse for Canada. Bell, for instance, noted in 1973 that "available statistics on child abuse in Canada are unreliable, and the true incidence is difficult to establish."[3] In the absence of reliable information for this country, there was a tendency in these reports to transpose the results of studies done elsewhere as though they were applicable to the Canadian situation.

3. *Need for More Comprehensive Reporting.* Several reports called for the establishment of more effective reporting systems in order to facilitate the more complete identification of child abuse and to serve as a basis for planning more effective treatment programs.

4. *Optional versus Mandatory Reporting of Cases.* The prevailing assumption in the reports was the belief that the ethical physician should exercise his or her discretion as to whether cases should or should not be reported to the authorities. Opinions on this issue were divided. Boone, for instance, recommended in 1970 that "where an accusation of battering has been made, this is a legal problem and must be reported immediately to the police."[4] This perspective was endorsed in 1976 by Segal who observed that "in the best interests of the child, he (the physician) is justified by law to make the report. He is protected by any loss or damage as a reprisal against making such a report, or giving evidence in courts."[5] In contrast, Jacobs noted in 1978 that "my own view is that mandatory reporting on general lines will achieve little, since it will be too difficult and costly to effect".[6]

5. *Patient History Protocols.* Several reports outlined the types of information which should routinely be obtained or considered by the attending physician during an examination of a child who was known or suspected to have been physically abused.

6. *Health Team Approach.* All of the general reviews focussing on the issue of child physical abuse advocated that a team approach be adopted in the management of physically abused children. Typically, the composition of the team envisaged included: paediatricians and/or psychiatrists, nurses, social workers and a number of other health workers. Both Segal and Carter reported that by the mid-1970s, a number of hospital-based child abuse teams had been established across Canada.

> Noting the different membership of these teams, Segal observed that "the success of a child abuse team rests not so much on its organization as upon the talents of specific individuals."[7] Notably absent from the composition of the recommended child abuse teams which were advocated in these reports was participation by: community child protection workers, the police, Crown attorneys or community volunteers. In a number of hospitals across Canada, child abuse teams had already included representatives from these disciplines or agencies. On the omission of other workers in the membership of these hospital teams, Segal noted that "many members of the medical profession have been unaware of the specialized and other community resources available to them and this may have contributed to . . . a tendency to attempt management that could well have been handled by non-medical professionals."[8]

On the basis of the Committee's review, it is evident that significant changes had occurred between the date of publication of these reports and the beginning of this decade when facilities for providing special services for sexually abused children began to be established. Unlike the units from which several of these new programs had evolved, the membership of these teams has been broadened to include a number of other disciplines involved in the protection of children. These changes constituted a gradual shifting away from a "medical model" and the gradual adoption of a philosophy of shared interdisciplinary management of these cases.

The general reviews on child abuse in Canada highlight a number of concerns expressed by senior clinicians which as yet have not been resolved. On the basis of the Committee's review, it is concluded that the classification system for diseases and/or conditions precludes the identification for statistical purposes of many conditions involving child sexual abuse. It is also evident from the Committee's research findings and discussions with physicians that medical opinion is still strongly divided on the matter of the optional or mandatory reporting of known or suspected cases of sexual abuse to the authorities. In the course of its visits to different hospitals across Canada, the Committee found that on occasion there was little knowledge of the work of comparable programs elsewhere in the nation. There was often a better knowledge of special clinical programs in the United States, United Kingdom or France than of the operation of a number of well established Canadian specialty units.

Clinical Research Studies

In its search for Canadian clinical research on child sexual abuse, the Committee undertook a review spanning three decades prior to July, 1983 of indexed inventories of medical research. In addition, the Board of the Canadian Paediatric Society approved the publication of a notice in its *Bulletin* that requested reports of studies on these issues and copies of medical protocols being used in the assessment of sexually abused children. The research studies identified by these means paralleled the shifting sequence in the focus of scholarly attention that was noted in the general clinical reviews for the field. Several of the initial studies focussed on physical child abuse. Towards the end of the 1970s, reports of research on child sexual abuse began to appear in

professional journals. Because of their relevance to the issues being considered by the Committee, some of the principal findings of these clinical studies are presented.

1957-1971 Winnipeg Child Abuse Study

The experience of 132 children who had been physically abused and who had been treated at the Children's Hospital of Winnipeg between 1957 and 1971 was documented in this report, the first of its kind in Canada.[9] The study documented the physical and emotional injuries of these children, 34 of whom were followed up and medically re-examined. Less than half of the group of patients who were reassessed two years following their initial admission to hospital were considered to have developed normally. The remainder were found to be retarded, emotionally disturbed or showed evidence of having suffered brain damage.

This detailed review of physical child abuse provided no separate listing of the children in this group who may have been sexually abused. One child was reported to have had a torn rectum but the cause of this injury was not identified.

Like Kempe's study undertaken in the United States, this baseline Canadian report outlined steps for the improvement of the clinical management of these cases. The researchers recommended that their care be provided by "experienced medical and social work personnel"; that there was a "necessity of letting the medical facts speak for themselves"; and that there should be "follow-up surveillance of these families."[10]

1965-1967 Edmonton Rape Study

Based on referrals from the Edmonton Police Force, 100 sexually assaulted females were medically examined between July, 1965 and January, 1967.[11] Of this number, 38 were girls who were age 15 or younger. The study found that "child molestations are more common in the summer months." The injuries of the patients were not reported separately for children. For all patients, it was reported that five had suffered bruised extremities, four had contusions and 14 had lacerated hymens.

The study did not state how many of the females who had been sexually assaulted had not been physically injured. Based on the findings presented, and assuming that no patient had received multiple injuries, then slightly over three in four females (77 per cent) were reported not to have been physically injured.

1966-1970 Nova Scotia Child Abuse Study

The results of this extensive interdisciplinary study of child abuse are cited elsewhere in the Report.[12] Of the 59 cases of child abuse which were identified over a five year period, one involved a child who had been sexually abused. No specific information was given about this child.

1972-1976 Toronto Child Sexual Abuse Study

On the basis of the cases of child sexual abuse treated at the Hospital for Sick Children from 1972 to 1976, 50 were selected for an indepth analysis involving 99 variables.[13] The principal findings of this extensive report were:

- *Age and Sex.* Of the 50 children, 42 were girls and eight were boys. The average age of the children was 8.1 years.
- *Number of Assaults and Time Taken to Report.* Of the 23 children who had been assaulted once, the average time taken to report the incident was about half a day while for the 27 children who had been victimized more than once, the average time elapsed was over three months.
- *Identity of Suspect.* About one in four (25.5 per cent) suspects was a family member or a relative, 41.8 per cent were friends or acquaintances and 32.7 per cent were strangers.
- *Consent and Coercion.* About one in four (26 per cent) children was reported to have consented to the assault and the same proportion had actively resisted their assailants.
- *Child's Awareness of Act.* Half of the children (52 per cent) were judged to have known the meaning of what had happened to them, 42 per cent were reported not to have been aware that "something bad" was being done to them, and no information on this point was available for the remainder of the children.
- *Physical Injuries.* Only reported physical injuries to the child were recorded in this study. No information was given about the nature of these harms. Based on the information listed in hospital charts, 48 per cent of the children had been injured, an equal proportion had not been hurt, and no information was given for the remainder of the cases. Of the children who had been assaulted by strangers, one in four (27.8 per cent) had been injured, while of those who knew their assailants, half (51.4 per cent) had been physically hurt in some way.
- *Referrals Between Agencies.* Over half of the patients (54 per cent) were known to have been in contact with child protection services before they had attended the hospital. Following their medical assessment and treatment, 11 patients were referred to a child protection service, 27 were medically referred and 10 children had not been referred to other services.

  The report noted: "With respect to the Children's Aid Societies' referrals, again it is astonishing that there were only 11 referrals. It is the policy of the Hospital for Sick Children to "automatically" refer all alleged sexual assault cases to the appropriate Children's Aid Society. The records at the Hospital do not indicate why adherence to this policy is not being maintained".[14]

- *Liaison with Police.* Almost nine in 10 (88 per cent) of the children were brought to the hospital for assessment by the police. No information was given of the proportion of cases in which charges were laid. In 10 instances, the assailants were known to have been prosecuted, and of these, seven were convicted.

- *Laboratory Procedures.* On an average, 2.3 laboratory procedures were ordered on behalf of each patient. The number of these tests varied in relation to whether the suspected offenders were family members (1.7) or strangers (2.3).

1976-1979 Ottawa Child Sexual Abuse Study

Sexually abused patients who were referred to the gynaecological outpatient service of the Children's Hospital of Eastern Ontario (Ottawa) were assessed and treated by a team comprised of a gynaecologist, a nurse and a social worker.[15] Over a period of about two and a half years, 31 sexually abused children were seen at this service.

- *Age.* Of the 31 children, 12 were 12 years or younger and 19 were between 13 and 17 years-old. The sex of the children was not reported.

- *Involvement with Helping Services.* Slightly less than half (45 per cent) of the children had had prior contact with child protection and/or psychiatric services.

- *Social Difficulties.* Prior to attending the clinic, there had been an earlier identification of social difficulties for 47 per cent of the children and 75 per cent of the adolescents.

- *Identity of Suspect.* In 84 per cent of the cases, the identity of the suspect was known (family, 36 per cent; neighbours, 32 per cent; and peers, 16 per cent).

- *Use of Force.* Force was reported to have been used against 8 per cent of the children and 37 per cent of the adolescents.

- *Follow-up of Patients.* About half (47 per cent) of the adolescents, but only 8 per cent of the children were followed up by the clinic for a period of a year or longer.

- *Notification of Authorities.* It was reported that "the police were contacted in the majority of the cases" and "court involvement proceeded with 35 per cent of the population." Referrals to child protection services were not reported.

This report on the experience of sexually abused children did not specify their gender, no information was given on the findings of their medical examinations and no findings were reported on the injuries which they may have sustained as a result of having been sexually assaulted.

1977-Ongoing, Montreal Child Sexual Abuse Study

The most extensive clinical research on child sexual abuse for Canada has been undertaken at the Centre Hospitalier Sainte-Justine.[16] The initial report on this research which was started in 1977 reviewed the experience of 125 sexually abused children. The scope of the study was subsequently extended to include the documentation of the experience of 407 young patients who had been seen by the end of 1981. A component of this research has been the follow-up of 107 children and their families 13 months after the offence had initially been reported to the Hospital.

In 1977, a protocol was developed for taking medical histories from sexually abused patients. At this Centre Hospitalier, most of these patients were seen on an outpatient basis. The findings of the initial study of the experience of 125 children included:

- *Age and Sex.* Most of these patients were females (119 girls, six boys); 56 of the children were age 11 or younger, and 69 were between 12 and 17 years-old.
- *Sexual Acts.* Of the 56 children, 80.4 per cent had had their genitals touched and 10.7 per cent had been a victim of sexual intercourse, while for the 69 adolescents, the proportions for these acts were 31.9 and 44.9 per cent respectively.
- *Identity of Suspect.* The suspect was not known in relation to 39 per cent of the children and 46 per cent of the adolescents. Of the 64 suspects who could be identified, 36 were age 20 or younger.
- *Time Taken to Obtain Medical Assistance.* About seven in 10 of the patients were seen at the hospital within 48 hours after they had been sexually assaulted.
- *Injuries.* Of the 125 patients, only one was reported to have required surgery, and for 50 patients for whom laboratory tests were obtained, positive spermatozoid results were found for 21, three of whom had contracted a sexually transmitted disease.

The preliminary findings of the follow-up study of 107 patients which were reported to the Committee indicated that about half of the teenagers had discontinued seeing their boyfriends and a number had transferred to other schools.[17] About one in four (26 per cent) was still found to be afraid and about one in three (29 per cent) was highly emotional about a year after the assaults had occurred. Most of the children had sought to resume their usual activities, but in this respect, some of them were thwarted by the reactions of their families. About one in five of the parents of these children was still angry (21 per cent) at what had happened or tended to blame the victim (18 per cent). About a third of the parents (30 per cent) refused to discuss the incidents with their children and they reacted as though nothing had happened to them.

In the context of comparable clinical research on child sexual abuse, the longitudinal study undertaken at the Centre Hospitalier Sainte-Justine is unusual with respect to: its size; the amount of the information obtained; the

length of the review carried out over a period of several years; and the follow-up of patients in order to document the long-term effects of sexual assaults against young victims.

1977-1978 Toronto Child Sexual Abuse Study

Drawing on records of the Emergency Department of the Hospital for Sick Children, a total of 843 cases of child sexual abuse was identified for the years 1962, 1967 and 1970-78.[18] An average of about 76.6 cases was reported per annum with the largest number of cases having been seen in 1970 (95), 1971 (97) and 1978 (96). A more detailed review was undertaken of 175 hospital charts for 1977-78, for which sufficient information was obtained for 164 cases. The 1972-76 study of child sexual abuse undertaken in this hospital was not referred to in this review. Consequently, there was no comparison of the results of the two inquiries based in the same hospital.

- *Age and Sex.* Of the sexually abused patients who were seen between 1977-78, 89.4 per cent were girls and 10.6 per cent were boys. The average age of the children was 9.8 years.
- *Identity of Suspects.* In two of three cases, the children knew their assailants (close relatives, 27.6 per cent; friends, acquaintances, 38.5 per cent).
- *Mentally Retarded Victims.* Seven of the children (4.0 per cent) "were diagnosed previously as mentally retarded . . . with a mean age of 14.3 years. All, but one, were girls. The assailant was unknown in three cases, an acquaintance in three other cases and a relative in one case."[19]
- *Physical Injuries.* The 1972-1976 study undertaken in the Hospital for Sick Children reported that 48 per cent of the sexually assaulted children had been physically injured. In contrast, the 1977-78 study at this hospital concluded that "physical injury is involved in a relatively small proportion of alleged sexual assault cases seen by physicians . . . in our study, the incidence was 14 of 174, or 8 per cent."[20] No listing of the nature of these injuries was given.
- *Previous Contact with Hospital.* Of the 114 children who had been sexually assaulted by persons whom they knew, about half (52.6 per cent) had previously been treated at the hospital for unrelated conditions. However, in one in seven of these cases, information in the patient's charts indicated that medical personnel had previously suspected that a child had been sexually abused.
- *Referral to Child Protection Service.* Of the 164 children for whom this information was noted, referrals were made to child protection services in about one in four cases (28.0 per cent). The proportion of such referrals was: incest (57.4 per cent); patients who knew their assailants (17.9 per cent); and children who did not know their assailants (14.0 per cent).
- *Notification of Police.* Of the charts in which this information was noted, the police had been notified in about four in five cases (78.6 per cent). Charges were laid in about a third (36.9 per cent) of the cases in which the assailants were known and in one in nine cases (11.1 per cent) in which strangers had sexually assaulted a child.

1980 St. John's Child Abuse Study

The Child Protection Team of the Janeway Child Health Centre (St. John's) was initially established in 1974 to review cases of suspected abuse admitted to the hospital. The work of this team, which was comprised of two physicians, the Director of Ambulatory Services, a social worker and a representative of the provincial Department of Social Services, was subsequently extended to include external referrals. A review was undertaken of 78 child abuse victims seen by the team during six months in 1980.[21]

"The team dealt with six cases of sexual abuse—four were girls and two were brothers. Five of the six were over ten years of age and the sixth was eight years-old, and thus were able to tell someone that they were being abused."[22] No separate analysis was given of these six patients. The report noted that while "all but one child had a complete physical examination," "when information in the chart concerning the injury was reviewed, it was found, in most cases, to be poorly documented. Such documentation should contain sufficient information to indicate if abuse was considered, and if it was ruled out by the attending physicians . . . the chart is not useful as a document in court to support a charge of child neglect, unless it is complete."[23]

Of the physically abused children who were seen at this hospital during six months, "in 56 of the cases, recommendations were made, but these were reviewed at a subsequent meeting for only 37 cases."[24]

Clinical Research on Injured Sexually Abused Children

The review of Canadian clinical research reporting findings on child abuse between 1957 and 1980 shows that towards the end of the 1970s, there was a growing medical concern about the documentation of child sexual abuse. What is common to these medical reports, with the exception of the 1966-70 Nova Scotia study, is that the research focussed on the experience of small groups of patients examined and treated at hospitals. In this respect, these findings cannot be generalized to encompass the experience of all medically examined young victims of sexual assaults. The findings of the National Population Survey indicate that when sexually assaulted children seek medical attention, a substantial proportion of this care is provided by family doctors in community practice.

The central focus in these reports was to provide a social description of the sexually abused child. Less attention was paid to reporting: the findings of the medical histories of these patients; the results of the procedures undertaken; the clinical management of the children; and a listing of their physical and emotional injuries. Accordingly, the presentation of findings in these reports precludes: a consideration of the effects of the sexual assaults on very young children; an analysis by the sex of the victims of these experiences; and a relevant review of the legal implications of the findings. None of the reports, for

instance, provided a detailed listing by the age and sex of the children in relation to: the acts committed; how the children were injured and the medical procedures undertaken. The classification of the types of sexual acts committed and the type of association between the victims and suspected offenders was typically listed in general, and non-replicable, terms. The definition of incest, for instance, was variously broadened to include all types of sexual acts committed; these acts were listed in relation to broad and vaguely defined groupings of family members and relatives. As a result, it is not possible drawing on the findings of these reports to determine how many incest cases were examined, who the suspected offenders were and the specific nature of the harms the victims may have experienced.

Like the research on the extent of sexual offences occurring in the population undertaken by non-medical disciplines (see Chapter 4), this body of clinical research on child sexual abuse is professionally insular. None of these reports cited any of the available Canadian social surveys on the occurrence of sexual offences. There was also virtually no cross-referencing between the results obtained in these studies and those reported in other Canadian clinical studies dealing with these problems.

In reviewing this research, the Committee sought to learn what was known with respect to: the medical assessment of injuries sustained by sexually abused children; the clinical assessment of the short and long-term consequences for the child of these assaults; and the procedures undertaken in the assessment and treatment of sexually abused patients.

The review of the main published reports on physical and sexual child abuse for Canada identified 426 medically examined children who had been sexually assaulted (Table 30.1). In five of the clinical research reports, primarily those focussing on physical child abuse, either no information was given separately about cases of child sexual abuse or the findings were aggregated for the victims of all categories of child abuse (battered child syndrome, physical and emotional abuse, maltreated child, neglect and sexual abuse). In the three remaining clinical research reports, findings were given for 349 sexually abused children, of whom 42 (12.0 per cent) were diagnosed as having been physically injured.

In two of the three research reports in which findings were reported on the physical injuries sustained by sexually abused children, no description was given of these injuries which may have ranged from minor scratches and bruises to more serious conditions. The Committee learned from the researchers who had conducted one of these studies that the reason why more specific information on physical injuries had not been reported was that this information was found to have been incompletely listed in the patients' hospital charts. **A detailed listing of the injuries sustained by sexually abused children was given in only one report which gave details of injuries for four young patients. In relation to published medical reports dealing with injuries sustained by sexually assaulted children and youths, these sources do not comprise a sufficient**

Table 30.1

Physical Injuries of Sexually Abused Children Reported in Canadian Clinical Medical Research Studies

Research Report	Group Studied	Number of Sexually Abused Children (n = 426)	Physical Injuries Associated with Sexual Assault[1]
Winnipeg (1957-1971)	physically abused children (132)	1	possible indication of sexual assault for one child, but not so identified
Edmonton (1965-1967)	rape victims (100)	38	no separate analysis for experience of 23 children
Nova Scotia (1966-1970)	physically abused children (59)	1	no injuries reported
Toronto (1972-1976)	child sexual abuse (50)	50	no findings given of types of injuries to 24 children
Ottawa (1976-1979)	child sexual abuse (31)	31	no findings reported
Montreal (1977-ongoing)	child sexual abuse (125)	125	specific types of injuries listed for 4 children
Toronto (1977-1978)	child sexual abuse (174)	174	no findings given of types of injuries to 14 children
St. John's (1980)	abused/neglected children (78)	6	no separate analysis given for 6 patients

[1] Findings on Injuries:

(1) Total suspected, indicated cases	66
(2) Total confirmed cases	42
(3) Total confirmed cases providing information on specific injuries	4

basis upon which to assess the nature and extent of the physical and emotional harms experienced by these young victims.

The findings of clinical medical research reports on child sexual abuse suggest that, of the young patients who had been medically examined, seven in eight had not been physically injured. To the extent that this observation is valid, it is apparent that the provision relating to inflicting bodily harm specified in two of the forms of the sexual assault offence introduced by the 1983

amendments to the *Criminal Code* would have been inapplicable in most of these cases as a legal basis for the prosecution of suspected assailants. While one in eight of the clinically assessed victims of sexual assault was reported to have been injured, even this information was incomplete. For the majority of these cases, no information was given specifying in detail the nature of these physical injuries.

*In only two of the research reports, those undertaken at the Centre Hos*pitalier Saint-Justine and the 1972-76 study at the Hospital for Sick Children, were results given about the length of time that elapsed between the sexual assault of a child and the provision of medical care. The findings of these studies suggest, but do not confirm, that the length of the interval taken to seek medical attention may have affected whether there was a clinical identification of injuries associated with sexual assaults. The inference which can be drawn from these studies is that the longer this interval is, the greater likelihood there is that the minor injuries incurred (e.g., scratches, bruises or inflamed genitalia) may have healed before the examination occurred. Therefore, where long delays occur in seeking medical care, a record of such injuries either may be unknown or omitted from the results of the medical examinations of these young patients. These trends are only partially documented in the clinical research reports. In no instance were the results of the examinations considered in relation to the types of sexual acts committed against children.

The results of the clinical research reports contain little information about how many of these sexually assaulted young patients were routinely examined in relation to whether they may have contracted a sexually transmitted disease. In the absence of sufficient statistical documentation of the clinical findings for children who have been subjected to unwanted intercourse, it has on occasion been assumed that the risk of their contracting a venereal disease either does not occur or is minimal. With the exception of one clinical research report, this body of research does not address this issue.

None of the published medical research reports considered in this review provided an assessment of the emotional and behavioural harms experienced by these sexually abused patients. An anomaly which emerges in the clinical research on child sexual abuse is that, while the most extensive documentation of how children may have been harmed is reported in the studies on incest, the documentation of injuries in these sources is given in relation to emotional and behavioural consequences. No findings are given in the research studies on incest about how children may hae been physically injured. The prevalent assumption in the reports on incest is that young incest victims are seldom, if ever, physically injured. This assumption appears to have been reached without benefit of confirmation in the form of the published results of physical examinations undertaken by physicians.

The Committee acknowledges that the clinical research studies contain relevant information about certain dimensions of child sexual abuse. These sources, however, provide insufficient documentation upon which valid conclusions can be reached about: how many sexually assaulted children are treated

by physicians; the usual types of clinical services provided for them; how they may have been injured; or the types of medical and social services required to provide these patients with more effective protection.

Hospital Child Sexual Abuse Programs

Clinical programs for physical child abuse were initially started at a small number of Canadian hospitals during the 1960s. By the end of the 1970s, it was estimated that about two dozen hospitals across the country had established similar units. The commonly-held objectives of these programs were: to foster the earlier identification of these problems; to develop services requisite for their assessment and treatment; and to establish a multidisciplinary approach for the care and follow-up of these young patients. At several hospitals across Canada, an informal liaison initially evolved between hospital staff and members of community agencies. As the number of physically abused children who were identified grew, these informal arrangements were gradually replaced by the appointment of co-ordinating committees and the designation of special clinical teams.

Most of these special hospital programs were initially designed to serve the needs of all types of abused and neglected children. This approach to the organization of clinical services is still followed in many hospitals. In all of the initially established programs, child sexual abuse was recognized as an important problem, but one that, because of the small number of cases seen, did not warrant the separate development of special services or units. This situation changed first in a number of major tertiary hospitals which, in response to a heavier caseload of sexually abused children, began to develop guidelines and examination protocols for the management and treatment of these patients. By the end of the 1970s, several hospitals across Canada had established special clinical programs along these lines.

Information on the objectives and services provided by hospital programs for child sexual abuse is typically found in institutional reports prepared for hospital administration or medical advisory committees. The examples of the special programs established at a number of Canadian hospitals reported here do not constitute a representative cross-section of all such services. The programs listed, however, illustrate the breadth and diversity of the steps which have been taken.

Dr. Charles A. Janeway Child Health Centre (St. John's)

This hospital's Child Protection Team is comprised of: a chairman who is a paediatrician; the Directors of Ambulatory Services and Social Work; a representative of the provincial Department of Social Services; and on an *ad hoc* basis, other professionals from the hospital or community agencies who are invited to provide consultation on specific cases.

At its weekly meetings, the Janeway Child Protection Team may perform the following functions:

1. Review the paediatric assessments of suspected child abuse victims.
2. Review the social work assessments of these patients.
3. Consider the need to report suspected or confirmed cases of child abuse to the provincial Director of Child Welfare.
4. Prepare recommendations for cases for which referrals may be made concerning the management and subsequent treatment of these patients.
5. Review the clinical findings that may serve as the basis for providing expert testimony to courts and reports made to the Department of Social Services.
6. Serve as a focal point for the training of staff concerning child abuse.
7. Provide the focal point for the ongoing monitoring of the treatment of selected cases.

The Team is reported to act as an advocate for the development of resources required in relation to services for abused children.

Centre Hospitalier Sainte-Justine (Montreal)

The membership of this hospital's multidisciplinary Sexual Abuse Team includes representatives of a half dozen departments in the hospital (e.g., paediatrics, gynaecology, microbiology, etc.). The hospital has designated two of its social workers to handle all sexual abuse-related cases.

Most of the victims seen by the Team are brought to the Emergency Room—usually by the police. As the reputation of the service has become more widely known, the number of referrals from other departments in the hospital and of self-referred patients has increased.

Upon arrival at the hospital, the patient is seen by a paediatrician and, if necessary, by a gynaecologist (the latter is routinely called upon to attend most victims between ages 12 and 18, but to fewer prepubescent children). In the Emergency Room, a chart is completed for each patient. In addition, a basic information sheet on the offence is completed as well as a special government accident form for Le Comité de la protection de la jeunesse. The charts and basic information sheets are forwarded to the hospital's Child Protection Clinic, while those of the 12 to 18 year-olds are sent to the Adolescent Clinic of the Department of Paediatrics. Following intake, all cases are reviewed at intervals of two weeks and three months.

Montreal Children's Hospital

One of the activities undertaken by Quebec's Le Comité de la protection de la jeunesse has been to seek to improve the co-ordination between professionals in Quebec hospitals in dealing with physical and sexual abuse cases. A program of this sort had been initially developed for child abuse in 1962 at the Montreal Children's Hospital, operating out of the Emergency Room. A child arriving at this unit, who presents signs of being sexually abused, will first be seen by a nurse who notes the child's appearance and stated reasons for being brought to the hospital. Next, the child is taken to a private cubicle and examined by a resident or intern (where possible, of the same sex as the child), who follows the procedures outlined on a "sexual assault protocol" prepared by the hospital.

A social worker is on call for consultation at the Emergency Room. If a child suspected to have suffered abuse is brought to this unit during the day, the social worker will be called to assess the child's situation. Where the child is brought in at night or on a weekend, the medical staff attending the child will use their best judgment in deciding whether to call the social worker immediately or to arrange for an appointment the next day. However, when an immediate "social management" decision must be made (e.g., whether to make a social admission of the child as an inpatient), the social worker will be paged. Where the suspected abuser is the child's father, or another person living with the child, the social worker may be called in to recommend a "social" admission. If this happens, the child remains an inpatient until the family situation is assessed and measures are taken to assure the child's security.

If the child is treated as an outpatient and released, an appointment for a follow-up in the hospital's gynaecology clinic will be arranged, and the child's case will also be referred to an accessible community-based social agency. The case is likely to be referred to an outside agency if it is judged that the child does not require the services of other disciplines available at the hospital.

The hospital maintains a multidisciplinary Child Protection Committee. The Committee receives and keeps records of abuse cases, and confers on the handling of especially difficult or problematic cases, such as those involving incest or high risk of abuse. Professionals from outside the hospital may be invited to participate in the Committee's conferences.

Children's Hospital of Eastern Ontario (Ottawa)

The child protection program of this hospital, established in 1974, operates at two levels. The Executive Committee is concerned with the development of policies in relation to child abuse. The membership of this group consists of: the Head of Emergency Services, the Head of Ambulatory Care, the Senior Hospital Social Worker, the Head Nurse of Emergency Services, a paediatrician, a psychiatrist, a surgeon, the Vice-President of Professional Services, the

Co-ordinator of Child Abuse Programs and the Supervisor of the Services Division from the local Children's Aid Society, the Director of the Ottawa-Carleton Regional Health Unit and a Community Volunteer. Responsibility for consultation on specific cases is assigned by the Executive to the Child Protection Team, whose membership represents emergency care, nursing, social work, psychiatry and paediatrics.

Until October, 1981, the membership of the Team also included a case worker from the local children's aid society and a public health nurse. At the time, in response to guidelines on the reporting of child abuse cases prepared by the Ontario College of Physicians and Surgeons, the Ontario Medical Association, the Ontario Ministry of Health and the Ontario Ministry of Community and Social Services, these external members were dropped from the child abuse Team. This guideline stipulated that:

> The physician should be particularly careful not to discuss the details of the case with anyone except where normal professional consultation with colleagues is needed. This may include discussion within a hospital-based child abuse committee comprising members of the hospital staff and which may include paramedical members, so long as it does not have members representing agencies outside the hospital. The requirements of confidentiality about the deliberations of such a committee are subject to the *Public Hospitals Act*. Specifically, in cases which have become public knowledge, he should be extremely wary of any discussion with persistent members of the news media, or concerned members of the public, politicians, etc.[25]

The members of the Team meet weekly; its work includes:

1. Confirmation of diagnoses of child abuse.
2. Reporting abuse cases to the local children's aid society.
3. Co-ordination of in-hospital resources for the effective short-term management of cases.
4. Co-ordination of the professionals involved in the management of cases to assure that external agencies receive relevant information.
5. Recommendation of long-term treatment options.
6. Review and follow-up of previously admitted cases.

The members of the Committee provide in-service, child abuse-related educational programs for hospital staff. Activities in public education include: media appearances; and lectures to medical and nursing students and to community groups.

The Committee has developed procedures intended to facilitate the clinical identification of child abuse cases. One of these measures is a specialized protocol to be used in the emergency room as a procedural guideline for the management of child sexual abuse cases.

The Committee's'Alert System was designed to permit the early discovery of child abuse cases. The system employs a screening questionnaire—the Home

Accident Injury Survey—which must be filled out by the nursing staff or medical personnel, for every case ostensibly involving any accident in the home. The screening of these forms is undertaken by the Emergency Social Worker in consultation with the Head of Emergency Room Services.

Where the responses to the questionnaire raise concerns or suspicions, a preliminary assessment is carried out. A code based on the use of different coloured decals has been developed; black decals are affixed to the medical charts of patients against whom it has been confirmed that sexual or physical abuse has been committed. Blue decals denote cases in which there is judged to be a high risk of abuse or neglect. The code is used as an instantaneous means of alerting medical staff to the nature of the cases that they are handling.

Finally, a card file has been developed in which are recorded the names of all children whose cases have been discussed during Child Protection Committee meetings. The Alert System was designed as a means of promoting the early—and where possible, the immediate—identification of abuse cases, in order to eliminate unnecessary delays in intervention.

Hospital for Sick Children (Toronto)

Established as part of the Child Abuse and Neglect Program set up in 1973 at the Hospital for Sick Children, the Sexual Abuse Team consists of: a paediatrician, a psychiatrist, a social worker, an emergency room nurse, a public health nurse and a secretary. The social worker is a hospital employee, assigned to the Team on a full-time basis. The Team's responsibilities include the following duties:

1. The identification of sexual abuse cases presented at the hospital.
2. The medical treatment of such cases.
3. Providing a place of safety by means of victim hospitalization (only occasionally required).
4. Public and professional education.
5. The collection of statistics on all cases.
6. The provision of support and consultation to other facilities and agencies; this may involve accepting referrals from other medical centres and hospitals.
7. Resource development (on a limited scale).
8. The collection of evidence in case of trial and provision of expert testimony.

The Team acts as a central co-ordinating agency for marshalling resources to treat child sexual abuse cases. Fulfilling this function led to the development of liaisons between the Team and the Children's Aid Society and the Metropolitan Toronto Police Department. Involvement with law enforcement may include the referral to the Team of victims identified through police investiga-

tions. Also, in cases in which it is felt that the police may be reluctant to press charges against an offender, and the Team considers prosecution necessary for the victim's protection, police representatives may be invited to attend case conferences.

In the management of cases of child sexual abuse, the Team conducts a physical examination of the child and prescribes whatever form of medical treatment is indicated. The preference is to de-emphasize the use of the hospital Emergency Room as a site for conducting initial examination and assessment procedures; since many of the cases which come to light involve sexual abuse that has been ongoing for an extended period of time, they do not qualify, strictly speaking, as emergency situations (i.e., as suddenly arising crises requiring instant treatment in order to guarantee the patient's medical safety).

It is felt that bringing a child into an emergency room immediately after the sexual abuse is discovered—perhaps in the middle of the night—constitutes an overly emotional reaction which may be psychologically injurious to the child without providing significant medical benefit.

The Team encourages community case workers who learn or suspect that a child has been sexually abused to arrange for an appointment to have the child receive a medical examination as soon thereafter as possible. The examination usually is conducted within a day of contact having been made.

The Sexual Abuse Team manages the medical and psychosocial aspects of each case. Physical examinations are conducted; medical problems arising from sexual abuse are identified; and the most appropriate forms of treatment are assessed and arranged. The Team's social worker and psychiatrist often function in tandem, with the psychiatrist treating the offender, and the social worker providing therapy to the victim and her mother, either separately or together (although this pattern of treatment may vary from case to case). Where possible, an attempt is made to involve the victim's siblings in the therapy process.

The Team advocates the development of policies like those of the Children's Hospital of Winnipeg—that is, a greater and more consistent use of the courts and the criminal justice process to induce offenders to seek treatment and to protect the child by effecting the offender's removal from the home. The Team favours court-ordered treatment, as opposed to imprisonment, and further believes that the offender's bail should be made conditional on his agreement to stay away from the family.

The Sexual Abuse Team provides evidence for use in the trial of persons charged with sexual abuse-related offences. The evidence falls into two categories. First, there is the physical proof of abuse, in the form of specimens and clothes collected at the time of the victim's medical examination. Second, the Team members are called upon to give expert testimony concerning victims and/or alleged offenders with whom they have had contact.

Children's Hospital of Winnipeg

In conjunction with the clinical research on physical child abuse undertaken at this hospital, hospital-based paediatricians and representatives of local children's aid societies began meeting in 1968 on a regular basis to review the diagnoses and management of physically abused children. These informal arrangements continued until the mid-1970s, when more structured procedures evolved that included consultation between hospital staff, the police, local child protection services and the provincial Department of the Attorney General. At this time, representatives from each of these programs began to meet on a regular basis to review cases of suspected child abuse. In a review of the development of this program prepared for the Committee, it was noted that:

> The regular participation of the Police in cases of child abuse was reluctantly received by the medical and social work contingent and, only through the case-by-case involvement and time, did the group's members begin to understand, accept and respect the other's professional biases and value the various approaches required in the management of child abuse."

The special program at the Children's Hospital provides for the assessment and treatment of victims, offenders, and where indicated, members of the victim's family. In the physical examination of these patients, the physician's role is:

1. To document the history given by the victim by medical evidence, where possible.

2. To obtain forensic evidence for possible legal proceedings.

3. To treat the acute problems of physical trauma, sexually transmitted disease and the risk of pregnancy.

4. To follow-up the patient for psychological effects of trauma, pregnancy, sexually transmitted disease and assess with respect to the need for referrals for long-term therapy. This may require:

(a) initial examination with full forensic examination on the day of the victim's reporting of the assault;

(b) a booked appointment for assessment; i.e., in a "cold" incest situation;

(c) several assessment visits, i.e., if a traumatized child requires time to develop trust before she can allow the intrusion of a pelvic examination;

(d) immediate examination under anesthesia, i.e., where there are perineal and/or vaginal lacerations; and

(e) at least one follow-up visit for follow-up cultures and VDRL and psychological re-assessment.

In addition to the physical examination, the hospital offers treatment for non-offending parents as well as for victims and abusers. The treatment given is usually in the form of group therapy or self-help and places strong emphasis on assertiveness training. Where the victim and the other members of her family wish it, the goals of treatment may include re-uniting the offender with

the family; however, no pressure is placed on the family to adopt this goal, and typically, the process of reunification is a gradual and protracted one.

The treatment of some families has continued from the program's inception; the length of the treatment in these cases is seen as a means of addressing any residual problems in the family and of monitoring for any sign of recurrent abuse. The philosophy in providing this treatment is that every professional worker who comes in contact with the victim must communicate to the child that his or her story is believed, that he or she has done nothing wrong and that he or she is in no way to blame for the offender's actions.

A detailed set of procedures has been developed with respect to the management of offenders. An initial psychological assessment of the abusing parent may be ordered (and usually is carried out by a private practitioner) to determine whether the accused's problem is psychological or behavioural. Decisions concerning the action to be taken are made by the Sexual Abuse Sub-Committee at its twice monthly meetings.

The primary avenue of treatment where prosecution is stayed, is the unit operating in the Children's Hospital. Any failure by the abusive parent to attend treatment sessions, or to make a serious effort at correcting his behavioural problems, is reported in writing by the hospital's staff to the Crown Attorney; such lapses may trigger a resumption of prosecution. It is intended that the offender be given a tangible incentive to work earnestly at rehabilitating himself.

Where an abusive parent has been charged with an offence more serious than indecent assault (e.g., where he has had sexual intercourse with the victim), every effort is made to persuade the accused to plead "guilty", and then to offer him treatment at the Children's Hospital. Such treatment will continue until the trial date. If the personnel providing the treatment feel that the accused's treatment will be cut short prematurely by an early trial date, they will so advise the Crown Attorney who then may move for a postponement.

The example set by the Winnipeg program in developing wide-ranging multidisciplinary co-operation in dealing with child abuse has been influential throughout the province. For instance, a small experimental child abuse unit has been established at the Churchill Health Centre. The objective in setting up this facility was to assess the extent to which a specialized treatment unit (like that operated at the Children's Hospital of Winnipeg) could be effective in making its services accessible to smaller, outlying or isolated rural communities.

Alberta Children's Hospital (Calgary)

This program, established in 1975, is operated jointly by the Children's Hospital and the Ambulatory Care Centre of Foothills Hospital. The multidis-

ciplinary members of this program are responsible for the assessment, treatment and follow-up of cases characterized by: suspected or known non-accidental physical injury; the non-medical failure to thrive or lack of banding; and patients deemed to be at high risk of being physically injured.

The evaluation procedures followed by this program include: paediatric examination; social work assessment; co-ordination of past medical and social data; psychological testing; psychiatric and nursing assessments; and evaluation of parental skills.

The program's policy is to admit all suspected abuse victims for short-term hospitalization in order to permit diagnoses and the formulation of appropriate treatment plans. The treatment plans are developed at dispositional conferences involving members of an 18 member advisory committee. Treatment may entail: parent education groups designed to inculcate appropriate expectations and attitudes and to develop parental skills; psychotherapy; family therapy; marital counselling; play therapy; outpatient treatment for psychiatric disorders; and crisis intervention.

The program emphasizes the co-ordination of resources and several appropriate agencies may be contacted to assist in handling a given case. The program also stresses follow-up through the development and deployment of such complementary resources, such as: crisis nurseries; the use of lay therapists; and education programs for professional groups and the public.

Vancouver Medical Clinic

Established as a pilot project to deal exclusively with child sexual abuse cases, the medical clinic established in Vancouver by the British Columbia Ministry of Human Resources represents an unusual community-oriented approach to these problems. The clinic, in operation since 1981, was designed: to develop procedures and protocols for the medical examination of sexually abused children; to perform such examinations; to supply medical and legal reports and expert court testimony; and to conduct programs of professional education aimed at improving the level of care provided in cases of child sexual abuse by attending physicians and hospital personnel.

While referrals to the clinic were made from a number of sources, most of the children were referred directly by social workers or the local offices of the Ministry of Human Resources. The clinic helped to promote the establishment of a Sexual Assault Emergency Centre which began its work at the Shaughnessy Hospital in 1982.

The Centre was staffed by 11 physicians, and by means of assignments based on a rotating roster, a physician was on call at all times of the day. The Centre's services were geared to provide emergency medical services for victims who were age 14 and older.

Younger sexually abused children who required emergency care received services either at the Vancouver Children's Hospital or from physicians on the medical staff of the Centre. The two hospitals are located on the same general site with their emergency rooms being separated by a corridor, an arrangement that facilitates the channelling of patients to the appropriate treatment resource. The Child Abuse Team established at the Children's Hospital in 1975 draws upon an interdisciplinary membership. Its caseload was initially comprised mostly of physical child abuse cases, but in recent years, the proportion of sexually abused children treated at this facility has risen steadily.

What is unusual about the medical programs for child sexual abuse in Vancouver is: the combination of community and hospital-based approaches; the co-ordination of services between different facilities; the availability of especially trained staff on a 24 hour coverage basis; and the development of clinical programs designed specifically to meet the needs of these young patients.

Emerging Trends in Hospital-based Programs

The case studies of hospital-based clinical programs providing services for sexually abused children document that a number of different practices have evolved in relation to the treatment and management of these patients. These approaches include:

General vs. Specialized Clinical Teams

In some hospitals, all types of child abuse are managed by co-ordinating committees or clinical teams. In other centres, specialization has evolved in the form of designated units or special teams which are assigned responsibility for the management of child sexual abuse.

Professional Experience

In some hospitals, the decision has been made to assign only those staff members who have had special training or experience with these problems to the management of child sexual abuse cases. Elsewhere, hospital staff at both the intake and treatment stages may be assigned according to their availability, or on a rotating basis regardless of their prior experience with these problems. As noted in the following chapter, the Committee believes that these workers require special training to work with these children and that funding should be provided for this purpose.

Composition of Teams

The membership of the child abuse/child sexual abuse teams varies widely in terms of: the representation of different disciplines working in hospitals (e.g., paediatrics, nursing, gynaecology, psychiatry, family medicine, clinical psychology, social work, child life specialists); the co-operation with community child protection services, which ranges from full participation to complete exclusion; and the participation or non-participation of the police, Crown Attorneys and lay persons from the community. There is also much variation with respect to whether all members of a committee or team meet regularly, or whether some members are called upon only in relation to particular cases.

Provision of Treatment Services

The range of clinical and social services provided by these hospitals varies according to: the types of examinations that may or may not be routinely undertaken with respect to certain types of child sexual abuse; the scope of services provided by social workers; and whether services are provided exclusively for sexually abused children, or are also provided for members of their families and suspected assailants.

Guidelines and Examination Protocols

Most of the hospitals listed in the case studies had developed guidelines and protocols for the examination of sexually abused children. In some instances, these protocols had been developed for the medical examination of all types of physical child abuse. The contents of the examination protocols vary widely in relation to the identification or non-identification of particular items specified as part of the routine medical examination undertaken for suspected cases of child sexual abuse (e.g., testing for sexually transmitted diseases and how evidence is collected for forensic purposes).

In the course of implementing its National Hospital Survey, the Committee obtained copies of the medical history protocols used at a larger number of hospitals than the number of case studies which have been described. As was the case for the protocols used in the hospitals whose programs have been listed, there was no uniformity in the child abuse protocols of these other hospitals in the classification of items as these related to the identification and examination of child sexual abuse. It was also apparent from the Committee's review that a considerable number of hospitals had no designated procedures in this regard, with these decisions being left to the discretion of attending physicians. This situation contrasts sharply with the procedures adopted in a few major medical centres, in which detailed protocols have been developed with respect to patient management procedures, referral practices and examinations.

Patient Referral Procedures

Children who are sexually abused may come to the attention of a number of different hospital units, such as: the emergency room; child protection and adolescent medicine departments; and special services involving, among others, gynaecology, paediatrics, psychiatry, general medicine, family medicine, social services and clinical psychology.

In some hospitals, special procedures have been devised to facilitate the reporting and referral of child sexual abuse cases between these different units and to special programs, where these have been established. Arrangements of this kind are not standard operating procedures in all hospitals and, where this is the case, it is unknown how many sexually abused children who are treated elsewhere in a hospital are not reported to a hospital's special program. The Committee learned of instances in several hospitals in which other hospital services, in spite of adopted hospital policies requiring consultation, chose to retain the clinical management of these patients without involvement of the abuse team.

Outpatient Treatment and Admission to Hospital

Unless sexually abused children had been seriously injured, the unusual case which would invariably be admitted to a hospital, the usual practice was to treat sexually abused children on an ambulatory or outpatient basis. In some instances, exceptions to this practice were made with respect to sexually abused children who, while they may not have been physically injured, were admitted to hospital on "social" grounds as a means of affording them immediate protection.

Summary

The hospital case studies of special clinical programs for child sexual abuse show that there has been strong leadership taken in mounting comprehensive services for these children in some hospitals across Canada. When the elements of the different programs are considered together, they constitute a broad range of protective care services from the initial identification of cases through to their long-term follow-up. Few of the hospital programs providing special services for sexually abused children incorporate the full range of activities listed in the case studies. In the absence of documentation, the efficacy of particular measures in improving the care and protection of these patients is unknown. It is also unknown whether hospital-based special programs designed to serve these patients are a more effective means of managing their needs than the medical care provided to sexually abused children attended by physicians in community practice. The Committee believes that more complete information than is now available about how the medical care

of sexually abused children is provided should be obtained, and that on the basis of such a review, consideration be given to how the work of these programs might be strengthened. The findings of the National Hospital Survey presented in Chapter 31 indicate that such a review is warranted.

References

Chapter 30: Research and Treatment Programs

[1] Canada. Department of National Health and Welfare. *Child Protection in Canada*. Ottawa, 1981, pp. 120-52.

[2] Kempe, C.H., F.N. Silverman, B.F. Steele, W. Droegemueller and H.K. Silver, "The Battered Child Syndrome", in J.V. Cook and R.T. Bowles (editors), *Child Abuse: Commission and Omission*, Toronto: Butterworth and Co., 1980, p. 52.

[3] Bell, G., Parents who Abuse their Children, *Canadian Psychiatric Association Journal*, 18:223, 1973.

[4] Boone, J.E., The Battered Child: Family Physician's Role, *Canadian Family Physician*, 6:1970, p. 55.

[5] Segal, S., A Medical Overview of Child Abuse in B.C., *British Columbia Medical Journal*, 18:1976, p. 42.

[6] Jacobs, J., Child Abuse, Neglect and Deprivation and the Family, in S.M. Smith (editor), *The Maltreatment of Children*, 1978, p. 265.

[7] Segal, S., *op. cit.*, p. 43.

[8] Segal, S., *op. cit.*, p. 41.

[9] McRae, K.N., C.A. Ferguson and R.S. Lederman, The Battered Child Syndrome, *Canadian Medical Association Journal*, 7: 859-66, 1973.

[10] *Ibid.*, p. 865.

[11] Ringrose, C.A.D., Medical Assessment of the Sexually Assaulted Female, *Medical Trial Technique Quarterly*, 1968 pp. 245-47.

[12] Fraser, F.M., J.P. Anderson and K. Burns, *Child Abuse in Nova Scotia*, Halifax, 1973 (mimeo), 295 pp.

[13] Donovan, M.V., *Sexual Assault of Children: Under Twelve Years of Age*, Toronto: University of Toronto M.A. Thesis, 1978.

[14] *Ibid.*, pp. 106-107.

[15] Corsini-Munt, L., Sexual Abuse of Children and Adolescents, *Proceedings of the International Symposium*, Montreal: Editions Etudes Vivantes, 1980, pp. 647-58.

[16] Wilkins, J., M. Berard-Giasson, R. Gagne, G. Rivard and J.-Y. Frappier, Les assauts sexuels chez les enfants et adolescents: Etude de 125 cas, *l'Union Medicale du Canada*, 108: 1304-08, 1979.

[17] Special Report presented to the Committee, October 19, 1981.

[18] Shah, C.P., C.P. Holloway and D.V. Vakil, Sexual Abuse of Children, *Annals of Emergency Medicine*, 11: 18-23, 1982.

[19] *Ibid.*, p. 42.

[20] *Ibid.*, p. 43.

[21] Wood, E., *Child Abuse in Newfoundland: A Review of Cases Presented to the Child Protection Team of the Janeway Child Health Centre*: January to June, 1980. St. John's, 1980 (mimeo), 52 pp.

[22] *Ibid.*, p. 33.

[23] *Ibid.*, pp. 38 and 37.

[24] *Ibid.*, p. 43.

[25] Reporting Child Abuse: Guidelines to Physicians, *Ontario Medical Review*, 48: 559-60, 1981.

Chapter 31

Injuries Sustained

The National Hospital Survey was undertaken to provide documentation of the nature of the physical injuries and emotional harms sustained by sexually assaulted children and youths, the medical examination and treatment of these conditions, and to give an assessment, if feasible, of the long-term consequences for the young victims. On the basis of the National Population Survey, the Committee learned that only a small proportion of persons who as children had been sexually assaulted stated that either they had been injured or had obtained medical attention. The survey's findings also showed that when medical care had been sought, about half of the persons had turned to physicians in community practice and the other half had obtained care at hospitals. It is the experience of the latter group for which research findings are given in this chapter.

In its review of previously completed clinical research, the Committee had found that there was insufficient information available about the medical procedures typically followed in cases of this kind and that the documentation of the nature of the injuries and harms sustained by victims was incomplete. The results of the other national surveys — population, police forces, child protection services — showed that only a small proportion of victims was known to have been injured. In none of the other national surveys, however, was precise and detailed information available in relation to the medical examination, treatment and followup of sexually abused children.

Design of the Survey

In designing the research protocol to collect information in relation to the clinical assessment and treatment of sexually assaulted children, the Committee drew upon: its Terms of Reference; the issues and research findings identified in the available Canadian clinical research on child sexual abuse; the history-taking and medical examination protocols used in a number of hospitals across the country; the results of a small pretest; and an assessment of the revised protocol provided by an expert medical advisory committee.

The Committee's Terms of Reference either directly specified or subsumed a number of medical, social and legal issues for which specific questions were developed in the hospital research protocol. These items included, for instance, documenting the medical procedures undertaken, the results of examinations, an assessment of the injuries incurred, and legal questions pertaining, among others, to the age, sex and types of association between patients and their assailants, the interval between an incident and when medical care had been received, and whether cases of confirmed child sexual abuse had been reported to external services (e.g., child protection services, the police).

On the basis of these preparatory steps, a draft research protocol was pretested at three hospitals. These hospitals were: The Hospital for Sick Children (Toronto) — 19 children; the North York General Hospital (Toronto) — two children; and the Children's Hospital of Winnipeg (Winnipeg) — eight children. Seven of the 29 cases had involved incest and in four instances, some form of incestuous behaviour was reported to have occurred (i.e., sexual acts other than intercourse). There were 11 other types of sexual acts committed against children; in seven cases, insufficient information was available to determine what acts had been committed or the type of association between victims and suspected assailants.

The pilot testing of the draft protocol indicated that in the absence of certain types of essential information in some hospital charts, it would be necessary, where feasible, to obtain the findings directly from physicians and other health personnel who had cared for these children. This procedure was adopted when the survey was subsequently implemented. The pretest also sharpened the identification of the denominator to be used in relation to which types of cases should be included or excluded in the survey. It was learned, for instance, that while some hospital child sexual abuse teams had reviewed cases, some of them had not been medically assessed or admitted to an outpatient service. In one hospital, a quarter of the cases reviewed by the hospital team fell into one or other of these categories.

The appointment records for patients' visits proved to be an inappropriate means upon which to base the selection of cases for inclusion in the survey. In a number of instances, it was found that appointments had not been kept or that a family member other than the sexually abused child had visited the hospital to obtain advice or counselling. On the basis of these considerations, the cases of child sexual care included in the final survey were limited to those known to a hospital team and for whom a medical assessment had been provided. Excluded were those children whose condition had not been identified by the attending staff and those instances where personnel may have known that child sexual abuse had occurred but had not reported these cases to the hospital's child abuse and/or child sexual abuse teams.

The revised research protocol was reviewed by an Expert Medical Advisory Committee convened by the Committee. Based on this assessment, the final format of the research protocol was prepared and in co-operation with 11 major tertiary hospitals across Canada, the survey was undertaken which

included all reported cases of child sexual abuse that had been medically assessed and for whom treatment had been provided (for which information could be obtained) between January 1, 1981 and June 30, 1982.

In its contacts with several other hospitals across Canada, the Committee learned that it was believed that few sexually abused children had been examined or treated, that it was deemed to be too difficult to identify these conditions, and that insufficient information was available about cases of this kind. Thus, it was on the basis of these considerations that the Committee sought and received the co-operation of several major hospitals known to have specialized in the examination and treatment of sexually abused children. After the hospital survey started, several other hospitals offered to participate; due to constraints of time and assigned resources, their inclusion in the survey was not feasible.

The hospitals participating in the survey were located in eight provinces. In most instances, they were major tertiary institutions providing specialized services for regions within and beyond provincial boundaries. The hospitals were:

- Dr. Charles A. Janeway Child Health Centre (St. John's)
- The General Hospital Health Sciences Centre (St. John's)
- Izaak Walton Killam Hospital for Children (Halifax)
- Centre Hospitalier Sainte-Justine (Montreal)
- The Montreal Children's Hospital (Montreal)
- The Children's Hospital for Eastern Ontario (Ottawa)
- The Hospital for Sick Children (Toronto)
- The Children's Hospital of Winnipeg (Winnipeg)
- University Hospital (Saskatoon)
- University of Alberta Hospital (Edmonton)
- Vancouver General Hospital (Vancouver)

In the collection of information, the ethical codes concerning research were observed in obtaining approval of the participating hospitals and in the collection of information. There was no identification of the names of the patients whose experience was documented.

In reporting the findings of the survey, the Committee recognized that the group of 623 cases for whom information was obtained does not constitute a sample of: all children in the population who have been sexually assaulted; all such victims who may have sought medical care; and cases of this kind examined by other services in the participating hospitals. The Committee acknowledges these limitations in relation to the findings obtained.

In light of the findings obtained in previous clinical research on the medical assessment of child sexual abuse and the documentation of injuries sustained, however, **the Committee believes that the medically assessed experi-**

ence of the 623 sexually abused children constitutes the largest group for whom such information has yet been obtained in Canada, and possibly, elsewhere. Until more complete information along these lines is available, the Committee believes that the survey's findings obtained from major hospitals across Canada constitute a reasonably reliable basis upon which to reach conclusions and upon which recommendations can be grounded.

The findings obtained in the National Hospital Survey are given in the following three sections of this chapter, respectively: characteristics of patients; medical examination and injuries; and hospital management of sexually abused children.

Characteristics of Patients

A summary of the characteristics of sexually assaulted children and youths examined and treated at the 11 hospitals is given in Chapter 7, *Dimensions of Sexual Assault*. These findings are not re-introduced here except to recall that victims known to hospitals typically were somewhat younger, more were females and more had experienced serious sexual assaults than victims whose experience was documented in the national population and police force surveys. As noted in Chapter 6, following an incident involving sexual assault, one of several types of assistance may or may not be sought, and only one of these involves turning to hospitals for medical care. It is reasonable to presume that when such assistance is sought, the victims, their families or guardians, and professional workers believed that medical attention was needed.

In comparison with how the police and child protection services learned of cases of sexually assaulted children and youths, the patients referred to hospitals fell in between the two polar trends involving patient and family-initiated contacts and those originating from professional services. Unlike cases known to the police in which a majority of the referrals were initiated by victims, family members and friends or acquaintances, these sources accounted for about a third (31.1 per cent) of the referrals of male patients and about two in five (44.3 per cent) of those for female patients.

What is unexpected in the findings of the National Hospital Survey is the small fraction of cases in which these patients were referred by other physicians. Such referrals were made for only one in 12 male patients (8.1 per cent) and for one in about 17 female patients (6.0 per cent). An inference that can be drawn from these findings is that physicians in community practice who treat sexually abused children may believe the care that they have provided is sufficient, and consequently, that the special services offered by a growing number of hospitals are not required.

A major difference between the sexually assaulted children seen at hospitals and those whose experience was documented in the other national surveys was the high proportion of incidents involving actual or attempted vaginal and anal penetration.

Acts Involving Actual/Attempted Penetration	Male Patients (n=74)	Female Patients (n=549)
	Per Cent	Per Cent
Vaginal penetration (actual/attempted)	—	64.4
Anal penetration (actual/attempted)	47.4	7.5
TOTAL	47.4	71.9

Attempted penetration included incidents in which a penis, finger/hand or object had been used by an assailant against a victim. Actual or attempted acts of penetration had been committed against over seven in 10 (71.9 per cent) young female patients and almost one in two (47.4 per cent) male patients. **In comparison with the children whose experience was documented in other national surveys, a majority of the patients examined at the 11 hospitals had been victims of serious sexual assaults, and on this basis, proportionally more may have sustained physical injuries and emotional harms.**

Medical Examination

Presenting Complaint

"Presenting Complaint" is a term used by physicians to refer to a problem as it is perceived and described to them by a patient. The presenting complaint may consist of: a sensation, such as a pain in the abdomen; a visible entity like a swelling; a report of an occurrence, for example, exposure to an infectious disease; or a need for assistance, such as diet counselling in weight reduction. The presenting complaint may be identical to a physician's diagnosis, such as when a patient comes for help with acne, and the diagnosis is, indeed, acne. However, the diagnosis may be quite different from the complaint, for example, when a patient complains of back pain and the diagnosis is a kidney infection.

In the National Hospital Survey, the presenting complaint of about nine in 10 patients (88.8 per cent) was "alleged sexual abuse" (Table 31.1). For nine patients, incest was specified, and in one instance, an incestuous rape. Alleged sexual abuse by itself was the presenting complaint in 490 of 553 patients. Alleged sexual abuse associated with reproductive tract symptoms (pregnancy or genital discharge, infection, soreness, bleeding), behavioural problems (school difficulties, suicide attempt), abdominal or urinary problems, or physical abuse accounted for 43 of the 553 patients. Sexual assault, sexual relationship (both undefined in the charts) and rape, 11 cases in all, completed the alleged sexual abuse group.

Table 31.1

Presenting Complaints of Sexually Abused Children and Youths

Presenting Complaint	Males		Females	
	Number	Per Cent	Number	Per Cent
I. Alleged Sexual Abuse	68	91.8	485	88.3
• Alleged sexual abuse only (ASA)	61		429	
• ASA and vaginal discharge, bleeding, infection; pregnancy or vaginal/penile soreness, sexually transmitted disease (STD)	1		12	
• ASA and behavioural problems, school problems and suicide attempt	3		14	
• ASA and alleged physical abuse	2		9	
• ASA and abdominal pain or Enuresis	0		2	
• Incestuous Relationship	0		8	
• Rape/Incest	0		1	
• Rape	0		7	
• Sexual assault, recurrent and sexual relationship	1		3	
II. Alleged Physical Abuse or Injuries	2	2.7	6	1.1
III. Reproductive Tract Symptoms	0	—	22	4.0
• Vaginal discharge, discharge and abdominal pain, bleeding and STD	0		13	
• Pregnancy, contraception, therapeutic abortion	0		8	
• Vaginal laceration	0		1	
IV. Psychological/Behavioural	1	1.4	19	3.5
• Suicide attempt or ideation, drug overdose	0		9	
• Behavioural problems, need to talk, disturbed sleep, panic disorder, emotional assessment	1		10	

Table 31.1 (continued)

Presenting Complaints of Sexually Abused Children and Youths

Presenting Complaint	Males		Females	
	Number	Per Cent	Number	Per Cent
V. Physical Symptoms and Miscellaneous	2	2.7	15	2.7
• Abdominal pain, nausea and vomiting	0		5	
• Blackouts/fainting	0		2	
• Backache, pneumonia, asthma, visual impairment, hernia repair follow-up	1		5	
• Burn, hepatitis	1		1	
• Came for physical examination	0		2	
VI. Not Reported — Total	1	1.4	2	0.4
TOTAL	74	100.0	549	100.0

National Hospital Survey.

The presenting complaint in 22 of the 623 children involved reproductive tract symptomatology without allegations of abuse, including: vaginal discharge, bleeding, laceration or sexually transmitted disease (14 cases); pregnancy, contraception and therapeutic abortion (8 cases). Twenty children presented with psychological or behavioural problems. These problems included a suicide attempt, ideation or drug overdose in nine patients and a variety of behavioural disorders in 11 children.

For 17 children, the presenting complaint included a miscellaneous group of symptoms and occurrences. Among them were: abdominal pain, nausea/vomiting, fainting, backache, pneumonia, asthma, visual impairment, hernia repair follow-up, burn and hepatitis. In all of these patients, at some point during their management by the hospital, the sexual abuse came to light.

In summary, of the 623 children presenting at hospital, for 553 (88.8 per cent) the initial complaint was of alleged sexual abuse, 4.8 per cent presented with alleged physical abuse or injuries or reproductive tract symptoms, 3.2 per cent with psychological or behavioural problems, and the remainder with an

assortment of other conditions. On the basis of the types of presenting complaints documented, there is a relatively low proportion of potentially hard to diagnose cases. These findings run counter to conventional professional wisdom which states that many, if not most, cases of child abuse must be unearthed by wary and conscientious professionals. Some possible sources of bias accounting for the survey's results may include that:

1. Cases of "hidden" sexual abuse among the paediatric caseload of these hospitals were not so diagnosed, and therefore, were not included.
2. Cases without a presenting label of alleged sexual abuse, rape or a similar diagnostic category were inadvertently excluded in the case selection process.
3. Since a high proportion of these cases was referred by professional services and agencies, these referral sources identified the reasons for the referrals and viewed the hospitals as the most appropriate treatment service to deal with all of the clinical and social ramifications of the sexual abuse.

Physical Examinations

Of the 623 children, 526 (84.4 per cent) underwent a general physical examination immediately upon arrival in hospital. In addition, 413 had a gynaecological examination, 314 a more or less formal mental health assessment, 86 a social services' assessment and 52 a developmental assessment (these examination categories are not mutually exclusive). Some children had no examinations, and others had as many as three or four.

A general physical examination usually includes visual inspection, touching with hands (palpation) and the use of instruments to evaluate the condition of the entire body, with emphasis and more detail on the areas of concern. Ears, eyes, nose and throat, head, neck, chest, back, abdomen and extremities are normally all examined, and attention is paid to the internal organs, such as heart, lungs, liver, spleen, bowel and kidneys. On males, a complete physical should include at least a visual inspection of the penis, testicles, buttocks and anus, and a rectal examination with the finger, when indicated.

On female children, especially those not sexually active, inspection of the labia, hymenal opening, anus and buttocks would also usually be included in a general physical examination. However, if there were concern about rape, sexually transmitted disease or any genital or urinary tract trauma, a full pelvic examination, including speculum examination, internal examination (bimanual palpation) and the taking of cultures would be planned. The extent of the examination would depend on the age, size, maturity, prior sexual activity and present mental state of the child.

It is not possible to state the degree of completeness of the general physical examinations performed on the children about whom information was obtained in the National Hospital Survey. Many details of the examinations were not recorded in the questionnaires. Likewise, it is also not possible to

know whether the gynaecological assessment on girls was cursory or complete, or whether it was done as part of the general physical examination on some girls who were not specifically noted to have had a separate gynaecological assessment.

On the basis of the information available, it appears that these young patients received the following types of examinations immediately upon arrival in hospital.

Type of Examination	Males (n=74)		Females (n=549)	
	Number	Non. Accum.%	Number	Non. Accum.%
General physical	60	81.1	466	84.9
Pelvic/gynaecological	—	—	413	75.2
Mental health assessment	27	36.5	287	52.3
Social service assessment	12	16.2	74	13.5
Developmental assessment	7	9.5	45	8.2
Other (e.g., medicolegal, general interview, abortion or unspecified)	1	1.4	15	2.7
Laboratory tests	3	4.1	328	59.7

A general physical examination was performed on 526 children (84.4 per cent). Specific reasons were cited why 52 children had not received a general physical examination on arrival in hospital. Of these children, 27 had been examined previously or were to be transferred elsewhere, five refused examination, four demonstrated behavioural difficulties due to past sexual trauma and two did not come to hospital. In the latter instance, it was not known whether these children ever visited hospital at all, whether charts were opened on them as a result of a relative's visit or telephone call, or whether the child appeared once and did not reappear for an examination scheduled later. In nine cases, the examination was postponed and in three none was performed due to the time lapse between when the abuse had occurred and when the child had visited the hospital. For two children, no reason was specified. An additional 39 children were either not examined, or were examined, but there was no chart record of the examination.

Of the 526 children (466 girls, 60 boys) who underwent the general physical examination, 424 (80.6 per cent) were found to have no physical abnormalities, 373 females (80.0 per cent) and 51 males (85.0 per cent).

Reporting of Abnormalities	Males (n=60)		Females (n=466)	
	Number	Per Cent	Number	Per Cent
Abnormalities found	9	15.0	93	20.0
No abnormalities found/Not reported	51	85.0	373	80.0
TOTAL	60	100.0	466	100.0

Positive findings (not mutually exclusive) included: 106 occurrences of bruising, abrasions, scratches or welts; 14 lacerations; three bites; seven burns, including one cigarette burn; and one sprain. Five children demonstrated inflammation, chapped skin or tenderness in the chest area, and in 17 cases the findings were listed as "other" and not specified.

Abnormality/ies Found	Males	Females
	Non-Accumulative	
Bruising	6	64
Abrasions	1	16
Scratches	—	17
Lacerations	2	12
Burns	3	3
Bites	—	3
Cigarette burns	1	—
Welts	—	2
Sprains	—	1
Inflammation	—	1
Chapped skin around mouth	—	1
Tenderness around chest	1	2
Unspecified	1	16
TOTAL NUMBER OF ABNORMALITIES FOUND	15	138

Gynaecological Examination

A gynaecological examination was carried out on 413 of 549 girls. For the remainder, no explanation was given for the lack of examination of 54 cases. (As noted previously, it is possible that inspection of the genitals, anus, perineum and buttocks had occurred as part of the general physical examination and was not recorded separately. This would most likely have been the case for the younger girls). Of the remaining 82 girls who had no gynaecological examination, in 36 cases this procedure had been postponed; in 13, it had already been performed by another physician; in 19, the examination was considered unnecessary; in six, the patient refused; in another six, the reason for no examination was the time elapsed between the event and the patient's arrival in hospital; and, finally, two patients did not come to hospital.

The component parts of the gynaecological examination varied considerably. Vaginal swabs were taken from 305 girls, vaginal washings were obtained from 79 and cervical swabs from 152. A bi-manual examination was performed on 191 of the female patients and a speculum examination on 193. Pregnancy tests were done on 104 of the girls and a V.D.R.L. on 294. Anal and rectal swabs were taken on 162 and 157, respectively.

The variation in the frequency with which the different examinations were undertaken may be partially accounted for by the ages of the girls and by the nature of the reported abuse. For example, speculum examination, bimanual examination and cervical culture might not be performed on prepubertal girls or on those who denied that vaginal penetration had occurred. It must also be remembered, that these examinations can be physically and/or psychologically traumatic for some girls, and that they should only be performed with good reason.

The findings on the gynaecological examination were as follows:

Labia — 250:

Normal appearance (150 not reported or not applicable). Among those examined and demonstrating pathology, there were the following signs (some children may have had more than one finding):

Laceration	10
Scratches or abrasions	18
Erythema or inflammation	29
Bleeding, bruising or hyperemia	16
Discharge	4
Adhesions	1
Small pimple, rash, infection or other	5
Total	83

Hymen — 239:

Normal appearance, including the following designations:

No signs fresh trauma	55
Intact	89
Tight or not lax	72
Normal	23
Total	239

The condition of the hymen was not noted for 135 girls and the examination was considered not applicable for 134.

Pathology of the hymen included:

Hyperemia, erythema	3
Tears, splits, lacerations	17
Bleeding	5
Edema	1
Old scars, adhesions/lacerations	3
Lacerations of introitus	1
Total	30

Vagina — 185:

Normal appearance: the condition of the vagina was not noted in 133 girls; the examination was considered non-applicable in 60, and was impossible for two girls due to pain.

Vaginal findings were difficult to interpret, since vaginal discharges, vaginitis, vulvitis and erythema are not uncommon findings, even in sexually inactive girls. However, they were reported by physicians as follows:

Discharge	95
Bleeding	18
Menstruating	8
Bruising	11
Inflammation (e.g., vulvitis, vaginitis)	5
Infection/warts	4
Larger than normal for age	2
Surgery re: lacerations	2
Erythema	7
Total	152

Breasts (girls) — 180:

Normal appearance: for 233, the condition of the breasts was not noted; for 58, it was considered non-applicable. In younger, pre-pubescent girls, the breast area may not have been specifically noted.

Pathological findings included:

Lacerations	1
Bruising	6
Burns	1
Scratches	1
Erythema	1
Other	3
Total	13

Examination of Male Genitalia

Penis

The condition of the penis was not noted on the chart or such examination was deemed inapplicable for 23 of the 74 boys. For 43 boys, the penis was found to be normal.

Pathological findings included:

Lacerations	1
Bruising	1
Inflammation	1
Infections	1
Pain	1
Erythema	1
Discharge	1
Total	7

Testicles

The condition of the testicles was not noted on the chart or such examination was deemed unnecessary for 26 boys. For 39 boys, the testicles were exam-

ined and found to be normal in appearance. There were two boys for whom palpation of the testicles was painful (no other pathology noted).

Both Sexes — Examination of Perineum, Buttocks, Rectum and Anus

Perineum

The condition of the perineum was deemed not applicable and/or not noted for 304 children and was found to be normal on examination of 212 (29 boys, 183 girls). Among the remaining children, the findings included:

Condition	Males	Females
Bleeding	—	7
Splits/tears	—	9
Inflammation or irritation	—	14
Infection	—	1
Bruising	—	4
Erythema	1	25
Total	1	60

In addition to the above conditions, seven children were found to demonstrate "poor hygiene" in the perineal area.

Buttocks

The condition of the buttocks was considered not applicable and/or not noted for 372 children, and was found to be normal for a further 115. Other findings included:

Condition	Males	Females
Laceration	—	1
Bite	—	1
Scratches/abrasions	—	5
Bruising/erythema	4	7
Drawing on buttocks	—	2
Total	4	16

Anus

The condition of the anus was not noted (or was considered inapplicable) for 340 children. It was considered to be normal for 163. Five children were found to have poor hygiene in the area and two males complained of pain on defecation. Other findings included:

Condition	Males	Females
Loose anal ring	2	1
Bleeding	1	2
Tears	1	3
Swelling	1	2
Inflammation	3	—
Spasm	—	1
Bruising/tenderness	4	4
Total	12	13

Rectum

It is not known whether examination of the rectum included digital and/or visual examination. The report of "poor hygiene" in two cases suggests that positive response to rectal examination may have included those situations in which only inspection of the perineum and anus was carried out. The condition of the rectum was not noted or such examination was considered inapplicable in 373 cases, and the rectum was examined and found normal in 150. Positive findings included, in addition to two cases of "poor hygiene":

Condition	Males	Females
Inflammation	1	1
Lesion (unspecified)	1	1
Tear	—	1
Total	2	3

Other Conditions

Other conditions thought to be present in the children included:

Condition	Males	Females
Genitourinary infection	—	20
Primary syphillis	1	1
Gonorrhea	—	12
Pregnancy	—	4
Suspected sexually transmitted disease	—	4
Pelvic Inflammatory Disease	—	1
Herpes Simplex type I	1	1
Vaginal warts	—	1
Unspecified	—	14
Total	2	58

Physical Injuries and Harms

Of the children examined in hospital, about four in five had no abnormalities on general physical examination. Of those having positive findings, bruising, abrasions and scratches accounted for a majority of the conditions. The 14 children with lacerations and the seven with burns were the only ones with physical injuries that could be deemed medically serious, but for these cases, the extent of damage was not fully documented. Even assuming all of these children had been seriously injured, they represent less than one in 20 of those examined requiring significant medical attention.

Among the girls, three in four (75.2 per cent) underwent gynaecological examination. Of this group, 10 had labial lacerations, 22 had hymenal tears, 18 had vaginal bleeding (presumably non-menstrual), two had vaginal lacerations requiring surgery, one had a breast laceration and one a burn on the breast. Sixteen girls had perineal tears or bleeding, one had a laceration of the buttock, four had anal-rectal tears and 43 were thought possibly to have a sexually transmitted disease. In all, about a third of the presenting findings appear to

have required medical attention. (This may have been less than a third of girls, since some had more than one finding).

Among the boys, one had a penile laceration, one an infection of and one a discharge from the penis. One had an anal tear.

Under certain circumstances, admission as an inpatient to hospital might be considered as an indication of the severity of the physical injuries sustained by sexually assaulted children. Such admissions were made on behalf of one in 14 cases (7.1 per cent), but a review of the experience of these children suggests that in relation to the types of sexual acts committed against them and the physical injuries sustained, that they differed little in these respects from those children who had been treated as ambulatory outpatients.

A disproportionate number of the 44 patients admitted to hospital, in comparison to other patients in the survey, were older children. The ages of these children were:

Age	Per Cent
Under age 7	27.9
7–11 years	16.3
12–13 years	13.9
14 years and older	41.9

Of the 623 children presenting at hospital, 71.9 per cent had been victims of actual or attempted acts of vaginal or anal penetration. Of the children admitted as inpatients, 69.8 per cent had experienced acts of this kind. With regard to the types of physical injuries that they had sustained, about a third each had had none (30.2 per cent), some (37.2 per cent) or injuries which could be deemed serious (32.6 per cent).

It is noteworthy in this regard that two of the 11 hospitals accounted for more than half (55.8 per cent) of the children admitted as inpatients. The findings obtained in relation to whether sexually abused children were admitted as inpatients to hospital suggest that this action was often taken for custodial purposes, and in some instances, to permit further investigations.

On the basis of the medical charts reviewed in the National Hospital Survey, 20 of the children (17 girls, 3 boys) were noted as suffering "serious" general or gynaecological/genital injuries. This group represents 3.2 per cent of all of cases.

From a medical standpoint, the most striking aspect of the physical findings is that most of the actual injuries sustained by the sexually abused children who were medically examined appear to be minimal. A small number of the children had lacerations, more had bruising, redness and inflammation, and only one in 14 was admitted to hospital, many for custodial purposes or for further investigation. Supporting this conclusion were the results of a question in the survey which asked, in the opinion of the attending professional staff, whether the child had suffered any long-term physical harms as a result of the

sexual abuse. It was reported that about one in 42 children (2.4 per cent) in the judgment of these professionals fell into this category.

If the children with harms documented on the basis of the general physical examination are taken together — girls with gynaecological harms and boys with genital harms — then these total 143 children of the 623 patients presenting to hospital. In other words, on the basis of the medical examination of sexually assaulted children and youths, a maximum of about one in four (23.1 per cent) may have required medical attention, and in many instances, only physical injuries of a minor nature had been sustained or the care was required for conditions other than those related to the sexual abuse. These children were more likely to have suffered psychological and emotional harms, the findings presented next, than to have been victims of physical injuries.

Mental State Examination

Many physicians, consciously or unconsciously, make an assessment of the mental state of their patients whenever patients are seen. If a patient's emotional, behavioural and thinking patterns appear to be within the normal range and are unchanged from previous visits, then no note may be made in the chart. However, if a patient was excessively depressed or elated, if his or her thinking patterns seemed bizarre, or if he or she demonstrated unusual behaviour, the physician would likely make a note in the chart or, at least, would tend to remember the abnormal pattern.

In the National Hospital Survey, several questions dealt with manifestations of the patient's mental state. One related to the observed behaviour and emotional state noted in the initial examination. This first examination may not have included a formal mental health assessment (e.g., patients coming to the emergency room), and hence, observations on the demeanour of the patient may have been recorded simply because they were noteworthy or because the presenting complaint (e.g., alleged sexual abuse) suggested the need for documentation of mental state. During the initial examination or on a subsequent visit to hospital, a mental health assessment may have been made either by the principal examiner or by means of referral of patients to other hospital services. Where information on these assessments was recorded, these findings were documented in the survey. Finally, information was sought in the survey about the emotional and behavioural reactions of children which were considered by attending staff to have resulted from sexual abuse. Reactions of this kind were judged not to have preceded the abuse and were attributable to it having occurred.

Initial Impressions. It is difficult and highly subjective to attempt to classify children's behaviours or emotions as positive or negative, since, for example, a crying child might well be reacting more appropriately in a stressful situation than one gaily chatting who is suppressing fear or anger.

Table 31.2

Initial Impressions of Physicians of Sexually Abused Children: *Behavioural* Reactions

Initial Clinical Impressions of Behavioural Reactions	Males (n=74)		Females (n=549)	
	No.	Non-Accum.%	No.	Non-Accum.%
Distressed/Unco-operative	8	10.8	161	29.3
• crying, sobbing, weeping	1		52	
• fidgeting, pacing, nervous	2		28	
• recoiled, flinching, shy	4		41	
• fearful, resisted examination	1		40	
Neutral/Passive	12	16.2	79	14.4
• no visible reaction	6		19	
• silent, apathetic	6		60	
Not Distressed/Co-operative	45	60.8	279	50.8
• alert, active, lucid	19		104	
• body relaxed	3		30	
• smiling, humming	5		25	
• outgoing, talkative	9		40	
• talked freely about abuse	9		80	

National Hospital Survey

Table 31.3

Initial Impressions of Physicians of Sexually Abused Children: *Emotional* Reactions

Initial Clinical Impressions of Emotional Reactions	Males (n=74)		Females (n=549)	
	No.	Non-Accum. %	No.	Non-Accum. %
Distressed/Unco-operative	18	24.3	250	45.5
• angry	—		10	
• hysterical, demanding	—		8	
• irrational, confused	1		5	
• depressed, worried	3		42	
• reluctant to discuss	7		66	
• distressed, upset	4		80	
• frightened	3		39	
Neutral/Passive	2	2.7	28	5.1
• didn't think it abuse	—		13	
• flip, embarrassed	2		15	
Not Distressed/Co-operative	61	82.4	310	56.4
• calm, composed	18		86	
• cheerful, happy	12		47	
• co-operative	18		115	
• responsive, related well	13		62	

National Hospital Survey

Notwithstanding this observation, it is valuable to note how these children presented themselves, since certain behaviours may eventually turn out to be prognostic indicators. The behavioural and emotional presentation of the children is divided into: distressed/unco-operative; neutral/passive; and not distressed/co-operative. These findings noted by the principal examiner are listed in Tables 31.2 and 31.3.

Lacking a control group, for instance, having findings about the customary demeanour of children coming to emergency services, it is unknown whether the reported reactions of sexually abused patients were usual or markedly different from those of other children. The findings indicate somewhat different reactions by males than by females, with considerably more of the latter being distressed or unco-operative in both behavioural and emotional reactions.

Typologies have sometimes been developed which list the reactions said to be characteristic of children who have been sexually abused. The survey's findings in relation to the initial impressions of attending examiners reveal that there was no stereotypic demeanour presented by victims. On the contrary, the findings clearly show a full range of behaviours and emotions, from children who were very distressed to those who were apparently composed and happy.

Case Studies. Before presenting the statistical findings obtained in relation to the mental state assessment of sexually abused children, a number of case studies are given which show the types of harm attributable to offences of this kind. The excerpts were taken from the notes in patients' charts made by attending professional health workers.

Case Study 1. Two year-old boy who experienced attempted anal intercourse by a male babysitter. Attending professional's comment: "It is unlikely that this child will have any long-term effect as a result of this incident by itself — but if the mother continues to remain anxious and under distress, the child may eventually react to the mother's extreme over-protectiveness."

Case Study 2. Three year-old boy who experienced anal intercourse by an unknown male. Social worker's comment: "Patient's behaviour has changed for the worse since the time of the assault: temper tantrums, angry testing episodes, difficult to manage, encopresis, wild behavioural misconduct."

Case Study 3. Three year-old girl who was the victim of thigh intercourse, oral-anal contact and an object inserted in her vagina by a family friend. Psychiatrist's comment: "Since sexual abuse, child fondles mother's male friends and is involved in bestiality, bizarre dreams and tantrums."

Case Study 4. Six year-old boy sexually fondled by father. Attending professional's comment: "Will require long-term counselling".

Case Study 5. Six year-old girl sexually fondled by uncle. Attending professional's comment: "Serious emotional aftermath; preoccupation with sex; severe anxiety."

Case Study 6. Seven year-old girl sexually fondled by father. Attending professional's comment: "Fear that court order (two years probation and no visiting rights) and sexual abuse had forced her to give up hope of ever having a relationship with her dad . . . fear of abandonment by mother now that she had lost her father."

Case Study 7. Nine year-old girl, victim of thigh intercourse, attempted rape and vaginal penetration by a finger by a neighbour. Social worker's comment: "Patient now exhibits difficulty sleeping and preoccupation with incident."

Case Study 8. Nine year-old girl raped by adoptive father, grandfather and her two brothers. Psychiatrist's comment: "Patient does not know how to approach male adults in any other way than in a fashion which would be considered to be very seductive. Patient sexualizes all relationships with males, has disturbing dreams and would like to go home to adoptive parents, but is simultaneously fearful of them. She will require long-term sexual psychiatric treatment".

Case Study 9. Nine year-old girl, victim of a finger penetration in her vagina. Social worker's comment: "A psychological trauma is anticipated, even if the patient has adequate parenting. She is afraid of being alone, of the dark and perhaps in the future, of men."

Case Study 10. 10 year-old girl whose genitals were fondled by a family friend. Social worker's comment: "Patient is now suffering from anxiety, sleeplessness, separation anxiety and nightmares."

Case Study 11. 10 year-old girl, finger penetration of vagina by her stepfather. Paediatrician's comment: "Patient panics when left alone or is in a crowd; she believes everyone knows she was involved with incest; has been eating compulsively; provocative to peer group males; phobia of older men."

Case Study 12. 11 year-old girl who was tied up and forced to witness a friend being raped by a stranger. Psychiatrist's comment: "Patient became a compulsive eater (30 plus pounds in three months). At one point, she stated that she was only staying alive for her mom and dad's sake. Mother states that child has feelings of lack of self-worth. Child is scared at night of someone breaking into the house. She feels down most of the time; there is no fluctuation in this. She thinks she would be better off dead because she wouldn't have to deal with troubles. All in all, a very depressed, angry little girl."

Case Study 13. 11 year-old girl raped by her stepfather. Attending professional's comment: "Lost interest in school work and activities she used to enjoy; withdrawal; severe depression."

Case Study 14. 11 year-old girl sexually fondled by her father. Attending professional's comment: "Guilt because father is on probation; depression; sexual preoccupation."

Case Study 15. 11 year-old boy, anal intercourse and fellatio by foster father. Attending professional's comment: "Problems at school; personality disorder."

Case Study 16. 11 year-old boy, anal intercourse by friend's father. Attending professional's comment: "Fear of adult males; questions his own sexuality."

Case Study 17. 12 year-old girl, raped by foster father. Attending professional's comment: "Danger of sexual abuse, promiscuity and prostitution; preoccupation with sex."

Case Study 18. 12 year-old girl, genitals fondled by mother's common-law partner. Social worker's comment: "Sexual acting-out; very low self-esteem; negative behaviour; harming herself. This, plus her whole family turning against her, has led to a very disruptive life for a 12 year-old girl."

Case Study 19. 13 year-old girl, sexually fondled by her father. Attending professional's comment: "Long-term emotional and social problems because the family don't believe her."

Case Study 20. 13 year-old girl, fellatio and attempted rape by her step-father. Attending professional's comment: "Attempted suicide; drug use; guilt."

Case Study 21. 13 year-old girl, was raped by her uncle, became pregnant and had an abortion. Attending professional's comment: "Guilt about rape and aborting baby; will need long-term one-to-one therapy."

Case Study 22. 13 year-old girl, sexually molested by her mother, had intercourse with mother's common-law partner. Attending professional's comment: "Attempted suicide; severe depression; withdrawal."

Case Study 23. 14 year-old girl, raped by her father. Attending professional's comment: "Depression; guilt re sexual abuse; will require ongoing intervention in the family situation as well as psychotherapy."

Case Study 24. 14 year-old boy, victim of anal intercourse by mother's common-law partner. Attending professional's comment: "Preoccupation with sex; attempted bestiality."

Case Study 25. 15 year-old girl, raped by her father. Attending professional's comment: "Patient feels guilty: 'If I didn't tell anyone, no one would ever know and my father would be in no trouble'."

Case Study 26. 15 year-old girl, sexually fondled by her mother's common-law partner. Social worker's comment: "Patient experiences concerns about her own sexuality and an 'emotional deadening' towards males her own age; tends to overeat. Feels she has few friends, partly through choice, because she does not 'trust' people."

Case Study 27. 15 year-old girl, raped and forced to commit fellatio by five unknown males. Attending professional's comment: "This young girl's total behaviour — home, school, family and peer group disintegrated after incident. If no proper psychotherapy follow-up, prognosis bad."

Case Study 28. 15 year-old girl, sexually molested by uncle. Attending professional's comment: "Suicidal; negative social behaviour."

Case Study 29. 15 year-old girl, raped by her uncle and her mother's common-law partner. Attending professional's account: "Long-term problems; tried to harm herself with a knife; very anxious."

Case Study 30. 16 year-old girl, raped when she was age 11 by three cousins. Social worker's comment: "Emotional, developmental and social growth affected . . . has become involved in negative behaviour i.e., sexual promiscuity, drug abuse. Self-image is poor—sees herself as a sexual object that has been abused. High need for intimacy which patient has not been able to meet in a satisfying way therefore causing lack of trust in people and in herself."

Case Study 31. 17 year-old girl, raped by her father when she was age 13. Psychologist's comment: "Patient needing intense counselling and support during this period to help her work through her feelings. Patient stated she felt like a prostitute at times, has had thoughts of killing herself, and portrays a very low self-esteem."

The case studies provide deeply personal dimensions to the summary statistics about the types of emotional and behavioural problems experienced by children who have been sexually abused. It is evident, even in children as young as two or three years-old, that there can be major behavioural changes and symptoms of severe psychological distress. The manifestations of distress can be general — anger, tantrums, nightmares or sexually oriented, such as the three year-old girl who fondled her mother's male friends.

Another clinically important point illustrated by the case studies is that fondling and other acts which might be considered less traumatic than vaginal and anal intercourse, can cause significant levels of disturbance in the child. For almost all of the very young children, the attending health professionals allude either to the need for long-term therapy or they describe symptoms that seem serious and that are unlikely to be resolved quickly or without assistance for the child and family.

The case studies for slightly older children, those between ages 10 and 12, demonstrate a multifaceted psychopathology. Depression in its various manifestations occurs often. Harm to self and suicidal thoughts become more obvious in this age group, as do preoccupation with sex and sexual acting out. Among some of the girls, compulsive eating became a compensating behaviour. For children in this age group, the excerpts from the patients' charts indicate that the emotional and psychological harms were serious and, in some instances, would require a significant amount of treatment.

A number of different reactions become evident when the experience of adolescent victims is considered. These adolescent girls seem to feel and express guilt, shame and a loss of self-worth. Depressive symptoms were evident and there were suicide attempts as well as drug use. Particularly poignant is the verbalization of a loss of trust. Several of the girls expressed fear of men, but two at least seemed to have lost the ability to trust friends or persons in general. The sense of betrayal emanates from their comments. Doubts about sexuality, fear of the opposite sex and lack of trust combined would suggest that disturbed sexual relationships later in life may be an outcome for some of these sexually abused children.

Mental State Assessment

A mental state assessment of a sexually abused child may have been made in the course of the initial presentation, have been done then and followed later by a fuller assessment, or no such examination may have been provided. During the pretest stage of the National Hospital Survey, it was realized that in some instances, patients' charts were incomplete in relation to certain types of information being sought. Where this occurred, an attempt was made to seek missing information from members of the professional staff who had attended or had known about these patients.

On the basis of the findings obtained in the survey, it was found that 60.8 per cent of the males and 70.3 per cent of the females who had been sexually abused were reported to have had some form of mental assessment during their initial presentation to hospital or during the first scheduled follow-up visit. No information was reported concerning such assessments for two in five male victims (39.2 per cent) or for about one in three female victims (29.7 per cent). Of the 431 children for whom such information was recorded, the mental state assessment had been given for 304 (70.5 per cent) during their initial presentation to hospital.

Table 31.4

Examining Professional's Impressions of Mental State of Sexually Abused Children

Findings of Mental State Examination	Males (n=74)		Females (n=549)	
	No.	Non-Accum.%	No.	Non-Accum.%
Distressed/Unco-operative	11	14.9	165	30.1
• depressed, worried	2		53	
• distressed, crying, tense	7		82	
• reluctant, negative, frightened	1		26	
• hysterical, irrational	1		4	
Neutral/Passive	1	1.4	3	0.5
• no visible reaction	1		3	
Not Distressed/Co-operative	22	29.7	177	32.2
• calm, sensible, relaxed	17		142	
• cheerful, happy, attentive	5		35	
Other Reactions	19	25.7	145	26.4
• hyperactive, fidgeting nervous	6		39	
• immature, flip, nervous	3		27	
• personality disorder (behavioural problem, neurotic, psychotic)	5		21	
• retarded, inarticulate	4		27	
• other	1		31	
No Report of Mental Health Examination	29	39.2	163	29.7

National Hospital Survey

The findings of these assessments (Table 31.4) are generally comparable to those noted in the initial impressions of the professional staff who had examined these patients. On the basis of these assessments, it was found that sexually abused children displayed a wide range of emotional and behavioural reactions and that girls were about twice as likely as boys to have been distressed or unco-operative. About a third of the children of both sexes were reported to have shown no visible distress.

Provision of Mental State Assessment	Males		Females	
	No.	Per Cent	No.	Per Cent
Physician at time of initial presentation	29	39.2	275	50.1
Psychiatrist	2	2.7	33	6.0
Psychologist	4	5.4	22	4.0
Medical social worker	1	1.3	25	4.5
Admitting nurse	7	9.5	24	4.4
Other professionals	2	2.7	7	1.3
No report of assessment given	29	39.2	163	29.7
TOTAL	74	100.0	549	100.0

In considering these findings, it is unknown how many of the children's reactions are attributable to sexual abuse, to how they may comport themselves in hospital, to their previous experience with physicians and hospital personnel, or to their general behavioural patterns irrespective of these considerations.

Psychological and Emotional After-effects of Sexual Abuse

Information was obtained in the survey about the reported psychological and emotional after-effects to children of sexual abuse. In all, a total of 985 psychological and behavioural reactions was recorded which in the judgment of the attending staff were considered to have resulted from (and post-dated) the sexual abuse (Table 31.5). This is a huge pathological load. The most frequently reported reactions included: insomnia, nightmares, and fears of going to bed alone; general school problems; angry outbursts, running away; fear, anxiety, guilt and embarrassment, and depression.

Psychological and Behavioural Reactions Following Sexual Abuse	Males (n=74)		Females (n=549)	
	No.	%	No.	%
None, not reported	34	46.0	281	51.2
One or more signs	40	54.0	268	48.8
Judged by professional examiners to be long-term harms	14	18.9	97	17.6

For one in two children (50.6 per cent), no psychological and behavioural consequences attributable to sexual abuse were reported. Of those for whom these reactions were recorded, on average, female patients had 3.4 and boys had 2.1.

In the judgment of attending hospital staff, about one in six (17.8 per cent) sexually abused children was considered potentially to have suffered long-term emotional and/or behavioural harm. The proportions were comparable for male (18.9 per cent) and female victims (17.6 per cent). These findings contrast sharply with the proportion of children requiring medical attention for various physical ailments (23.1 per cent) and the number who were considered to have suffered long-term physical harms (2.4 per cent) resulting from sexual abuse.

Table 31.5

Psychological and Social Behaviour Exhibited by Patients Following Sexual Abuse

Psychological and Social Behaviour Exhibited Following Sexual Abuse	Males (n=74)		Females (n=549)	
	No.	Non-Accum.%	No.	Non-Accum.%
None, not reported	34	46.0	281	51.2
Irritability	5	6.8	31	5.6
Unnecessary, persistent fears	5	6.8	70	12.8
Anxiety	1	1.4	3	0.5
Angry outbursts	7	9.5	38	6.9
Guilt	—	—	2	0.4
Excessive dependency	3	4.1	30	5.5
General depression	2	2.7	49	8.9
Enuresis	2	2.7	18	3.3
Encopresis	1	1.4	1	0.2
Anuresis	—	—	1	0.2
Dysuria	—	—	1	0.2
Thumbsucking, nailbiting	—	—	8	1.5
Withdrawal	2	2.7	44	8.0
Lack of motivation for play	2	2.7	11	2.0
Less verbal communication	1	1.4	25	4.6
More verbal	—	—	1	0.2
Change in behaviour with peers at school	5	6.8	38	6.9
Truancy, chronic absenteeism	—	—	21	3.8
Lack of interest in school	2	2.7	40	7.3

Table 31.5 (continued . . .)

Psychological and Social Behaviour Exhibited by Patients Following Sexual Abuse

Psychological and Social Behaviour Exhibited Following Sexual Abuse	Males (n=74)		Females (n=549)	
	No.	Non-Accum. %	No.	Non-Accum. %
Preoccupation with abuse	5	6.8	39	7.1
Disturbed sleep pattern	5	6.8	65	11.8
Fear of going to bed alone	—	—	12	2.2
Nightmares	6	8.1	66	12.0
Loss of appetite	1	1.4	23	4.2
Vomiting	—	—	12	2.2
Nausea	—	—	13	2.4
Overeating	—	—	10	1.8
Heightened embarrassment/ disgust	1	1.4	7	1.3
Difficulty completing routine tasks	2	2.7	11	2.0
Acting out, running away	6	8.1	34	6.2
School failure	2	2.7	16	2.9
Unusual sexual behaviour	4	5.4	24	4.4
Masturbating	—	—	1	0.2
Transvestite	1	1.4	—	—
Questions of sexual behaviour	3	4.1	19	3.5
Fear of pregnancy	—	—	14	2.6
Fear of venereal disease	—	—	4	0.7
Suicidal behaviour	2	2.7	23	4.2
Drug, alcohol use	1	1.4	22	2.0
Other	6	8.1	72	13.1

National Hospital Survey

Although the clinical information about the mental health state of sexually abused children following these incidents was not documented for all children in the survey, there can be no doubt that **the main findings are that substantially more children were found to have been emotionally harmed than had been physically injured, and that proportionately, long-term emotional harms were over six times as likely as long-term physical injuries to be consequences of child sexual abuse.** While the survey's findings on the mental state of sexually abused children are incomplete in relation to information obtained from

the initial impressions of professional health examiners and the mental state assessments made during or shortly after the child's initial presentation to hospital, the emotional and psychological needs of the children were clearly recognized by attending hospital staff. Follow-up care was recommended for about nine in 10 patients (88.1 per cent), and for most of them, referrals were made for mental health assessment, social work assessment and counselling.

Hospital Management of the Patient

The hospital management of the patient begins with his or her first presentation in person (occasionally by telephone) and continues until final discharge. Discharge may not mean the end of care, merely that any further management is not under the aegis of the hospital itself. For example, some patients may be referred to physicians or other health personnel not affiliated with the hospital.

Referrals to Hospital

In Chapter 7, *Dimensions of Sexual Assault*, a summary is given of children referred to different public services. In the National Hospital Survey, it was found that slightly over half of the sexually abused children examined at the hospitals surveyed were referred by a professional individual or an agency. About two in five of the hospital visits were initiated by the families or friends of victims.

Hospital Service First Seeing Patient

A majority of child abuse victims were initially seen in the emergency room. There were no reports about the initial service provided for seven children (six girls, one boy). A total of 406 children (65.2 per cent) was first seen in the emergency room; this group included 361 girls and 45 boys.

Why was the emergency room the initial service turned to by so many sexually abused victims? Was it by chance or by choice? The hustle and bustle of the typical emergency department appear to make it the least appropriate service in a hospital to provide optimal care to a victim of child sexual abuse. Several factors may account for the high level of use of this department.

Although patients arriving at the emergency department in most large hospitals are asked by a clerk or nurse what their problem is, information about sexual abuse may have been withheld by the patient (or accompanying individual) until she or he was alone with the medical examiner. In some cases, the patient may have named another related or unrelated problem, for example, bruising or vaginal discharge in order to avoid a discussion of sexual abuse until meeting the doctor. Another possibility is that since most hospital clinics

Table 31.6

Hospital Service by Patients Initially Attended

Service	Males		Females	
	No.	%	No.	%
Emergency Room	45	60.8	361	65.7
Gynaecology	1	1.4	35	6.4
Family Medicine	2	2.7	4	0.7
Medical Outpatient/ Ambulatory Services	8	10.8	19	3.5
Medical Social Service/ Social Work	2	2.7	16	2.9
Paediatric Service	2	2.7	28	5.1
Psychiatry	2	2.7	11	2.0
Teen/Adolescent Clinic	2	2.7	28	5.1
Child Protection/ Abuse Team	1	1.4	18	3.3
Sexual Abuse Team	8	10.8	18	3.3
Developmental Clinic	—	—	1	0.2
Children's Clinic	—	—	4	0.7
Not reported	1	1.4	6	1.1
TOTAL	74	100.1*	549	100.0

National Hospital Survey. Charts were opened for two patients not presenting at hospital.

*Rounding error

and physicians schedule their work during the day, if patients arrived outside of these normal working hours, the emergency room might be the only place where treatment was available. For the 621 patients who presented to hospitals (two did not), there was information on the arrival time of 448. Sixty-three patients arrived between midnight and 8.00 a.m., another five between 8.00 and 9.00 a.m., 198 between 9.00 a.m. and 5.00 p.m., 23 between 5.00 and 6.00 p.m., and 159 between 6.00 p.m. and midnight. Thus, while 226 children appeared in hospital between 8.00 a.m. and 6.00 p.m., an almost equal number, 222, arrived outside normal working hours.

In addition to these considerations, a sizeable number of referrals were made by professional workers. It is possible that they may have made inappropriate follow-up arrangements for the children, that it was deemed the child needed prompt medical attention, or that the visit was scheduled to obtain forensic evidence. The findings show clearly, however, that it was not the special child abuse or child sexual abuse programs, where such programs had been established, to which most of the patients initially presented themselves.

Of the children first seen by departments other than the emergency service, 36 were seen by the gynaecology service (35 girls and one boy — the boy

for reasons not explained), 30 in teen or adolescent clinics, 30 in the paediatric clinic, 27 in the medical outpatient or ambulatory care service, 26 by the sexual abuse team, 19 by the child protection or abuse team, 18 by the social service/social work department, and the remainder by family medicine, psychiatry, developmental or children's clinics. In general, with the predictable exception of the gynaecology service, the proportions of boys and girls seen in the various services were similar; the exceptions were that 10.8 per cent of boys compared to 3.5 per cent of girls were seen in medical outpatient and ambulatory services, and 10.8 per cent of boys, but only 3.3 per cent of girls were seen first by the sexual abuse team.

Principal Staff Member Conducting Initial Examination

The principal staff member conducting the initial examination was the emergency room physician in 206 cases, the paediatric resident in 109, the sexual abuse team or a member of it in 82, the child abuse team in 55 cases, a paediatrician in 60 cases, and a gynaecologist in 31 cases.

Table 31.7

Principal Staff Member Conducting Examination

Staff Member Conducting Examination	Males		Females	
	No.	Per Cent	No.	Per Cent
Child Protection Abuse Team	1	1.4	12	2.2
Sexual Abuse Team	1	1.4	8	1.5
Member of Child Protection/ Abuse Team	4	5.4	38	6.9
Member of Sexual Abuse Team	10	13.5	63	11.5
Emergency Room Physician	19	25.6	187	34.1
Family Practice Resident	1	1.4	7	1.3
Gynaecologist	—	—	31	5.6
Medical Social Worker	1	1.4	10	1.8
Paediatrician	12	16.2	48	8.7
Paediatric Resident	18	24.3	91	16.6
Psychiatrist	2	2.7	17	3.1
Gynaecology Resident	—	—	7	1.3
Pathologist	2	2.7	11	2.0
Other	2	2.7	9	1.6
Not reported, inapplicable	1	1.4	10	1.8
TOTAL	74	100.1*	549	100.0

National Hospital Survey.

*Rounding error

The sex of the principal examining staff member was ascertained and reported for 390 children. Among the 43 boys for whom this was known, 27 (62.8 per cent) were examined by male staff, 15 (34.9 per cent) by female staff and one by both. Of the 347 girls, 178, or just about half (51.3 per cent) were examined by male attending staff. Whether the child had an adverse reaction to the sex of the staff member was reported only in 177 cases. Of these, 14 children were recorded as having had an adverse reaction; 163 did not. The 14 were all girls; the examining physician was male in 11 cases, female in two and not reported in one. (With no reports for 446 cases, the significance of findings for 14 of 163 cases is questionable). Seven girls requested another physician.

Termination of Care After Initial Presentation

For 17 patients (six males, 11 females), hospital care was terminated by attending staff immediately following discovery of sexual abuse. The reasons noted were: further care was not recommended (3); the patient refused care (3); the patient's family refused care (1); the patient didn't come to hospital (1); the patient was referred to external agency (6); the patient didn't keep the appointment (2); and the police had arrested the offender (1).

Follow-up Care

In view of the complexity of the possible harms resulting from child sexual abuse, it is clear that some fairly extensive examinations should optimally be performed upon the victim. These would minimally include a general physical examination, gynaecological examination, where appropriate, developmental assessment, mental health assessment, family assessment, and possibly others, such as indicated laboratory tests, intelligence tests and forensic tests. Since most of the children first presented in the emergency service, it would be expected that a large number of referrals would be made to other services and that these would result in a significant number of follow-up visits.

This was, in fact, the case. Of the 592 children (95.0 per cent) for whom information was available, further medical and/or psychosocial follow-up within the hospital was recommended for 549 (92.7 per cent). The proportion for girls was slightly higher than that for boys which likely reflects the need for a detailed gynaecological assessment for many of the girls.

Recommended Follow-up Care	Males (n=74)		Females (n=549)	
	No.	%	No.	%
Medical/psychosocial follow-up	63	85.1	486	88.5
No follow-up recommended	8	10.8	35	6.4
Not reported, inapplicable	3	4.1	28	5.1

A recommendation that further assessment and care are needed does not ensure that such follow-up will occur or that if no recommendation is made that additional care will be sought. However, among the children surveyed, compliance, at least initially, appeared to be the rule. Of the 549 children for whom follow-up was recommended, information was available for 544, and of these, nine in 10 (89.9 per cent) obtained at least some of the recommended follow-up care.

Patients Receiving Recommended Follow-up Care	Males (n=63)		Females (n=486)	
	No.	%	No.	%
Within hospital	20	31.8	223	45.9
External source	14	22.2	58	11.9
Hospital and external source	23	36.5	151	31.1
None, not reported	6	9.5	54	11.1

Reasons for Follow-up Care

A total of 762 medical and psychological reasons were given concerning the need for the follow-up of 549 children for whom such care had been recommended. Most of the reasons given indicated the need for further assessment, of which over seven in 10 reasons indicated the need for psychosocial evaluation or counselling of the child (Table 31.8). The reasons for follow-up reflect the concerns of the initial examiner. It is likely that in the actual follow-up assessment and provision of care, further recommendations would reflect subsequent findings and the child's and family's progress.

It was recommended that seven boys and 17 girls should be followed up for investigation of sexually transmitted disease. Vaginal swabs were obtained from 305 girls and cervical swabs from 152. While 28 of these young patients (26 girls and two boys) were given a prophylactic medication, no information was listed in the hospital charts concerning whether these were 'confirmed' cases of sexually transmitted disease.

For patients for whom counselling was recommended by the initial examiner (for 248 girls and 36 boys), in some instances a notation was made either of the kind of counsellor being suggested, or of the kind of counselling desired. When the counsellor (or counselling agency) was specified, it was the hospital's abuse team in 80 cases, the child protection agency in 73, a social worker in 38, psychiatrist/psychologist in 38, and a child or adolescent clinic in 33. The types of counselling recommended were: family counselling, 28 cases; counselling in sexuality, sex abuse trauma/rape or birth control, 30 cases; and supportive counselling of parents or victim, 12 cases.

Table 31.8

Reasons Given by Attending Staff for Medical and Psychosocial Follow-up of Sexually Abused Children

Reasons Given for Follow-up	Males (n=63)		Females (n=486)	
	No.	Non-Accum.%	No.	Non-Accum.%
Repair of tears, lacerations	—	—	5	1.3
Abortion	—	—	2	0.4
Sexually transmitted disease	7	11.1	17	3.5
Pregnancy test	—	—	10	2.1
Gynaecological examination	2	3.2	108	22.2
Laboratory tests	2	3.2	27	5.6
Mental health assessment	6	9.5	59	12.1
Social work assessment	23	36.5	210	43.2
Counselling	36	57.1	248	51.0

National Hospital Survey. The gynaecological examination of two males is presumed to be in relation to more extensive examination of genitalia and anus/rectum than that provided on the initial examination.

For two in five (38.8 per cent) children, more than one follow-up service was recommended; this occurred twice as often for girls (41.2 per cent) as for boys (20.6 per cent). It is possible that this difference is accounted for by the initial impressions of physicians who had noted that a higher proportion of girls than boys had displayed symptoms of distress.

External Follow-up Care

Of the 246 children (209 girls and 37 boys) known to have received some of their follow-up care from an external service, the largest single group received that care from a child protection agency (172 cases). The instances of external aid also included: 38 children seen at a social service centre or by a social worker who had previously known the child; 26 seen at another hospital; 12 at a private clinic; 12 by the family physician; and 10 in a group home setting.

Almost half (45.5 per cent) of the reasons cited for recommending that external assistance be provided to children were made to meet legal requirements (e.g., requests by the police, child protection service, court). In a number of other instances, care had been initiated elsewhere, or the source of assistance was closer to the patient's home. In only two in five instances (41.5 per cent) was the source of external care otherwise initiated by hospital staff, i.e., a majority of the external assistance was recommended in order to meet legal requirements, to serve the convenience of patients, or because care had

been previously initiated by another agency. Of the 549 children for whom follow-up care was recommended, only one in five (18.6 per cent) received external assistance that was purposively sought out by hospital staff.

Sources of External Care	Males (n=37)		Females (n=209)	
	No.	Non-Accum. %	No.	Non-Accum. %
Child protection service	27	73.0	145	69.4
Social service/previous social worker	6	16.2	32	15.3
Other hospital	4	10.8	22	10.5
Private clinic	3	8.1	9	4.3
Family physician	2	5.4	10	4.8
Group home	—	—	10	4.8
School social worker/ worker/counsellor	1	2.7	6	2.9
Public health nurse	—	—	4	1.9
Other	—	—	5	2.4

In-hospital Follow-up Care

Of the 549 sexually abused patients for whom follow-up care was recommended, three in four (76.0 per cent) received some or all of their care from the hospitals participating in the survey. Such care was received from a multiplicity of providers, with many children being seen by the staff of more than one service, department or facility. The 417 children who were in some way involved with the hospital for follow-up obtained their care, on average from two services, departments or facilities (2.0).

In-hospital Follow-up Services	Males (n=43)		Females (n=374)	
	No.	Non-Accum.%	No.	Non-Accum.%
Social Service Department	17	39.5	170	45.5
Sexual Abuse Team	22	51.2	152	40.6
Child Protection/Abuse Team	21	48.8	144	38.5
Teen/Adolescent Clinic	4	9.3	113	30.2
Gynaecology	1	2.3	89	24.8
Psychiatry/Psychology	6	14.0	45	12.0
Paediatric Service	3	7.0	16	4.3
Nephrology/Urology	1	2.3	10	2.7
Other (emergency room, family medicine, infectious ward, prenatal clinic, medical outpatient)	4	9.3	22	5.9

Of the children who received outpatient follow-up care in hospital, reports on visits were available for 393. Of these children, 272 (69.2 per cent) made one or two visits each. Another 74 children (18.8 per cent) were seen between three and five times each and 34 had between six and nine visits. Thirteen children were seen at the hospital between 10 and 61 times, suggesting that intensive therapy had been provided.

For most of the physical injuries sustained by the children, redness, swelling, abrasions, bruising and so forth, one or two visits to the hospital would likely suffice to provide adequate care. Testing for the treatment of sexually transmitted diseases might have involved three or four visits. If the child originally presented in the emergency room, arranging gynaecological and psychosocial assessments could itself have involved another one to several visits. For a child involved in incest, or sustaining long-term recurrent abuse, supportive counselling, family therapy and/or individual psychotherapy may be warranted over a period of several months or even years.

Termination of Contact with Hospital

At the end of the period of a year and a half for which findings concerning sexually abused children were obtained in the National Hospital Survey, about one in five patients (18.3 per cent) was still receiving care or services from hospital personnel. Of the four in five children (81.7 per cent) for whom hospital services had been terminated, one in five closures had resulted from a decision made by a patient and his or her family, or the patient's family had moved elsewhere. Patient or family -initiated decisions to terminate receiving hospital services were twice as likely to have been made for female than for male patients. In about one in five cases, the decision to terminate services provided by hospital staff was made either by child protection services or a physician in community practice.

Summary

On the basis of the findings of the National Hospital Survey, it is concluded that:

1. About one in four (23.1 per cent) sexually abused children presented to the hospitals surveyed required medical attention for physical injuries or conditions (not all of which were attributable to sexual abuse).

2. In the judgment of the examining physicians, 2.4 per cent of these patients sustained physical injuries representing long-term harms. The majority of the children were adjudged not to have been physically injured by the sexual abuse, and of those who had been physically harmed, most of the injuries sustained were of a minor nature.

3. On the basis of the mental state assessment of the children, it was found that half (49.4 per cent) had suffered one or more emotional and behavi-

Table 31.9

Termination of Hospital Services for Sexually Abused Children

Status of Case When Survey Conducted	Males		Females	
	No.	%	No.	%
Patient still receiving services	8	10.8	106	19.3
Case closed	66	89.2	443	80.7
Total	74	100.0	549	100.0
Reason Case Closed				
Patient wished no more care (includes patients not reached by hospital, those who did not keep appointments, etc.)	3	4.0	56	10.2
Patients' parents wished no further care (includes prefer other source of care, etc.)	6	8.1	57	10.4
Review of case by hospital protection/ abuse team	11	14.9	39	7.1
Review of case by hospital sexual abuse team	9	12.2	34	6.2
Decision alone of primary examiner (e.g., M.D., social worker)	9	12.2	50	9.1
Decision of primary examiner in consultation with other hospital staff	4	5.4	34	6.2
Child Protection Agency doing follow-up care	6	8.1	66	12.0
Family physician, other hospital or agency doing follow-up	6	8.1	35	6.4
Care no longer necessary — child no longer at risk or considered well	6	8.1	48	8.7
Family moved	—	—	15	2.7
Not reported	6	8.1	9	1.6
TOTAL	66	89.2	443	80.6*

National Hospital Survey.

*rounding error.

oural harms resulting from sexual abuse. In the judgment of the attending professional health workers, about one in six children (17.8 per cent) potentially sustained long-term emotional or behavioural harm attributable to sexual abuse.

4. A majority of sexually abused children (65.9 per cent) initially presented to the emergency service of hospitals. This finding indicates the need for there to be a strong and effective liaison between this service and the specialty services of hospitals whose primary purpose is the care of children and that in this regard special attention should be given to the early identification and treatment of the emotional and behavioural needs of these children.

5. For most of the sexually abused children who presented to hospitals, a majority of their follow-up care was provided by hospital-based personnel, and setting aside referrals required for other purposes (e.g., legally required), only about one in five children was referred to external agencies.

   This finding reflects the common practice, particularly in large tertiary hospitals, to look for help within the hospital complex and to give less attention to the use of alternative facilities in the community that may be more accessible, less structured and formidable, and able to provide a wider range of services to complement those available in the hospital itself.

6. Most of the children appeared to have received a comprehensive examination, but this was not true in all cases. It was found that essential information was often missing about the details of the physical and mental examinations given, the nature of the harms sustained and the services provided.

   The review of the findings indicates the need for the development and use of an examination protocol which would serve as an examination and treatment guideline in the care of sexually abused children.

Accordingly, on the basis of the findings of the National Hospital Survey, **the Committee recommends that the Office of the Commissioner in conjunction with the Department of Justice, the Department of National Health and Welfare, and Provincial Departments of Health and Provincial Departments of the Attorneys-General, establish on a short term basis an interdisciplinary expert advisory committee:**

1. **To develop a standard protocol for the collection of information, examinations to be conducted, findings to be recorded and other necessary procedures.**

2. **To make this protocol widely available, particularly to those likely to have the first contacts (such as paediatricians, family practitioners and the staff of emergency departments), that regular in-service instruction be provided in its appropriate use, and that a reimbursement item be developed for the completion of the protocol.**

The Committee further recommends that the Office of the Commissioner in conjunction with the Department of Justice and the Department of National Health and Welfare fund, directly or by other means, a national research study focussing on injuries to sexually abused children. This research would seek to obtain information on: the efficiency of different clinical programs in providing protection and optimum management for these children; the nature of long-term harms sexually assaulted children experience; and how they can most effectively be prevented, anticipated, detected and treated. The Committee regards this as a priority area for research funding. Investigation should be undertaken in conjunction with major hospitals across Canada specializing in providing treatment for sexually abused children.

While the Committee recognizes that matters relating to the provision of health care fall largely within the jurisdiction of the provinces, it believes that a

national initiative is needed in developing procedures and guidelines for the clinical assessment and treatment of sexually abused children. The Committee is also cognizant of the fact that a number of other legislative and advisory bodies have made somewhat comparable recommendations. The recommendations that the Committee proposes are both feasible and warranted.

The Committee believes that a national initiative along the lines recommended would be one means to strengthen the care and protection of sexually abused children by serving to alert health professionals to the signs of these problems; to indicate the types of examination and procedures it may be appropriate to consider and undertake for these children; to provide a basis for the clear specification of how these children may have been harmed and the follow-up required for their assessment and care by medical and social services; and to develop criteria that are both medically and legally specific in the collection and documentation of evidence.

Chapter 32

Medical Classification of Sexual Assault

Statistical classification systems that accurately identify sexual offences and their resulting injuries are essential to the network of public services affording protection for victims of these crimes. To the extent that these classification systems validly reflect the nature of these acts and the harms incurred, they provide an indispensable means of assessing the extent of this problem, the scope of services provided to victims and the nature, gravity and duration of the harms and risks that are entailed.

During the past century, several different statistical systems have been developed with respect to the classification of deaths, diseases and injuries. The most widely recognized system of classification is the *Manual of the International Statistical Classification of Diseases, Injuries and Causes of Death* (Ninth Revision) adopted by the Twenty-Ninth World Health Assembly of the United Nations.[1] The codes in the *Manual* (I.C.D.-9) have been periodically revised to reflect changes in knowledge about the causes of disease, disability and death.

Since the advent of government-sponsored hospital and medical care insurance programs in Canada, all provinces and territories have established statistical classification systems for the identification of diseases, injuries and deaths or for the payment of services provided by hospitals and physicians. Despite variations in the listing of the codes used in these systems, each includes the full range of services provided; most have adopted the principles of codification which comprise the basis of the *International Classification of Diseases*.

It is on the basis of information assembled by these classification systems for diseases, injuries and deaths that assessments are made concerning the general health of Canadians, the extent of disease and disability in the nation and the need for particular types of services. With respect to sexual offences committed against children, youths and adults, these classification systems are a potential source of significant information about the nature and elements of the sexual acts committed and the physical injuries and emotional harms resulting from these acts.

In undertaking its review of the medical assessment and treatment of sexually abused children, the Committee found little consensus among physicians concerning the recognition and identification of a number of the signs of these conditions. Further, there was a sharp discrepancy between the diagnoses made by physicians with respect to these acts and their codification for the purpose of the statistical classification of diseases and injuries. Because the nosological classification systems are intended to be used to assemble information about diseases, injuries and deaths, there is little differentiation in these codes permitting the specification of diagnoses of different types of assaults committed against persons.

The medical research on child abuse and child sexual abuse undertaken in Canada has not relied on existing disease classification systems as reliable sources of baseline information for the purpose of identifying children who have been victims of these offences. In this chapter, some of the limitations noted by researchers about these systems are reviewed, an assessment is given of the categories established for the codification of sexual acts in the *Manual* of the International Classification of Diseases (Ninth Revision), and findings are presented from the National Hospital Survey on the clinical diagnoses made by physicians and their classification in accordance with the codes in the *Manual*. The Committee received valuable assistance in this regard from the Nosology Reference Centre of Statistics Canada and from the Department of Medical Records of the Hospital for Sick Children (Toronto).

Use of Classification Systems in Medical Research

Few of the Canadian medical research studies on child sexual abuse have relied upon statistical systems for the classification of diagnoses as a principal source of information for the purpose of identifying these types of cases. When this step has been taken, it is typically reported that these sources were incomplete or inappropriate for this purpose; most medical researchers drew directly on listings of child sexual abuse which they had established and had retained separately from the composite statistical classification systems. While this practice is undoubtedly a sound basis upon which to mount research along these lines, the consistent rejection of the classification systems in medical research indicates that these sources have been found to be neither reliable nor valid in providing adequate clinical and statistical information.

Of the main Canadian medical research studies on child abuse and child sexual abuse, only two relied exclusively on cases selected from a hospital's statistical record system. In one of these studies (Nova Scotia Child Abuse Study), a number of participating hospitals had developed special categories for the identification of child abuse.[2] In three of the major research studies, the findings were derived from cases examined or treated by the researchers or their colleagues. In the remainder of the research reports, both means of identifying cases were used, but in each instance, it was noted that the quality of the

information collected directly about patients was more reliable than that which had been derived from the statistical disease classification systems.

That few of the medical researchers who have studied child sexual abuse have relied on disease classification systems as sources of their information is due in part to the fact that when the studies were undertaken, only a few broad categories of child sexual abuse had been assigned in classification systems. In addition, the primary concern of these physicians was to identify, treat and provide protection for the children who were in their care. How these conditions might be clinically identified and subsequently listed were likely to be secondary, if not irrelevant, concerns. In this respect, the Committee knows of no review which has considered, in detail, the medical classification of clinical diagnoses made with respect to sexually assaulted persons (children or adults), or how well these listed categories accord with the full range of sexual acts committed and the types of injuries or harms that patients sustained.

Manual of the International Classification of Diseases

The *Manual of the International Statistical Classification of Diseases, Injuries and Causes of Death* (Ninth Revision, 1975) was developed for worldwide use as a statistical method for the classification of these conditions. The use of this classificatory index has been mandatory since January 1, 1979 across Canada in the classification of causes of death; starting on April 1, 1979, its use was adopted officially by Statistics Canada in relation to published reports for the classification of inpatient hospital morbidity statistics received from provincial hospital insurance programs. Some provincial medical care plans have adapted sections of the Manual for purposes of making payments to physicians by using the code at three or four digit levels, depending upon the degree of specificity required.

The *Manual* of the International Classification of Diseases is divided into 17 chapters in which diseases are grouped by type, site or circumstance. In addition to the classification of diseases, the *Manual* contains several supplementary means of classification:

1. The E Code for the identification of external causes of injury and poisoning.
2. The V Code for the identification of factors that may affect the health status of persons or contacts that patients may have with health services.
3. A dual method of classification for certain conditions according to etiology (identified by a dagger) and localized manifestation (identified by an asterisk), e.g., tuberulous meningitis with a dagger code in the chapter for infectious diseases and an asterisk code in the chapter for diseases of the nervous system.

The dagger and asterisk supplementary codes are not used in the classification of different types of sexual behaviour, acts or offences.

The codes listed in the *Manual* are designed to designate in numerical form the reasons why patients contact health services and the cause(s) of death. The codes may be assigned in relation to a patient's condition based on examination and/or treatment for: an emergency visit; outpatient treatment; inpatient admission; or a visit to a physician's office. With respect to how the codes in the *Manual* may be used in relation to these different types of contacts by patients with health services, no consistent practice is adopted across the nation. Likewise, there is no uniform policy with respect to the number of codes that may be assigned to each patient.

The Nosology Reference Centre of Statistics Canada reports that all provincial hospital insurance plans have adopted the *Manual* of the International Classification of Diseases (or an American modification of this system) for purposes of coding inpatient hospital morbidity statistics. In many provinces, this information is submitted for processing to the Hospital Medical Records Institute (H.M.R.I.). In Ontario, it is mandatory that hospitals submit records for day surgery and treatment for statistical processing to the Institute. The Nosology Reference Centre reports, however, that in most provinces there is no classification of the reasons why patients use hospital outpatient services (ambulatory care provided by hospital clinics and hospital emergency room services). In this respect, the procedures adopted by the Hospital for Sick Children are unusual as information on the causes of injuries are collected and coded for outpatients.

The American adaptation of the *Manual*, the I.C.D.-9-C.M. system, is used by several provincial hospital insurance programs. This system introduces greater specificity in the listing of diseases and conditions by using a 5-digit instead of 4-digit code. The *Diagnostic and Statistical Manual of Mental Disorders* (D.S.M.-3) is another system of classification which extends the scope of certain categories given in the *Manual* (I.C.D.-9), particularly with respect to the identification of psychiatric disorders.[3] The D.S.M.-3 system has been adopted by some Canadian hospitals, but its use is not officially recognized by provincial or federal departments of health. As a result, no provincial or national statistics have been assembled drawing upon this source.

Although their numerical codes vary for some items, the categories of the *International Classification of Diseases* and the *Diagnostic and Statistical Manual of Mental Disorders*, as listed in Table 32.1 are generally comparable with respect to the identification of sexual behaviour, sexual diseases and sexual character disorders. The codes listed in Section 302, Sexual Deviations and Disorders, of the *Manual* of the International Statistical Classification of Diseases are used for persons who seek or are provided with medical attention which can be classified by these categories. In instances in which several conditions are grouped together in one code category, retrieval of one of these conditions is impossible by using the code number alone. The existing categories for some conditions could be used as a means of identifying persons who may have committed certain types of sexual assaults, but there is no means whereby the victims of these offences who received medical attention could be identified by the codes given in Section 302.

Table 32.1

Medical Classificaton of Sexual Deviations and Disorders

International Statistical Classification (I.C.D.-9)		Diagnostic & Statistical Manual of Mental Disorders (D.S.M.-3)	
Sexual Deviations & Disorders		**Psychosexual Disorders**	
		Gender Identity Disorders	
302.5	Trans-sexualism	302.5x	Trans-sexualism
302.6	Disorders of psychosexual identity	302.60	Gender identity disorder of childhood
302.6	Disorders of psychosexual identity	302.85	Atypical gender identity disorder
		Paraphilias	
302.8	Other sexual deviations and disorders	302.81	Fetishism
302.3	Transvestism	302.30	Transvestism
302.1	Bestiality	302.10	Zoophilia
302.2	Paedophilia	302.20	Pedophilia
302.4	Exhibitionism	302.40	Exhibitionism
*302.8	Other sexual deviations and disorders	302.82	Voyeurism
302.8	Other sexual deviations and disorders	302.83	Sexual masochism
302.8	Other sexual deviations and disorders	302.84	Sexual sadism
*302.8	Other sexual deviations and disorders	302.90	Atypical paraphilia
		Psychosexual Dysfunctions	
*302.7	Frigidity and impotence	302.71	Inhibited sexual desire
*302.7	Frigidity and impotence	302.72	Inhibited sexual excitement
*302.7	Frigidity and impotence	302.73	Inhibited female orgasm
*302.7	Frigidity and impotence	302.74	Inhibited male orgasm
*306.5	Genitourinary malfunction arising from mental factors	302.75	Premature ejaculation
302.7	Frigidity and impotence	302.76	Functional dyspareunia
306.5	Genitourinary malfunction arising from mental factors	306.51	Functional vaginismus
*302.7	Frigidity and impotence	302.7	Atypical psychosexual dysfunction
		Other Psychosexual Disorders	
302.0	Homosexuality	302.00	Ego-dystonic homosexuality
*302.8	Other sexual deviations and disorders	302.89	Psychosexual disorder not elsewhere classified
**302.9	Unspecified sexual deviations and disorders		

* Not specifically indexed, but judged to fit in this category.

**No equivalent DSM-III category.

In addition to the items listed in Section 302 of the International Classification of Diseases, Chapter XVII classifies the nature of any injuries sustained and the supplementary E Codes classify the external causes of the injuries. In the Ninth Revision of the *Manual*, which is widely used across Canada, there is an E Code to identify that a patient has been a victim of rape, but there are no categories for other types of sexual assault such as incest or acts of vaginal or anal penetration.

The existing codes in the Ninth Revision of the *Manual* could be adapted to permit the identification of the injury which was sustained by the type of act committed and to indicate the identity of the suspected or known perpetrator. A child who had been *raped*, for instance, could be classified in this system according to:

• Nature of injury	e.g., 959.1	
• Plus E Code for rape	E 960.1	
• Plus E Code for child	E 967.0	by parent
• Battering & other maltreatment	E 967.1	by other specified person
	E 967.2	by unspecified person

There is no nature of injury code in this system which identifies that a child has been abused or molested other than the Code for the child maltreatment syndrome (995.5). A child who had been the victim of *incest* could be classified according to:

• Nature of injury	e.g., 959.1	
• Plus E Code for child	E 967.0	by parent
• Battering & maltreatment	E 967.1	other specified person
	E 967.9	by unspecified person

Under the current usage of the I.C.D.-9, cases classified by the E 967 Code would be grouped with victims of physical maltreatment, making retrieval of sexual maltreatment impossible.

The V Code of the Ninth Revision of the *Manual* is used to identify a number of abnormal family circumstances e.g., V61.2, Parent-Child Problems, which includes the seeking or obtaining of care as a result of child abuse. The V Code is not used for the purpose of identifying sexual offences committed against children or adults. This section also excludes the specific identification of maltreated children. Cases of this kind are coded 995.5 (child maltreatment syndrome), which includes: battered baby; and the emotional and/or the nutritional maltreatment of the child.

With respect to the identification of child sexual abuse by the codes listed in the *Manual* of the International Statistical Classification of Diseases, the Committee concluded that:

1. **Except for the E Code which might be adapted for this purpose, the I.C.D.-9 does not permit the identification of events since it is a system developed for the statistical classification of diseases.**

2. **There is no direct means for the identification of the results of most categories of sexual assault, unless injuries had been sustained.**

3. **The adaptation of the existing system, in order to identify victims of sexual assault, would likely prove to be cumbersome, except for specialists in nosology who were expert in using this system.**

4. **The use of the system is limited in practice across Canada to the classification of deaths or the conditions of patients who had been admitted to hospitals. The use of the system has not been extended to include the classification of conditions of patients provided with outpatient hospital services or those who are treated by physicians in private medical practice. Since the Committee's findings show that a majority of sexually assaulted children receiving medical care are not hospital inpatients, most cases of child sexual abuse would still fail to be identified, even if the existing classification system were amended.**

Classification of Medical Diagnoses

In the National Hospital Survey, the diagnoses made by physicians who had examined or treated sexually assaulted children were transcribed, as they had been written in hospital charts, to the research protocols. A total of 65 clinical diagnoses was given with respect to children and youths who were suspected or confirmed to have been sexually abused. With the assistance of the Nosology Reference Centre of Statistics Canada and the Department of Medical Records of the Hospital for Sick Children, these 65 clinical diagnoses were coded using the system set out in the *Manual* of the International Statistical Classification of Diseases (Ninth Revision). In the case of the Hospital for Sick Children, these diagnoses were classified with respect to a supplementary 2-digit code adopted by the Department of Medical Records of the Hospital.

The results of the statistical classification of the 65 clinical diagnoses made by physicians of child sexual abuse are given in Table 32.2. The first column, Diagnoses Given by Attending Physician, lists the diagnoses transcribed directly from patients' charts in the National Hospital Survey. In the second and third columns, the numerical and written classification of these diagnoses is listed in accordance with the Coding Book used by the Hospital for Sick Children. The fourth and fifth columns list a comparable assessment of the physicians' diagnoses provided by the Nosology Reference Centre of Statistics Canada.

Table 32.2

Statistical Classification of Medical Diagnoses given for Suspected/Confirmed Cases of Child Sexual Abuse

Diagnoses Given By Attending Physician	Hospital for Sick Children		Nosology Reference Centre	
	ICD-9 (adapted)	Code Book Classification	ICD-9	Code Book Classification
Abdominal pains	7890	Abdominal pain.	789.0	Abdominal pain.
Alleged physical abuse	9955-01	Battered child syndrome.	995.5 E 967.9	Child maltreatment syndrome; child battering & other maltreatment by unspecified person.
Alleged rape	—	—	V 71.5	Observation following alleged rape or seduction.
Alleged sexual abuse & behavioural problem	—	—	995.5 E 967.9 V 40.9	Child maltreatment syndrome; child maltreatment by unspecified person; unspecified mental & behavioural problems.
Alleged sexual abuse molestation	—	—	995.5 E 967.9	Child maltreatment syndrome; child battering and other maltreatment by unspecified person.
Alleged sexual abuse & skin irritation	—	—	995.5 E 967.9 709.8	Child maltreatment syndrome; child maltreatment by unspecified person; other disorders of skin.
Alleged sexual abuse/urinary tract infection	—	—	995.5 E 967.9 599.0	Child maltreatment syndrome; child maltreatment by unspecified person; urinary tract infection, site not specified.
Alleged sexual abuse & venereal disease	—	—	995.5 E 967.9 099.0	Child maltreatment syndrome; child maltreatment by unspecified person; venereal disease, unspecified.
Alleged sexual assault/venereal disease	—	—	— 099.0	Venereal disease, unspecified.

Table 32.2 (*continued*)

Statistical Classification of Medical Diagnoses given for Suspected/Confirmed Cases of Child Sexual Abuse

Diagnoses Given By Attending Physician	Hospital for Sick Children		Nosology Reference Centre	
	ICD-9 (adapted)	Code Book Classification	ICD-9	Code Book Classification
Alleged sexual assault without penetration	—	—	—	—
Alleged/suspected/possible sexual assault	—	—	—	—
Alleged sexual intercourse with a minor	—	—	—	—
Anxious, distracted	3000	Anxiety/neurosis/reaction	300.0	Anxiety states
Assault	—	—	959.9 E 968.9	Injury NOS, unspecified site assault, unspecified means
Attempted sexual assault	—	—	—	—
Balanitis (urinary tract infection — inflammation)	6071	Balanitis	607.1	Balanoposthitis (inc. Balanitis).
Bruising	9198	Superficial injury	924.9	Contusion, unspecified site.
Corrupting the morals of a child	—	—	—	—
Distress re: home situation	—	—	V 61.9	Family circumstances, unspecified.
Drug overdose	9779	Poisoning, drugs.	977.9	Poisoning, unspecified drug.
Eczema or other skin disease	6918 7099	Infantile eczema/dermatitis. Disease, Skin/subcut. tissue.	692.9 709.9	Eczema NOS. Disorder of skin, unspecified.
Facial trauma	9590	Facial	959.0	Injury NOS, face and neck.
Family patterns of violence and failure	—	—	—	—
Gastritis	5355	Gastritis	535.5	Unspecified gastritis and gastroduodenitis.
Gross indecency/Indecent assault	—	—	—	—

Table 32.2 (*continued*)

Statistical Classification of Medical Diagnoses given for Suspected/Confirmed Cases of Child Sexual Abuse

Diagnoses Given By Attending Physician	Hospital for Sick Children		Nosology Reference Centre	
	ICD-9 (adapted)	Code Book Classification	ICD-9	Code Book Classification
Gynaecologically normal (not indicated if sexually active or not)	—	—	—	—
Hepatitis B and Gonococcal (G.C.) infection	0703 0988-98	Hepatitis B, viral, without hepatic coma. Gonococcal infection.	070.3 098.0	Viral hepatitis B without mention of hepatic coma. Acute gonococcal infection of lower genitourinary tract
History of third party sexual abuse	—	—	—	—
Incest	—	—	—	—
Infection/irritation	1368	Infectious/parasitic disease.	136.9	Infection, unspecified.
Infection & venereal disease	—	—	136.9 099.9	Infection, unspecified; Venereal Disease, unspecified.
Intent to sexually assault	—	—	—	—
Medically healthy child	V719	No disease found.	—	—
Negative behaviour, poor self-image due to sexual abuse	—	—	V 40.3	Other behavioural problems.
No evidence of vaginal penetration	—	—	—	—
Pelvic inflammatory disease (P.I.D.)	6149	Pelvic inflammatory disease.	614.9	Unspecified inflammatory disease of female pelvic organs and tissues.
Perineal bleeding	—	—	624.8	Other non-inflammatory disorders of vulva and perineum.
Perineal trauma	—	—	959.1	Injury NOS, trunk (inc. perineum).
Physical injuries	—	—	959.9	Injury NOS, unspecified site.
				—

Table 32.2 (*continued*)

Statistical Classification of Medical Diagnoses given for Suspected/Confirmed Cases of Child Sexual Abuse

Diagnoses Given By Attending Physician	Hospital for Sick Children		Nosology Reference Centre	
	ICD-9 (adapted)	Code Book Classification	ICD-9	Code Book Classification
Physical & sexual abuse	—	—	995.5 E 967.9	Child maltreatment syndrome; child maltreatment by unspecified person.
Possible sexual molestation by sibling	—	—	—	—
Pregnancy	V222	Pregnant state.	V22.2	Pregnant state NOS.
Questionable whether abuse has occurred	—	—	—	—
Rape	—	—	959.9 E 960.1	Injury NOS, unspecified site. Rape
Reactive behavioural problem	3099-02	Childhood adjustment reaction.	V 40.3	Other behavioural problem.
Second & third degree burns	9490-01	Burn.	949.2 949.3	Burn, unspecified site, 2nd degree. Burn, unspecified site, 3rd degree.
Sexual abuse (incest)	—	—	995.5 E 967.0 (or .1)	Child maltreatment syndrome; child maltreatment by parent (or by other specified person).
Sexual abuse without penetration, incest.	—	—	995.5 E 967.0 (or .1)	Child maltreatment syndrome; child maltreatment by parent (or by other specified person).
Sexual abuse & urinary incontinence (not related to sexual abuse)	—	—	995.5 E 967.9 788.3	Child maltreatment syndrome; child maltreatment by unspecified person; incontinence of urine.
Sexually active/ intercourse has occurred.	—	—	—	—
Sexual assault	9599-02	Sexual assault.	—	—
Sexual assault/digital penetration only	—	—	—	—

Table 32.2 (*concluded*)

Statistical Classification of Medical Diagnoses given for Suspected/Confirmed Cases of Child Sexual Abuse

Diagnoses Given By Attending Physician	Hospital for Sick Children		Nosology Reference Centre	
	ICD-9 (adapted)	Code Book Classification	ICD-9	Code Book Classification
Sexual assault (Incest)	—	—	—	—
Sexual molestation with penetration	—	—	—	—
Social problems	V629	Social problem.	V 62.9	Other psychosocial circumstances, unspecified.
Subject of lesbian activities	—	—	—	—
Suicide attempt	3009-04	Suicidal attempt.	959.9 E 958.9	Injury NOS, unspecified site suicide and self-inflicted injury, unspecified means.
Suspected sexual abuse	—	—	995.5 E 967.9	Child maltreatment syndrome. Child maltreatment by unspecified person.
Use of psychological defense mechanisms/psychological reaction to abuse	—	—	—	—
UTI	5990-01	UTI.	599.0	Urinary tract infection, site not specified.
Vaginal discharge	6235	Vaginal discharge.	623.5	Leukorrhoea, not specified as infective (inc. vaginal discharge NOS).
Vaginal discharge possible sexual assault	—	—	623.5	Leukorrhoea, not specified as infective (inc. vaginal discharge NOS).
Venereal disease	0999	Venereal disease.	099.0	Venereal disease, unspecified.
Venereal disease unlikely	—	—	V 71.8	Observation for other specified suspected condition.
Vulvovaginitis with hymenal lacerations	6163-03	Vulvovaginitis.	616.1 878.6	Vaginitis and vulvovaginitis. Open wound of vagina, without mention of complication.

The findings indicate that relying upon the coding procedures adopted by the Hospital for Sick Children's system, about two-thirds (64.6 per cent) of the medical diagnoses given in relation to suspected and/or confirmed cases of sexual abuse were not identified for purposes of statistical identification.

A review was undertaken of the 65 medical diagnoses in relation to their confirmation or non-confirmation that a child had been sexually abused. The diagnoses were categorized with respect to whether there was: a *definite* indication of sexual abuse; a *probable* indication of sexual abuse; a *possible* indication of sexual abuse; and *no indication* that the condition identified was likely to be related to an incident of sexual abuse.

Diagnostic Indications of Sexual Abuse	Number of Diagnoses	Diagnoses Identified by Adapted I.C.D.-9/H.S.C.	Proportion of All Diagnoses Identified by Adapted I.C.D.-9/H.S.C.
			(%)
Definite	11	1	9.1
Probable	13	4	30.8
Possible	15	3	20.0
No Indication	26	15	57.7
TOTAL	65	23	35.4

Of the 11 diagnoses made by physicians which provided a *definite* indication that child sexual abuse had occurred, only one (9.1 per cent) was identified by means of the coding procedures used at the Hospital for Sick Children. The proportion of the diagnoses identified by this means rose to 30.8 per cent for diagnoses indicating *probable* incidents of sexual abuse, dropped slightly to 20.0 per cent for diagnoses indicating *possible* incidents of this kind, and accounted for about three in five (57.7 per cent) of the diagnoses in which there was *no indication* of sexual abuse having occurred.

In the fourth and fifth columns of Table 32.2, the results are listed of the classification of the 65 diagnoses undertaken by the Nosology Reference Centre of Statistics Canada. These findings differ from those obtained involving the classification of diagnoses undertaken by the Department of Medical Records of the Hospital for Sick Children. With respect to identifying statistically diseases and conditions, two in three (67.7 per cent) of the 65 diagnoses were coded in relation to the listings given in the *Manual* of the International Statistical Classification of Diseases.

In the review of the 65 diagnoses made by the Nosology Reference Centre, slightly over half (54.5 per cent) of the diagnoses providing a *definite* indication of child sexual abuse were identified by means of the codes in the I.C.D.-9 *Manual*. The proportions of the diagnoses for the remaining three categories of diagnoses were: *probable* indications of sexual abuse, 76.9 per cent; *possible*

Diagnostic Indications of Sexual Abuse	Number of Diagnoses	Diagnoses Identified by I.C.D.-9/N.R.C.	Proportion of All Diagnoses Identified by I.C.D.-9/N.R.C.
			(%)
Definite	11	6	54.5
Probable	13	10	76.9
Possible	15	9	60.0
No Indication	26	19	73.1
TOTAL	65	44	67.7

indication of sexual abuse, 60.0 per cent; and *no indication* of sexual abuse, 73.1 per cent.

While two in three of the 65 diagnoses were statistically coded by the Nosology Reference Centre in relation to the classification of the I.C.D.-9, a number of these listings fell into general categories. For instance, the listing in the I.C.D.-9 Manual of "Abuse, Child" is considered under: Child Maltreatment Syndrome (995.5); and Child Maltreatment by Unspecified Person (E 967.9). No differentiation is made in these categories between physical and sexual abuse. Although the diagnoses providing a definite indication of child sexual abuse may be classified in relation to these codes of the I.C.D.-9, for the purposes of identifying child sexual abuse, much of this information is effectively lost; for certain codes in the *Manual*, no identification of child sexual abuse having been diagnosed can subsequently be retrieved from the diagnostic statistics compiled by this means.

When diagnoses which were classified under general non-specific codes are set aside, and only those for which there was a specific indication of sexual abuse are retained, then about half (49.2 per cent) of the 65 diagnoses are accurately identified with respect to their classification in relation to the I.C.D.-9 *Manual* undertaken by the Nosology Reference Centre. In relation to the four categories of diagnoses, the proportions identified in the revised listing were:

Diagnostic Indications of Sexual Abuse	Number of Diagnoses	Revised Listing of Diagnoses Identified by I.C.D.-9/N.R.C.	Proportion of All Diagnoses Specifically Identified by I.C.D.-9/N.R.C.
			(%)
Definite	11	4	36.4
Probable	13	7	53.8
Possible	15	5	33.3
No Indication	26	16	61.5
TOTAL	65	32	49.2

In the revised listing, of the 11 diagnoses providing a *definite* indication of sexual abuse, about one in three (36.4 per cent) was accurately identified in relation to the I.C.D.-9 classification. The proportions for the other categories were: *probable* indications of sexual abuse, 53.8 per cent; *possible* indications of sexual abuse, 33.3 per cent; and *no indication* of sexual abuse, 65.4 per cent.

The findings from the reviews undertaken by the Department of Medical Records of the Hospital for Sick Children and the Nosology Reference Centre of Statistics Canada indicate that there is a sharp discrepancy between diagnoses made by physicians and how these diagnoses may be subsequently classified for purposes of statistical diagnostic classification. With respect to the intended use of the statistical classification systems, it must be noted that they were developed for the purposes of identifying diseases, injuries and causes of death. However, it is apparent that in this respect, some types of sexual acts and behaviour are identified, while others are omitted or are subsumed within general codes. It is also evident that there is a considerable loss of specific types of information in relation to the identification of certain diagnoses due to their conversion to code numbers representing groups of diagnoses or conditions. There is also a lack of differentiation (in the E Codes, in particular) between physical and sexual abuse.

These findings on the statistical classification of diagnoses obtained in relation to the examination of sexually abused children indicate that the utility of any classification system is contingent upon the quality of the information provided. A number of the diagnoses given by physicians in relation to child sexual abuse lacked specificity with respect to indicating the details of the cases examined.

With respect to the identification of suspected or confirmed instances of child sexual abuse, the basic disease classification system which is widely used (or adapted) across the nation must be considered inadequate, if not invalid.

Virtually none of the major conditions diagnostically identified by physicians in relation to sexual abuse is recognized in the existing statistical codes. These unidentified conditions, include, among others: alleged/confirmed sexual abuse/assault; intercourse with a minor; vaginal and anal penetration; incest; perineal bleeding/trauma; rape; and the touching/fondling of the sexual parts of the body.

Summary

In the Committee's view, having a disease classification system which identifies with reasonable accuracy medically examined cases of suspected and/or confirmed sexual abuse is an essential component of the services required for the protection of victims of these offences. In the absence of such a system, it is not possible to determine the extent of these medically reported conditions and, of greater importance for the well-being of the child, to assess

the physical and emotional harms sustained and their long-term impact on the child's health.

The existing disease classification system provides for the identification of fetishism, pedophilia, exhibitionism, sexual deviation, homosexuality and transsexualism, among others. All of these categories pertain to persons having these attributes or committing these acts. These categories do not permit the identification of persons against whom sexual acts may be committed. It is an anomaly that while certain types of sexual behaviour and disorders are identified, no specific reference is made to persons committing incest or sexual assaults.

The existing classification system for the identification of sexual behavioural and character disorders is a conceptual compost heap which has been added to without sufficient consideration being given to the specification of particular categories or to the sum of its parts. It is inconsistent, for instance, with respect to the inclusion of some categories, but the exclusion of other major types of sexual behaviour. Most of the existing categories are loosely defined and do not permit a reasonably uniform and consistent identification of behaviours and disorders, e.g., pedophilia. In the Committee's view, most of these categories should be dropped and be replaced by a classification system which is inclusive with respect to the identification of the types of sexual acts for which persons may have a predisposition to commit and the acts committed.

The main deficiency of the existing classification systems is that they do not permit the sufficient or complete identification of persons against whom sexual acts are committed and how they may be injured. What is required is a classification system having the capacity to identify accurately:

1. The types of sexual acts committed.
2. The circumstances or events under which the acts were committed (e.g., involving assault).
3. The type of association between the person committing the act and the patient (e.g., incest).
4. The types of physical injuries and emotional harms sustained.

Elsewhere in the Report, the Committee has developed categories for the specific identification of sexual acts, persons committing these acts and the circumstances under which the acts occur. These elements should comprise the basis for the development of a revised classification system.

On the basis of the Committee's review of the clinical medical research dealing with child sexual abuse, it is evident that these sources cannot, as yet, be considered as an adequate system for the identification of the types of medically examined cases of child sexual abuse, nor do they provide sufficiently detailed information about how sexually abused children were injured. With respect to these issues, there is now virtually an informational vacuum in Canada. Neither the widely used systems for the classification of diseases and

conditions nor the body of available clinical medical research provides adequate information concerning the identification of these conditions or the injuries resulting from them.

The Committee recognizes that a review of the *International Classification of Diseases* (Ninth Revision) is being undertaken by the World Health Organization. This review is scheduled to be completed before the end of the 1980s. The Committee believes that the Government should not postpone consideration of the revision of the I.C.D.-9 now being widely used across Canada until the international review has been completed. There is no assurance that the international review will address the concerns identified by the Committee.

The Committee recommends that the Office of the Commissioner in consultation with the provinces, the Department of Justice, the Department of National Health and Welfare and Statistics Canada, appoint an expert advisory committee comprised of experts in nosology, paediatrics and the law to:

1. **Review the codes of the *International Classification of Diseases* (Ninth Revision) in order to determine how these do or do not permit the identification of diagnoses relating to persons, both children and adults, who have been sexually abused.**

2. **Develop a revised classification with respect to the identification of physical injuries and emotional harms associated with sexual assault.**

3. **Enlarge this system with respect to the identification of the events or persons associated with these assaults (e.g., incest), in relation to:**

   (i) **the types of sexual acts committed;**

   (ii) **the circumstances or events under which the acts were committed;**

   (iii) **the type of association between the person committing the act and the patient; and**

   (iv) **review and make recommendations with respect to the identification of sexual abuse within the framework of medical services provided to: hospital outpatients; and patients examined and treated by physicians in private medical practice.**

On the basis of the review and recommendations provided by the expert advisory committee, the Committee recommends further that the Office of the Commissioner in co-operation with the Government of Canada should:

1. **Implement the recommended revisions with respect to the classification by Statistics Canada of hospital morbidity and death statistics.**

2. **Consult with the provinces to review means whereby the classification of medical services provided on an ambulatory basis can be revised to identify statistically persons who have been sexually assaulted and injured.**

3. **Make representation to the international nosological review committee of the World Health Organization with respect to effecting amendments along these lines to be contained in the Tenth Revision of the *International Classification of Diseases.***

References

Chapter 32: Medical Classification of Sexual Assaults

[1] World Health Organization. *Manual of the International Classification of Diseases, Injuries and Causes of Death*. Ninth Revision. Geneva, 1978.

[2] Fraser, F.M., J.P. Anderson and K. Burns, *Child Abuse in Nova Scotia*. Halifax, 1973, pp. 25-27.

[3] American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. Third edition. Washington, D.C., 1980.

Chapter 33

Live Births, Therapeutic Abortions and Sexually Transmitted Diseases

An outstanding characteristic of the sexual offences in the *Criminal Code* is the attempt to provide protection by means of prohibitions against sexual intercourse with young females. This no doubt reflects moral concerns, as do other prohibitions against sexual misconduct. However, the prohibitions against sexual intercourse specified in the *Criminal Code* also indicate concern with the consequences for young girls of health risks from pregnancy and sexually transmitted diseases. Although these concerns were expressed almost 60 years ago in the United Kingdom *Report of the Departmental Committee on Sexual Offences Against Young Persons*,[1] comprehensive information on these health risks has yet to be obtained.

The findings presented in this chapter draw upon official national statistics concerning live births and therapeutic abortions of young Canadian females. In relation to sexually transmitted diseases contracted by children and youths, the Committee was provided with national statistics by the Bureau of Epidemiology of the Department of National Health and Welfare. The Manitoba Department of Health, Sexually Transmitted Disease Control Program, made findings available to the Committee concerning reported cases for 1980 and 1981 involving children who were age 16 and younger.

Live Births

The 1925 United Kingdom *Report of the Departmental Committee on Sexual Offences Against Young Persons* noted that:

> "Another argument which impresses us is the physical injury to a girl of 15 or younger who gives birth to a child. Whether she consents or not, modern legislation and public opinion desire to make her interest paramount."[2]

This argument was advanced in support of a recommendation for an absolute prohibition against sexual intercourse with a girl under 16. At the time, there was no question of performing a legal abortion. Today, females 15 or younger who become pregnant are recognized to be in a high risk category and

require specialized care and attention. They are subject to greater hazards at different trimesters of pregnancy. They are likely to deliver prematurely and to have babies who are also likely to be in a high risk category.

There is a substantial number of these hazardous pregnancies in Canada.[3] In 1981, there was one live birth to an 11 year-old, one to a 12 year-old, 35 to 13 year-olds, 231 to 14 year-olds, 938 to 15 year-olds and 2,749 to 16 year-olds. Of the 268 live births to females under 15 years, four were second births, and of the 938 live births to 15 year-olds, 17 were second births. Most of the 268 live births to females under 15 years (97.6 per cent) were to single women. For purposes of comparison, 59.2 per cent of the 29,062 live births to females 15 to 19 years were to single women.

Therapeutic Abortions

The *Criminal Code* was amended in 1969 to permit therapeutic abortions to be performed in certain circumstances. In 1981, 10 twelve year-olds, 84 thirteen year-olds and 450 fourteen year-olds had their pregnancies terminated. One of the 14 year-olds had one previous delivery. In addition, 1,262 fifteen year-olds had their pregnancies terminated. Fourteen of these cases had one previous delivery. For purposes of comparison, 2,850 sixteen years-olds had their pregnancies terminated. Of these, 65 had a previous delivery and one had two previous deliveries. Most of the 15 year-olds (99.6 per cent) and 16 year-olds (99.2 per cent) were unmarried.[4] The average therapeutic abortion rate per 100 live births for females between 15 and 17 from 1974 to 1981 was 4.5 times the average rate for all ages. For females under 15, the therapeutic abortion rates for the same period were between 3.2 (1974) and 2.3 (1981) times the rates for those between 15 and 17 (average 2.6).[5]

Table 33.1 shows that the proportion of pregnant females having therapeutic abortions in the first trimester in 1981 varied from 76.6 per cent of those under 14 to 82.6 per cent of those 18 and 19. At the same time, the proportion having abortions from 13-20 weeks' gestation varied from 23.4 per cent of those under 14 to 17.2 per cent of those 18 and 19. The most important fact here is that more than three-quarters of teenage girls and those even younger having therapeutic abortions had had them during the first trimester. However, there is also a slight gradual rise in the proportion of earlier abortions from 14 to 19 years, with a corresponding slight gradual decrease in the proportion of later abortions.[6]

The proportion of females under 15 years having complications associated with a therapeutic abortion is almost double that for females of all ages at all stages of gestation. The complication rates per 100 therapeutic abortions for females under 15 years is 25 per cent higher than for those 15-19 years of age, and almost twice as high as for those 20-24 years of age.[7] Abortion complications for girls under age 15 included: haemorrhage; laceration of the cervix; perforation of the uterus; and retained products of conception. Infection was an additional complication with those 15-19 years.[8] Later complications may

Table 33.1

Therapeutic Abortions among Females under Age 20 by Weeks of Gestation, Canada, 1981

Weeks of Gestation	Under 14 Years (n=94)	14–15 Years (n=1 712)	16–17 Years (n=6 662)	18–19 Years (n=9 801)
	Per Cent	Per Cent	Per Cent	Per Cent
Under 9 weeks	19.2	18.4	17.5	19.5
9 – 12 weeks	57.4	59.9	61.9	63.1
13 – 16 weeks	18.1	14.9	14.5	12.7
17 – 20 weeks	5.3	6.1	5.9	4.5
21 weeks and over	—	0.7	0.2	0.2
TOTAL	100.0	100.0	100.0	100.0

Canada. Statistics Canada. *Therapeutic Abortions 1981*, Ottawa: Supply and Services Canada, 1983, based on Table 26, p. 79.

include: infertility and tubal pregnancies secondary to tubal adhesions or to partial or complete obstruction after infection; and premature delivery in subsequent pregnancies which may be related to the laceration of the cervix and the later inability of the uterus to retain an increasing mass of a normally developing pregnancy. The abortion complication cases from 1974 to 1981 as a proportion of the total abortion cases for the period show a general decrease for all ages. However, the figure for females under 15 years is always the highest, followed by the figure for those 15 to 19 years-old. In the former case, it was 9.3 per cent in 1974 and 4.4 per cent in 1981. In the latter, it was 4.1 per cent in 1974 and 3.3 per cent in 1981. For purposes of comparison, the proportion for females 20-24 years-old was 2.8 in 1974 and 2.3 in 1981.[9]

The 1977 *Report of the Committee on the Operation of the Abortion Law* found that "the contraceptive practices of young and single females made them a high-risk group in terms of becoming pregnant".[10] Females 15 and younger who become pregnant are considered to be in a high risk category. Therapeutic abortions performed on young girls carry a higher than normal risk of complications at all stages of gestation and pregnancy subjects young girls to substantial risk of harm. The enactment of the legislation proposed by *Bill C-53* and the *Working Paper* would have significant implications for pregnancy and the resulting risk of harm. Removing the criminal law prohibition against sexual intercourse with young girls from substantial proportions of their partners who are close in age would do nothing to protect the girls against the physical risks of pregnancy.

Sexually Transmitted Diseases

Provincial and Territorial governments recognize the importance of providing protection against the spread of sexually transmitted disease through a system of public health statutes and regulations which require the reporting and treatment of cases of venereal disease. These provisions encourage accurate diagnosis and appropriate treatment; however, it would appear that in a great many cases where treatment is given for sexually transmitted disease, there is no reporting and no follow-up to prevent the further spread of the disease to other persons.

The medical philosophy that has emerged in recent years appears to be directed towards treating individual cases as symptoms and signs without necessarily confirming the diagnosis and tracing and treating the patients' contacts. This philosophy is buttressed by what has become a general concern for confidentiality, so that it is common for physicians not to report these conditions. Indeed, there is a reluctance to record a specific diagnosis of a venereal disease.[11] The result is that the public health objectives supported by the statutes and regulations are not as actively pursued, although current outbreaks of diseases, such as Acquired Immune Deficiency Syndrome, are drawing attention again to the importance of public health protection. The Committee believes that failure to improve and enforce the provisions of the public health laws deprives children and youths of an important protective mechanism against the health consequences of these diseases.

In order to assess the extent to which children who had been sexually assaulted were at risk of contracting a sexually transmitted disease, the Committee sought to obtain this type of information in each of the national surveys in which it appeared feasible that such findings might be identified. The Committee was assisted in this review by the Bureau of Epidemiology of the Department of National Health and Welfare, which provided national statistics on the reported distribution of gonococcal infections and which listed provincial programs in which existing reporting procedures identified higher rates for these diseases than other provinces.

In this respect, the Committee received valuable assistance from: Social Hygiene Services of the Alberta Department of Social Services and Community Health; and the Manitoba Department of Health, Sexually Transmitted Disease Control Division. On behalf of the Committee, the latter Program assembled information on all children who were age 16 years and younger for 1980 and 1981 in relation to cases examined and/or treated by physicians and agencies reporting notifiable cases to the Control service. The unique information presented in this chapter was made possible by the recording practices of the Manitoba STD Control Program which operates in accordance with the terms of the public health law. No names were identified in the information provided to the Committee, yet the importance of this information for monitoring the effectiveness of laws for the protection of children and youths is obvious in relation to the significant findings obtained.

In presenting these findings, the Committee recognizes that the children and youths for whom this information is given are not representative of all children who have been victims of sexually transmitted disease. In addition to the difficulties involved in obtaining information about children who have been sexually assaulted, attempting to ascertain whether they may have contracted a venereal disease requires lifting the veil on an issue about which there is an equal, if not greater, social stigma. For these reasons, there appear to have been few attempts made to obtain such information, and the cases that are known are generally believed to comprise a small fraction of the actual prevalence.

Nosology

The term, "venereal disease", which more recently has been referred to by the phrase, "sexually transmitted diseases", includes a number of different infectious diseases acquired by sexual intercourse and other sexual acts. The term 'sexually transmitted disease', or as it is known in Europe, 'sexually transmissible diseases', includes the full listing of the following conditions.

1. Syphilis, caused by Treponema pallidum
2. Gonorrhea, caused by Neisseria gonorrheae
3. Chancroid, caused by Haemophilus ducreyi
4. Lymphogranuloma venereum caused by Chlamydia trachomatis serotypes L1, L2 and L3
5. Granuloma inguinale, caused by Calymmatobacterium granulomatis
6. Nongonococcal urethritis, cervicitis and vaginitis for which there are a number of agents including Chlamydia trachomatis, Ureaplasma urealyticum and Gardnerella vaginalis
7. Trichomoniasis caused by Trichomonas vaginitis
8. Genital herpes infection, caused by Herpes virus hominis, Types I and II
9. Opthalmia Neonatorum caused by Chlamydia trachomatis. This is a purulent eye disease in infants.

In addition to these conditions, there are many other forms of sexually transmitted diseases. Male homosexuals, for instance, may transmit a group of gastrointestinal maladies, including amoebiasis, giardiasis, parasitic worms, shigellosis and salmonellosis. The recently discovered disease, AIDS (Acquired Immune Deficiency Syndrome), is also found in some homosexual or bisexual males and in their sexual partners. The etiological agent for this disease has not been identified.

The etiology, or the factors that are known or suspected to cause these diseases, varies in relation to each condition. Gonorrhea, for instance, is caused by the gonococcus, Neisseria gonorrheae, and spread by sexual contact. Some women are asymptomatic carriers of the organisms. Asymptomatic infection is

also found in some homosexual men, especially in the oropharynx and rectum. The usual incubation period in both sexes is between two and seven days. There is pain in the urethra and burning on urination, with frequency of urination and a purulent yellowish green discharge. The associated complications resulting from this disease include chronic urethral inflammation, epididymitis and, at a late or chronic stage, orchitis. There may be abscesses around the urethra and prostate, with subsequent urethral strictures and fistulae.

In women, symptoms of gonococcal infection are often absent or frequently so mild as to pass unnoticed. If sought, cervicitis, and occasionally urethritis, may be found. The most serious complication is salpingitis, occurring frequently in women under the age of 25, including small girls. Abdominal pain of variable intensity is present and accompanied by fever. Tubal and pelvic abscesses may occur. The resulting scarring of the fallopian tubes may result in infertility or ectopic pregnancy. Gonorrhea may also cause serious infections of the eye, especially in newborns which, if not prevented or inadequately treated, may result in blindness.

Disseminated gonococcal infection spreading throughout the whole body with joint pains may be a considerable diagnostic challenge. Gonococcal arthritis is more common in women than in men. The onset is acute, usually occurring in one joint, which is severely painful with fever. All forms of gonorrhea can be adequately treated with appropriate antibiotic drugs. The prevalence of penicillin-resistant gonorrhea is becoming more common all over the world.

Medical Classification

The *International Classification of Diseases* (Ninth Revision) identifies diseases numerically and by title, and groups these diseases into a number of broad types of conditions. One of these categories, Infective and Parasitic Diseases, lists those conditions that are generally recognized as being communicable or transmissible, and within this category, the numerical identification is given for sexually transmitted diseases.

A number of different codes may be used with respect to the different manifestations of syphilis and gonorrhea. From a perspective of prevention, emphasis is warranted on those diseases which can be transmitted between persons. With respect to non-gonococcal urethritis, cervicitis and vaginitis, it is now more feasible than it was a few years ago to make more accurate diagnoses in terms of the agents involved. For certain conditions which are believed to be more prevalent now than in the past (e.g., herpes and chlamydia), a more complete and detailed listing is required for the specific identification of these conditions.

In the Committee's judgment, consideration is warranted in relation to the development of a consolidated and distinctive classificatory grouping that brings together all types of sexually transmitted diseases.

Types of Conditions	International Statistical Classification 9th Revision 1975
The Traditional Venereal Diseases	
• Syphilis	090-097
• Gonorrhea	098 (and others)
• Chancroid	099.0
• Lymphagranuloma venereum	099.1
• Granuloma inguinale	099.2
Conditions Formerly Grouped Together as Non-gonococcal Urethritis (NGU and Non-gonococcal Cervicitis & Vaginitis	099.4
• Chlamydia urethritis (& cervico-vaginitis)	
• Mycoplasma urethritis (& vaginitis)	
• Corynebacterim vaginitis (& urethritis)	
• Non-specific urethritis	
• Non-specific vaginitis	
• Trichomoniasis	131.0 (and others)
• Vulvovaginal candidiasis	112.1
Other Sexually Transmitted Diseases	
• Venereal Warts (Condylomata accuminata)	078.1
• Molluscum contagiosum	078.0
• Genital herpes infection	054.1
• Crab lice infestation	132.2
• Scabies	133.0
• Hepatitis A	070.1
• Hepatitis B	070.3
• Genital Group B streptococcal infection: — Amoebiasis	006.9
— Shigellosis	004.9
• Genital cytomegalic infection	078.5
• Reiters Disease	099.3

Section 253 of the Criminal Code provides:

> 253. (1) Every one who, having venereal disease in a communicable form, communicates it to another person is guilty of an offence punishable on summary conviction.
>
> (2) No person shall be convicted of an offence under this section where he proves that he had reasonable grounds to believe and did believe that he did not have venereal disease in a communicable form at the time the offence is alleged to have been committed.
>
> (3) No person shall be convicted of an offence under this section upon the evidence of only one witness, unless the evidence of that witness is corroborated in a material particular by evidence that implicates the accused.
>
> (4) For the purposes of this section, "venereal disease" means syphilis, gonorrhea or soft chancre.

Section 253 was first enacted, in somewhat different terms, in 1919.[12] The section then created a new criminal offence in Canada, as it had been decided

in the late nineteenth century that the communication of venereal disease was not an offence at common law.[13] The restrictive definition of "venereal disease" in the current section 253 has remained unchanged since its original inclusion in 1919.

The only reported legal decision in Canada concerning this offence[14] is the 1926 case of *R. v. Leaf*.[15] The accused was charged and convicted of manslaughter, on the basis that he communicated venereal disease to a woman who subsequently died as a result. According to medical evidence adduced at trial, the woman's death was directly attributable to the venereal disease communicated to her by the accused. On appeal, the accused's sentence of four years' imprisonment was reduced to 12 months' imprisonment, with hard labour.

With respect to the elements specified in the section 253 offence, it appears on clinical grounds that a considerable proportion of persons having these diseases may in fact be unaware that they are infected. In many instances, either information is not volunteered by patients concerning the identities of their partners or, where this information is known, it is not listed in clinical records. According to the communicable disease specialists consulted by the Committee, the major obstacle in identifying sexually transmitted diseases is the persistent reluctance by physicians to report these cases and, in many instances, the provision of treatment without the benefit of laboratory examination of specimen cultures. These practices have become so widespread that the enforcement of section 253 of the *Criminal Code* has effectively ceased.

Because this statute is ineffective in affording protection either for children and youths or adults, the Committee recommends that it be repealed. In the following sections of this chapter, steps are recommended which we believe are warranted to provide better protection in this regard for children, youths and adults.

National Statistics

National statistics on the incidence and prevalence of sexually transmitted diseases are assembled by the Bureau of Epidemiology of the National Department of Health and Welfare from reports on these conditions provided by provincial infectious disease services. While the Committee did not undertake a review of the organization of these provincial programs or of the various procedures followed in the identification and treatment of persons having these diseases, it is generally recognized by experts in this field that there are considerable variations across the country. Due to differences in how the provincial programs are structured and operated, sharply contrasting provincial rates of identification of these diseases are officially reported. There is no reason to suspect that these disparities in the reported rates are due to provincial variations in the actual distribution of sexually transmitted diseases.

Table 33.2

Reported Gonococcal Infections in Children and Youths: Canada, 1980

Province	Rates Per 100,000					
	Males			Females		
	0–4 Yrs.	5–9 Yrs.	10–14 Yrs.	0–4 Yrs.	5–9 Yrs.	10–14 Yrs.
Newfoundland	0.0	0.0	9.2	0.0	3.5	9.6
Prince Edward Island	—	—	—	—	—	—
Nova Scotia	—	—	—	—	—	—
New Brunswick	0.0	0.0	0.0	3.7	0.0	0.0
Quebec	2.9	0.0	2.0	3.0	1.4	5.0
Ontario	1.6	0.0	2.8	2.0	1.0	10.2
Manitoba	2.4	4.8	16.5	17.9	5.1	86.2
Saskatchewan	0.0	0.0	9.5	5.0	2.6	25.0
Alberta	1.1	1.2	11.3	11.4	14.7	61.5
British Columbia	2.0	1.0	1.9	3.3	4.4	22.2
Yukon	0.0	0.0	111.1	1,000.0	0.0	125.0
Northwest Territories	0.0	83.3	40.0	793.1	333.3	960.0

Bureau of Epidemiology, Department of National Health and Welfare

The national statistics given in Table 33.2 on the reported prevalence of gonococcal infections in children and youths for 1980 show how few cases of these conditions are reported officially and sharp provincial variations in these rates. In 1980, in Canada, a total of 340 cases of gonococcal infections was reported for children who were age 14 or younger. Of this total, 17.3 per cent were boys and 82.6 per cent were girls. For children of both sexes, the reported occurrence rose sharply with age.

Age	Number of Reported Gonococcal Infections in Canada, 1980	
	Boys	Girls
0 – 4 years	10	54
5 – 9 years	6	34
10 – 14 years	43	193

In Table 33.2, the 340 cases of gonococcal infections for children 14 years and under are given as rates per 100,000 persons (age specific) for the population. These results show that the provincial rates vary, in some instances by as much as several thousand per cent.

Notifiable and Non-notifiable Infections

On the basis of its review and as documented in Tables 33.3 and 33.4, the Committee concluded that present provincial regulations and statutes concerning venereal disease control are inadequate. Only two of the diseases currently listed, syphilis and gonorrhea, are of serious public health significance, while others (see Table 33.4) are not considered (e.g., non-gonococcal urethritis and genital infections, genital herpes and certain complications of these such as neo-natal herpes).

Table 33.3

Notifiable Sexually Transmitted Diseases: Canada, 1984

Reported by	Disease
All provinces	Chancroid Gonococcal Ophthalmia Neonatorum Gonococcal Infections
New Brunswick Nova Scotia	Granuloma Inguinale Lymphogranuloma Inguinale
Prince Edward Island	Gonorrhea, Genito-Urinary Gonococcal Ophthalmia

Bureau of Epidemiology, Department of National Health and Welfare

Table 33.4

Non-notifiable Sexually Transmissible Infections of Public Health Importance: Canada, 1984

Notifiable in All Provinces, and Nationally, But Not Identified as "Sexually Transmitted"
• Non-gonococcal Urethritis/Cervicitis • Trichomoniasis • Moniliasis • Genital Warts • Hepatitis
Notifiable in British Columbia, Alberta, Ontario and Quebec, not Nationally
• Acquired Immunodeficiency Syndrome
Also Transmitted by Non-Sexual Modes
• Herpes Genitalis • Neonatal Herpes • Hepatitis • Acquired Immunodeficiency Syndrome

Bureau of Epidemiology, Department of National Health and Welfare

In order to obtain a better estimate of the actual occurrence of sexually transmitted diseases in Canada, the Committee recommends that the Office of the Commissioner in conjunction with federal and provincial health authorities establish an interdisciplinary advisory committee in order to develop surveillance and diagnostic criteria for all sexually transmitted infections. Once this list has been established, the diseases listed should be made reportable under the Provincial Acts and Regulations. The support of the Provincial Colleges of Physicians and their equivalents in each province should be actively sought to ensure compliance in reporting.

The maintenance of absolute confidentiality for infected individuals threatens the objectives of communicable disease control and prevention. These strategies form the bases of interrupting the continuing transmission of infection in Canadian society. They have fallen into disuse and should be reinstated and reinforced. It is possible to maintain relative confidentiality, while ensuring protection for all individuals. The application of this recommendation is of particular importance in the control of infection in children and youths, as well as in adults. The intention of this recommendation is to protect the rights of children and youths to receive treatment in situations where they may be unaware of the serious threat to their health and personal well-being.

National Surveys

In several of the national surveys undertaken by the Committee, information was sought about the experience of sexually assaulted children who may have contracted a sexually transmitted disease as a result of the acts committed against them. The nature of the information obtained varied greatly in reliability and in the identification of the specific types of sexually transmitted diseases that may have been contracted.

In the National Population Survey, a random sample of persons was asked whether, as a result of having been sexually attacked, they had been hurt. In the listing of injuries, an item was included specifying: "got VD (sexual disease)". The results given in response to this question may not reflect the true occurrence of the number of these diseases that resulted from incidents of sexual assault, particularly for those conditions which may not have been recognized or detected. The information from this survey is valid, however, to the extent that it reveals whether persons who participated in the survey believed or knew that they had had a sexually transmitted disease, and whether they believed that the infection had resulted from their having been sexually assaulted.

In the case of similar information obtained in the other national surveys, it is recognized that the determination of whether these diseases had been contracted is limited by the timing and nature of the interventions that these services provided with respect to sexually assaulted children. In many of the cases investigated by the police, the information listed in the general occurrence

records of their investigations did not contain long-term follow-up information about these children and youths. If a child had contracted a venereal disease and had received medical treatment for this condition some time after the police had completed their investigation, these findings would not usually have been included in police files unless an investigation was still in progress.

The same problem is evident in the records of child sexual abuse maintained by child protection services. Generally, as noted in Chapter 28, *Provision of Child Protection Services*, the records of these agencies do not record detailed information about the findings of medical examinations of these children. Further, as in the instance of police files relating to sexually assaulted children, the incorporation of information about whether children had contracted sexually transmitted diseases depends upon when a child protection worker was in contact with a child in relation to when the assault occurred, and whether, during the time the case was still open in the files of an agency, if a medical examination had been undertaken.

The most reliable information about the nature of the sexually transmitted diseases contracted by sexually assaulted children was obtained in the National Hospital Survey. A limitation of these results is that relatively few such cases were reported in the National Hospital Survey and that there was no longitudinal follow-up concerning the long-term harms sustained. As the findings of the other national surveys show, only a small proportion of children who were sexually assaulted subsequently sought or received medical attention, and of this number, only a portion obtained such treatment as inpatients at a hospital.

National Population Survey

The information on sexually transmitted diseases obtained in the National Population Survey, although the questions asked were limited in scope, is the first study of its kind for Canada that has sought to document the experience in this regard of a national sample of the Canadian population. While the findings obtained identify only a small number of cases of venereal disease resulting from sexual assault, if these results are projected to the Canadian population, then a sizeable number of persons, both children and adults, may have been involved in episodes of this kind, and as a result, may have contracted sexually transmitted diseases.

In the Committee's view, the significance of the findings obtained derives less from the actual number of cases identified than from the implications of these results for the need to undertake more comprehensive and detailed community surveys of these conditions, particularly since it is known that some types of undetected sexually transmitted diseases may result in long-term harms to the health of persons later in their lives.

A total of 38 out of 1006 females in the National Population Survey reported that they had been raped; of this number, five indicated that they had contracted a sexually transmitted infection (13.2 per cent). None of the

females who were 15 years-old or younger when the incidents had occurred said that she had contracted a venereal disease as a result of having been raped. Of the five cases in which this had happened, two females were between 16 and 17 years of age, one was under age 20 and two were adults. In these instances, because females are usually asymptomatic, it is unknown whether the infection may have been present for some time before the assault occurred, or had been transmitted by the assailant.

Of the 1002 males who participated in the National Population Survey, six reported that they had been victims of having a penis forced into their anus. In two of these incidents, both involving males who were 15 years-old or younger when the incidents had occurred, a sexually transmitted infection was reported to have been contracted.

The results of the National Population Survey show that 3.8 per cent of all females said that they had been raped, and one in 201 had been raped and had subsequently reported having contracted a sexually transmitted disease. Of the males in this survey, 0.6 per cent had been victims of an act of buggery, and of 1002 males, one in 501 had been a victim of this offence and had reported having contracted a sexually transmitted infection. When these proportions are prorated to the Canadian population, and assuming the validity of these findings, then a total of approximately 80,000 persons would be estimated to have contracted a venereal disease resulting from a sexual assault. Observations of this kind must be interpreted cautiously, for they are based on the experience of a small number of cases for which no medical confirmation is available. The findings, however, are based on the results of a representative sample of the Canadian population and, because of the asymptomatic nature of some of these conditions, the results are likely to represent an under-estimate rather than an over-estimate of actual occurrence.

As previously noted, certain types of sexually transmitted diseases may result in serious and long-term harms to the health of persons later in their lives. Not only do these diseases entail great misfortune and personal anguish for some patients but, to the extent that they remain undetected, a pragmatic concern is the considerable public costs which may be incurred in the treatment of the resulting complications. In this regard, the widespread practice of non-reporting to protect confidentiality has served to mask the extent to which children and youths are at medical risk.

Because of the extent of the sexual behaviour of Canadian boys and girls, a sizeable but unknown proportion is likely to contract sexually transmitted diseases. **In light of the potential complications or disabilities that these early contacts may entail for the future health of these children and youths, it is imperative, in the Committee's judgment, that more comprehensive and detailed information be obtained with respect to: the knowledge by children and youths about the signs of sexually transmitted diseases; the number, age and sex of children and youths who report that they have contracted these infections, and the age and sex of their partners; the steps taken to seek and**

obtain pertinent medical attention; and the identification of long-term harms resulting from these diseases.

National Police Force Survey

In the National Police Force Survey, of girls who were 15 years-old or younger and who had been raped or who had been the victims of attempted rape, 15 were reported to have had vaginitis and eight had contracted gonorrhea. If these conditions are grouped together, then 3.8 per cent of these girls had contracted a sexually transmitted disease, some of whom had contracted gonorrhea (1.3 per cent).

A total of 91 cases of attempted buggery and buggery against boys who were 15 years-old or younger was reported in the National Police Force Survey. Of this number, five cases (5.5 per cent) were reported to have had an infected rectum.

National Hospital Survey

In this survey, a total of 549 female patients presented to hospital, of whom 413 received a gynaecological examination. Of this group, 43 (10.4 per cent) were considered to have contracted a sexually transmitted disease and 17 were referred for a further follow-up assessment. Of the 74 male patients for whom information was obtained, seven (9.5 per cent) were referred for a follow-up assessment in relation to a sexually transmitted disease.

Manitoba Study of Sexually Transmitted Diseases

On the basis of the information obtained concerning national statistics on the reported prevalence of sexually transmitted diseases, the senior officials who were responsible for the programs established to control these diseases in Manitoba and Alberta were contacted by the Committee. In the case of both programs, considerable effort has been made to develop special programs and means of liaison to identify and serve children who may be at risk of contracting these diseases. In Manitoba, for instance, close co-operation has been established with child protection services, and as a result of the several special measures taken, larger numbers of children having these diseases are identified. As a result of the way in which information was retained about persons treated, it was not feasible with respect to cases known to Alberta Social Hygiene Services to assemble information about the ages of children who had contracted these diseases with information pertaining to the ages of their suspected or known partners. As information of this type could be assembled by the Manitoba Department of Health, Sexually Transmitted Disease Control Division, a collaborative review by this Service and the Committee was undertaken

of the reported cases of sexually transmitted diseases contracted by children in 1980 and 1981.

In order to ensure confidentiality and accuracy in handling the case records of children for whom information had been obtained, a statistical profile was assembled of each case by the Control Division. This information was given to the Committee for statistical analysis. Provision was made in the profile for information, where available, on:

1. Age of the patient;
2. Sex of the patient;
3. Age of suspected/known partner;
4. Sex of suspected/known partner;
5. Association of patient and partner (e.g., family member, relative, friend, acquaintance, stranger);
6. Source of reporting of case (e.g., self-referral, community physician, clinic/hospital, police or community agency referral);
7. Type of sexually transmitted disease (diagnosis);
8. Number of known sexual partners;
9. Information on examination of sexual partner;
10. Types of treatment provided;
11. Notifications that were made (e.g., parents, family physician, clinic/hospital, police and/or community agency);
12. Whether the disease had been contracted as a result of a sexual assault of the child.

Presenting Symptoms and Treatment

The Manitoba Department of Health survey of sexually transmitted diseases among children and youths identified 452 children with these conditions who were age 16 or younger. About four in five (79.6 per cent) patients were girls and the remainder (20.4 per cent) were boys. When the types of sexually transmitted diseases from which these children suffered are considered, for 15 girls under age 10, confirmation was made by a positive culture of *N. gonorrheae* (14 cases) and in one instance, by a positive smear. In two of these cases, girls under 12 months-old were involved; the cultures obtained from them were non-genital specimens (one ear, one conjunctiva), suggesting that these conditions resulted from nonsexual transmission of infection. The mother of one of these female infants was positive on culture, while the mother of the other child yielded a negative result.

Of the three boys who were under age 10, no information was available about the sex partners of two of these patients. In the two cases in which the identity of the partner was known, both had positive smears for *N. gonorrheae*: the patients were ages five (female) and 12 (male) respectively.

There were six cases in which gonococcal infections appear to have been contracted as a result of male homosexual contacts. The ages of the six boys

were: age nine (one); age 13 (one); and age 16 (four). One 16 year-old boy was bisexual, having had five male and two female sexual contacts. All of the other boys were reported to have had a single male partner. The 16 year-old bisexual patient had been treated twice during 1980-81. In the first examination, the infection was confirmed by urethral culture, and in the second examination, a pharyngeal culture was obtained. This patient's sexual partners were reported to be: males aged 16 (two), 19 and 29 years; and two females who were age 18. Confirmation of a gonococcal infection for the five boys who were reported to have had only one sexual partner was obtained by positive cultures for four cases and by positive microscopy in another. The ages of their partners were: 12 (a relative), 18, 21 and 22. The age of one partner was not reported.

Pelvic inflammatory disease is the most serious complication resulting from gonorrhea among young females. Because the major symptom of this condition is a form of abdominal pain which resembles other abdominal infections, the clinical identification of this disease may be difficult to make. Among the girls who were examined in the 1980-81 Manitoba study, a diagnosis was given for 229 patients (e.g., vaginal discharge, abdominal pain,pelvic inflammatory disease) or a method or place of diagnosis listed (e.g., type of contact, hospital, screening or follow-up). In 15 cases, a diagnosis of pelvic inflammatory disease was made. In addition to these cases, there were 14 patients who had "abdominal pain", a condition which may also have been a pelvic inflammatory disease. Without additional clinical information for these cases, no confirmation can be made. A review of the information about other patients suggests that in addition to the 29 cases noted, there may have been 25 more cases in which a pelvic inflammatory disease was suspected.

On the basis of the available information, it appears reasonable to conclude that about one in four female patients for whom a diagnosis was given in the Manitoba study had or was likely to have had pelvic inflammatory disease. These results cannot be generalized to the experience of all young Canadian girls and women who may have these diseases. However, if only a small fraction of these diseases were to occur, as indicated by the findings of the National Population Survey, then a sizeable number of Canadian females may be at considerable risk of complications resulting from these infections.

The prognosis for these young girls is unfortunate and bleak. Clinical experience indicates that further consequences are likely to include:

- **Between 15 and 20 per cent will experience infertility in later life, a condition that may entail multiple hospital admissions and possible surgical intervention.**
- **Of the remainder, should these girls subsequently become pregnant, then in 14 instances an ectopic pregnancy may occur in which the fetus will be lost and in which the mother's life may be placed at risk.**

Association between Patient and Sexual Partner

Because of the nature of the information obtained in the Manitoba study, and the presumed reluctance of many patients to identify their sexual partners, the information obtained about the type of association between these persons was incomplete and, in some instances, inaccurate, particularly with respect to the involvement of family members, relatives and close friends.

In the Manitoba survey, there were six children for whom the suspected or known sexual partners were family or household members. One of these cases involved a boy of age nine whose suspected sexual partner was listed as a "relative". The five girls whose sexual partners were suspected or known to be family or household members for whom positive smears were obtained, included:

- Girl age 4 — uncle and mother's cousins
- Girl age 4 — mother's common-law partner and his two sons
- Girl age 7 — three family members
- Girl age 10 — aunt, grandmother and grandfather
- Girl age 16 — mother's common-law partner

The number of cases involving children who had sexually transmitted diseases which may have been contracted from family members is small, representing 1.1 per cent of the children in the study. **On the basis of the Committee's findings from the several national surveys conducted, the results indicate that in cases of intercourse involving children and family members, testing is warranted to determine whether a sexually transmitted disease has been contracted.**

Sexual Assault

Apart from a few cases where the inference could be drawn from the age of the child, the records of the children who were examined and treated in the 1980-81 Manitoba Study of sexually transmitted diseases did not yield information about the extent to which these children may have been the victims of sexual assaults. The absence of this information does not mean that such offences did not occur, but only that, within the scope of the information available, acts of this kind were not recorded. At the end of 1981, the Control Division arranged to notify provincial child protection services of all cases involving a child diagnosed as having gonorrhea or syphilis. The Control Division seeks to identify the source and transmission of the infection and the Child Protection Branch undertakes an assessment to determine whether the child is in a safe social situation.

Legal Significance of Manitoba Study

The sexual abuse of children and young persons by means of assaultive or arguably *non-consensual* behaviour is examined elsewhere in this study. The findings from the Manitoba study provide an opportunity to examine sexual abuse where most of the conduct may be seen as *consensual* in fact despite any legal prohibitions. The ages of patients and partners as well as the numbers of partners give some idea of the sexual abuse of patients by their peers and by those considerably older. It is not known whether there are similar patterns in geographic areas other than that covered in the Manitoba study.

When the Committee was conducting its review, there were two different legislative proposals being considered which were intended to deal with sexual conduct with children that is not "assaultive" but that should be proscribed for other reasons. These proposals were contained in *Bill C-53*[16] and in the *Working Paper for Offences Against Young Persons.*[17] A central assumption of the proposals was that consensual sexual behaviour between young persons who are close in age is generally not harmful to the younger person and, accordingly, should not be proscribed by the criminal law. The research findings provide a means for testing the soundness of this assumption and they are considered in terms of:

1. The legal significance of instances involving a patient under 14, where the child's sexual partner(s) was less than *three* years older;
2. The legal significance of instances involving a patient 14 or 15, where the child's sexual partner(s) was less than *three* years older;
3. The legal significance of instances involving a patient 14 or 15, where the child's sexual partner(s) was less than *five* years older; and
4. The legal significance of instances involving a patient 16. Patients in this age group would not be affected by the proposals. The research findings given are presented for purposes of comparison.

Patients Under 14, Having a Sexual Partner Less Than Three Years Older

Of the partners who had sex with children 13 or younger (and for whom information on the partners' ages was available), only two (5.0 per cent) were less than three years older than the child in question. In contrast, 95.0 per cent of the sexual partners of children age 13 or younger were more than three years older than the child, and all were males.

Children Under Age 14	Partner Less Than 3 Years Older	Partner More Than 3 Years Older
Male	1	—
Female	1	38
Total	2	38

These findings are significant in relation to the sexual assault provisions of the *Criminal Code* enacted in 1983 and to the provisions of the proposed *Bill C-53* and the *Working Paper*. Consensual heterosexual or homosexual conduct between persons, one of whom is under 14 and the other of whom is less than three years older than the younger person is exempted from the prohibitions in the sexual assault provisions of the *Criminal Code*.[18] However, the absolute prohibition in section 146(1) against sexual intercourse with females under 14, which was to have been repealed under *Bill C-53*, remains in the *Code*. So do buggery and gross indecency. The latter offences were to have been repealed by *Bill C-53*, but gross indecency was to have been re-enacted. Most of the sexual acts engaged in by the children under 14 involved heterosexual intercourse where the male partner was more than three years older than the female, and neither the sexual assault provisions of the *Code*, *Bill C-53*, nor the *Working Paper* would affect the culpability of these partners. Under *Bill C-53*, however, the incidents involving sexual partners who were less than three years older than the young patient would be exempted from the prohibition against sexual misconduct with a person under 14.

Patients 14 or 15, Having a Sexual Partner Less Than Three Years Older

The findings on the ages of male partners of females 14 or 15 are significant for the legal changes proposed by *Bill C-53*. Sixty-eight of these partners were less than three years older that the female patient, while 90 of them were more than three years older. The ages of the 15 year-old females' sexual partners comprised a wide spectrum: two were 14 years-old; twelve were 15; twelve were 16; thirty were 17; eighteen were 18; thirteen were 19; five were 20; and thirty were 21 or older.

Bill C-53 would repeal the prohibition against sexual intercourse with females 14 or more and under 16 in section 146(2) of the *Criminal Code*,[19] and would introduce the vague offence of "sexual misconduct" (which would, presumably, include consensual sexual intercourse with young girls).[20] Where a female is 14 or 15, however, and the sexual intercourse is consensual, *Bill C-53* provides a complete exemption from this offence to a partner who is less than three years older.[21] Accordingly, 68 of the 158 male sexual partners (43.0 per cent) would have a complete legal defence under *Bill C-53*, a defence which they do not enjoy under the present law. The health risks to the female, especially when her sexual partner has a communicable sexual disease, are, of course, independent of her partner's age.

Of the partners of male patients aged 14 or 15, nine were less than three years older than the patient, while four were more than three years older. As with the partners of female patients, the incidents involving the partners of male patients who were less than three years older would be exempted from the "sexual misconduct" offence in *Bill C-53*. However, as already indicated, the offence of gross indecency, which applied to the extent that these incidents involved homosexual acts, was to have been re-enacted by *Bill C-53*.

Patients 14 or 15, Having a Sexual Partner Less Than Five Years Older

The study found that, of the sexual partners of the 14 and 15 year-old patients for whom information was available:

1. 13 sexual partners of male patients were less than five years older than the male in question and none was more than five years older;
2. 113 sexual partners of female patients were less than five years older than the female in question and 45 were more than five years older.

The *Working Paper* states that "'sexual exploitation', in relation to a young person, means any sexual conduct where the young person is involved as a participant or otherwise"[22] and defines "sexual conduct" as including "any touching of a sexual nature or any sexual performance, but does not include conduct of an affectionate nature that is normal in a family context".[23] Accordingly, "sexual exploitation" would presumably include sexual intercourse with a young female.[24] The *Working Paper* provides that every one who engages in the sexual exploitation of a person 14 and under 16 is guilty of an indictable offence and is liable to imprisonment for 10 years.[25] It further provides, however, that no one shall be guilty of this offence if he establishes that at the time the sexual incident took place, he was either under 16 years of age[26] or he is less than five years older than the complainant.[27] On their face, the proposals in the *Working Paper* would exempt three-quarters of the cases (126 of the 171 instances) cited in the study in which the sexual partners were less than five years older than the 14 and 15 year-old patients from the offence of sexual exploitation of a person between 14 and 16.

Sexual Partners of Patients 16 Years-old

Information was obtained in the study on ages of sexual partners (where known) of the 16 year-old patients. Some 118 male sexual partners (those age 18 or older) of the 16 year-old female patients could potentially have been charged with the "seduction" offence in section 151 of the *Criminal Code*, provided that the female in question was of previously chaste character. All of the partners of the 16 year-old female and male patients could potentially have been charged with the offence of contributing to juvenile delinquency, and the partners of the 16 year-old male patients could have been charged with the offences of buggery or gross indecency, depending on the circumstances.

Children Aged 16 Years	Partner Aged 16 or 17	Partner Aged 18, 19 or 20	Partner Aged 21 or Older
Male	34	16	8
Female	44	62	56
Total	78	78	64

Multiple Partners

Some of the young females about whom information was obtained in the survey were reported to have had intercourse with four, five and six or more partners within short periods of time. In this regard, it is relevant to recall that *the proposed changes to the Criminal Code would apply to these circumstances* as well as to situations involving single partners. The findings show that cases of multiple partners involved a range of ages in partners. If it is "normal" for these females to have "friends" with a range of ages and the physical harms are independent of the partners' ages, there would appear to be no justification for distinguishing among these partners according to age for the purpose of determining criminal responsibility. The findings on multiple partners show the arbitrariness of removing the protection of the criminal law where the partner is close in age to the patient.

Of the 293 girls in the Manitoba study, 129 had multiple partners. However, the ages were only known for 106 girls and for 68 of their 293 partners. About one in three girls (36.2 per cent) had multiple partners, as compared with about one in six boys. Over half (54.5 per cent) of the girls 12 and 13 had three or four partners. Almost one-quarter (24.4 per cent) of the girls 14 and 15 had three or four partners; and 13.3 per cent had five or six partners. Almost one-tenth (9.4 per cent) had more than six partners. A little more than one-quarter (26.0 per cent) of the 16 year-old girls had three or four partners, and two per cent had more than six partners.

Table 33.5

Girls Age 16 and Under Treated for Sexually Transmitted Diseases Who Had More Than One Partner

Age of Patients	Number of Girls	Number of Partners	Age Range of Partners	Average Age of Partners	Proportion of Girls Having Partners Age 21 and Older
Under age 14	11	26	15-75	30.7	36.4
14 — 15 years	45	126	14-35	18.2	28.9
16 years	50	116	15-36	20.6	54.0
TOTAL	106	268	14-75	20.5	41.5

The age range of partners of the 12 and 13 year-old girls having multiple partners was 15-75 years. For 14 and 15 year-old girls, it was 14-35 years, and for 16 year-old girls it was 15-36 years. The average age of the partners was 30.7 years for girls of 12 and 13; 18.2 years for girls 14 and 15; and 20.6 years for 16 year-old girls. The numbers of multiple partners and the range of ages of these partners belies any assumption that the sexual partners of young females

can conveniently be grouped into two discrete legal categories, namely: male partners close in age, in which case the sexual activity is "experimental" and should accordingly fall outside the prohibition of the criminal law; and male partners substantially older than the female, in which case the sexual activity should be proscribed on grounds of public policy. The reality appears to be that a number of younger as well as older males take their sex where they can get it, and the overall picture in these multiple partner cases is one of casual sexual exploitation.

The proportion of girls having one or more partners aged 21 and older was 41.5 per cent. For girls less than 14, it was 36.4 per cent; for those 14 and 15, it was 28.9 per cent; and for those 16, it was 54.0 per cent. However, for girls under 14, of 26 partners, 16 were between 15 and 20 years of age. For girls 14 and 15, of 126 partners, 109 were between 14 and 20.

The provisions of the proposed *Bill C-53* and the *Working Paper* would decriminalize consensual sexual intercourse with young girls where the girl is under 14 and the partner is less than three years older, and where the girl is 14 or 15 and the partner is less than three (*Bill C-53*) or five years (*Working Paper*) older than the female. The findings on females with multiple partners are similar to those with respect to the application of the proposed *Bill C-53* and the *Working Paper*. For 11 girls 12 and 13 years of age having 26 partners, none of the partners was less than three years older. For girls of 14 and 15, 40.5 per cent of the partners were less than three years older. Almost one-quarter (24.1 per cent) of the partners of the 16 year-old girls were aged 16 or 17, which means that they could not have been charged with the "seduction" offence in section 151 of the *Criminal Code*. The general findings show a similar figure. A little more than one-quarter (27.2 per cent) of the partners of the 16 year-old girls were aged 16 or 17.

Table 33.6

Difference in Age Between Female Patients Treated for Sexually Transmitted Diseases and Ages of Multiple Partners

Age of Patient	Proportion of Partners Less Than Three Years Older	Proportion of Partners Less Than Five Years Older	Proportion of Older Partners Under Age 18
	Per Cent	Per Cent	Per Cent
Under age 14	0.0	15.4	42.3
14 – 15 years	40.5	72.2	50.0
16 years	39.7	59.5	24.1

The findings on the partners of 16 year-old girls are given mainly for purposes of comparison (the offence of seduction in section 151 of the *Criminal*

Code is rarely charged). With respect to the partners of girls 14 and 15, the enactment of the legislation proposed in *Bill C-53* and the *Working Paper* would remove the criminal law prohibition against sexual intercourse with young girls from a substantial proportion of their partners who were close in age.

There is currently no defence to a charge of sexual intercourse with young girls based on the closeness in age of the accused to the complainant. The proposals in *Bill C-53* and the *Working Paper* to create defences based on closeness in age are an attempt: to ensure that the provisions of the *Criminal Code* apply equally to persons of both sexes;[28] and to de-emphasize the prohibition against sexual intercourse, by subsuming sexual intercourse under a general offence of sexual exploitation which may be committed by males and females and which may include other types of sexual conduct less likely to pose health risks. The exception for partners close in age would exclude these other types of conduct.

Underlying the proposed exception for partners close in age may be a concern that despite the health risks to the female, the punishment is too severe where the partner is close in age and there is evidence of genuine affection. In circumstances where there is no evidence of sexual abuse other than the age of the female, there should be greater flexibility available in the application of the sanction. It is at the sentencing stage that the judge can determine what weight should be given to the fact that the partner was close in age to the young girl. It has been shown throughout the findings presented in the Report that there is a great deal of discretion exercised in the law enforcement process. The findings from the National Police Force Survey indicate that very few cases of the type under discussion are reported to the police. Where they are, perhaps by angry parents, the prosecutor may decide that in the circumstances it is not appropriate to proceed any further with the case. Where the prosecutor decided to proceed, male partners who were close in age were usually charged under the provisions of the *Juvenile Delinquents Act* (replaced by the *Young Offenders Act*). Under these Acts, the judge has a wide range of alternatives to incarceration. The sanction can be selected to suit the circumstances. Under the *Juvenile Delinquents Act*, the case could be adjourned indefinitely, subject to being brought on again if the juvenile did not comply with the conditions set by the court. Under the *Young Offenders Act*, the young offender can receive an absolute discharge, possibly with a warning, or probation, the completion of which has the same effect as a conditional discharge. All young persons up to 18 years of age are dealt with under the *Young Offenders Act*.

Where an accused was just over the then current Ontario juvenile age of 16, but was close in age to the girl who was less than a month away from her fourteenth birthday, a conviction in adult court under the *Criminal Code* resulted in the imposition of a suspended sentence together with a year's probation.[29] Section 662.1(1) of the *Criminal Code* provides for an absolute and a conditional discharge. However, section 146(1) of the Code provides a maximum punishment of imprisonment for life, and section 662.1 (1) cannot be used if the offence is punishable by imprisonment for 14 years or for life. It

would be advisable to reduce the maximum punishment under section 146 in order to make an absolute or a conditional discharge available in cases where the partner is close in age and there is no other evidence of exploitation.

Because in the area of sexual offences against children the criminal law is not just morally based, and serves a protective function against specific health risks, the law must include all cases which may produce the risks in order to be effective. But comprehensiveness does not preclude appropriate disposition by the legal process, which should provide flexibility in appropriate circumstances. In view of the findings, the Committee believes that consideration should be given to including specific guidelines in the *Young Offenders Act* for dealing with such youths.

The Committee recommends maintaining the prohibition against sexual intercourse with female persons under 14 in section 146(1) of the *Criminal Code*. The Committee has also concluded, on the basis of the findings of the present study, and pending the obtaining of more complete information on the sexual abuse of young females and the attendant health risks, that the prohibition in section 146(2) against sexual intercourse with female persons 14 or more and under the age of 16 should be maintained. However, sections 146(2)(b) [complainant must be of previously chaste character] and 146(3) [court may find accused not guilty if he is not more to blame] are inappropriate to the offence and should be repealed. The Committee recommends that should an analysis of more complete information on the sexual abuse of young females not indicate significant attendant health risks, consideration should be given to repealing the prohibition against sexual intercourse in section 146(2).

Summary

1. In 1981, there were 1206 live births to girls age 15 and younger.
2. In 1981, 1806 girls age 15 and younger had therapeutic abortions.
3. The existing system for the medical identification and classification of sexually transmitted diseases requires revision with respect to the more detailed and co-ordinated listing of these conditions.
4. The present provincial statutes and regulations concerning venereal disease are inadequate. Only two of the diseases currently listed are of serious public health significance while others are not considered.
5. In the National Population Survey, one in 201 females who had been raped and one in 501 males who had been a victim of an act of buggery had contracted sexually transmitted diseases.
6. In the National Police Force Survey, one in 18 girls aged 15 years or younger who had been raped and about one in 10 boys in the same age category who had been a victim of an act of buggery were reported to have contracted a sexually transmitted disease.
7. In the National Hospital Survey, 10.4 per cent of females and 9.5 per cent of males were considered to have contracted a sexually transmitted disease.

8. In 1980, the federal Bureau of Epidemiology reported 340 cases of gonococcal infections among children age 14 or younger. The rates of these reported cases varied substantially between provinces.

9. In the 1980-81 Manitoba Study of sexually transmitted diseases in which information was given for 452 children who were 16 or younger, it was found that:

   (i) the ratio of girls to boys was more than 4:1;

   (ii) on the basis of available information, it appears that about one in four instances of gonococcal infections was likely to have pelvic inflammatory disease; and

   (iii) between 15-20 per cent of these patients may experience infertility in later life and a number of the girls will likely have ectopic pregnancies in the future.

10. In five cases involving children having sexually transmitted diseases, their partners were reported to have been relatives or family members.

11. With respect to the ages of the children and their partners, the study found that:

   (i) of children under age 14, 95 per cent of older partners were more than three years older;

   (ii) of children who were 14 and 15 years-old, 45.0 per cent of their partners were less than three years older;

   (iii) of children who were age 16, about a third of their partners (35.5 per cent) were age 16 but less than age 18; and

   (iv) for all children for whom the ages of their partners were reported, 25.1 per cent of their partners were adults age 21 or older.

On the basis of its review, the Committee recommends that section 253 of the *Criminal Code* be repealed. In its place, we recommend: that provincial health regulations and statutes be sharply strengthened; that more effective surveillance and diagnostic criteria be developed; that extensive research be undertaken to obtain necessary information; and that information about the health risks of those diseases be incorporated in the national program of public education and health promotion recommended elsewhere in the Report.

The Committee recommends that the Office of the Commissioner, in conjunction with the Department of Justice, the Department of National Health and Welfare in consultation with the provinces and non-governmental agencies appoint an expert interdisciplinary advisory committee having assigned responsibilities:

1. To conduct comprehensive research at a national level to document the known prevalence of sexually transmitted diseases contracted by children and youths and to assess the health risks involved.

2. **To develop ways of collecting information in a standard fashion across jurisdictions with regard to the occurrence of sexually transmitted disease, for children and youths under the age of 16 years.**

3. **To advise on the updating of the group of sexually transmitted disease protocols of standard and expected treatment practice, and separately advise on which of these infections should be made reportable in relation to cases involving children and youths under the relevant provincial statutes and regulations, and that in this regard, the full participation and co-operation of the Provincial Colleges of Physicians and Surgeons, and their equivalents, be sought to take an active role to encourage compliance in reporting.**

4. **To review the classification of sexually transmitted diseases and to make recommendations in relation to the modernization of the existing categories used in medical and hospital information systems across Canada.**

5. **To undertake a national survey of the experience and knowledge of children, youths and adults about sexually transmitted diseases and pregnancy, and to make recommendations with respect to the development of programs of public education and health promotion focussing upon the more effective provision of preventive and treatment services.**

In view of the findings of the present study on the health risks to young persons of pregnancy and sexually transmitted diseases, the Committee recommends that:

1. **Section 146(1) of the *Criminal Code* be retained, and that the maximum punishment for this offence be changed to a sentence of less than 14 years' imprisonment.**

2. **Section 146(2) be retained, but that sections 146(2)(b) and 146(3) of the *Criminal Code* be repealed.**

3. **Section 140 of the *Criminal Code* be amended to specify the age of 16 years instead of the present age of 14 years.**

4. **Section 147 of the *Criminal Code*, which states that no male person shall be deemed to commit an offence under section 146 while he is under the age of 14 years, should be repealed. This provision is a legal anachronism, and no longer serves any useful purpose. The relevant age should be the general age of criminal responsibility, which is set at 12 in the *Young Offenders Act*.**

The Committee considers that the proposed amendments to section 146 constitute a threshold legal means of providing needed protection for children and youths for the risks associated with pregnancy and sexually transmitted diseases. We believe that the proposed amendment of the law, by itself, will accomplish little unless it is accompanied by the undertaking of national surveys of the prevalence of and the health risks associated with these conditions, and by the provision of information necessary to make young persons and their parents fully aware of these risks.

References

Chapter 33: Live Births, Therapeutic Abortions and Sexually Transmitted Diseases

[1] United Kingdom *Report of the Departmental Committee on Sexual Offences against Young Persons*. London: H.M.S.O., Cmd. 2561, 1925, pp. 12-13, 25-26.

[2] *Ibid.*, pp. 25-26.

[3] Canada. Statistics Canada. *Vital Statistics. Volume I. Births and Deaths, 1981*. Ottawa: Supply and Services Canada, 1983, pp. 6-7.

[4] Canada. Statistics Canada. *Therapeutic Abortions, 1981*. Ottawa: Supply and Services Canada, 1983, pp. 65-66.

[5] *Ibid.*, p. 114.

[6] Based on Statistics Canada, *supra*, note 4, p. 79.

[7] *Ibid.*, pp. 100-101.

[8] *Ibid.*, p. 103.

[9] *Ibid.*, p. 136.

[10] Canada. *Report of the Committee on the Operation of the Abortion Law*. Ottawa: Supply and Services Canada, 1977, p. 348.

[11] Ontario. *Report of the Commission of Inquiry into the Confidentiality of Health Information in Ontario*, Volume 3. Toronto: Queen's Printer for Ontario, 1980, pp. 73-113.

[12] *An Act to amend the Criminal Code*, S.C. 1919, c. 46, s. 8.

[13] *R. v. Clarence* (1888), 22 Q.B.D. 23.

[14] See *Re Keenan and The Queen* (1979), 57 C.C.C. (2d) 267 (Que. C.A.), on the issue of judicial interim release of an accused suffering from venereal disease and charged as a "found-in" under s. 193(2) of the *Cr. Code*.

[15] (1926), 45 C.C.C. 236 (Sask. C.A.).

[16] *Bill C-53* received first reading in the House of Commons on January 12, 1981, but was not enacted. It was intended to deal with both assaultive sexual offences and sexual offences against young persons.

[17] The *Working Paper for Offences Against Young Persons* is a discussion paper prepared by the federal Department of Justice dealing with sexual offences against children, including the use of children in the making of pornography. It revises some of the provisions of *Bill C-53*.

[18] *Cr. Code*, s. 246.1(2).

[19] *Bill C-53*, clause 5.

[20] *Ibid.*, clause 6.

[21] *Ibid.*, clause 6, proposed new s. 167(2)(b).

[22] *Working Paper*, clause 1, proposed new s. 137.1.

[23] *Ibid.*

[24] Clause 3 of the *Working Paper* provides for the repeal of s. 146 of the *Cr. Code*.

[25] *Working Paper*, clause 1, proposed new s. 137.3.

[26] *Ibid.*, clause 1, proposed new s. 137.3(2)(a).

[27] *Ibid.*, clause 1, proposed new s. 137.3(2)(b).

[28] Explanatory note to *Bill C-53*, p.1(a).

[29] *Regina v. Stevens* (1983), 5 C.R.R. 139 (Ont. C.A.) and n, leave to appeal to the Supreme Court of Canada granted June 6, 1983 (S.C.C.).

Chapter 34

Genetic Risks of Incest

In addition to religious and social concerns, one of the reasons for the almost universal prohibition of incest (in Canada, the prohibition is in section 150 of the *Criminal Code**) is that over the centuries it has been observed that the offspring of such matings are more likely than other children to display severe abnormalities or mental retardation. Extensive studies on animals and humans have demonstrated that mortality and morbidity are increased, and that growth and vigour are decreased, in the first-generation offspring of closely consanguineous parents, as compared with offspring of unrelated parents.

In this chapter, the genetic risks to children of incest are reviewed with respect to the likelihood of their experiencing more hereditary disabilities than children born from other types of parents and a synopsis is given of the findings of a number of research studies which have dealt with these issues. A glossary of genetic terms and phrases is provided as a guideline for non-geneticists.

Risks of Defects in the General Population

Not every couple is fertile, not every conception leads to a live birth and not every liveborn child is normal. On the contrary, one child in 30 in the general population has some significant handicap. Examples of some of the risks faced, based on a summary by Harper[1] modified on the basis of recent Canadian vital statistics, are listed below. These statistics serve as a baseline against which the risks to children of incest can be assessed.

Basic Risks for the General Canadian Population

• Risk that a couple will be infertile	1 in 10
• Risk of spontaneous abortion	1 in 8

---

*150 (1) Everyone commits incest who, knowing that another person is by blood relationship his or her parent, child, brother, sister, grandparent or grandchild, as the case may be, has sexual intercourse with that person.

(4) In this section, "brother" and "sister", respectively include half-brother and half-sister.

- Risk of perinatal death 1 in 80
- Risk of death in first year of life after first week 1 in 200
- Risk of a serious physical or mental defect present at birth 1 in 50
- Risk of a significant handicap apparent in early childhood 1 in 30

Figure 34.1
Glossary of Genetic Terms*

Autosomal. Determined by a gene on one of the 22 pairs of automes (not the sex-chromosomes).

Autosomal Dominant. Pattern of inheritance in which the autosomal gene responsible is on only one chromosome of a pair, matched with a normal partner gene.

Autosomal Recessive. Pattern of inheritance in which the autosomal gene responsible must be on both chromosomes of a pair.

Carrier. An individual who is heterozygous for a normal gene and an abnormal gene that is not expressed phenotypically, though it may be detectable by appropriate laboratory tests.

Coefficient of Consanguinity. The probability that an individual has received both alleles of a pair from an identical ancestral source; or the proportion of loci at which he is homozygous.

Chromosome. When a cell divides, the nuclear material (chromatin) loses the relatively homogeneous appearance characteristic of non-dividing cells, and condenses to form a number of rod-shaped organelles which are called chromosomes (chromos, colour, soma, body) because they stain deeply with certain biological stains.

Consanguinity. Relationship by descent from a common ancestor.

Empiric Risk. Estimate that a trait will occur or recur in a family based on past experience rather than on knowledge of the causative mechanism.

Gene. Units of genetic information (genes) are encoded in the deoxyribonucleic acid (DNA) of the chromosomes.

Heterozygous. An individual who has two different alleles, one of which is the normal allele, at a given locus on a pair of homologous chromosomes.

Homozygous. An individual possessing a pair of identical alleles at a given locus on a pair of homologous chromosomes.

Inbreeding. The mating of closely related individuals. The progeny of close relatives are said to be inbred.

Multifactorial. Determined by multiple factors, genetic and possibly also nongenetic, each with only a minor effect.

Mutation. A permanent heritable change in the genetic material.

X-linked. Pattern of inheritance of genes on the X chromosome.

*Thompson, J.S. and M.W. Thompson, *Genetics in Medicine*, 3rd ed., Philadelphia: Saunders, 1980.

Genetic Principles

To review briefly the basic facts about the elements of human genetics: humans, like other sexually propagating organisms, have a double inheritance, receiving from each parent a full set of 23 chromosomes with their specific content of genes. In turn, each child receives a copy of one member of each of the 23 pairs; it is purely a matter of chance which one of any pair the child receives. Fertilization (the union of an egg and a sperm) restores the double quota. The genes, of which humans probably have about 50,000 pairs altogether, contain in coded form the blueprint for the production of all the structural and functional components of the organism.

Genetic defects can be caused by a number of mechanisms involving mutational changes in single genes (Mendelian or single-gene inheritance), by inappropriate combinations of many genes with small individual effects, and also in some cases, affected by environment (multifactorial inheritance) and alterations of chromosomal number or structure. Certain environmental factors can increase the risk of birth defect, in the absence of any specific genetic mechanism.

Almost all of the defects which are more common in children of consanguineous parents ("inbred children") than in children of unrelated parents ("outbred children") are of two main kinds: many are rare traits determined by single genes with autosomal recessive inheritance, and others are abnormalities (malformations or mental retardation) with multifactorial inheritance. These types of disorders reflect the two major genetic effects of inbreeding.

1. An increase in the probability that the child will inherit some rare autosomal recessive gene in double dose, thus causing a major defect.
2. An increase in the variance of the genetic liability to multifactorial conditions, thus increasing the risk of common congenital malformations and of mental retardation.

Autosomal recessive disorders are caused when both members of a gene pair are abnormal, each parent having transmitted the same abnormal gene to their child. In this case, the affected child is homozygous and both parents are usually heterozygous for the abnormal gene ("carriers"), although occasionally, one or both may be homozygous. Autosomal recessive conditions can occur only when a child inherits two copies of a particular abnormal gene, one from each parent. It is generally agreed in genetic research on the basis of human population studies that most persons are heterozygous for one or more genes which have little or no effect in heterozygotes, but which would be lethal if they were homozygous.[2] If one parent is a carrier of such a gene, the other parent is much more likely to carry the same gene if the parents are related by descent than if they are unrelated. Thus, though the same autosomal recessive conditions can affect either inbred or outbred children, there is a higher risk that they will occur when the parents are related.

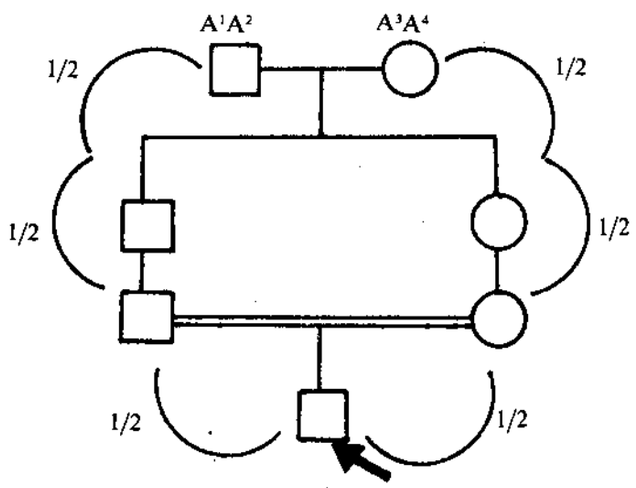
Individually, the numerous autosomal recessive diseases are all quite rare. Cystic fibrosis, which affects one in every 2000 children in Canada, is perhaps the most common such disease of this kind, although worldwide, certain blood disorders (sickle cell anemia and thalassemia) occur even more frequently. Many diseases with the autosomal recessive pattern of inheritance are exceptionally rare in the general population. Since heterozygotes are usually symptomless, as a rule the only way parents learn that they are heterozygous is by having an affected child.

An important feature of autosomal recessive inheritance is that heterozygotes are much more common than homozygotes. For example, although only one child in 2000 is homozygous for cystic fibrosis, almost one parent in 20 is heterozygous for the gene. Even for a much rarer condition, such as the classic form of phenylketonuria which has a population frequency in Ontario of about one in 30,000 births, more than 1 per cent of the population is heterozygous.

Although the general risk of being a carrier is high, it is much lower than the risk that a close relative of a carrier will also be a carrier. To give an example: if a woman is a carrier of albinism, the risk that her child will be an albino is only about one in 300 if the child's father is an unrelated person, but it is one in 32 if the father is a first cousin of the mother and one in eight if the father is the mother's brother or her father. Other types of genetic disorders (autosomal dominant or X-linked single-gene traits, or chromosomal defects) contribute little to the increased genetic risk for offspring of close relatives.

Measurement of Inbreeding

For formal analysis of inbreeding effects, geneticists use the inbreeding coefficient, F for short, which measures the closeness of a relationship in terms of the probability that both members of any gene pair in the child are identical by descent.



Chance:

A^1A^1	=	1/64
A^2A^2	=	1/64
A^3A^3	=	1/64
A^4A^4	=	1/64
F	=	1/16

To illustrate how F is calculated, the accompanying sketch shows the child of a first cousin mating.

At any specific gene locus, the child's great-grandparents have two genes each, or four in all. They are labelled A^1, A^2, A^3 and A^4 in the figure. For A^1 to be homozygous in the child, it must be passed from great-grandfather to grandfather to father to child, *and* from great-grandfather to grandmother to mother to child. The probability that A^1 will be transmitted (rather than its partner) is 1/2 for each step, altogether $(1/2)^6$ or 1/64. But there are four ways in which the child can be homozygous for a gene present in one of his or her parents' common grandparents: A^1A^1, A^2A^2, A^3A^3 or A^4A^4. His or her inbreeding coefficient is therefore $4(1/2)^6$ or 1/16.

Several types of consanguineous mating are shown in Figure 34.2, and the corresponding degrees of relationship and inbreeding coefficients are given in Table 34.1. Theoretically, the genetic risk to the offspring of a consanguineous marriage is proportional to the inbreeding coefficient; in other words, the risk is twice as high for an uncle-niece mating and four times as high for a parent-child or brother-sister mating as for a first-cousin mating. The studies of consanguineous matings reported in the medical genetics literature, in general, support this theoretical viewpoint.

Genetic Effects of Consanguineous Mating

Offspring of Cousin Matings

Risks to children of cousin matings have been reported for a number of populations. The most extensive studies of this kind were those undertaken in Japan after World War II as an offshoot of studies of the children born to parents exposed to the atomic bombing of Hiroshima and Nagasaki.[3-5] The frequency of consanguineous marriage is relatively high in Japan, at least by Western standards. In the study population at the time of the inquiry, between 4 and 5 per cent of all marriages were between first cousins. The studies compared the offspring of first cousins, first cousins once removed, second cousins and unrelated parents. The findings showed that inbreeding increased the frequency of major congenital malformations, and of mortality, especially in the first nine months of life. The differences, though statistically significant, were not large. Major defects had an approximate occurrence of 8.5 per cent in the offspring of unrelated parents and 11.7 per cent in the offspring of first cousins. The proportion of infant deaths was 3.5 per cent in liveborn children of unrelated persons and 5.5 per cent in children of first cousins. Achievement in school was slightly depressed in the children of the inbred matings, the difference indicating that their average intelligence quotient was about six points lower than that of the comparison group. There was also evidence that inbred children had an increased susceptibility to infection.

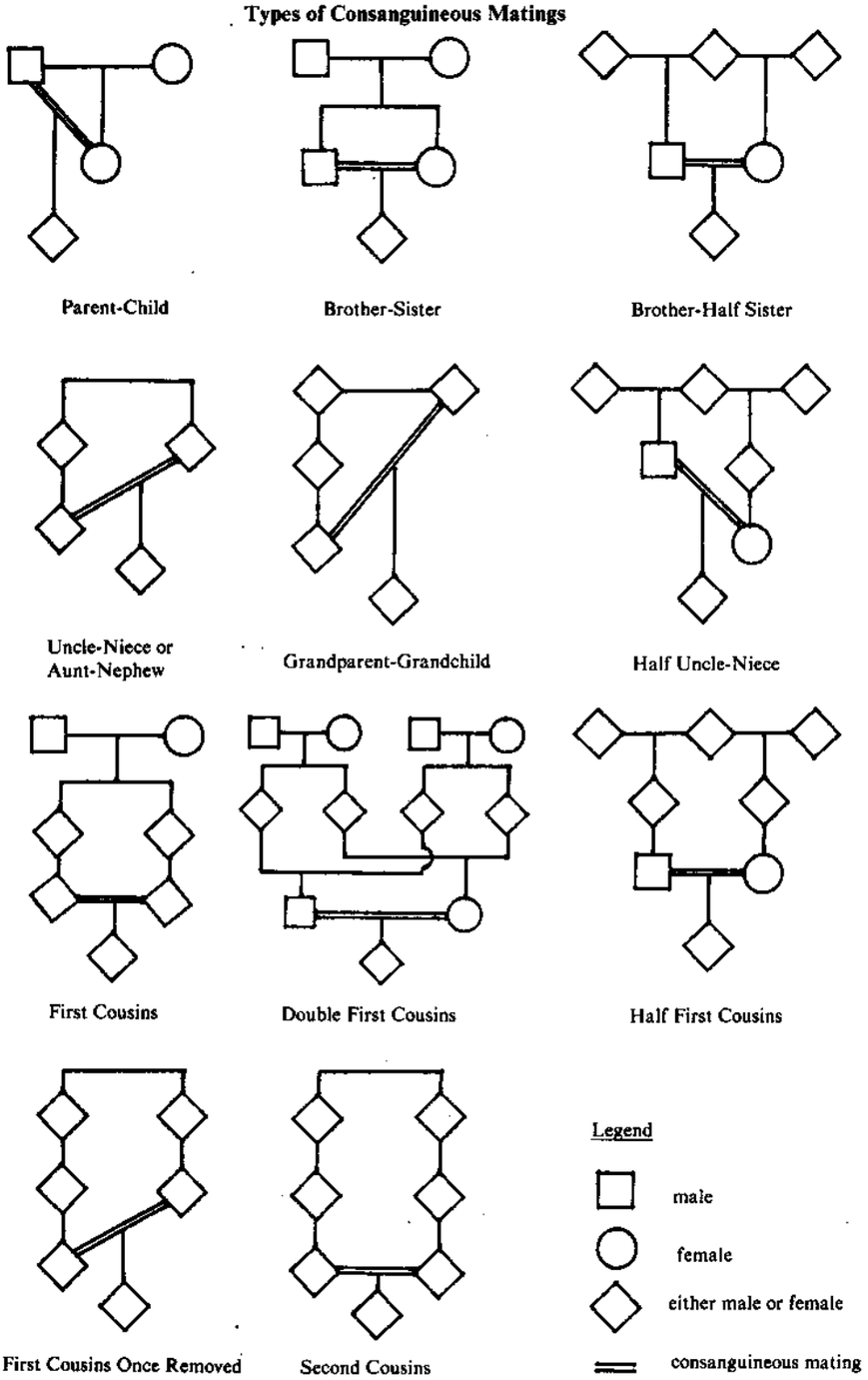
Table 34.1

Types of Consanguineous Matings and Consequences for the Offspring

Category of Mating	Degree of Biological Relationship	Proportion of Genes Shared by Mates	(Coefficient of Inbreeding of Child)	Risk that Child will be Homozygous for a Particular Recessive Gene carried by one Parent
Parent/child	1st Degree	1/2	1/4	1/8
Brother/sister (including twins)	1st Degree	1/2	1/4	1/8
Brother/half sister	2nd Degree	1/4	1/8	1/16
Uncle/niece or aunt/nephew	2nd Degree	1/4	1/8	1/16
Grandparent/grandchild	2nd Degree	1/4	1/8	1/16
Half uncle/niece (or similar combination)	3rd Degree	1/8	1/16	1/32
First cousins	3rd Degree	1/8	1/16	1/32
Double first cousins (all four grandparents in common)	2nd Degree	1/4	1/8	1/16
Half first cousins (one grandparent in common)	4th Degree	1/16	1/32	1/64
First cousins once removed	4th Degree	1/16	1/32	1/64
Second cousins	5th Degree	1/32	1/64	1/128

Figure 34.2

Types of Consanguineous Matings



Other variables measured having no difference or only a slight difference between the inbred and outbred children were: the frequency of stillbirths; physical growth and development; dental characteristics; and neuromuscular status.

Although other studies of the effects of consanguinity[6-12] agree in general that there is a small increase in empirical risk of mortality, severe abnormality or retardation in the offspring, the findings of these studies vary considerably with respect to the magnitude of the risks. A generally accepted figure, one used by many medical geneticists for the purposes of genetic counselling, is that the increased risk (above the baseline risk to any child) for the offspring of first-cousin parents is 3 per cent, and for the offspring of first cousins once removed or second cousins, it is about 1 per cent.[13] More distant consanguineous matings are not considered to differ genetically from so-called "random matings".

Fraser and Biddle approached the estimate of consanguinity effects by using records on consanguineous couples ascertained through a child with an abnormality, and correcting for bias by measuring the frequency of conditions other than that through which the matings were ascertained.[14] These researchers analyzed the experience of 58 families with first-cousin parents, 27 with second-cousin parents and 85 unrelated controls. There was a significant increase in the proportion of infant deaths occurring below one year of age in the consanguineous children (8.9 per cent) as compared with that of the controls (3.5 per cent). The occurrence of morbidity was 3.7 per cent in the consanguineous group in comparison to 1.9 per cent in the controls; the difference was not statistically significant, but in its direction and size it was similar to the results obtained in other studies. No autosomal recessive disorders were recognized in either group. The authors cautioned that the increased infant mortality associated with inbreeding may partly be accounted for by environmental differences between the consanguineous and nonconsanguineous parent groups.

Offspring of Uncle-niece Matings

Although uncle-niece marriage is legal in some populations, a report of the offspring of 27 uncle-niece marriages in the Moroccan Jewish community in Israel is the only objective description available of the genetic consequences of this type of mating.[15] Since the families were identified by means of the Jerusalem Perinatal Study, only those matings in which the wife was pregnant at the time of the study (1966-68) were considered; thus there was a bias with respect to the exclusion of sterile or relatively infertile couples and those whose pregnancies may have aborted early. The 27 uncle-niece couples had had 155 previous pregnancies. A control group of 27 couples, matched for country-of-birth (Morocco), age and socioeconomic status, had had 154 previous pregnancies. The mortality rate was much higher (16.8 per cent) in the children of the uncle-niece matings than in the controls (6.7 per cent). The malformation rate

was 8.9 per cent in the inbred children and 3.7 per cent in the controls. Birth weight was lower in the inbred group, but the difference was small and not statistically significant. The occurrence of stillbirths was not affected.

Although there are no other reports of the genetic consequences of uncle-niece matings, Bashi's study on the cognitive performance in children of closely related Arab parents in Israel provides findings on the intelligence of children of double first cousins, for whom $F = 1/8$, the same as for uncle-niece pairs.[16] Bashi studied 125 offspring of double first cousins, 970 offspring of first cousins, and 2,108 children of unrelated parents. All of the children were between 10 and 12 years of age and attending school, but on all the tests of cognitive ability used, the offspring of double first cousins ranked lowest in average standing, the offspring of first cousins were intermediate, and the offspring of unrelated parents were highest.

Offspring of Parent-child and Brother-sister Matings

Because of the stigma associated with incest, it is not surprising that there is little precise information on the genetic consequences to the children of first-degree relatives. There have been only five studies dealing with these unions, four of which describe the experience of small numbers of persons. The findings of these studies are summarized in Table 34.2.

The first report was that by Carter from England who identified 13 children of incest prior to birth or as newborns and followed them for a period of between four and six years.[17] Only five were normal. Three had died, one of a definitely autosomal recessive disease, one of a disease which was probably autosomal recessive, and one of a cardiac defect which is now considered to have multifactorial inheritance. One child was severely retarded and the four others were educationally subnormal.

In Michigan, Adams and Neel studied 18 children of incest and 18 controls whose mothers were matched as closely as possible for race, age, stature, weight, intelligence and socioeconomic status.[18] All of the mothers were unwed and were pregnant for the first time. The cases were ascertained during pregnancy, and the children were examined at birth, at the age of six months, and later, if there were abnormal findings. The children of incest averaged one-half pound (240 g) less at birth than the weight of the control children. Of the 18 children, only seven were normal. By the time of the six month evaluation, five had died, one had a major malformation (bilateral cleft lip), two were severely retarded and three were less severely retarded, with intelligence quotients (IQs) of about 70. By comparison, all of the children in the control group had survived, of whom one had a major malformation (a branchial cleft cyst), 15 had average intelligence (IQ of 91 or more), and three were mildly retarded (IQ of 80-90). The frequency of "death-plus-major defect" was 33 per cent in the children of incest and 5.4 per cent in the comparison group. In addition, the frequency and severity of mental retardation was higher in the children of incest.

Table 34.2

Risks to Children of Incest

Author	Number of Children	Number Living at Time of Follow-up	Number Normal	Probably Autosomal Recessive	Abnormalities Reported[1]		Non-specific Retardation	
					Probably Multi-factorial	Unclassified	Severe	Mild
Carter, 1967	13	10	5	2	1	—	1	4
Adams & Neel, 1967	18	13	7	—	1	—	2	3
Seemanova, 1971	161	138	78	—	—	51	20[2]	Not Stated
Knight (cited by Bundey, 1980)	23	Not Stated	7	3	3	—	5	11
Baird and McGillivray, 1982	29	29	9	3	—	9	6	

[1] Some children had more than one abnormality.

[2] Twenty other children were both retarded and physically abnormal.

The largest series of the offspring of incest studied, a group of 161 children, was reported from Prague by Seemanova.[19] In this retrospective study, the children were identified after birth by means of their medical records. The comparison group consisted of 95 children born to the same mothers with unrelated partners. Although this choice of controls has obvious advantages, the two groups differed with respect to maternal age (four to five years older in the control group) and with respect to parity (the pregnancies producing the children of incest were usually the mothers' first pregnancies). Twenty-three of the 161 children of incest (14.3 per cent) and five of the 95 controls (5.3 per cent) had died by the time of follow-up. Among the survivors, 78 of the 138 children of incest (56.5 per cent) were classified as normal; the remainder had: congenital malformations; other types of abnormalities probably inherited as autosomal recessive, such as congenital deafness and mucopolysaccharidosis; mental retardation; or a combination of these disorders. In the comparison group, 85 of the 90 children were normal.

A short series of 23 children of incest, ascertained at or shortly after birth, was analyzed by Knight.[20] Only seven children were normal at follow-up, three had autosomal recessive disorders, three had malformations presumed to be multifactorial, five were severely retarded, 11 were mildly retarded and five had other defects. (Some children had more than one abnormality.)

A study conducted in British Columbia has provided findings on 29 children, 21 of whom were ascertained because of incest and eight because of medical problems that warranted referral to a paediatric genetics unit.[21] A high risk of early death, abnormality and retardation was found. In the group of 21 children, nine were normal and 12 had abnormalities, nine of which were severe. Eight had low birth weights (less than 2500 gm) that could only be accounted for in part by the young age of their mothers (average age being 16 years). Six of the children were developmentally delayed or retarded. In the second group, all of the children were abnormal. One of the first group and three of the second had autosomal recessive conditions. Two children had died a few months after birth of sudden infant death syndrome.

None of the research studies of the children of first-degree relatives is ideal with respect to the size of the groups investigated or with respect to the design of the research methods used. Each study suffers from certain unavoidable methodological weaknesses. Four dealt with relatively small groups, three lacked controls and in none was information given about the risk of sterility or early fetal loss. The ascertainment of cases, the classification of the defects observed and the duration of the period of follow-up were not uniform. It is often impossible to be sure from the findings presented whether a particular identified abnormality was autosomal recessive, multifactorial, otherwise genetically determined or nongenetic. **Although it is difficult to compare the findings of the studies, nevertheless, they are in general agreement on one point, namely, that children of incest are at high empirical risk of abnormality, severe mental retardation and early death.**

Comparative Risk of Genetic Disease

The risk of serious abnormality in the offspring of a first-degree mating (parent-child or brother-sister) is about one-half and the risk for a child of a second-degree mating (grandparent and grandchild) is close to one-tenth. Both of these rates are well above the risk in the general population of between 2 and 3 per cent. Early childhood mortality is exceptionally high in both groups.

These risks are clearly not negligibly low. They should certainly be taken into account by physicians, adopting parents and others responsible for children who are or might be of incestuous origin.[22-23] One basis that can be used in considering the level of these risks is the standard used in genetic counselling. There is a tendency among genetic counsellors and parents who consult them to characterize a risk of genetic disease below 10 per cent as "low" and a risk above 10 per cent as "high". However, there is another principle to which genetic counsellors, almost without exception, subscribe; namely, that the parents themselves must be the final arbiters of their own risk. In practice, it is found that there is a very wide variation in the parents' perception of risk. Some parents will continue to have children, even when those children face a 50 per cent risk of having a serious genetic disease. In contrast, other parents will shy away from a risk as low as 1 per cent and will refrain from having more children.

The risk of genetic disease in the offspring of a first-degree incestuous mating falls in the same range as that for single-gene diseases. For example, if one parent has a dominantly inherited disease (i.e., a disease which occurs when only one of a pair of genes is defective) and the other parent is healthy, the risk of a child of the marriage having the same disease as the affected parent is one half. If two normal parents have a child with a recessively inherited disease (i.e., a disease which occurs when both genes of a pair are defective), then the risk of their next child having the same disease is one quarter. In both of these examples, the risk would be predictable in advance. The parents would, if they sought counsel, be informed of these risks, but they would be encouraged and helped by their physician or genetic counsellor to reach their own decision about whether they should have more children. As noted, it is known as a matter of experience that some parents, though perhaps a minority, will, when faced with risks of this magnitude, still elect to have more children. In this respect, there is no law which prohibits them from doing so.

In summary, with respect to the comparative risk of children having a genetically inherited disease, the offspring of incestuous matings are subject to exactly the same genetic defects as other children; that is to say, any genetic disorder seen in the child of an incestuous union may also be found in the offspring of unrelated parents. The risk of genetic disorders in children of incest lies in the same range as the risks to children of unrelated parents who are genetically predisposed to have defective children. However, **the probability that a genetic disorder will be present is much higher for children of incest than for children of unrelated parents in the general population (as high as about 50 per cent rather than about 2 to 3 per cent).**

Summary

On the basis of comparative studies of inbred and outbred human populations and of studies of experimental organisms, the following conclusions are reached:

1. Inbred children are at increased risk of early mortality, congenital abnormalities and cognitive disability.
2. The disorders seen in inbred children are not different in nature from those for which any child is at risk.
3. The probability, however, that a genetic disorder will be present in the children of incest is much higher than it is for children of unrelated parents in the general population.
4. The more closely related the parents, the higher the risk of defective offspring.
5. The risk is higher when the parents are from a normally outbred population than when they are from a relatively inbred group.
6. With minor exceptions, the increase in risk applies only to the first-generation offspring of related parents, not to subsequent generations.
7. The magnitude of the risk, even for children of parent-child or brother-sister unions, is in the same range as the risk to children of unrelated parents having certain genetic constitutions.

The incest prohibition in the *Criminal Code* includes blood relationships where there is a risk of genetic disorder in the children well above the risk in the general population. Of course, children of some unrelated parents may have a similar chance of having a serious genetic disease. Today, it is possible, in an increasing number of cases, to determine whether the parent is affected. But it is necessary to make the determination. The incest provision in the *Criminal Code* serves the useful purpose of providing a specific indicator of higher risk for the limited number of blood relationships it describes.

As other findings in the Report clearly show, most incest relationships involve adults and children and typically entail harassment, seduction, threats or the use of physical force against the child. In the Committee's view, while the social and legal considerations given elsewhere in the Report alone warrant the retention of the offence of incest in the *Criminal Code*, the findings of the review of the genetic risks to children of incest support further the case for retaining the incest prohibition.

References

Chapter 34: Genetic Risks of Incest

[1] Harper, P.S., *Practical Genetic Counselling*. Baltimore, University Park Press, 1981.

[2] Morton, N.E., J.F. Crow, H.J. Muller, An estimate of the mutational damage in man from data on consanguineous marriages. *Proceedings of the National Academy of Sciences U.S.A.*, 42: 855-863, 1956.

[3] Schull, W.J., Empirical risks in consanguineous marriages: sex ratio, malformation, and viability. *American Journal of Human Genetics*, 10: 194-343, 1958.

[4] Morton, N.E., Empirical risks in consanguineous marriages: birth weight, gestational time, and measurements of infants. *American Journal of Human Genetics*, 10: 344-349, 1958.

[5] Schull, W.J., J.V. Neel, *The Effects of Inbreeding on Japanese Children*, New York, Harper and Row, 1965.

[6] Book, J.A., Genetical investigations in a north Swedish population: the offspring of first cousin marriages. *American Journal of Human Genetics*, 32: 191-221, 1957.

[7] Slatis, H.M., R.H. Reis, R.E. Hoene, Consanguineous marriages in the Chicago region. *American Journal of Human Genetics*, 10: 446-464, 1958.

[8] Sutter, J., Recherches sur les effets de la consanguinite chez l'homme. *Biologie Medicale* 47: 563-660, 1958.

[9] Freire-Maia, N., A. Freire-Maia, The structure of consanguineous marriages and its genetic implications. *American Journal of Human Genetics*, 25: 29-39, 1961.

[10] Shine, I., *Serendipity in St. Helena*. Oxford: Pergamon Press, 1970.

[11] Bashi, J., Effects of inbreeding on cognitive performance. *Nature*, 166: 440-442, 1977.

[12] Fraser, F.C., C.J. Biddle, Estimating the risks for offspring of first-cousin matings: an approach. *American Journal of Human Genetics*, 28: 522-526, 1976.

[13] Harper, P.S., *op. cit.*

[14] Fraser, F.C. and C.J. Biddle, *op. cit.*

[15] Fried, K., A.M. Davies, Some effects on the offspring of uncle-niece marriage in the Moroccan Jewish community in Jerusalem. *American Journal of Human Genetics*, 26: 65-72, 1974.

[16] Bashi, J., *op. cit.*

[17] Carter, C.O., Risk to offspring of incest. *Lancet*, 1:436, 1976.

[18] Adams, M.S., J.V. Neel, Children of incest. *Pediatrics*, 40: 55-67, 1976.

[19] Seemanova, E., A study of children of incestuous matings. *Human Heredity*, 21: 108-128, 1971.

[20] Knight, I.G., cited by S. Bundey, The child of an incestuous union. In: Wolkind S(ed): *Medical Aspects of Abortion and Foster Care*, London, Heinemann (Clinics in Developmental Medicine 74: 36-41).

[21] Baird, P.A., B. McGillivray, Children of Incest, *Journal of Pediatrics*, 101: 854-857, 1982.

[22] Hall, J.G., Children of Incest: when to expect and how to evaluate? *American Journal of Diseases of Children*, 132: 1045, 1978.

[23] Thompson, J.S., M.W. Thompson, *Genetics in Medicine*, 3rd ed. Philadelphia, Saunders, 1980.

Chapter 35

Criminal Injuries Compensation Boards

In each province and territory (except Prince Edward Island), there is an administrative board whose function is to award compensation to innocent victims of violent crime. This chapter reviews the practice of these boards in awarding compensation to young victims of sexual assault.

Compensation

The role of criminal injuries compensation boards has been outlined in a 1983 report compiled jointly by Statistics Canada and the Federal Department of Justice:[1]

> From a social security point of view, criminal injuries compensation forms part of a large network of programs to ensure that Canadian residents enjoy both income security and necessary social services, regardless of their socio-economics status . . . From a justice perspective, criminal injuries compensation represents a significant development to improve the criminal justice system, by compensating innocent victims of violent crime. It is seen as part of a wider effort which includes amendments to Canada's *Criminal Code*, the development of modified procedural rules, the placing of increased emphasis on services for crime victims and the encouragement of community based alternatives to the regular criminal court process and prisons.

Funds for the payment of compensation awards and for the administration of the programs come from the Consolidated Revenue Fund of each province and territory.[2] These outlays are reimbursed in part by the federal government, through the operation of a federal-provincial cost-sharing program established in 1973 and revised in 1977.[3] Although the compensation programs in each province and territory differ in important respects, the broad outline of these programs can be stated briefly. Compensation is awarded for injury or death resulting from:

1. A specified crime (including most sexual offences) committed by another person.
2. An effort to prevent crime (either with or without the assistance of a peace officer).
3. An effort to arrest an offender or suspected offender.[4]

The injured party or his or her representative must apply within stated time periods which normally may be extended at the discretion of the Board. The Board must be satisfied that the injury or death for which compensation is claimed resulted from one of the three reasons specified above. It is empowered to hear all relevant evidence regardless of whether such evidence would be admissible in a court of law. In eight Canadian jurisdictions, the Board may hold the hearing *in camera* in appropriate circumstances, for example, where the applicant is a victim of sexual assault. In four jurisdictions, the Board may issue an order prohibiting the publication of evidence raised at the hearing.

The arrest or conviction of the offender is not a prerequisite to the granting of compensation. Where the offender has been apprehended, convicted and has exhausted his or her legal appeals, this is considered conclusive proof that a criminal offence has been committed.

Compensation may be awarded in the form of lump sum payments, periodic payments, or both. Victims may proceed, simultaneously, to seek criminal injuries compensation and a civil remedy in the courts. Where a victim is successful in obtaining both a compensation award and a civil judgment for damages, he or she is required to repay the compensation received, in whole or in part. If the victim obtains a compensation award and does not launch a separate civil action for damages, the victim's future right of action is normally subrogated to the Board or to the relevant provincial Minister.

From the perspective of sexual assault victims, a key issue is the nature and amounts of damages which may be awarded under criminal injuries compensation schemes. All jurisdictions impose a statutory maximum on the amount of compensation which may be awarded. Beyond these statutory upper limits, no additional compensation may be granted, regardless of the severity of the applicant's injury or disability. Moreover, these upper limits are far lower than the largest amounts for damages awarded in civil actions.

A further problem is the kinds of damages for which compensation may be awarded. The principal damages suffered by sexual assault victims will often be non-pecuniary; the victim may have suffered no permanent physical injury, but may nonetheless have incurred lasting emotional and psychological injuries (non-pecuniary damages) which, in some jurisdictions, are considered non-compensable. For example, there is no provision for compensating "pain and suffering" in the criminal injuries compensation schemes in Quebec, Manitoba, Alberta and the Northwest Territories. Further, in two of the provinces in which compensation for "pain and suffering" may be awarded — New Brunswick and Saskatchewan — it appears that only pain and suffering experienced by the victim can be claimed, and not that experienced by the victim's dependants or by the persons responsible for a disabled victim's maintenance.

There are, however, statutory provisions which directly address at least a narrow class of sexual assault victims. The inclusion of pregnancy and nervous shock within the definition of "injury" in all jurisdictions, except Nova Scotia, suggests that some compensation will be awarded to sexual assault victims in

this category. Further, payments for the maintenance of a child born as a result of a sexual assault are expressly authorized in eight jurisdictions.

Year	Total Number of Cases Compensated	Proportion of Compensation for Sexual Assault Cases
		Per Cent
1975–76	1963	3.7
1976–77	2586	3.7
1977–78	2604	3.6
1978–79	3232	4.5
1979–80	3812	4.5

Although compensation for sexual assault cases constitutes a small proportion of all awards for which compensation has been provided, the proportion of these cases rose from 3.7 per cent in 1975-76 to 4.5 per cent in 1979-80 for eight provinces and territories (except Prince Edward Island and Nova Scotia).[5] This trend indicates that there is a growing recognition of these Boards as a public resource that can be turned to as a means of assistance for victims of sexual assaults.

Case Studies

The case studies obtained from the official records of the criminal injuries compensation boards in Ontario, Saskatchewan and British Columbia illustrate the range of considerations which these boards take into account in assessing the level of compensation that should be awarded to young victims of sexual assault. The year in which the award was made is indicated in each case; information tending to identify the victims has been deleted.

Compensation Awards in Ontario

Although the Ontario Criminal Injuries Compensation Board has made several compensation awards to young sexual victims since 1979, the case studies presented below are taken from 1978-79 and preceding years; the incidents involving young sexual victims who applied for compensation in more recent years are not reported fully enough to serve as a basis for case studies.

The amounts awarded for pain and suffering to each applicant constitute a part of the total compensation award in each case.

Case Study 1 (1978-79)

> The victim, a six year-old boy, was enticed into a garage where he was beaten with an empty bottle. There was also an attempted sexual assault. He sustained lacerations to his head, arm and leg, and still has nightmares. The offender was charged and convicted of assault causing bodily harm. He received a suspended sentence with three years' probation.

Compensation Awarded: Total — $1,080.00 (pain and suffering, $1,000.00).

Case Study 2 (1976-77)

The applicant, then age 16, was attacked and raped in a field after accepting a ride from an unknown male. After stabbing the victim twice, the offender piled bricks and rocks on top of her. The offender was convicted of attempted murder and sentenced to life imprisonment.

Compensation Awarded: Total — $3,000.00 (pain and suffering, $3,000.00).

Case Study 3 (1976-77)

The applicant's daughter, age 15 at the time of the hearing, was returning to her sister's home in Toronto when a man who had been following her tried to force himself upon her. When she resisted, he slashed her across the throat with a knife and also across the palm of her right hand. The offender was convicted of wounding and sentenced to three and a half years in federal penitentiary.

Compensation Awarded: Total — $2,765.00 (pain and suffering, $2,000.00).

Case Study 4 (1976-77)

The applicant's son, then age four, was indecently assaulted by a 16 year-old male. The victim suffered bodily harm and nervous mental shock. The latter condition, at the time of the compensation hearing, was still evident to his doctors. The victim was undergoing regular weekly treatments as a result. The offender was convicted of indecent assault and given a suspended sentence with two years' probation.

Compensation Awarded: Total — $3,910.00 (pain and suffering, $3,500.00).

Case Study 5 (1976-77)

The applicant's daughter, then age 13, was the victim of a brutal assault and rape. She sustained extensive bruising and swelling on the left side of her face, two front teeth were broken and there was a large bruise around her neck where she had been tied with a rope. The victim became withdrawn and introverted. The offender was sentenced to eight years' imprisonment for rape and two years' concurrent for robbery.

Compensation Awarded: Total — $5,250.00 (pain and suffering, $5,000.00).

Case Study 6 (1976-77)

The applicant's daughter, then age eight, was abducted and raped by the offender. She was found nude in a ditch with one of her socks tied around her throat. She sustained massive injuries to the vaginal wall extending to the cervix and through to the rectum. The offender was sentenced to two concurrent terms of life imprisonment for attempted murder and rape, and to a concurrent sentence of four years for the kidnapping.

Compensation Awarded: Total — $11,896.20 (pain and suffering, $11,000.00).

Case Study 7 (1976-77)

The applicant's daughter, then age 16, was returning home from a party when she was approached by the offender and threatened with a knife. The offender took her to a deserted spot and, after gagging her with a scarf and tying her hands with leather thongs, raped her two or three times. He then started to torment her by throwing lighted matches at various parts of her body, after dousing her with alcohol. He then slashed her left breast with the

knife. The offender was convicted of rape and sentenced to 15 years' imprisonment.

Compensation Awarded: Total — $6,385.00 (pain and suffering, $6,000.00).

Case Study 8 (1975-76)

The applicant, a 16 year-old girl, was walking to her place of residence one night when she was punched and raped by an unknown male. She subsequently became pregnant and was recommended for a therapeutic abortion, which she had.

Compensation Awarded: Total — $3,080.90 (pain and suffering, $2,000.00).

Case Study 9 (1975-76)

The victim, a 12 year-old girl, was invited by neighbours to their cottage for two weeks. One night during this visit, the husband-neighbour raped the victim. The offender was subsequently convicted of the offence of unlawful sexual intercourse with a female under 14 years of age and was sentenced to imprisonment for two years less a day.

Compensation Awarded: Total — $1,817.30 (pain and suffering, $1,500.00).

Case Study 10 (1975-76)

The victim, a 14 year-old girl, was playing with two friends when she was grabbed by the offender and beaten until she was unconscious. He then dragged the victim to a shack where he raped her and forced her to commit fellatio. The victim sustained bruises about the face and external genitalia. The offender was convicted of rape and sentenced to 12 months' imprisonment to be followed by an 18 month probationary period.

Compensation Awarded: Total — $2,603.20 (pain and suffering, $2,000.00).

Case Study 11 (1975-76)

The applicant, a 17 year-old student, had just completed some shopping when she was approached by two young men who offered her a ride home. She accepted the offer and was beaten and raped en route to her home. She sustained a fractured nose, a chipped front tooth and two black eyes. The principal offender was convicted of rape and sentenced to imprisonment for two years less a day to be followed by a one year probationary period.

Compensation Awarded: Total — $1,135.28 (pain and suffering $800.00).

Case Study 12 (1975-76)

The victim, a 12 year-old boy, was walking to a hockey arena near his home when he was approached by the male offender, who told the boy to get into his car. The victim was then driven to a hockey arena and later to a motel where he was forced to engage in gross sexual indecencies. The boy was then beaten and left in a state of unconsciousness. The offender was convicted of assault causing bodily harm and, according to the Board's report, "was sentenced to 3 years consecutive to two life sentences then being served."

Compensation Awarded: Total — $2,997.40 (pain and suffering, $2,000.00).

Case Study 13 (1975-76)

The 10 year-old victim and her girlfriend (age not given) were lured into the offender's house and subjected to physical and indecent assault. The

offender was convicted on charges of indecent assault and gross indecency. He received a total sentence of five years' imprisonment.

The victim suffered damage to her genital area and emotional trauma. The victim's girlfriend sustained burns to her naval area, welts over the buttocks and damage to the genital area. At the time of the hearing, the child had recovered from her physical injuries, but continued to experience nervous tension.

Compensation Awarded: Total — $1,420.00 (pain and suffering, $1,250.00).

Case Study 14 (1974-75)

The victim, age seven, was indecently assaulted and, although no physical injury was sustained, she underwent a psychiatric examination. The offender pleaded guilty to indecent assault and was given a two year suspended sentence with probation.

Compensation Awarded: Total — $710.00 (pain and suffering, $700.00).

Case Study 15 (1973-74)

The victim, age 15, was brutally assaulted and raped by a casual acquaintance. The offender was convicted of rape and indecent assault; he was sentenced to seven years' imprisonment.

Compensation Awarded: Total — $2,376.00 (pain and suffering, $2,000.00).

Case Study 16 (1973-74)

The victim, age 16, was raped and beaten to death by male persons unknown. The applicant, the father of the deceased victim, received compensation for expenses incurred as a result of his daughter's death.

Compensation Awarded: Total — $497.37.

Case Study 17 (1973-74)

A young girl, 14 years of age, was the victim of a vicious knife attack, wounding and rape. She lost the sight of her right eye as a result of the attack. The offender was sentenced to a total of 12 years' imprisonment on charges of rape and wounding.

Compensation Awarded: Total — $10,331.00 (pain and suffering, $9,500.00).

Compensation Awards in Saskatchewan

Case Study 18 (1983)

The victim was 16 years-old at the time of the incident. Late one summer night, she was raped while staying in an apartment in a Saskatchewan city. She was taken to a hospital, where it was determined that she suffered lower quadrant abdominal pain, severe anxiety and trauma. She was later treated by a chiropractor for multiple subluxations with concomitant muscle contusions to the right cervical muscle and upper right trapezius muscle. The victim recovered from the physical injuries in about one month. Her assailant was convicted of rape and sentenced to three years' imprisonment.

The victim applied for compensation on the grounds of pain and suffering and incidental expenses incurred. The Board made the following award to the applicant, to be placed in trust with the Official Guardian's Office until she reached the age of majority:

Compensation Awarded:

For pain and suffering	$3,500.00
For damaged clothing	72.50
To the applicant's lawyer	100.00
TOTAL AWARD	$3,672.50

Case Study 19 (1983)

The female applicant was 18 years-old at the time of the incident: she was staying with relatives in a Saskatchewan city. In late summer, 1982, at about 1:00 a.m., she was listening to a record at her cousin's house when she was sexually assaulted by him. The applicant was seen by a physician some time later and was diagnosed as suffering from a linear tear to her hymen, in addition to suffering from reactive depression and anxiety. In December, 1982, the applicant underwent surgery to repair the injury to her hymen. According to a psychologist's report, she had made good progress in recovering from the trauma induced by the sexual assault.

The incident was reported to the police by a third party report made by a Rape Crisis Centre in the western province in which the applicant normally resided. To date, no charges have been laid against the assailant.

Compensation Awarded:

For pain and suffering	$4,000.00
For estimated income loss	850.00
For damaged clothes	70.00
For travelling expenses	789.80
Contribution towards telephone calls	100.00
For miscellaneous expenses	30.00
For medical care	155.00
For medical bills	290.00
For legal advice	10.00
TOTAL AWARD	$6,294.80

Case Study 20 (1979)

The female applicant, A.B., was 14 years-old at the time of the incident. In October, 1977, A.B. was employed as a baby-sitter for X, and in the course of her employment stayed at his residence until about 2:00 a.m. one morning when X, X's wife and Y returned to X's residence. X and Y agreed to take the applicant home, but instead drove her to another residence and then to a field several miles outside the city. There she was forcibly undressed and sexually assaulted a number of times before getting out of the car on the pretext of going to the washroom. She then ran away. X and Y attempted unsuccessfully to find her. She eventually found her way back to the highway, was picked up by a passing motorist and taken to a police station.

The victim's father, C.B., made the application on his daughter's behalf. Evidence presented to the Board established that these events had had a severely traumatic effect on A.B.; the attending physician stated that A.B. was more distraught than any of the rape victims he had ever examined. The parents of A.B. testified that she had suffered a great deal of stress as a result of the incident, and had lost her self-confidence and most of her friends. She was depressed for a prolonged period and was extremely nervous about leaving the family home by herself. During the period prior to the criminal trial, she could not work as a baby-sitter and suffered a consequent loss of wages. She began to improve after court proceedings were completed, has since

obtained employment and made some progress towards normalizing her social life. The male assailants X and Y were convicted of rape.

Compensation Awarded:

To A.B., to be paid to the Official Guardian on her behalf for pain and suffering	$5,000.00
To A.B., for lost wages	$ 800.00
To C.B., for pecuniary loss regarding clothes, glasses and incidental medical expenses	$ 200.00
TOTAL AWARD	$6,000.00

Case Study 21 (1979)

In February, 1978, the applicant, a 16 year-old girl, was walking home when a stranger asked her to help him start his car. She refused, but the stranger persisted. As she approached the car, the man pulled out a knife and forced her into his car, where he indecently assaulted and raped her.

A warrant was issued for the arrest of the offender on a charge of rape, but the offender committed suicide before the warrant was effected.

As a consequence of being raped, the applicant became pregnant and underwent a suction curettage during the first trimester of her pregnancy. Medical complications ensued and necessitated a second operation 10 days later. At the compensation hearing, the applicant's parents stated that, although her physical recovery from the ordeal was satisfactory, she continued to suffer from emotional tension and from a generally unstable emotional state.

Compensation Awarded:

To E.F. (the applicant), to be paid to the Official Guardian on her behalf and to be placed in trust until she reached the age of majority	
For pain and suffering	$4,800.00
For medication	20.00
For damaged clothing	138.00
TOTAL AWARD	$4,958.00

Case Study 22 (1977)

This was an application on behalf of A.D., a girl who was 13 years-old at the time of the incident. While she was baby-sitting at the home of a friend, her friend's 23 year-old brother engaged her in conversation. He then grabbed her, threatened her with a knife and compelled her to submit to sexual intercourse. The forced sexual act was repeated several times before the assailant eventually left the premises. A.D. complained to a girlfriend later that evening and told her mother of the incident the following morning. The police were notified and A.D. was taken to a hospital where she was medically examined.

The assailant, G.H., pleaded guilty to a charge of unlawful sexual intercourse with a female person who is under the age of 14 years.

The medical evidence indicated physical injuries consistent with violent sexual intercourse. A.D. was seen on nine subsequent occasions by the con-

sulting physician who reported that she was gradually recovering from a state of extreme nervousnesses and sleeplessness caused by the sexual assault.

In the text of its opinion, the Saskatchewan Board issued the following statement: "The Board views an assault of this nature as a most serious and traumatic incident in the life of an individual, notwithstanding that the physical injury involved was not great. We think such cases call for substantial compensation if the *Criminal Injuries Compensation Act* is to have any meaning."

Compensation Award: The Board awarded a sum of $3,500.00 for pain and suffering, to be paid to the Official Guardian on behalf of A.D.

Case Study 23 (1977)

The victim of this tragic incident was five years-old when she was forcibly sexually assaulted by her biological father. The application for compensation was made by the victim's mother.

The applicant was married to J. in 1959. A daughter K. (the victim of the sexual assault) was born to them in 1961. In the next four years, two other children were born into the family. The parties separated a year later, on the grounds of the cruelty of J. towards his wife and children and because of his sexual advances to the young child K. A few years later the parents were divorced. K.'s mother remarried and relocated herself and her three children with her new husband in a different city.

During the period of her separation from her first husband, the husband came to pick up the children to take them, in accordance with his visitation rights, to see his parents. The next time the mother saw her daughter K. was in the hospital, where she had been taken after being sexually assaulted by her father. The father was subsequently convicted of incest.

During her original stay in the hospital, the child K. was in great pain and severe emotional trauma. She remained in the hospital for six weeks, and later, when she was eight years-old, spent two months in a hospital in a different city. In the interim two and a half year period, she had no bowel control. She underwent a colostomy so that the bowel damage could be repaired; this procedure was then reversed before she was discharged.

Seven years after the sexual assault, K. was psychologically tested. She was still displaying symptoms of anxiety and abnormal fear of darkness and strangers. The Compensation Board stated in its report: "For the first year after the incident, she slept with her mother and was extremely tense and subject to nightmares. She has developed into a very quiet, worried type of person who has a limited social life but is coping reasonably well. She suffers from stomach ulcers. She still has frequent infections and may have to have further surgery on her bowels due to the presence of a fistula. At this time, it is not known whether she will ever be able to bear children, but there is a good chance that she may not. Her mother stated that K. plans to be a nurse. She did not wish to attend the hearing because of the emotional effect it would have on her. She still sees doctors regularly because of infection. In summary, we find that she was most grievously assaulted and should be compensated liberally."

Compensation Award: The Compensation Board awarded K. a sum of $9,000.00 for pain and suffering, to be paid to the Official Guardian on her behalf. An award to K.'s mother of $1,050.00 for pecuniary loss and medical expenses was later withdrawn by the Board, as such payment was, in the circumstances, barred by the Saskatchewan compensation statute.

Case Study 24 (1981)

An eight year-old girl was attacked, forcibly undressed and indecently assaulted by a male person in a deserted garage in Vancouver. The victim and two young friends of hers had been lured into the garage by the assailant on the pretext of looking for a lost dog. At the time of the application, the assailant had not yet been identified.

The eight year-old victim suffered multiple contusions and abrasions, and severe anxiety.

Compensation Awarded: Total—$2,000.00

Case Study 25 (1981)

A 13 year-old girl was attacked, threatened, indecently assaulted, raped and forced to perform an indecent sexual act by a male person in a deserted area near Coquitlam. The assailant was later apprehended and charged with rape.

The victim suffered multiple contusions and emotional trauma.

Compensation Awarded: Total—$3,000.00

Case Study 26 (1979)

A 12 year-old girl was attacked, indecently assaulted and raped by a male person at his residence in a small community. The victim had gone to this residence at the request of the male assailant's family, in order to babysit his two children. He later pleaded guilty to a charge of indecent assault on a female.

The victim, as a consequence of the attack, suffered from a severe state of mental anxiety.

Compensation Awarded: Total—$2,500.00

Case Study 27 (1979)

A seven year-old girl, over a period of about two years, was subjected to acts of indecent assault and gross indecency by a male person at several locations, including the assailant's residence in Victoria. He later pleaded guilty to several counts of indecent assault involving this incident as well as assaults on other children.

The seven year-old victim suffered from anal scar tissue, nervousness and mental anxiety.

Compensation Awarded: Total—$6,000.00

Case Study 28 (1978)

A 15 year-old girl was abducted by a man while walking down a street in Vancouver. She was forced into a vehicle, blindfolded, bound with rope, beaten and raped. At the time of the compensation hearing, the assailant, who was wanted by the police in connection with other, similar assaults, had not yet been apprehended.

The victim sustained multiple abrasions and contusions, rope burns, swelling about the wrists, multiple superficial lacerations and trauma.

Compensation Awarded: Total—$3,000.00

Summary

The Committee considers it a matter of fundamental justice that victims of sexual assault be adequately compensated for the full range of injuries and losses they sustain as a consequence of these crimes. We strongly endorse the view put forward by the *Law Reform Commission of Canada* in this context:[6]

> At the basis of any society is a shared trust, an implicit understanding that certain values will be respected . . . A violation of those values in some cases may not only be an injury to individual rights, but an injury as well to the feeling of trust in society generally. Thus, the law ought not only to show a concern for the victim's injury but also take concrete measures to restore the harm done to public trust and confidence . . . Compensation . . . is directed towards the victim and should not be lost sight of as another meaningful and visible demonstration of societal concern that criminal wrongs be righted.

In the Committee's judgment, much more needs to be done to publicize the existence and purpose of compensation boards in each jurisdiction. As documented in the Committee's National Population Survey (see Chapter 6), these public resources are not seen as sources of assistance by most young victims of sexual assault or their families. Likewise, it is significant that in the Committee's national surveys of police forces, hospitals and child protection services, criminal injuries compensation boards were seldom identified or referred to as a potential source of assistance to be contacted. In this regard, one legal commentator has referred to the "almost total public ignorance of the schemes [for criminal injuries compensation],"[7] and this ignorance extends to eligible victims as well. According to the *Canadian Federal-Provincial Task Force on Justice for Victims of Crime*, which presented its Report in June, 1983, "a 1983 Department of Justice survey has found that few victims are even aware of the existence of such programmes."[8]

Clearly, there needs to be much greater public information made available about these compensation schemes if they are to better realize their professed goals, particularly in relation to victims of sexual assault.

Another evident deficiency in the operation of some of these programs is the non-compensability of certain forms of non-pecuniary damages, in particular, damages for pain and suffering. The several case studies cited leave no doubt about the nature of the genuine pain and suffering experienced by young victims of violent sexual assaults and the willingness of the Compensation Boards in Ontario, Saskatchewan and British Columbia, for example, to take these harms into account in awarding compensation.

The Committee considers it essential that the pain and suffering experienced by victims of sexual assault be explicitly recognized in the enabling legislation in each jurisdiction and that this recognition be attended by a substantial increase in the federal-provincial funding of criminal injuries compensation programs in Canada. As Burns has stated:[9]

> Finally, we must ask ourselves why we are compensating victims of crimes. If our scheme is enacted to soothe the public or the victim, then how can we justify withholding compensation for pain and suffering? Take the case of a schoolgirl covered by provincial health care who is raped. As a schoolgirl she is probably not working and will not lose any wages, and as an insured person she will probably not incur any significant medical expenses. If we deny her compensation for pain and suffering we end up giving her nothing. This can hardly be said to manifest society's concern for its members, or to help restore those ties which bind society together and which were weakened by the assault.

In the Committee's judgment, without more adequate provincial and federal funding of criminal injuries compensation programs, neither increased public visibility nor wider categories of compensable damages will substantially improve the plight of sexual assault victims of all ages who are injured as a consequence of these crimes. Several of the remedial measures which the Committee recommends have also been advocated by the *Canadian Federal/ Provincial Task Force on Justice for Victims of Crime.*

In co-operation with the Department of Justice, the Department of National Health and Welfare, and Provincial and Territorial Governments, the Committee recommends that the Office of the Commissioner:

1. **In conjunction with Recommendation 2 relating to the undertaking of a national program of public education and health promotion, launch a vigorous campaign to inform citizens of the existence and purpose of Criminal Injuries Compensation Boards. This campaign should involve both the communications media and the police, hospitals, child welfare agencies, and other helping services.**
2. **Review the funding of criminal injuries compensation programs and, where appropriate, recommend that the federal and provincial levels of support be increased in order to provide a more appropriate level of compensation for victims of sexual offences.**
3. **This legislation be amended to provide explicitly for awards for physical and emotional pain and suffering to the victim, in order to ensure a more appropriate level of compensation for victims of sexual offences.**

References

Chapter 35: Criminal Injuries Compensation Boards

1. Statistics Canada/Department of Justice, *Criminal Injuries Compensation 1983* (Ottawa: Supply and Services Canada, 1983) at 3.

2. *Ibid.*, at 16.

3. *Ibid.*, at 16-18.

4. *Ibid.*, at 13.

5. *Ibid.*, at 93.

6. Law Reform Commission of Canada, *Restitution and Compensation: Working Paper No. 5* (Ottawa: Supply and Services Canada, 1974) at 17.

7. Burns, *Criminal Injuries Compensation* (Toronto: Butterworth, 1980) at 124.

8. *Report of the Canadian Federal-Provincial Task Force on Justice for Victims of Crime* (Ottawa: Supply and Services Canada, 1983) at 34. The Report does not discuss the methodology or specific findings of the 1983 Department of Justice survey.

9. *Supra*, note 7, at 218-19.

Part VII

Correctional Services

Chapter 36

The Research Record

The Committee's Terms of Reference stipulated that it should examine "the effectiveness of criminal sanctions and methods other than the application of criminal sanctions in dealing with the types of conduct involved in these offences". Following a review of the legal principles of sentencing as these pertain to sexual offences, the findings given in the remaining chapters of this section are taken from the National Corrections Survey conducted by the Committee of 703 convicted child sexual offenders who were in custody or under the supervision (probation or parole) of federal correctional services and those of eight provinces.

The National Corrections Survey was undertaken to complement the findings of the other national surveys in which information was obtained about suspected, known or charged offenders and to provide documentation concerning convicted child sexual offenders, their management and treatment, and their prior criminal record involving sexual offences. The findings of the Committee's several national surveys indicate that convicted child sexual offenders constitute only a small proportion of all persons who actually commit sexual offences against children and youths. Most of the research concerning this group has been based on the documentation of persons on probation, in custody or on parole. There is virtually no documentation about the selective process of winnowing that occurs between the actual occurrence of sexual offences and the conviction of a small proportion of offenders, about whether those who are convicted are more dangerous, or about the effectiveness of the different means used in their management. With respect to these complex and profound questions, the findings obtained in the National Corrections Survey are an earnest of the types of information required to provide a more complete documentation of these issues. The Committee returns to this matter in submitting its recommendations.

The findings in this section are presented in six chapters. In this chapter, a review is given of the methods and general findings of a number of previous advisory bodies and research studies that have dealt with these issues and the design of the National Corrections Survey undertaken by the Committee is described. Prior to undertaking this survey, the Committee, as part of its general review of the research literature on sexual offences against children and

youths, identified a number of research reports documenting Canadian experience with the management and treatment of convicted child sexual offenders. These studies constituted a necessary and useful starting point for the Committee's review. However, none of the studies contained a comprehensive and detailed assessment of who these offenders were and how they had been handled by correctional services. In order to obtain information about a broader cross-section of convicted child sexual offenders, the Committee undertook its national survey with the co-operation of federal and provincial correctional services.

A legal review of the general principles of sentencing as these pertain to sexual offences is given in Chapter 37, *Sentencing*. In this chapter, factors influencing the nature and length of sentences are considered, and in the chapters that follow, findings are presented concerning some of the circumstances which are taken into account on sentencing. These factors include, among others: the gravity of the offence; the ages of victims and offenders; the previous criminal record of the accused; the use of violence in committing the offence; the nature of the injuries sustained by victims; and gang sexual assaults.

In Chapter 38, *Convicted Offenders*, a description is given of the social background of convicted child sexual offenders. The Committee found in its review of the research literature that there was little consensus about who these offenders were, about their management, about the extent of their previous criminal record, or about the likelihood of their committing similar acts in the future. In order to provide a comparative baseline, where similar information is available from the other national surveys conducted by the Committee about suspected or charged offenders, these findings are drawn upon.

In Chapter 39, *Treatment*, available findings are given concerning the counselling and therapy that are provided for these convicted offenders. Across Canada, there is not a uniform policy with respect to whether medical, psychiatric and psychological assessments are kept separately for purposes of confidentiality from correctional management records or whether both types of information are stored together. For these reasons, the information on the treatment of convicted child sexual offenders obtained by the Committee is incomplete. In order to have assembled such information from all offenders included in the survey, it would have been necessary to have obtained the signed consent of each convict, a requirement which was not feasible in terms of the schedule and resources available to the Committee.

In Chapter 40, *Recidivism*, findings are given concerning the previous criminal records of convicted child sexual offenders and whether the offences occurred when they were minors or adults. On the basis of whether offenders were currently sentenced for homosexual or heterosexual offences against children, findings are given in relation to whether they had no previous criminal record, had committed only non-sexual offences in the past, or were known to have committed two or more sexual offences.

In Chapter 41, *Dangerous Sexual Offenders*, a review is given of all offenders having this designation whose victims were children or youths. A comparison is made between offenders having this classification and all other male convicted child sexual offenders for whom information was obtained in the survey.

Federal Inquiries

During the past half century, four major national inquiries have been appointed to investigate different aspects of correctional services operating under federal jurisdiction. While none of these advisory bodies dealt directly with convicted offenders having children and youths as victims, their recommendations led to a number of legislative amendments to the *Criminal Code* which affected the classification and management of convicted child sexual offenders. These reports also called for a re-structuring of correctional services, a more complete assessment of offenders and the provision of treatment services.

1. *1938 Royal Commission to Investigate the Penal System of Canada* (Archambault Report).
2. *1956 Committee to Inquire into the Principles and Procedures followed in the Remission Service* (Fauteux Report).
3. *1958 Royal Commission on the Criminal Law relating to Criminal Sexual Psychopaths* (McRuer Report).
4. *1969 Canadian Committee on Corrections* (Ouimet Report).

The 1938 *Archambault Report* undertook an extensive review of federal correctional services.[1] The Commission drew its information from an assessment of historical crime statistics, and in the instance of recidivism, it undertook a review of 188 incarcerated offenders having 10 or more convictions. No information was given in this Report concerning victims or the nature of offences previously committed by offenders.

On the issue of 'habitual' offenders, including those committing sexual offences, the Commission characterized these prisoners as "the costly worthless dregs of society, for whom no adequate arrangements have been provided in Canadian prisons."[2] The Report recommended special legislation in relation to these offenders, that special prisons be established for their custody, that they receive thorough medical assessment and treatment, and that "accurate statistical information" be assembled to permit assessment of "recidivism, the success or failure of probation, ticket-of-leave or parole and other kindred matters".[3]

Appointed by the federal Department of Justice, the 1956 *Fauteux Report* recommended the repeal of existing statutes concerning determinate plus indeterminate sentences and that a new approach be adopted towards the parole of convicted offenders.[4] The Report concluded that the application of

provisions relating to habitual offenders was not "uniformly or frequently employed"[5] and that "appropriate arrangements should be made... for the uniform enforcement, in all provinces, of the provisions of the *Criminal Code* relating to habitual criminals and criminal sexual psychopaths".[6]

On the question of sex offenders, the Committee recommended medical research concerning efficacious treatment and the establishment of separate prison — medical centres which would serve the special needs of these and other designated types of offenders. "The problem of the sex offender is [equally] difficult ... When such a crime occurs many proposals, some of them hysterical, are advanced for the solution of the problem. Medical science is still uncertain as to the kind of treatment that may be effective, but it is obvious that effective treatment can only be discovered if such persons are made the subjects of special study. We feel that sex offenders should be removed from the normal prison population and that intensified research on the problem should be carried out".[7]

The main empirical findings of the 1958 *McRuer Report* were based on statistical information assembled by the R.C.M.P. on 3110 convicted sexual offenders and an analysis of 23 incarcerated "sexual psychopaths".[8] While no separate assessment was made of convicted child sexual offenders, the information provided indicated that 43.2 per cent of the victims of the 3110 sexual offenders were children age 13 years and younger (65.7 per cent, girls; 34.3 per cent, boys).

The main conclusions of the 1958 Royal Commission in relation to recidivism and offences involving the use of violence were that: "recidivism is not prevalent among the sexual offenders generally"; and "we find no evidence that the sexual offender tends to progress from a less violent to a more violent crime".[9] These conclusions do not accord well with the documentation given in the Report. No comparative baseline was given which permits an assessment of the level of sexual recidivism with other types of offenders having prior criminal records. In addition, these observations were made in light of charges laid, a source of information which by itself is insufficient to determine the elements of offences, whether violence occurred, or if there is a progression from minor to serious crimes. If these limitations are disregarded, in the view of this Committee, the statistics given in the Report of the 1958 Royal Commission indicate that the level of sexual recidivism for certain types of offenders cannot be set aside as not being prevalent or that there is no progression in the types of crimes committed by recidivists. The statistics in the Royal Commission's Report indicate that following a first conviction, 19.6 per cent of offenders who were initially convicted of indecent assault on a female and 69.6 per cent of those who were initially convicted of indecent assault on a male were subsequently convicted of rape, buggery or gross indecency, or attempts to commit these types of offences.

The recommendations of the 1969 *Ouimet Report* reiterated several of the main concerns identified by earlier federal inquiries dealing with convicted offenders.[10] The Report called for the more uniform application of provisions in

the criminal law, the repeal of statutes pertaining to dangerous sexual offenders which it recommended should be replaced by dangerous offender legislation, and the mounting of extensive empirical studies concerning recidivism, treatment and sentencing of these offenders.

The Committee's research on these issues focussed on 80 incarcerated habitual offenders and 57 dangerous sexual offenders. In the analysis of the former group, no break-down was given of the proportion of convicted 'habitual' *sexual* offenders (the number of offences was listed); the appraisal of the latter group was limited to a brief review of existing legal provisions and the geographic distribution of locations where these offenders had been sentenced. No information was given concerning the ages of sexual offenders, the nature of the crimes committed, and the ages and sexes of their victims. In addition, no comparison was made between these offenders and other convicted sexual offenders who on sentencing had not been designated habitual or dangerous offenders. The paucity of empirical evidence assembled by the 1969 *Ouimet Committee* concerning these issues, however, did not serve to constrain it from concluding that "the present basis upon which a person may be found to be a dangerous sexual offender is inadequate" and that "the present legislation does not protect society against the offenders from whom society requires maximum protection".[11] These observations were made in the notable absence of reasonably sufficient documentation.

The findings of the four main federal inquiries that have dealt with convicted offenders do not provide a baseline with which a comparison can be made with the information obtained in the National Corrections Survey conducted by the Committee. These earlier national studies dealt with offenders having sentences of two years or longer who were in custody or under supervision of federal correctional services. None undertook a review of these offenders in relation to those having shorter sentences. Relying on official statistics, no information is given in the Reports of these federal inquiries concerning the elements of the offences committed, the circumstances of the offences and about the victims of offences.

Since the tabling of the 1938 *Archambault Report*, the several principal federal inquiries dealing with correctional services have reiterated a number of concerns about which no action has been taken that is congruent with the intentions of the recommendations submitted. The reports of these investigations have called, for instance, for more detailed and adequate official statistics, for comprehensive research on the efficacy of different means of assistance and treatment, and for a full assessment of recidivism in relation to the types of offences committed, sentencing decisions and the utility of different supervisory or custodial arrangements provided for convicted offenders.

The authorities receiving these reports have been impervious to these recommendations submitted by federally appointed inquiries. There is no published report for Canada that presents nationally assembled empirical findings

concerning the treatment and recidivism of convicted offenders, or of convicted sexual offenders. Even for the small group about which the most extensive documentation is available — habitual, dangerous and dangerous sexual offenders — no report has provided a reasonably sufficient or comprehensive assessment of these criminals.

In its recommendations given elsewhere in this Report, this Committee reiterates issues which have been cogently proposed by earlier federal investigations. There can be no doubt that more complete documentation concerning these issues is both feasible and warranted, and could serve as a requisite basis of assessing how better protection could be afforded victims of crime.

Previous Research Studies

In its review of available Canadian research reports, the Committee found that, for virtually each issue which was considered, even in relation to providing a basic description of who convicted child sexual offenders were, the findings were sharply contradictory.[12-58] This apparent confusion is largely accounted for by the fact that different definitions have been used, that different types of offenders have been studied, and that different sources of information have been drawn upon. In addition, these studies have typically reported findings about small numbers of offenders, often those who were incarcerated in a single institution.

The definitions adopted about who these offenders are have varied widely. It has been a common practice in these studies to draw upon the information stored in correctional management systems, some of which do not contain centrally computerized records about victims. There has been no common denominator in this research in the selection of offenders in relation to the ages of their victims. The selection of sharply different age levels of victims has served to include or exclude certain types of offenders, particularly in relation to those having committed certain types of sexual offences. These age listings are generally truncated with the experience of older adolescents having been excluded, although by law, there may be no specified age limit (e.g., incest) or special protection may be afforded persons who are under age 21. Almost without exception, these research studies have ignored the various age levels specified in the sexual offences in the *Criminal Code*.

The information about convicted child sexual offenders has come from a variety of corrections — related sources, each of which has predictably yielded somewhat different information about these offenders. A majority of the studies have relied upon the federal correctional system with the result that only the experience of offenders having sentences of two years or longer has been documented. (Conversely, but less often, only the experience of offenders in a provincial correctional system may be considered). Still other sources of information, each of which sharply affects the type of information obtained, have included: persons on probation; pre-sentencing reports; persons referred for

psychiatric assessment who may be either in or out of custody; and persons on parole.

Generally, Canadian research studies have dealt with the experience of only small groups of convicted child sexual offenders (this is equally true of studies of all types of convicted sexual offenders.) It is an anomaly that the most extensive survey, that by C.A. Searle of 495 convicted sexual offenders in federal custody, is an unpublished report. This limitation may be partially accounted for by: researchers having been associated with a single institution in which only a small group of offenders was incarcerated; the time and resources required by external researchers in order to be able to mount larger studies; and the complexity of the organization of correctional services which involves different jurisdictions, incomplete documentation about victims, and the requirement that access be granted to information contained in different record-keeping systems. The small denominators of the groups studied in these studies serve to limit sharply the nature of the generalizations that can be derived.

There is general agreement in the research literature that, on average, most of these offenders are relatively young men. Beyond this fact, however, the findings are ambiguous concerning their family backgrounds, their educational and work experience, their prior contacts with children or their marital status. In some reports, it has been found that most offenders had not used alcohol or drugs; in contrast, other studies have concluded that a majority had been frequent users of these substances.

Because of its mandate, the Committee was particularly attentive to the findings of previous research concerning: the extent to which convicted sexual offenders were known to have physically injured victims; the types of counselling and therapy provided them and what was known about the efficacy of these services; and on the basis of their previous criminal records, to assess reported trends in relation to recidivism. The findings from available research studies on each of these issues are inconclusive.

In a number of widely cited studies undertaken in Canada, the United Kingdom and the United States, it has been concluded that child sexual offenders rarely, if ever, physically injure victims. On the basis of these findings, alternatives other than imprisonment have been recommended as the most effective means of handling these cases. The options proposed have varied, but such recommendations commonly advocate probation coupled with counselling, treatment and a re-alignment of the offender's living conditions. Contrasting with the conclusion that few of these offenders are dangerous are the findings of a number of recent studies which have found that between half and three in five convicted offenders had physically hurt victims and that a substantial proportion had previous criminal records.

In recent years, there has been a strong and growing tendency in some quarters to regard child sexual offenders as being unassertive, weak and inadequate persons who are more likely to be in need of counselling and assistance

than receiving the double punishment of being convicted and, if imprisoned, the harsh penalties meted out by other inmates. In this respect, it has been variously proposed that these offenders, preferably following their initial detection or before sentencing occurs, should be given a psychological and/or psychiatric assessment, and that in the recommendations given on sentencing, counselling and treatment should be incorporated as integral elements of their subsequent management.

Usually without the benefit of control groups serving as a basis for comparison, it has typically been concluded in the psychological and psychiatric research on sexual offenders that most of these offenders suffer from character and behaviour disorders with only a small proportion known to have some form of severe mental illness. Several studies have concluded that group therapy and behaviour modification (including aversion therapy) have been effective in controlling deviant sexual urges, in modifying sexual preferences, or in improving the well-being of offenders in other ways. On the basis of a review of a number of the main reports on this issue, V.L. Quinsey has noted:

> "Few studies that compare different treatment techniques have appeared and comparative studies which involve follow-up data are almost non-existent.[59]

The research on the recidivism of child sexual offenders yields a wide range of estimates. The most commonly cited rates are between five and 15 per cent, but an upper limit has been reported in some studies of up to one in two offenders. Because of the ethical and procedural difficulties involved, prospective studies have seldom been attempted. The Achilles' heel of retrospective studies is the accuracy of the information obtained about the true extent to which sexual offences may have been committed in the past. As is the case for most of the other research findings about convicted child sexual offenders, the wide variation in the reported rates of recidivism can be attributed to the different sources of information drawn upon and, at least for Canada, the fact that most studies have relied upon the experience of relatively few offenders. This important information has not been available for Canada with the result that there is no firm or clear-cut documentation of the long-term consequences of the different sentences imposed by courts.

In addition to the limited utility of studies dealing with rates of sexual recidivism, relatively little is also known about whether those persons who have committed more than one offence are likely to commit similar acts again, about whether there is a progression from minor to more serious offences, or about whether, with age, some offenders may 'burn out' and cease to commit further offences regardless of the types of sentences imposed. Each of these possibilities, none of which is sufficiently documented, has been suggested in the research literature.

In recent years, legislation has been enacted in relation to habitual offenders, dangerous sexual offenders and dangerous offenders; as noted, persons so designated have been the subject of several federal inquiries. None of these

investigations has dealt specifically with offenders having children as victims. The Committee is not informed of any Canadian national study that has compared dangerous sexual offenders having children as victims with other types of convicted child sexual offenders (dangerous or otherwise). In this regard, it appears to be generally assumed, although it is undocumented, that proportionately more of the former than the latter group have physically injured victims, have committed more serious offences, and are more likely to be psychopathic. The presumed assumption of the special provisions pertaining to dangerous offenders is that the general offences in the *Criminal Code* do not afford sufficient protection for Canadians from these vicious criminals. In relation to the Committee's mandate, however, it is unknown how many convicted child sexual offenders not having this special designation may have committed similar acts, used coercion, or may have physically injured victims. Although a majority of the victims of dangerous sexual offenders are children and youths, the utility of this legislation as a means of affording children better protection has not been documented.

Canadians are deeply concerned about the need for adequate protection for children against sexual offences. Despite this fact, the Committee found in its review of the main research reports dealing with convicted sexual offenders that the available research is fragmentary, the principal findings are inconclusive and contradictory, and the utility of the recommendations proposed is limited due to the small size or the special nature of the groups studied. When the Committee undertook its review, there was no national assessment available concerning convicted child sexual offenders.

The Committee's review of the main research reports on these offenders indicates that there is a need for more extensive and indepth information to be assembled on a routine basis about their backgrounds and their management while in custody or under supervision, and that long-term prospective study is warranted in relation to assessing the consequences of different sentences imposed by courts as these may affect rates of recidivism.

Design of Survey

With the co-operation of the Correctional Service Canada and correctional services in eight provinces and the Yukon, information was obtained concerning 703 convicted child sexual offenders. Prior to the collection of information, a research protocol was developed and pretested using a number of federal and provincial correctional files. At this stage, valuable assistance was provided by a number of senior federal and provincial correctional officials who reviewed the initial and penultimate drafts of the research protocol and who facilitated the collection of information.

The research protocol was developed to assemble information in relation to: the *social characteristics* of convicted child sexual offenders, their victims, the offences committed, and the circumstances involved in the occurrence of

the offences; *recidivism* in relation to previous charges and convictions; and the *treatment* received by convicted offenders from physicians, psychologists, social workers and other professional personnel. In order to permit comparison of the findings to be assembled in the survey with those of the Committee's other national surveys, wherever it was appropriate and feasible in relation to available information, a similar means of classification was adopted. Because of the type of information being sought, the sources drawn upon included the institutional files of incarcerated offenders and the records of those on probation and parole.

In the National Corrections Survey, a convicted child sexual offender was defined in relation to: the types of sexual offences committed as these were then designated in the *Criminal Code*; and the age(s) of the victim(s). The date selected for the identification and selection of incarcerated or supervised convicted offenders was February 1, 1982. If an offender had been convicted of one of 22 sexual offences (including designation as a 'dangerous offender') and was under supervision on the cut-off date, then he or she was identified for possible inclusion in the survey. Offenders were identified on the basis of whether they had been convicted of one or more of the 22 offences listed in Table 36.1.

In the review of incarcerated and supervised offenders in the federal correctional system, five separate listings were undertaken to ensure that all such known offenders would be identified. The specific listings generated were:

1. All *incarcerated* offenders who had a *major offence* that was sexual in nature. A major offence was defined as:

   > "The offence for which the inmate was given the longest sentence. If more than one offence awarded the same sentence, the major offence is the most serious one, as measured by the maximum penalty allowed by the law. If more than one offence carries the same maximum penalty, the major offence is the first of these listed on the first Warrant of Committal. The major offence may differ from the admitting major offence because of events happening after admission."

2. All *incarcerated* offenders who had a *secondary offence* that was sexual in nature.

3. All *supervised* offenders who had a *major offence* that was sexual in nature.

4. All *supervised* offenders who had a *secondary offence* that was sexual in nature.

5. All offenders who were *Dangerous Sexual Offenders*. The category Dangerous Offender includes those offenders classified as Dangerous Sexual Offenders, Habitual Offenders with a sexual offence, and Dangerous Offenders with a sexual offence.

The second criterion used in the selection of convicted child sexual offenders was the age of the victim(s) involved in the current conviction(s). To ensure that inclusion of all offenders who had committed sexual offences specified in

the *Criminal Code*, the age adopted for the inclusion of victims was 20 years-old or younger.

Table 36.1

Sexual Offences Used as the Basis for the Selection of Convicted Child Sexual Offenders

Section of Criminal Code	Type of Offence
S. 143	• Rape
S. 145	• Attempt to commit rape
S. 146(1)	• Sexual intercourse with female under 14
S. 146(2)	• Sexual intercourse with female who is 14 years of age or more and is under the age of 16
S. 148	• Sexual intercourse with feeble-minded
S. 149(1)	• Indecent assault on female
S. 150(1)	• Incest
S. 151	• Seduction of a female who is age 16 but under age 18
S. 152	• Seduction under promise of marriage
S. 153(1)(a)	• Sexual intercourse with step-daughter, foster daughter, or female ward
S. 142(1)(b)	• Illicit sexual intercourse with a female person of previously chaste character and under the age of 21 years
S. 155	• Buggery or bestiality
S. 156	• Indecent assault on male
S. 157	• Acts of gross indecency
S. 166	• Parent or guardian procuring defilement
S. 167	• Householder permitting defilement
S. 168(1)	• Corrupting children
S. 169	• Indecent acts
S. 688 (after October 15, 1977)	• Dangerous offender
S. 193 (1)	• Keeping a common bawdy house
S. 194	• Transporting person to a bawdy house
S. 195	• Procurement
J.D.A. s. 33	• Contributing to juvenile delinquency

When the survey was undertaken, the findings obtained in relation to 703 convicted child sexual offenders included a sizeable proportion of all such offenders. For several reasons, however, the group studied does not constitute a sample nor is it all-inclusive. While it had initially been intended to obtain such information from all jurisdictions, this proved not to be feasible. No findings were obtained for convicted offenders who were in provincial custody in Saskatchewan and Quebec. For the former province, agreement was reached to proceed with the survey, but other circumstances intervened resulting in a postponement in the collection of information. When it was feasible to do so, the Committee's cut-off date for the collection of research information had passed. In the instance of Quebec, while the provincial Ministry of Justice had effectively participated through le Comité de la protection de la jeunesse in the

National Child Protection Survey, unforeseen factors precluded a collaborative study from being undertaken in relation to convicted child sexual offenders. The Quebec Ministry of Justice was most co-operative in providing general statistics from its computerized records.

There is no central inventory for Canada, except for the register of homicides, of convicted offenders. If information on criminals convicted of particular crimes is sought, then this information must be obtained separately from each jurisdiction concerned — federal, provincial and territorial.

The main information retained in corrections, probation and parole records is offender, not victim-oriented. Only a few jurisdictions can efficiently identify information about the victims of crime. When the survey was conducted, information about convicted offenders accessible on a computerized basis was available in only four of 10 jurisdictions participating in the study (Government of Canada, eight provinces and the Yukon). In other jurisdictions, the identification of particular types of criminals must be made by means of a direct search of records, and as the Committee learned, these may be stored centrally, regionally, or be retained at corrections or supervisory locations. Where these records are maintained regionally, it is necessary to visit regional offices to assemble information about offenders. In instances where records are retained at local institutions, permission is required involving their recall to a central and/or regional location.

In each participating jurisdiction, the full co-operation of senior correctional officials was afforded; it is believed that all known cases of convicted child sexual offenders were identified. However, as some offenders may have been charged and convicted of other offences (e.g., break-and-enter) yet have committed a sexual offence, there is no surety that all such convicted offenders were in fact identified. Following the identification of this group, the Committee learned of another dilemma in relation to the identification of persons convicted of sexual offences against children. This problem, which is characteristic of the system of correctional services in Canada, is perhaps best exemplified by considering the information available about that group considered to have committed the most serious crimes — dangerous sexual offenders.

The Committee obtained access from the Correctional Service Canada to the files of all 'dangerous' offenders convicted of having committed sexual offences who were under supervision on February, 1982. Of 84 such cases, a detailed review indicated that information on the age of the victim was unknown for about one in eight (13.3 per cent). This review included both an assessment of the main dossiers and attached subsidiary files (e.g., police general occurrence records, transcripts of court decisions, pre-sentencing reports). In instances where information concerning age was missing, the victims were variously referred to as a "child", "toddler", "teenager" or "young person". Upon undertaking a detailed review of records in the jurisdictions where all convicted sexual offenders had been identified, the Committee found that the proportion of cases in which the age of the victim was unknown or could not be

accurately identified in correctional files ranged between 0.0 per cent to 59.3 per cent.

An additional reason why the group of 703 convicted child sexual offenders does not constitute a sample is that while in seven of 10 jurisdictions, information on all identified cases was obtained, in the remainder due to time constraints imposed by the Committee's schedule, it was not feasible to assemble information on all identified cases; in two instances, retrieval from a number of widely scattered regional and/or local offices imposed operational constraints.

The Committee recognizes the limitations inherent in the information obtained in the National Corrections Survey. Although complete information was obtained in seven of 10 jurisdictions for all known convicted child sexual offenders, even here there is no surety that all offenders who had committed sexual offences were identified. The information that was obtained, however, constitutes a sizeable group of those convicted child sexual offenders who were in custody or under supervision in all parts of Canada when the survey was undertaken. (The federal system includes convicted offenders from all provinces and territories). The information obtained about the 64 dangerous child sexual offenders is inclusive of all such persons who on sentencing were found to be dangerous.

The Committee accepts the findings of the survey as likely being representative of a substantial proportion of all convicted offenders who were in custody or under supervision at the cut-off date set for the identification of cases in the National Corrections Survey. In the Committee's judgment, the survey's findings afford a sufficient basis permitting comparison between this group and suspected or known offenders identified in the Committee's other surveys.

References

Chapter 36: The Research Record

[1] Canada. *Report of the Royal Commission to Investigate the Penal System of Canada*. Ottawa: King's Printer, 1938.

[2] *Ibid.*, p. 218.

[3] *Ibid.*, p. 174

[4] Canada. Department of Justice. *Report of a Committee Appointed to Inquire into the Principles and Procedures followed in the Remission Service of the Department of Justice of Canada*, Ottawa: Queen's Printer, 1956.

[5] *Ibid.*, p. 20.

[6] *Ibid.*, p. 88.

[7] *Ibid.*, p. 48.

[8] Canada. *Report of the Royal Commission on the Criminal Law Relating to Criminal Sexual Psychopaths*. Ottawa: Queen's Printer, 1958.

[9] *Ibid.*, p. 70; see also, p. 72.

[10] Canada. Department of the Solicitor General. *Report of the Canadian Committee on Corrections*. Ottawa: Queen's Printer, 1969.

[11] *Ibid.*, p. 258.

[12] Barbaree, H.E., W.L. Marshall and R.D. Lanthier, *Deviant Sexual Arousal in Rapists*, Kingston (mimeo) 1977.

[13] Baxter, D.J., P.B. Malcolm and H.E. Barbaree, *Penile Response to Rape Stimuli: What Does It Tell Us About Rapists*, Kingston (mimeo), 1979.

[14] Christie, M.M., W.L. Marshall and R.D. Lanthier, *A Descriptive Study of Incarcerated Rapists and Pedophiles*, Kingston (mimeo) 1977.

[15] Davidson, P.R., *Penile Response Measurement: Operating Characteristics of the Parks Plethysmograph*, Kingston (mimeo), 1980.

[16] Davidson, P.R. and D.J. Baxter, *Recidivism Patterns among Groups of Rapists*, Paper given at Annual Meeting of Canadian Psychological Association, 1982.

[17] Freund, K., Diagnosing heterosexual pedophilia by means of a test for sexual interest, *Behaviour Research and Therapy*, 3: 229-234, 1965.

[18] Freund, K., Diagnosing homo- or heterosexuality and erotic age-preference by means of a psychophysiological test, *Behaviour Research and Therapy*, 5: 209, 228, 1967.

[19] Freund, K., Erotic preference in pedophilia, *Behaviour Research and Therapy*, 5: 339-348, 1967.

[20] Freund, K., A Note on the use of the phallometric method of measuring mild sexual arousal in the male, *Behaviour Therapy*, 2: 223-228, 1971.

[21] Freund, K., C.K. McKnight, R. Langevin and S. Cibiri, The female child as a surrogate object, *Archives of Sexual Behavior*, 2: 119-133, 1972.

[22] Freund, K., H.R. Seeley, W.E. Marshall and E.K. Glinfort, Sexual Offenders Needing Special Assessment and/or Therapy, *Canadian Journal of Criminology and Corrections*, 14: 345-365, 1972.

[23] Gigeroff, A.K., J.W. Mohr and R.E. Turner, Sex Offenders on Probation: I. The Exhibitionists, *Federal Probation*, 32(2): 18-21, 1968.

[24] Gigeroff, A.K., J.W. Mohr and R.E. Turner, Sex Offenders on Probation: II. Heterosexual Pedophiles, *Federal Probation*, 32(4): 17-21, 1968.

[25] Gigeroff, A.K., J.W. Mohr and R.E. Turner, Sex Offenders on Probation: III. Homosexuality, *Federal Probation*, 33(1): 36-39, 1969.

[26] Gigeroff, A.K., J.W. Mohr and R.E. Turner, Sex Offenders on Probation: IV. Overview, *Federal Probation*, 33(2): 22-26, 1969.

[27] Greenland, C., Dangerous Sexual Offenders in Canada, *Canadian Journal of Corrections*, 14: 44-54, 1972.

[28] Hartley, T.C. and G.R. Parker, *Assertiveness Training in the Treatment of Sexual Offenders*, Abbotsford (mimeo), 1978.

[29] Hartman, V., Some Observations of Group Psychotherapy with Paedophiles, *Canadian Journal of Corrections*, 3: 492-499, 1961.

[30] Hartman, V., Notes on Group Psychotherapy with Pedophiles, *Canadian Psychiatric Association Journal*, 10: 283-288, 1965.

[31] Hartman, V., Group Psychotherapy with Sexually Deviant Offenders (pedophiles) — the Group as an Instrument of Mutual Control, *Criminal Law Quarterly*, 7: 464-479, 1965.

[32] Marcus, A.M., A Multidisciplinary Two Part Study of those Individuals Designated Dangerous Sexual Offenders held in Federal Custody in British Columbia, *Canadian Journal of Corrections*, 8: 90-103, 1966.

[33] Marcus, A.M. and C. Conway, Dangerous Sexual Offender Project, *Canadian Journal of Corrections*, 11: 198-205, 1969.

[34] Marcus, A.M. Encounters with the Dangerous Sexual Offender, *Canada's Mental Health*, 18: 9-14, 1970.

[35] Marcus, A.M. and C. Conway, A Canadian Group Approach Study of Dangerous Sexual Offenders, *International Journal of Offender Therapy*, 5: 59-66, 1971.

[36] Marshall, W.L., A Combined Treatment Method for Certain Sexual Deviations, *Behaviour Research and Therapy*, 9: 293-294, 1971.

[37] Marshall, W.L., The Modification of Sexual Fantasies: A Combined Treatment Approach to the Reduction of Deviant Sexual Behaviour, *Behaviour Research and Therapy*, 11: 557-564, 1973.

[38] Marshall, W.L., The Classical Conditioning of Sexual Attractiveness: A Report of Four Therapeutic Failures, *Behaviour Research and Therapy*, 12: 298-299, 1974.

[39] Marshall, W.L., A Combined Treatment Approach to the Reduction of Multiple Fetish-related Behaviours, *Journal of Consulting Clinical Psychology*, 42: 613-616, 1974.

[40] Marshall, W.L. and R.D. McKnight, An Integrated Treatment Program for Sexual Offenders, *Canadian Psychiatric Association Journal*, 20: 133-138, 1975.

[41] Marshall, W.L. and M.M. Christie, Pedophilia and Aggression, *Criminal Justice and Behaviour*, 8: 145-158, 1981.

[42] McCaldon, R.J., Rape, *Canadian Journal of Corrections*, 9: 37-59, 1967.

[43] Mohr, J.W., Psychiatric Treatment: 3. The Contribution of Research to the Selection of Appropriate Alternatives for Sexual Offenders, *Criminal Law Quarterly*, 4: 317-328, 1961-62.

[44] Mohr, J.W., The Pedophilias: Their Clinical, Social and Legal Implications, *Canadian Psychiatric Association Journal*, 7: 255-260, 1962.

[45] Mohr, J.W., A Short Survey of Sexual Offenders in the Kingston Penitentiary, *Canadian Journal of Corrections*, 5: 176-179, 1963.

[46] Mohr, J.W. R.E. Turner and M.B. Jerry, *Pedophilia and Exhibitionism*, Toronto: University of Toronto, 1964.

[47] Mohr, J.W. and R.E. Turner, Sexual Deviations. Part IV -Pedophilia, *Applied Therapeutics*, 9: 362-365, 1967.

[48] Quinsey, V.L., Methodological Issues in Evaluating the Effectiveness of Aversion Therapies for Institutionalized Child Molesters, *Canadian Psychologist*, 14: 350-361, 1973.

[49] Quinsey, V.L., C.S. Steinman, S.G. Bergerson and T.F. Holmes, Penile Circumference, Skin Conductance, and Ranking Responses of Child Molesters and 'Normals' to Sexual and Non-Sexual Visual Stimuli, *Behaviour Therapy*, 6: 213-219, 1975.

[50] Quinsey, V.L. and G.W. Varney, Modification of Preference in a Concurrent Schedule by Aversive Conditioning, *Bulletin of the Psychonomic Society*, 7: 211-213, 1976.

[51] Quinsey, V.L. and S.G. Bergerson, and C.S. Steinman, Changes in Physiological and Verbal Responses of Child Molesters during Aversion Therapy, *Canadian Journal of Behavioural Science*, 8: 202-212, 1976.

[52] Quinsey, V.L. and S.G. Bergerson, Instructional Control of Penile Circumference, *Behaviour Therapy*, 7: 489-493, 1976.

[53] Quinsey, V.L., The Assessment and Treatment of Child Molesters: A Review, *Canadian Psychological Review*, 18: 204-220, 1977.

[54] Roy, C. and A. Saad, *The Treatment of Sexual Offenders Within the Canadian Penitentiary System — A New Initiative*, Abbotsford (mimeo), 1975.

[55] Searle, C.A., *A Study of Sexual Offenders in Canada and a Proposal for Treatment*, Ottawa: Canadian Penitentiary Service, 1974 (mimeo).

[56] Turner, R.E., Treatment of the Sex Offender, *Criminal Law Quarterly* 3: 461-472, 1961.

[57] West, D.J., C. Roy and F.L. Nichols, *Understanding Sexual Attacks*, London: Heineman, 1978.

[58] Wormith, J.S., *A Survey of Incarcerated Sexual Offenders*, University of Saskatchewan (mimeo), 1982.

[59] Quinsey, V.L., *op. cit.* (1977), p. 216.

Chapter 37

Sentencing

One of the most difficult tasks faced by Canadian judges is determining the appropriate sentence that an offender should receive on being convicted of a criminal offence, especially where the offence is of a sexual nature. This chapter reviews the general principles of sentencing in Canadian law and their application to adult offenders convicted of sexual offences. The unique circumstances of the offender and, to a lesser extent, of the offence he or she commits, underscore the importance of viewing sentencing as an individualized, human process.[1] Canadian courts tend to consider several objectives in sentencing an adult offender and the weight accorded to each will vary according to the circumstances of both the offender and the offence. There are four overarching sentencing objectives recognized by Canadian law:[2]

1. The protection of the public.
2. Retribution or punishment.
3. Deterrence.
4. The reformation and rehabilitation of the offender.

These general principles are not mutually exclusive; for example, it is often stated by judges that the "protection of the public" can best be achieved by a sentence that will promote the offender's reformation and rehabilitation. Canadian jurisprudence on sentencing suggests rather that these principles need to be "wisely blended"[3] in reaching an appropriate conclusion with respect to sentence. As the Nova Scotia Court of Appeal has noted:[4]

> [T]he relative weight or mix of the three basic factors — deterrence of the offender, deterrence of others, and rehabilitation and reform — varies not only with reference to the nature, history and character of the offender, but also with the kind of offence. And to the mixture in any given case must often be added a fourth factor . . . , namely, the need to express social repudiation and abhorrence of a particular crime by, to use a largely outmoded word, "punishment" of the offender.

Protection of the Public

According to one legal commentator, it is well accepted by Canadian courts that the principal purpose of the criminal law process, and hence of sentencing, is the protection of the public.[5] "Public protection" has many aspects:[6]

> If the defendant is imprisoned, he is removed from society at least temporarily, and the community is protected. Even if he is subjected to a program of rehabilitation by probation or otherwise, the ultimate aim is to protect society by making the defendant a responsible member of his community, thereby preventing his causing harm to society.

There are, however, cases in which the objective of public protection demands a sentence of extended incarceration, particularly where the offender committed a violent sexual assault.[7] The protection of the public as a primary sentencing objective takes its most stark form in the "dangerous offender" provisions of the *Criminal Code*, which authorize the indefinite detention of certain classes of offenders, including so-called "dangerous sexual offenders."

Retribution or Punishment

The concept of retribution (namely, that a crime should be punished and that the punishment should fit the crime[8]) plays an important role in determining the range of sentences for a particular type of offence.[9] That retribution does not imply societal revenge[10] is evident from the Ontario Court of Appeal's decision in *R. v. Warner*:[11]

> It should be said at once that the purpose of punishment for crime is not that, through the medium of a judge who is authorized by the law to impose it, vengeance may be wreaked upon the guilty for their crime, as though crime was private in character . . . Punishment . . . is the expression of the condemnation by the State of the wrong done to society. There must, therefore, always be a right proportion between the punishment imposed and the gravity of the offence. It is in that sense that it is said that certain crimes "deserve" certain punishments . . .

Where, however, an offender seriously violates fundamental social values, for example, in cases involving sexual offences against children, the offender's sentence will often be determined in a manner that expresses society's abhorrence and denunciation of the offenders conduct. In *R. v. W. and B.S.*,[12] the accused were convicted of several sexual offences which took place in the presence of, and sometimes with the participation of, two children aged eight and 13. The Ontario Court of Appeal, in imposing sentence, stated that "in such cases, the sentences should reflect fairly both the revulsion of society and its condemnation of conduct such as that displayed."[13]

Deterrence

Deterrence as a sentencing objective has two, sometimes conflicting, aspects: specific deterrence, in which the sentence is formulated in the hope of deterring the offender from committing further offences; and general deterrence, which is premised on the view that the sanction an offender receives for his or her conduct should also be such as will deter others from emulating that conduct.

The aim of specific deterrence as a sentencing consideration is the imposition of a punishment on the offender which will deter him or her from committing a future crime. In assessing what sort of sentence will meet the aim of specific deterrence, the court should have regard to the individual offender, his or her prior criminal record, his or her attitude, and his or her prospects for reformation and rehabilitation.[14]

The objective of general deterrence is to deter others from emulating the conduct of the criminal offender, by demonstrating to them the nature of the sanction they can expect if they follow his or her example.[15] The theory of general deterrence is based on companion assumptions: first, that an offender's sentence will become known to those who might be tempted to engage in comparable criminal conduct and, second, that appreciation of this risk of punishment will thereby have an inhibiting effect on criminal activity.[16]

There is little evidence of the validity of general deterrence, concerning either the kinds of crime that can be deterred or the sorts of potential offenders that are amenable to the general threat of punishment.[17] Even so, general deterrence has been adopted by Canadian courts as one of the primary aims of sentencing. In *R. v. McKeachnie*,[18] for example, the Ontario Court of Appeal held (in a case involving an indecent assault on a young girl) that deterrence is the primary consideration where sexual offences against young children are concerned, and that the protection of the public is best secured by such an approach. The principle of general deterrence has also been considered of primary importance in sentences imposed for rape,[19] attempted rape,[20] indecent assault on a female,[21] sexual intercourse with a female under 14[22] and incest.[23]

Rehabilitation

Canadian courts sometimes give precedence to the objective of rehabilitation of the offender when imposing sentence. Even so, the cases in which the offender's rehabilitation has been considered the paramount sentencing factor have not established general principles in this regard. Whether this approach is taken will depend on the circumstances of each case, and particularly on the court's assessment of an offender's prospects for reform.

The sentencing judgment in *R. v. Robertson*,[24] a case of homosexual pedophilia, is illustrative. The accused pleaded guilty to two counts of gross indecency and to one count of indecent assault on a male. He had sought psychiatric help prior to the commission of these offences, but had discontinued his treatment. At trial, the accused was sentenced to eight months' imprisonment. On appeal to the Ontario Court of Appeal, a sentence of time served (10 days) plus two years' probation was substituted. In substituting this sentence, the Court of Appeal emphasized the accused's evident rehabilitative prospects:[25]

> It was urged upon us by the respondent that a term of imprisonment was needed to demonstrate the revulsion of the public for this type of offence and as a deterrent to this man and others like him . . . .In our view, jail adds little by way of deterrence to persons with this type of propensity.
>
> The important thing in this case is that there was a very positive pre-sentence report and medical report before the Court, and that report was to the effect that it was probable that through the medical treatment outlined in the document the appellant could be cured. This offered the base assurance to the community for its protection which is the primary purpose of the criminal law.

Rehabilitation is often the guiding sentencing consideration with respect to first offenders, particularly youthful first offenders. In these cases, the aim of rehabilitation is a factor both in deciding whether a custodial term will be imposed and in determining the appropriate length of the term of imprisonment.

Nature and Length of the Sentence

In determining the sentencing objectives in a given case and the appropriate sentence in light of these objectives, Canadian courts typically consider a variety of factors arising from the circumstances of the offence. The Manitoba Court of Appeal has formulated a list of considerations which should be canvassed in imposing sentence:[26]

- The degree of premeditation involved.
- The circumstances accompanying the commission of the offence: the manner in which it was committed, the amount of violence involved, the employment of an offensive weapon and the degree of active participation by each offender.
- The gravity of the crime committed, of which the maximum punishment provided by statute is an indication.
- The attitude of the offender after the commission of the crime, as this serves to indicate the degree of criminality involved and throws some light on the character of the participant.
- The previous criminal record, if any, of the offender.
- The age, mode of life, character and personality of the offender.

- Any recommendation of the trial judge, any pre-sentence or probation officer's report, or any mitigating or other circumstances properly brought to the attention of the court.

These sentencing factors tend to fall within two sub-groups: those pertaining to the offender and those pertaining to the circumstances of the offence under consideration.

Sentencing Factors Pertaining to the Offender

Age

In the majority of cases, the offender's age influences the nature of the sentence imposed, particularly in regard to youthful offenders. The offender's age is especially pertinent to the court's determination of whether a custodial sentence should be imposed. According to one legal commentator, "the most common effect of youth of the offender is to indicate that individualized treatment will be appropriate. General deterrence is de-emphasized in sentencing youthful offenders: The preferred aims are rehabilitation and individual deterrence."[27]

Even so, the generally mitigating effect of the offender's youthful age may be outweighed by other considerations arising from the nature of the offence committed. If the offender, although young, has a lengthy criminal record for similar offences or the offence in question involved violence or the use of a weapon, the offender's youth will have a weaker mitigating effect on sentencing than otherwise.

Previous Criminal Record

One of the most significant mitigating factors in sentencing is the offender's lack of a prior criminal record. It is well established that the accused's character prior to the commission of the offence may be considered at the sentencing stage;[28] accordingly, where the offender has not been convicted of prior criminal offences, the court typically is disposed to treat him or her more leniently than the circumstances of the offence may appear to warrant. That the court will tend to lean towards the imposition of an individualized as opposed to a "tariff" punishment[29] is illustrated by the comments of the Ontario Court of Appeal in *R. v. Stein*,[30] in which Mr. Justice Martin stated that:

> . . . .before imposing a custodial sentence upon a first offender the sentencing Court should explore the other dispositions which are open to him and only impose a custodial sentence where the circumstances are such, or the offence is of such gravity that no other sentence is appropriate.

Where less serious offences are concerned, for example, the offence of "indecent act", the offender's lack of a prior criminal record will sometimes

result in the offender being discharged either absolutely[31] or on conditions of probation. In offences involving more serious criminal infractions, the absence of a prior criminal record will not prevent the imposition of a custodial sentence in appropriate cases, but will usually effect the length of the imprisonment imposed.[32] That an offender's prior criminal record should generally be taken into account, and accorded a weight appropriate to the circumstances of the offence in question, is an accepted sentencing practice in Canada.[33]

Mental Illness

Where an offender suffers from mental illness (short of the legal definition of insanity),[34] this may have either an aggravating or a mitigating effect on the sentence imposed. Apart from the "dangerous sexual offender" provisions in the *Criminal Code*, an accused's evident mental disorder will often result in the imposition of a more severe sentence. For example, in *R. v. D.*,[35] the accused raped his two step-daughters under circumstances described by the court as "savage, terrorizing and approaching stark horror". The accused had a prior conviction for incest and had been diagnosed as having a severe personality disorder. The court imposed sentences of 12 years' imprisonment on each count of rape, the sentences to run concurrently.

Where a court sentences an individual to a term of imprisonment, it cannot order that the offender receive treatment for a personality disorder while he or she is incarcerated. The court can only recommend to the correctional authorities that the offender receive such treatment.[36]

The offender's mental illness is more likely to be regarded as a mitigating factor in sentencing where it appears to the court that there is a real possibility that the offender can be rehabilitated through treatment. The sentencing judgment in *R. v. D.*[37] is illustrative. The accused pleaded guilty to two charges of indecent assault on a female. He had a history of mental disorder and showed an apparent need for psychiatric help. In sentencing the accused, the Nova Scotia Court of Appeal directed that he be placed on probation for two years, and that he undergo psychiatric treatment as a term of probation.

A similar approach was adopted by the Ontario Court of Appeal in *R. v. D.*,[38] a case involving indecent assaults on young girls. Prior to these offences, the accused had voluntarily sought treatment for his disorder, namely, heterosexual pedophilia. Evidence before the court indicated that continued, non-custodial treatment of the accused would likely effect a cure of his disorder. Accordingly, the Court varied the custodial sentence imposed at trial to a sentence of time served and a two year probationary period, with a condition that the offender continue to undergo psychiatric treatment.

Mental Retardation

An offender's mental deficiency or retardation will usually act as a mitigating factor in sentencing, unless it is such as to render him or her a continuing and serious threat.[39] In *R. v. S.*,[40] for example, that the 17 year-old male accused had a mental age of only 12 largely accounts for the court's leniency in imposing a sentence of two months' imprisonment and 18 months' probation for his offence of indecent assault on a female. That the accused undergo psychiatric treatment was a condition of his probation.

Entry of a Guilty Plea

The offender's plea of guilty will normally be regarded as a mitigating factor in sentencing, as it is considered to be in the public interest[41] and to indicate some measure of remorse on the offender's part.[42] According to Judge Salhany, however, this principle "is not of universal application and may be rejected by the court where the accused was inescapably caught in the commission of the crime."[43]

Consequences of Imprisonment

It is generally acknowledged that a sentence of imprisonment may have severe "collateral" consequences for a sexual offender during his or her incarceration. The extent to which this should influence a court at the sentencing stage was considered in *R. v. Campbell.*[44] A provincial magistrate had imposed a sentence of 23 months' imprisonment on the offender, pursuant to his conviction under section 146(1) of the *Criminal Code* (sexual intercourse with a female under 14 years-old). The magistrate expressed his concern about what would happen to the offender if he were sent to a federal penitentiary, and accordingly, sentenced him to a term of imprisonment short enough to allow him to serve the sentence in a provincial institution. The Nova Scotia Court of Appeal increased the offender's sentence to five years' imprisonment, and stated that the magistrate had erred in taking into account the "possibility [that] a sexual offender such as the respondent may be physically harmed in a federal penitentiary. That may well be the case, but that is not a matter for a court to take into account. The adequacy of the penal institutions and their ability to safeguard inmates is a matter for the officials of the penitentiary service and for Parliament."[45]

Recognition of the convicted sexual offender's unpleasant prospects while serving a penitentiary sentence may, however, influence the length of the sentence imposed. In *R. v. Piche, Caplette and Jones,*[46] the court stated that the sentences imposed on three accused involved in the homosexual rape of a fellow inmate:

> . . . .would have been much longer but for the fact that these accused would suffer indignities and additional punishment at the hands of other prisoners,

and would have to serve their sentences "in the hole" (segregated from the main prison population) for their protection.

Sentencing Factors Pertaining to the Circumstances of the Offence

Use of Violence

A crucial factor in the sentencing of sexual offenders is the degree of violence used in the commission of the offence. Violence, particularly when accompanied by the offender's employment of a weapon, is invariably an aggravating factor in sentences imposed on sexual offenders.[47]

Premeditation and Planning

In general, the greater the degree of premeditation and planning involved in the commission of the offence, the more serious the offence will be regarded by the court. Correspondingly, that the victim may, in the court's view, have led the offender to believe that sex would be the likely result of their social encounter may have the effect of mitigating the offender's sentence.[48]

Offences Committed by Groups

Particularly in the sentencing of sexual offenders, that an accused has acted in concert with others in committing a sexual offence is treated as an aggravating factor. In *R. v. Morrissette*,[49] the Saskatchewan Court of Appeal stated that, although rape is always a serious offence, it is even more serious where two or more men assault a female. Further, the court will usually be inclined to impose a heavier sentence on the instigator of a gang attack than on his confederates.[50]

Breach of a Position of Trust

Where an accused flagrantly breaches a position of trust in committing a sexual offence, the court will typically consider such breach of trust an aggravating factor in sentencing the accused. A common breach of trust that arises in sexual offences is that involving a parent or someone with a special ascendancy over a young person. Situations involving serious breaches of trust in this context are by no means restricted to offences involving incest[51] between a father and his daughter; comparable abuses of authority by offenders have arisen in prosecutions for gross indecency,[52] indecent assault on a male,[53] indecent assault on a female,[54] and rape[55] among others.[56] Even where no familial

ties or other special relationships exist between the offender and a young victim, the courts have acknowledged the natural ascendancy of an adult over a child and have tended to sentence such offenders more severely.[57]

Pre-sentence Reports

Pursuant to section 662 of the *Criminal Code*, the court may require the preparation and presentation of a pre-sentence report, in order to assist the court in determining an appropriate sentence for the offender and, more particularly, in determining whether the offender should receive a discharge. Whether or not a pre-sentence report will be requested with respect to a given offender is in the discretion of the court. In general, a pre-sentence report will be ordered where the court feels that it needs additional information on an offender before imposing sentence.[58] Where an offender challenges or denies a statement contained in the pre-sentence report, the onus is on the Crown to prove the accuracy of the statement. Failing such proof, the challenged information should be disregarded. Further, a statement in the pre-sentence report which alleges that the accused is suspected of other crimes for which he or she was not charged should not be considered in imposing sentence.[59]

Although the *Criminal Code* does not provide guidelines concerning the proper contents of pre-sentence reports, certain types of information are expected to be standard inclusions: the offender's level of education, criminal record, family status, employment record, and social and medical history. Recent legal judgments in Canada have formulated broad guidelines in this regard. In *R. v. Rudyk*,[60] the court stated that:

> . . . a pre-sentence report (should) be confined to its very necessary and salutary role of portraying the background, character and circumstances of the person convicted. It should not, however, contain the investigator's impressions of the facts relating to the offence charged, whether based on information received from the accused, the police or other witnesses, and whether favourable or unfavourable to the accused.

In *R. v. Bartkow*,[61] MacKeigan made the following remarks on the proper function of pre-sentence reports in sentencing an offender:[62]

> Their function is to supply a picture of the accused as a person in society — his background, family, education, employment record, physical and mental health, associates and social activities, and potentialities and motivation. Their function is not to supply evidence of criminal offences or details of a criminal record or to tell the court what sentence should be imposed.

Sentencing Alternatives to Imprisonment

The *Criminal Code* provides the sentencing court with several alternatives to the sanction of imprisonment, namely, fines, absolute or conditional discharges, and the suspension of the passing of sentence, with probationary conditions.

Fines

The imposition of a fine is one sentencing alternative to imprisonment. The general principle is that, unless the offence of which the offender was convicted specifies a minimum term of imprisonment, the court may sentence the offender to a fine. This principle is significantly modified, however, by section 646(2) of the *Criminal Code*, which provides that an accused who is convicted of an indictable offence punishable with imprisonment for more than five years may be fined in addition to, but not in lieu of, any other punishment that is authorized. Accordingly, this section precludes the court from imposing a fine as the sole punishment for most sexual offences. A fine may be imposed as the sole punishment for some sexual offences, however, most notably for the offence of "indecent act" (which is the criminal charge most often used in cases of male exposure).

Canadian courts have enunciated general principles concerning the use of fines in sentencing an offender:

> The amount of the fine should not be excessive, neither in regard to the financial means of the offender nor in regard to the gravity of the offence committed.[63]

> Any term of imprisonment imposed as an alternative to payment of a fine should not be out of proportion to the fine.[64]

> Where the court imposes a fine, it may allow the offender an appropriate length of time in which to pay the amount specified, but the court cannot order that the offender be detained in custody pending payment of the fine.[65]

Discharge Provisions

The *Canadian Committee on Corrections* advocated in 1969 that:[66]

> . . . there should be provisions that permit the court to deal with first offenders charged with a minor offence in such a way that would avoid the damaging consequences of the existence of a criminal record.
>
> A conviction against a first offender establishes a record that can carry with it life-long consequences that continue long after rehabilitation is complete and risk to the community is no greater from this individual than from the average citizen. In fact, the record may be the result of what the individual considered a prank and the individual may at no time have been a danger to society. In other cases, the exposure to public trial has a deterrent effect in itself, so that the imposition of additional punishment is superfluous, costly and damaging to both the individual and the community.
>
> An alternative should be open to the court, at this preconviction stage, so that action appropriate to the individual case may be planned, including a period of probation to test the court's assessment of the offender. This should take the form of absolute discharge, either with or without conditions.

In furtherance of these recommendations, the *Criminal Code* was amended in 1972 to provide for the absolute or conditional discharge of an offender. Section 662.1 of the *Criminal Code* authorizes the court to grant an

offender an absolute or conditional discharge, where circumstances warrant, provided the offence is one for which there is no specified minimum punishment and the offence is punishable by less than 14 years' imprisonment. Before granting an accused a discharge, the court must consider that such a disposition is both in the accused's best interests and is not contrary to the public interest.

In commenting on the requirement that a discharge be "in the best interests of the accused," the Ontario Court of Appeal has stated:[67]

> I take this to mean that deterrence of the offender himself is not a relevant consideration in the circumstances, except to the extent required by conditions in a probation order. Nor is his rehabilitation through correctional or treatment centres, except to the same extent. Normally, he will be a person of good character, or at least such character that the entry of a conviction against him may have significant repercussions.

It is apparent that discharges are sometimes used in sentencing an offender for the offence of indecent act, for example, in cases of "streaking"[68] and "mooning".[69] In *R. v. Miceli*,[70] the accused was observed masturbating himself in a department store. The court, in granting him an absolute discharge, emphasized the fact that this was a first offence and that the accused's employment prospects would be jeopardized by the existence of a criminal record.

Where the granting of a discharge is deemed to be in the accused's best interests, the court must go on to consider whether a discharge in the circumstances would not be contrary to the public interest. The need to deter others who may be disposed to commit a similar offence is a proper consideration; the more serious the offence committed by an accused, the less the likelihood that a discharge will be appropriate. Exceptions to this rule, however, do arise. In *R. v. Konzelman*,[71] the accused was found guilty of indecently assaulting a woman. Evidently, the accused had, pursuant to a bet with some friends, grabbed the complainant's breasts and shook them. The Manitoba Court of Appeal substituted a conditional discharge and one years' probation for the suspended sentence imposed at trial.

The British Columbia Court of Appeal in *R. v. Fallofield*[72] enunciated eight general principles relating to the use of the discharge provisions in section 662.1 of the *Criminal Code*:

1. The section may be used in respect of any offence other than an offence for which a minimum punishment is prescribed by law or the offence is punishable by imprisonment for 14 years or for life.

2. The section contemplates the commission of an offence. There is nothing in the language that limits it to a technical or trivial violation.

3. Of the two conditions precedent to the exercise of the jurisdiction, the first is that the Court must consider that it is in the best interests of the accused that he should be discharged either absolutely or upon condition. If it is not in the best interests of the accused, that, of course, is the end of

the matter. If it is decided that it is in the best interests of the accused, then that brings the next consideration into operation.

4. The second condition precedent is that the Court must consider that a grant of discharge is not contrary to the public interest.

5. Generally, the first condition would presuppose that the accused is a person of good character, without previous conviction, that it is not necessary to enter a conviction against him in order to deter him from future offences or to rehabilitate him, and that the entry of a conviction against him may have significant adverse repercussions.

6. In the context of the second condition the public interest in the deterrence of others, while it must be given due weight, does not preclude the judicious use of the discharge provisions.

7. The powers given by s. 662.1 should not be exercised as an alternative to probation or suspended sentence.

8. Section 662.1 should not be applied routinely to any particular offence. This may result in an apparent lack of uniformity in the application of the discharge provisions. This lack will be more apparent than real and will stem from the differences in the circumstances of cases.[73]

Suspended Sentence and Probation

Section 663 of the *Criminal Code* discloses two basic situations in which a sexual offender may be directed to comply with the terms of a probation order: where the passing of sentence is suspended, and where the sentence is either a fine or term of imprisonment not exceeding two years.

A suspended sentence implies the suspension of the passing of sentence, not the suspension of the operation of the sentence.[74] The suspended sentence is often imposed where the court considers that the accused is unlikely to commit a further, similar offence and will benefit from conditions of probation. For example, in *R. v. C*,[75] the court imposed a suspended sentence and probationary terms on a man who had pleaded guilty to incest. The court, noting that a term of imprisonment would probably cost the offender his job, considered that the evidence indicated that the accused was unlikely to commit such an offence again. In the probation order, the offender was required to undergo psychiatric evaluation, and treatment, if necessary.

Mewett, in discussing probation, has stated that:

> . . . .the object of probation is to provide for some method of dealing with those people who can be easily rehabilitated and who, with proper guidance and control, are unlikely to become criminals.[76]

A term of probation (which may not continue in force for more than three years)[77] may be imposed in addition to either a fine or imprisonment, but not in addition to both.[78] In determining whether probation is an appropriate disposition, the court will have regard to the nature of the offence, the circumstances

of its commission, the offender's age, character and antecedents.[79] A pre-sentence report may be ordered to assist the court in making this determination.

Some offences, by their very nature, are considered unsuitable for disposition of the offender by way of probation.[80] Even so, the appropriateness of probation tends to be influenced more by the circumstances of the offence than by the type of offence committed. In *R. v. St. Onge*,[81] for example, the charge against the accused was sexual intercourse with a female under 14 years of age. The 13 year-old complainant had apparently instigated the act of sexual intercourse; the court suspended the passing of the accused's sentence and put him on probation for one year.

Probation orders are commonly imposed on young, first offenders where the potential for reform is considered high.[82] A sentence incorporating probationary terms is often ordered where the court considers that the offender would benefit from some form of treatment, be it for psychiatric disorder[83] alcohol abuse[84] or drug abuse.

The frequent use of probation in the sentencing of non-violent sexual offenders[85] signifies the judicial adoption of the "treatment model" in this context.[86] For example, in *R. v. Doran*,[87] a school teacher convicted on two counts of indecently assaulting young girls was originally sentenced to a prison term of 12 months' definite and six months' indeterminate. On appeal, this sentence was varied to time served, and the offender was placed on two years' probation on the condition that he undergo psychiatric treatment on an outpatient basis. In substituting this sentence, the Court of Appeal stated:[88]

> We have before us material not presented to the trial judge which disclosed that, if the appellant were to continue his treatment with Dr. Tisdall and also take treatment at the Clarke Institute of Psychiatry, the chance of being cured is favourable. If such treatment outside the prison is likely to effect such a cure, and his imprisonment may not, we think that it is in the general interest of society to have him treated rather than imprisoned.

In reference to these judicial remarks, Schiffer has commented:[89]

> This statement represents what is perhaps the classic rationale behind the use of probationary psychiatric treatment. It articulates the widely held belief that psychotherapy, if it is to be effective at all, is most properly conducted outside the prison environment. Recognizing that the locking of an individual behind bars may not be the ideal way to effect his healthy readjustment to society, it advances an alternative method of psychic rehabilitation which, though coerced, seems rather more workable.

Imprisonment

Section 659 of the *Criminal Code* governs the institutional placement of convicted offenders who are sentenced to a term of imprisonment. In general, prison terms of less than two years are served in provincial correctional institutions and prison terms of two years or more are served in federal penitentiaries.[90] Provincial institutions vary widely in the education, release and

treatment opportunities available to inmates.[91] Moreover, in some provinces, provincial correctional institutions are used to house both convicted offenders and those awaiting trial or appeal.[92]

An offender who has been sentenced to imprisonment for a term of two years or more must, subject to federal-provincial transfer agreements, serve his or her term in a federal penitentiary. There are three categories of federal prisons: maximum security; medium security; and minimum security. Following the handing down of sentence, the offender is classified for placement purposes; the offender's length of sentence, likelihood of escape and potential danger to the community if successful in an escape attempt are considered at this stage.[93] It is in the context of these custodial arrangements that sexual offenders who are deemed to require protection from other inmates may be placed in protective custody.

Provision of Treatment

There is no authority in the *Criminal Code* which enables a sentencing court, in imposing a term of imprisonment, to direct that the accused should receive treatment while incarcerated.[94] The court may only make recommendations concerning the provision of treatment to an offender while he or she is in prison. *In R. v. Leech*,[95] for example, the court, in imposing a sentence of life imprisonment for offences of rape and buggery, considered that "whilst under sentence the accused, though not legally insane, should be considered a suitable patient for psychiatric care."[96]

The problem with such judicial recommendations is that they are not binding upon penitentiary authorities, and consequently, the sentencing court cannot be confident that treatment will be made available to the offender.[97] According to the Law Reform Commission of Canada:[98]

> Sometimes such recommendations are followed, often they are not. Although it is theoretically possible for prison authorities to transfer mentally disordered offenders to mental hospitals, in practice, such transfers are rare. Because of the sparse facilities for psychiatric treatment in prisons generally, many prisoners suffering from serious mental disorders are detained without the prospect for treatment.

Pursuant to section 19(1) of the *Penitentiary Act*,[99] the federal Solicitor General may, with the approval of the Governor in Council, enter into agreements with the government of any province to provide for the custody, in a mental hospital or other institution, of persons found to be mentally ill or mentally defective at any time during their confinement in a penitentiary. Although judges sometimes recommend, at the sentencing stage, that the offender receive treatment under the provisions of section 19, these recommendations similarly have no binding effect on penitentiary authorities.

Remission and Mandatory Supervision

Remission shortens the time that inmates spend in custody, so that even if an inmate is not granted parole, he or she may nonetheless be released before the expiration of the sentence.[100] Prior to 1977, an inmate was eligible for two different types of remission: statutory remission and earned remission. Statutory remission, which amounted to one quarter of the term to which the inmate was sentenced, was credited upon entry to an institution and could be forfeited as a result of institutional infractions. Earned remission (which operated over and above the credited statutory remission) could be achieved where an inmate was of good behaviour. It accumulated at a rate of three days per calendar month and could not be lost.

In 1977, statutory remission was abolished, and the *Penitentiary Act* was amended to provide that, prospectively, all remission must be earned. A new formula for earned remission was introduced and incorporated in section 24 of the *Penitentiary Act*:[101]

> 24(1) Subject to section 24.2, every inmate may be credited with fifteen days of remission of his sentence in respect of each month and with a number of days calculated on a pro rata basis in respect of each incomplete month during which he has applied himself industriously, as determined in accordance with any rules made by the Commissioner in that behalf, to the program of the penitentiary in which he is imprisoned.

Section 24.1 (1) of the Act provides that every inmate may forfeit earned remission where he or she is convicted of a disciplinary offence. The earned remission may be forfeited in whole or in part, but no more than 30 days may be forfeited without the concurrency of the Commissioner or an officer of the Correctional Service Canada designated by him, or more than 90 days without the concurrency of the Minister. Section 24.2 provides for the maximum remission that can be gained by inmates who had accumulated statutory remission before its abolition.[102]

Accordingly, and notwithstanding that an inmate has not been paroled, he or she may nonetheless accumulate earned remission to the extent of one third of the total sentence of imprisonment and be released on "mandatory supervision" after serving approximately two-thirds of the sentence. The inmate's entitlement to be released from custody on mandatory supervision as a result of accumulated earned remission is a matter over which the National Parole Board has been granted no legal authority.[103] Under the provisions of the *Parole Act*,[104] the National Parole Board's supervisory role and corollary legal powers concerning inmates on mandatory supervision attaches only after the inmate has been released. The Board cannot legally apprehend and recommit into custody an inmate immediately after his or her release on mandatory supervision (a practice known colloquially as "gating") on the grounds that the inmate should not be at large; section 16 of the *Parole Act* confers no such power.[105]

Legislation introduced in the Senate (Bill S-32) would confer on the National Parole Board wider powers where an inmate breaches conditions of mandatory supervision after release from prison, but does not address the more difficult and central issue: To what extent should the National Parole Board be legally authorized to prevent inmates deemed to be a considerable risk to society from being released on mandatory supervision at all?

Parole

Unlike an inmate's legal entitlement to be released on mandatory supervision where he or she has accumulated earned remission (but has not been paroled), the decision to parole an inmate is a discretionary one made by a parole board. The National Parole Board, in addition to its role concerning federal inmates, oversees applications for parole from provincial parole applicants in those provinces which do not have a parole board. Determining the parole eligibility date of an inmate is a complex process,[106] and depends primarily on the nature of the inmate's offence and the length of sentence the inmate is serving.[107] In general, inmates are eligible for parole after having served one-third of their sentence or seven years, whichever is the lesser (but at least nine months if a federal inmate). Provincial inmates serving a sentence of less than two years are eligible for parole after having served one third of their sentence.[108] Inmates under preventive detention as "dangerous offenders" are eligible for parole after three years, with a mandatory review every two years thereafter.[109] An inmate's eligibility for day parole is contingent on his or her parole eligibility date.[110]

Under the provisions of the *Parole Act*,[111] the National Parole Board is authorized, in its discretion, to grant, refuse to grant, or revoke an inmate's parole. Section 10 (1) of the Act provides that the Board may grant parole to an inmate subject to any terms or conditions desirable, if the Board considers that:

1. In the case of a grant of parole other than day parole, the inmate has derived the maximum benefit from imprisonment.

2. The reform and rehabilitation of the inmate will be aided by the grant of parole.

3. The release of the inmate on parole would not constitute an undue risk to society.

If the Board decides to grant parole, the inmate will be released under specified conditions and supervision. An inmate whose parole has been denied may appeal this decision and, even if unsuccessful, may re-apply for parole at a later date.

Community Residential Centres

Implicit in the forms of conditional release is the legislative recognition that the "controlled reintegration" of offenders into society, under conditions of parole or mandatory supervision, is the most realistic means of helping offenders make the transition from life in prison to life in the community. In recommending a form of statutory conditional release on which the current "mandatory supervision" provisions were based, the Report of the *Canadian Committee on Corrections* stated:[112]

> The aim should be to develop a system under which almost everyone would be released under some form of supervision. It is best if he is released at the point at which the chances for his successful reintroduction to community life would be highest. This means the extension of parole as we now know it to every case possible.
>
> However, there will be many who will not qualify for parole and they should also be subject to supervision. This can be accomplished by making the period of statutory remission a period of supervision in the community, subject to the same procedures that apply to parole. This means the releasee would be subject to conditions and to return to complete his sentence in the institution if he violates those provisions. He should also receive the same kind of assistance and control through supervision that applies to parolees.

Community-based residential centres (privately funded) and community corrections centres (publicly funded) are intended to assist former inmates in this difficult period of transition and serve a variety of functions.[113]

> [S]ome cater exclusively to those on day parole or a temporary absence; others assist transients, alcoholics, drug addicts and the like who may be ex-offenders; some centres are operated by governmental agencies; those in the private sector may rely solely upon charitable donations with others receiving some funding from government in the form of grants-in-aid or fees for service.

The Task Force on Community-Based Residential Centres in 1973 identified 156 such centres;[114] by 1975, there were 218 in existence.[115]

Dangerous Offenders

Legislation relating to special classes of offenders deemed to warrant preventive detention has existed in Canada since 1947[116] and substantial changes were introduced in 1961 and 1977.[117] This review considers the current "dangerous offender" provisions proclaimed in force on October 16, 1977, with particular emphasis on those relating to sexual offenders.

Part XXI of the *Criminal Code* contains the statutory provisions authorizing the preventive detention of offenders whose conduct meets the criteria specified in that part. Central to these provisions is the definition of a "serious personal injury offence"; section 687 of the *Criminal Code* defines a "serious personal injury offence as:

(a) an indictable offence (other than high treason, treason, first degree murder or second degree murder) involving

(i) the use or attempted use of violence against another person, or

(ii) conduct endangering or likely to endanger the life or safety of another person or inflicting or likely to inflict severe psychological damage upon another person,

and for which the offender may be sentenced to imprisonment for ten years or more, or

(b) an offence or attempt to commit an offence mentioned in section 246.1 (sexual assault), 246.2 (sexual assault with a weapon, threats to a third party or causing bodily harm) or 246.3 (aggravated sexual assault).

An application by the Crown to have an offender found to be a dangerous offender must be brought after his conviction for an offence, but before the offender is sentenced.[118] The Crown must prove beyond a reasonable doubt[119] that:

. . . .the offence for which the offender has been convicted is a serious personal injury offence described in paragraph (a) of the definition of that expression in section 687 and the offender constitutes a threat to the life, safety or physical or mental well-being of other persons on the basis of evidence establishing

(i) a pattern of repetitive behaviour by the offender, of which the offence for which he has been convicted forms a part, showing a failure to restrain his behaviour and a likelihood of his causing death or injury to other persons, or inflicting severe psychological damage upon other persons, through failure in the future to restrain his behaviour,

(ii) a pattern of persistent aggressive behaviour by the offender, of which the offence for which he has been convicted forms a part, showing a substantial degree of indifference on the part of the offender as to the reasonably foreseeable consequences to other persons of his behaviour, or

(iii) any behaviour by the offender, associated with the offence for which he has been convicted, that is of such a brutal nature as to compel the conclusion that his behaviour in the future is unlikely to be inhibited by normal standards of behavioural restraint, or

(b) that the offence for which the offender has been convicted is a serious personal injury offence described in paragraph (b) of the definition of that expression in section 687 and the offender, by his conduct in any sexual matter including that involved in the commission of the offence for which he has been convicted, has shown a failure to control his sexual impulses and a likelihood of his causing injury, pain or other evil to other persons through failure in the future to control his sexual impulses.[120]

Where the Crown discharges its burden of proof, section 688 provides that "the court may find the offender to be a dangerous offender and may thereupon impose a sentence of detention in a penitentiary for an indeterminate period, in lieu of any other sentence that might be imposed for the offence for which the offender has been convicted."[121] Where the court does find that the accused is a "dangerous offender" within the legal meaning of that phrase, the

court nonetheless retains a discretion whether or not to impose the sentence of indeterminate imprisonment.[122] Where a sentence of indeterminate imprisonment is imposed, a further, definite term of imprisonment may not be made consecutive to it.[123]

Section 689 provides that the Attorney General of the province in which the offence was tried must consent to the making of the application; that such application must be heard and determined by the court in the absence of a jury; and that no such application shall be heard unless at least seven days' notice has been given to the offender by the prosecutor, following the making of the application, outlining the basis on which the application is intended to be founded.

On the hearing of the application, the court is required to hear the evidence of at least two psychiatrists, one of whom is nominated by the prosecution and the other by the offender. If the offender fails or refuses to nominate a psychiatrist, the court is required to nominate one on his behalf.[124] In addition to this mandatory psychiatric testimony, the court is required to hear "all other evidence that, in its opinion, is relevant, including the evidence of any psychologist or criminologist called as a witness by the prosecution or the offender."[125] Evidence of the offender's character and reputation may also be admitted for the purpose of determining whether the offender is or is not a dangerous offender.[126] Prior to the hearing, the court has the power to direct the offender to attend for observation or, where necessary, to remand him or her in custody for this purpose.[127]

Sections 694 and 695.1 of the *Criminal Code* outline the rights of appeal of the offender and the prosecution in this context, and the offender's parole status (which varies depending on whether the sentence of indefinite detention was imposed before or after the 1977 amendments came into force). Finally, section 695 provides that, where a court finds an offender to be a dangerous offender and imposes a sentence of detention for an indeterminate period, the court must order that "a copy of all reports or testimony given by psychiatrists, psychologists or criminologists and any observations of the court with respect to the reasons for the sentence, together with a transcript of the trial of the dangerous offender be forwarded to the Solicitor General of Canada for his information."

Dangerous Sexual Offender Applications

The purpose of the *Criminal Code* provisions relating to dangerous sexual offenders has been described by the Supreme Court of Canada as follows: "to protect persons from becoming the victims of those whose failure to control their sexual impulses renders them a source of danger."[128] As section 688 makes clear, an offender convicted of a sexual offence that meets the criteria of a "serious personal injury offence" in section 687 may be deemed a dangerous offender under the provisions of either section 688 (a) or section 688 (b). Even

so, the criteria in section 688 (b) are specifically pertinent to sexual offenders; the great majority of dangerous offender applications concerning sexual offenders are brought pursuant to the provisions of section 688 (b).

The group of sexual offences considered to be "serious personal injury offences" has changed somewhat over the years. Prior to the proclamation of Part XXI of the *Criminal Code* in October, 1977, a conviction for the offences of or attempts to commit buggery and bestiality would ground dangerous sexual offender applications. These two offences, however, were not carried over into the 1977 amendments. Prior to the January 1983 amendments, an offence or attempt to commit an offence of: rape, indecent assault on a female, indecent assault on a male, sexual intercourse with a female under 14 or 14 and 15 years-old, and gross indecency, was considered to be a "serious personal injury offence" rendering an offender eligible for preventive detention.

Further changes resulted from the restructuring of assaultive sexual offences by the 1983 amendments, which define a "serious personal injury offence" to mean the three forms of sexual assault described in sections 246.1, 246.2, and 246.3 of the *Criminal Code*. It is unclear whether the omission of the offences of unlawful sexual intercourse (which can only be committed against girls either under 14, or 14 or 15) and gross indecency (which often relates to cases of homosexual or heterosexual pedophilia) resulted from a policy decision to restrict the preventive detention provisions to forms of sexual *assault* (thereby tending to exclude other forms of sexual activity involving young persons), or from an oversight in legislative drafting.

The Alberta Supreme Court in *R. v. Butler* set forth the salient issues addressed in a dangerous sexual offender application:[129]

> A dangerous sexual offender means a person who, by his conduct in any sexual matter, has shown a failure to control his sexual impulses and is likely to cause injury, pain or other evil to any person through failure in the future to control his sexual impulses. There are, therefore, three issues into which the Court must inquire, namely:
>
> 1. Has the respondent by his sexual conduct in sexual matters shown a failure to control his sexual impulses?
> 2. If so, is he likely in the future to show a similar failure?
> 3. If so, is he likely to cause injury, pain or other evil to any person?

Each of these must be proven beyond a reasonable doubt.

Failure to Control Sexual Impulses

The element of "control" in the statutory phrase, "a failure to control his sexual impulses," has been judicially construed to imply the exercise of restraint or direction upon free action, or the capacity to dominate, command, or overpower one's impulses.[130] Accordingly, a sexual impulse is not controlled when it is gratified.[131] In *R. v. McAmmond*,[132] it was submitted on behalf of the offender that he possessed the requisite control. The submission was founded

on the basis that, when the seven year-old complainant requested that he stop indecently assaulting her, he belatedly did so. The Manitoba Court of Appeal considered that the offender's putative "control" evidenced itself only after he had molested the child and satisfied whatever sexual impulses motivated him. In reference to the offender's further submission that, for a three or four year prior period, he had not committed any act of sexual deviation and thereby had manifested sexual control, the Court relied on a psychiatrist's assessment that this period was less evidence of control than of the unavailability of an individual to be accosted.

Likelihood of Causing Injury, Pain or Other Evil

A sexual offender convicted of a "serious personal injury offence" (section 687) may be sentenced to preventive detention on a dangerous offences' application if, "by his conduct in any sexual matter including that involved in the commission of the offence for which he has been convicted, has shown a failure to control his sexual impulses and a likelihood of his causing injury, pain or other evil to other persons through failure in the future to control his sexual impulses" (section 688(b)). While the test of "future likelihood" has proven intractable both medically and legally,[133] the sorts of harms whose reoccurrence is sought to be prevented have been broadly construed by Canadian courts, particularly where young victims are concerned. The case of *R. v. Dwyer*[134] is illustrative. The offender had a lengthy record of offences of gross indecency and indecent assault on a male. In commenting on the meaning of "evil" in this context, the Alberta Court of Appeal stated:[135]

> Parliament has not seen fit to define "evil" and in construing the word for the purposes of [s. 688] a Court ought not by judicial pronouncements to narrow its scope and meaning beyond the necessities of the context in which it is used. The public interest looms large here. The sections have to do with sentencing, and by the very use of the words "preventive detention" in Part XXI of the *Criminal Code* in which the sections appear, the public interest primarily to be served is that aspect which gives weight to the protection of the public . . . .In general understanding, when "evil" is used as a noun it usually connotes moral badness or depravity. In the context of the sections and the circumstances of the present case, I think it must be taken to mean evil consequent on the commission of any offence within the second category of the grouping in *Klippert v. The Queen*, particularly in so far as it involves young boys. It is not disputed that the offences on which Dwyer was convicted are evil in the general understanding.

The words "other evil" are not necessarily related to injury and pain and, accordingly, damage caused to young persons' morals, especially where it is such as could lead them into male prostitution or other behaviours that exploit them, is a form of that evil.[136] It is not necessary that young persons be physically harmed by the offender, if they were patently exploited sexually by him.[137]

The most crucial aspect of dangerous offender proceedings, and undoubtedly the most problematic, is the question of the offender's "likelihood of . . .

causing injury, pain or other evil to other persons through failure in the future to control his sexual impulses".[138] It is the present likelihood of the sexual offender's future conduct of which the court must be satisfied beyond a reasonable doubt;[139] it is not necessary that the court be satisfied that the offender will in fact re-offend in the manner provided.[140]

The mandatory psychiatric testimony in dangerous offender proceedings is intended to provide the court with guidance on this issue. Even so, some Canadian courts have vigorously challenged the reliability and validity of psychiatric prediction techniques. In *R. v. Butler,*[141] a case in which the Crown's dangerous offender application was unsuccessful, the Supreme Court of Alberta remarked:[142]

> It is clear that the state of the art of predicting dangerousness in this area of the discipline of psychiatric medicine leaves much to be desired. It is one of the least developed areas. To predict dangerousness is, in itself, dangerous. The profession over-predicts.

A member of that province's Court of Appeal has expressed comparable scepticism:[143]

> Psychiatry in its present stage is far from an exact science in predicting human behaviour, whether the behaviour is to be given such treatment in the future as may be thought to help aberrations, or is to be allowed to go unchecked. The Court draws such help as it can from the testimony of the psychiatrists in the light of the whole case . . . .In weighing the evidence of psychiatrists it must be kept in mind that behavioural psychiatry is still an uncertain field influenced at times by theories which are not necessarily demonstrated when put into practice in the realities of life. We are dealing with the likelihood of evil, as perceived by the community, being caused to any person.

The purpose of the psychiatric examinations of the offender contemplated by Part XXI is to assist the psychiatrists in forming an opinion as to the likely future conduct of the offender in sexual matters.[144] At the hearing, the psychiatrists proffer their opinions in this regard as expert witnesses.[145] It is not proper to ask a psychiatrist whether the offender is a dangerous sexual offender, nor is it proper, where the facts are in dispute, to ask the psychiatrist to express an opinion on disputed facts.[146] Where the facts are not in dispute, however, different considerations apply. The Manitoba Court of Appeal has held:[147]

> [O]n the basis of undisputed facts or on an *ex hypothesi* basis, the psychiatrist may properly be asked his opinion on the likelihood of the accused causing injury, pain or other evil through failure in the future to control his sexual impulses, and upon the likelihood of his committing a further sexual offence. These are the areas in which a psychiatrist's expert opinion is most valuable . . . The final decision in all matters must rest with the Judge but he is entitled to the opinions of the psychiatrists, which he may accept or reject in whole or in part.[148]

In addition to psychiatric testimony, the court conducting a dangerous offender hearing is required to hear all other relevant evidence. Although the results of "phallometric tests" (which measure male sexual arousal by gauging

changes in the subject's penile circumference in response to different auditory and visual stimuli) have been adduced at dangerous sexual offender hearings, no Canadian court has yet accorded them evidentiary weight.[149] The Supreme Court of Ontario has held, on the basis of expert testimony, that the phallometric test is neither scientifically reliable nor scientifically acceptable as yet, and therefore, does not meet the standards of judicial use.[150]

In a dangerous sexual offender proceeding, the offender's prospects of treatment or cure are not relevant to the determination whether he or she is a "dangerous offender" within the legal meaning of that term.[151] These considerations are, however, relevant to the exercise of the judge's discretion whether or not to impose a sentence of indefinite detention. The court is entitled to take into account any psychiatric or other evidence which indicates that the offender's cure is probable with a determinate period, in assessing the appropriateness of a sentence of indeterminate imprisonment.[152]

References

Chapter 37: Sentencing

[1] See Culliton, "Sentencing Guidelines: A Judicial Viewpoint" in Grosman (ed.), *New Directions in Sentencing* (Toronto: Butterworths, 1980) at 295; and Hall, "Sentencing the Individual", *ibid.*, at 302.

[2] See, e.g., *R. v. Morrissette* (1970), 1 C.C.C. (2d) 307 (Sask. C.A.).

[3] *R. v. Willaert* (1953), 105 C.C.C. 172 at 176 (Ont. C.A.).

[4] *R. v. Jackson* (1977), 21 N.S.R. (2d) 17 at 20 (C.A.).

[5] Ruby, *Sentencing* (2d ed. Toronto: Butterworths, 1980) at 1.

[6] Decore, *Criminal Sentencing: The Role of the Canadian Courts of Appeal and the Concept of Uniformity* (1963-64), 6 Cr. L.Q. 324 at 325.

[7] See "Case Studies on the Sentencing of Sexual Offenders," *infra*.

[8] Griffiths, Klein, and Verdun-Jones, *Criminal Justice in Canada* (Vancouver: Butterworths, 1980) at 184.

[9] Nadin-Davis, *Canadian Sentencing Digest* (1981) at 25-26.

[10] See Weiler, "The Reform of Punishment" in Law Reform Commission of Canada, *Studies on Sentencing* (Ottawa: Information Canada, 1974) at 93-205.

[11] [1946] O.R. 808 at 815 (C.A.).

[12] (1976), 19 Cr. L.Q. 276 (Ont. C.A.).

[13] *Ibid.*

[14] *R. v. Morrissette* (1970), 1 C.C.C. (2d) 207 (Sask. C.A.).

[15] Law Reform Commission of Canada, *Fear of Punishment* (Ottawa: Supply and Services Canada, 1976) at 13.

[16] *Ibid.*

[17] Ruby, *supra*, note 5 at 9.

[18] (1975), 26 C.C.C. (2d) 317 (Ont. C.A.).

[19] *R. v. Walsh* (1979), 10 C.R. (3d) S-30 (Que. S.C.) and *cf. Amero v. The Queen* (1978), 3 C.R. (3d) S-45 (N.S.C.A.).

[20] *R. v. G.B.* (1981), 47 N.S.R. (2d) 541 (Fam. Ct.).

[21] *R. v. Trask* (1974), 28 C.R.N.S. 321 (Ont. C.A.).

[22] *Strickland v. The Queen* (1981), 22 C.R. (3d) 287 (Alta. C.A.).

[23] *R. v. M* (1979), 30 N.S.R. (2d) 638 (C.A.).

[24] (1979), 46 C.C.C. (2d) 573 (Ont. C.A.).

[25] *Ibid.*, at 576 *per* Brooke J.A. For a similar sentencing approach to pedophilic offenders, see *R. v. Doran* (1971), 16 C.R.N.S. 9 (Ont. C.A.).

[26] *R. v. Iwaniw* (1959), 127 C.C.C. 40 at 50-51 (Man. C.A.).

[27] Nadin-Davis, *supra*, note 9 at 54.

[28] *Lees v. The Queen* (1979), 46 C.C.C. (2d) 385 (S.C.C.).

[29] Nadin-Davis, *supra*, note 9 at 57.

[30] (1974), 15 C.C.C. (2d) 376 at 377 (Ont. C.A.).

[31] See, *e.g.*, *R. v. Niman* (1974), 31 C.R.N.S. 51 (Ont. Prov. Ct.).

[32] See, *e.g.*, *R. v. Pilgrim* (1981), 64 C.C.C. (2d) 523 (Nfld. C.A.) (indecent assault on a male); *R. v. D* (1981), 63 C.C.C. (2d) 351 (Que. C.A.) (incest); *R. v. McBride*, unreported, Oct. 14, 1981 (Ont. C.A.) (indecent assault on a female); and *R. v. Descalchuk* (1980), 22 C.R. (3d) 89 (B.C.C.A.) (rape).

[33] Ruby, *supra*, note 5 at 88.

[34] See generally Salhany, *Canadian Criminal Procedure* (2d ed. Toronto: Canada Law Book, 1978) at 228; Martin, "Mental Disorder and Criminal Responsibility in Canadian Law," in Hucker, Webster, and Ben-Aron, eds., *Mental Disorder and Criminal Responsibility* (Toronto: Butterworths, 1981) at 15; Tanay, "In Defence of the Insanity Defence," *ibid.*, at 121.

[35] (1981), 23 C.R. (3d) 56 (Ont. C.A.).

[36] Ruby, *supra*, note 5 at 111.

[37] (1974), 10 N.S.R. (2d) 94 (C.A.).

[38] (1971), 5 C.C.C. (2d) 366 (Ont. C.A.).

[39] *R. v. Hall* (1981), 63 C.C.C. (2d) 535 (Alta. C.A.).

[40] (1979), 35 N.S.R. (2d) 35 (C.A.).

[41] *R. v. De Haan* (1967), 52 Cr. App. R. 25 (C.C.A.); *R. v. Johnston and Tremayne*, [1970] 4 C.C.C. 64 (Ont. C.A.).

[42] Salhany, *supra*, note 34 at 268.

[43] *Ibid.* See *R. v. Spiller*, [1969] 4 C.C.C. 211 (B.C.C.A.).

[44] (1978), 26 N.S.R. (2d) 460 (C.A.).

[45] *Ibid.*, at 461.

[46] (1978), 21 Cr. L.Q. 25 (Alta. T.D.).

[47] *R. v. D* (1981), 23 C.R. (3d) 56 (Ont. C.A.).

[48] See *R. v. Simmons* (1973), 13 C.C.C. (2d) 65 (Ont. C.A.); *R. v. St. Onge* (1977), 17 N.B.R. (2d) 99 (C.A.); and *Strickland v. The Queen* (1981), 22 C.R. (3d) 287 (Alta. C.A.).

[49] (1970), 1 C.C.C (2d) 307 (Sask. C.A.).

[50] *R. v. Lévesque* (1980), 19 C.R. (3d) 43 (Que. S.C.).

[51] *R. v. I* (1976), 1 A.R. 27 (C.A.).

[52] *R. v. Wood* (1975), 26 C.C.C. (2d) 100 (Alta. C.A.).

[53] *R. v. Tomkulak* (B.C.C.A., Vancouver, N. 800960, June 16, 1981).

[54] *X. v. The Queen*, [1970] C.A. 1093.

[55] *R. v. D* (1981), 23 C.R. (3d) 56 (Ont. C.A.).

[56] Nadin-Davis, *supra*, note 9 at 105.

[57] *Ibid.*

[58] Parker, *The Law of Probation*, 19 Can. J. Crim. Corr. 51 at 115

[59] *R. v. Morelli* (1977), 37 C.C.C. (2d) 392 (Ont. Prov. Ct.).

[60] (1975), 1 C.R. (3d) S-26 at S-31 (N.S.C.A.).

[61] (1978), 1 C.R. (3d) S-36 (N.S.C.A.).

[62] *Ibid.*, at 40.

[63] Ruby, *supra*, note 5 at 231-242.

[64] *Ibid.*, at 237.

[65] *R. v. Berger*, [1971] 1 O.R. 765 (C.A.).

[66] *Report of the Canadian Committee on Corrections* (Ottawa: Queen's Printer, Canada, 1969) at 194.

[67] *R. v. Sanchez-Pino* (1973), 11 C.C.C. (2d) 53 (Ont. C.A.).

[68] *R. v. Niman* (1974), 31 C.R.N.S. 51 (Ont. Prov. Ct.).

[69] *R. v. Balazsy* (1980), 54 C.C.C. (2d) 346 (Ont. Prov. Ct.).

[70] (1977), 36 C.C.C. (2d) 321 (Ont. Prov. Ct.).

[71] (1980), 5 Man. R. (2d) 165 (C.A.).

[72] (1973), 13 C.C.C. (2d) 450 (B.C.C.A.).

[73] A record of the discharge is maintained pursuant to the provisions of the *Criminal Records Act*. An offender may remove such record by applying in accordance with the terms of the Act.

[74] Salhany, *supra*, note 34 at 283.

[75] (1981), 23 C.R. (3d) 71 (Que. C.A.).

[76] Mewett, *The Suspended Sentence and Preventive Detention* (1958-59), 1 Cr. L.Q. 268 at 271.

[77] *Cr. Code*, ss. 663(3) and 664(2)(b).

[78] *R. v. Smith* (1972), 7 C.C.C. (2d) 468 (N.W.T.T.C.); *R. v. Blacquiere* (1975), 24 C.C.C. (2d) 168 (Ont. C.A.); *R. v. St. James* (1981), 20 C.R. (3d) 389 (Que. C.A.).

[79] Mewett, *supra*, note 76 at 272.

[80] See, *e.g.*, *R. v. Shanower* (1972), 8 C.C.C. (2d) 527 (Ont. C.A.) (rape).

[81] (1977), 17 N.B.R. (2d) 99 (C.A.).

[82] See *R. v. Bélanger* (1979), 46 C.C.C. (2d) 266 at 268.

[83] *R. v. DeCoste* (1974), 10 N.S.R. (2d) 94 (C.A.).

[84] *R. v. Pharo* (1970), 12 C.R.N.S. 151 (Ont. Co. Ct.).

[85] See Schiffer, *The Sentencing of Mentally Disordered Offenders* (1976), 14 Osgoode Hall L.J. 307.

[86] *Ibid.*, at 321-22.

[87] *Supra*, note 25.

[88] *Ibid.*

[89] Schiffer, *supra*, note 85 at 322.

[90] *Cr. Code*, s. 659(1).

[91] Griffiths, Klein, and Verdun-Jones, *supra*, note 8 at 208.

[92] See *Report of the Canadian Committee on Corrections*, *supra*, note 66 at 289-92.

[93] Griffiths, Klein, and Verdun-Jones, *supra*, note 8 at 210-11.

[94] Ruby, *supra*, note 5 at 116.

[95] [1973] 1 W.W.R. 744 (Alta. S.C.).

[96] *Ibid.*, at 756.

[97] Schiffer, *supra*, note 85 at 331.

[98] Canada. Law Reform Commission of Canada, *The Criminal Process and Mental Disorder* (Ottawa: Information Canada, 1975, p. 46).

[99] *Penitentiary Act*, R.S.C. 1970, c. P-6, *as am.*

[100] See generally Griffiths, Klein, and Jones, *supra*, note 8 at 261 *et. seq.*

[101] *Penitentiary Act*, R.S.C. 1970, c. P-6, *as am.*

[102] *Penitentiary Act*; R.S.C. 1970, c. P-6, *as am.*, s. 24.1(1).

[103] *R. v. Moore* (1983), 33 C.R. (3d) 99 (Ont. C.A.), *aff'd* (1983), 33 C.R. (3d) 97 (S.C.C.). See also *Truscott v. Director of Mountain Institution and National Parole Board* (1983), 33 C.R. (3d) 121 (B.C.C.A.).

[104] *Parole Act*, R.S.C. 1970, c. P-2, ss. 10, 12, 15, and 16.

[105] *R. v. Moore*, *supra*, note 103; *Truscott v. Director of Mountain Institution and National Parole Board*, *supra*, note 103.

[106] See generally *Parole Regulations*, S.O.R. 178-428, 78-524, 78-628, 79-88, 81-318, and 81-487.

[107] Law Reform Commission of Canada, *The Parole Process* (Ottawa: Supply and Services Canada, 1976) at 4.

[108] Griffiths, Klein, and Verdun-Jones, *supra*, note 8 at 262.

[109] *Cr. Code*, s. 695.1(1). Section 695.1(2) governs the parole status of offenders in custody under a sentence of preventive detention imposed before the pertinent 1977 amendments came into force.

[110] Griffiths, Klein, and Verdun-Jones, *supra*, note 8 at 262-63.

[111] *Parole Act*, R.S.C. 1970, c. P-2, s. 6.

In the case of both Ontario and the three Prairie provinces, there was a closer matching between the proportional distribution of dangerous child sexual offenders and the relative distribution of the population living in these regions. In contrast, while the population of British Columbia, the Yukon and the Northwest Territories constituted 11.6 per cent of the country's population in 1982, about a third (32.3 per cent) of all dangerous child sexual offenders had been sentenced by courts in this region.

Within these regional groupings, it is evident that there are three jurisdictions which account for the majority of the applications to court in which offenders are found to be dangerous. Four in five dangerous child sexual offenders (79.0 per cent) had been sentenced in Ontario, Alberta and British Columbia. None had been sentenced in Newfoundland, New Brunswick, the Yukon and the Northwest Territories. A total of five offenders had been sentenced in Quebec in contrast to 20 persons who were found to be dangerous in Ontario.

Although two in three of the surveys dealt with all dangerous sexual offenders, and in the case of the 1974 Survey there was not an exact matching in relation to the designation of geographical regions, **the findings of the three surveys completed between 1968 and 1982 clearly document the occurrence of sharp and persistent regional disparities in the application of dangerous offender provisions to persons convicted of sexual offences.** It is evident that these provisions are less often applied in the Maritimes and Quebec, and that consistently, a disproportionate number of persons receive these sentences in British Columbia.

In the National Corrections Survey, information concerning the location of where the offences had been committed was also obtained in relation to whether the offences had involved offenders and victims living in the same households. In almost a quarter (23.7 per cent) of the offences committed by 633 convicted males, the offender and the victim had lived in the same household. In contrast, only three of the offences committed by dangerous offenders (4.8 per cent) had occurred under similar circumstances. When findings concerning both the location where the offence was committed and the type of association between victims and offenders are considered together, it is evident that few dangerous offenders had had a close association with their victims before committing their offences. Unlike the victims of other male offenders, most of whom had known their assailants, the majority of dangerous offenders were strangers.

Sex and Age of Victims

The sex and age distribution of the victims of the 62 dangerous child sexual offenders differs markedly from that of the other 633 convicted male child sexual offenders documented in the National Corrections Survey. About a third of the victims (32.3 per cent) of the former group were males, slightly less

[147] *Ibid.*, at 182.

[148] See also *R. v. Kelman*, *supra*, note 130.

[149] Kastner, "Dangerous Offenders", an unpublished paper prepared in 1982 for Ontario Crown Attorneys, at 49.

[150] *R. v. Carbone*, unreported, April 19, 1982 (Ont. S.C.).

[151] *Carleton v. The Queen*, *supra*, note 140.

[152] *Ibid.* See also *R. v. Hall*, *supra*, note 122.

Chapter 38

Convicted Offenders

The denominator used in the presentation of findings from the National Corrections Survey is 695 convicted male child sexual offenders. In addition to this group, eight convicted offenders were women; the circumstances of the offences committed by females are given separately as case studies. The 695 convicted male offenders are considered in relation to their victims, respectively: offenders having male victims (129), female victims (545) and two or more victims (21).

The review of the previous and current convictions of offenders in relation to the number and types of offences committed is given in Chapter 40, *Recidivism*. To consolidate the presentation of information given in relation to providing a description of the offenders and the review of recidivism (e.g., ages of victims and offenders), selected findings concerning the prior criminal record of offenders are given in this chapter.

Sex of Victims

Of male offenders having a single victim, 545 of the victims were females and 129 were males. For the small group of 21 male offenders having two or more victims, children of both sexes had been involved and, in some instances, the sex of the second child or additional victim was not specified.

In comparison with the findings of the National Population Survey, proportionately more victims of convicted offenders were females and fewer were males. In relation to the gender ratios of victims known to the public services documented in the other national surveys, the proportion of female victims of convicted offenders (78.4 per cent) was closer to that of the National Police Force Survey (77.7 per cent) than to those of the surveys of hospitals (86.3 per cent) and child protection services (85.6 per cent). In each of the four national surveys, proportionately fewer male victims were known to public services than the proportion documented in the National Population Survey.

The findings concerning the gender ratio of victims of convicted offenders suggest that once sexual offences come to the attention of the police, the sex of the victim appears to have little bearing in relation to whether offenders were subsequently convicted.

Table 38.1

Prior Criminal Records of Convicted Male Child Sexual Offenders: by Types of Victims of Offences Involving Current Convictions

Victims of Current Convictions	Prior Criminal Records of Offenders							
	None		Sexual Offences		Other Offences		Total	
	No.	%	No.	%	No.	%	No.	%
Male	49	38.0	51	39.5	29	22.5	129	100.0
Female	206	37.8	117	21.5	222	40.7	545	100.0
Multiple	7	33.3	11	52.4	3	14.3	21	100.0
TOTAL	262	37.7	179	25.8	254	36.5	695	100.0

National Corrections Survey. The information in this table provides the denominators for the presentation of findings concerning recidivism.

Sexual recidivism is assessed here in relation to the proportion of convicted male child sexual offenders having one or more previous convictions for sexual offences when they were adults. Excluded from this definition are: sexual offences which were committed, but never reported; offences committed when offenders were juveniles; and sexually motivated crimes resulting in charges or convictions which were otherwise classified. The classification used separates the convicted male child sexual offenders into: those having no prior convictions as adults; those previously convicted only for non-sexual offences; and those having previous convictions for sexual offences, some of whom had also been convicted earlier of non-sexual offences.

Despite the absence of national information on the level of recidivism of all types of convicted offenders in custody or under supervision of federal, provincial and territorial correctional services, the findings of the National Corrections Survey indicate that sexual recidivism involving one in four convicted child sexual offenders (25.8 per cent) is neither a rare nor isolated phenomenon.

While the *general* level of recidivism (all types of previous convictions as an adult) varied little in relation offences having different types of victims for which offenders were currently sentenced, sharp differences occur when *sexual* recidivism is considered separately from previous convictions for non-sexual offences. The levels of sexual recidivism for the three categories of convicted male child sexual offenders were: 21.5 per cent, heterosexual offenders; 39.5

per cent, homosexual offenders; and 52.4 per cent, offenders having multiple victims. While overall, two in three offenders (62.3 per cent) had a prior criminal record as an adult, only one in seven offenders subsequently having multiple victims (14.3 per cent) and about one in five (22.5 per cent) later convicted of a homosexual offence had previously been sentenced for a non-sexual offence. In contrast, two in five offenders (40.7 per cent) later convicted of a heterosexual offence had previously been sentenced for a non-sexual offence.

Age Distribution

Paralleling the findings of the other national surveys, proportionately more victims of convicted male offenders were young males and fewer were young females. Less than a half of the male victims (45.0 per cent) were age 11 or younger while only about a third (35.9 per cent) of female victims were in this age category. About one in six victims (16.4 per cent) was 16 years-old or older; proportionately, twice as many females as males were older adolescents. Of the 21 convicted offenders having two or more victims, when the age of the youngest victim is considered, six in seven (85.7 per cent) were young children age 11 or younger.

Ages of Victims	Male Victims		Female Victims		Multiple Victims	
	No.	%	No.	%	No.	%
Under age 7	14	10.9	71	13.0	6	28.6
7–11 years	44	34.1	125	22.9	12	57.1
12–13 years	25	19.4	91	16.7	—	—
14–15 years	21	16.3	66	12.1	1	4.8
16 years and older	12	9.3	102	18.7	—	—
Not reported	13	10.0	90	16.5	2	9.5
TOTAL	129	100.0	545	99.9*	21	100.0

* rounding error

In contrast to the findings on the age distribution of victims documented in the other national surveys, the victims of convicted offenders were proportionately older with fewer being young children age 11 or younger. This finding indicates that in a proportion of cases known to the authorities, the young age of the child appears to be an appreciable factor in determining the outcome of charges laid against child sexual offenders.

In relation to the prior criminal record of convicted offenders, the findings indicate that with the exception of the female victims of sexual recidivists, the male victims of homosexual offenders were typically younger than the female victims of first-time offenders and non-sexual recidivists. Regardless of the nature of the offender's previous criminal record, the victims of offenders committing sexual offences against two or more children consistently constituted the youngest group which was sexually assaulted.

Criminal Record of Offenders	Average Age of Victims of Current Convictions of Offenders			
	Male Victims	Female Victims	Multiple Victims	Total
None	10.7	10.9	8.1	10.8
Sexual offences	11.6	11.4	6.8	11.2
Other offences	11.6	12.1	8.0	12.1
TOTAL	11.2	11.5	7.5	11.3

The victims of offenders convicted for the first time were the youngest (10.8 years); they were followed by the victims of sexual recidivists (11.2 years) and the victims of non-sexual recidivists (12.1 years). In relation to the risk of the very young child being a victim of a sexual offence, sexual recidivists were no more dangerous than the other two categories of convicted male child sexual offenders. The most dangerous offender in this regard was typically the male who had been convicted for the first time.

Time of Occurrence

The reported seasonal distribution concerning when the offences committed by convicted offenders occurred parallels the findings in this regard of the National Police Force Survey. While overall there was a relatively uniform seasonal distribution, proportionately more offences had been committed during the summer and somewhat fewer during the winter. The seasonal distribution was: winter (21.4 per cent); spring (25.4 per cent); summer (30.2 per cent); and autumn (23.0 per cent).

Where the Offences Occurred

Using the same classification of private and public places as that adopted in the other national surveys, it was found that slightly less than half of the offences (46.8 per cent) committed by convicted male offenders had been committed in private places, about a third had occurred in public places (33.4 per cent), and the location of the remainder was not ascertained from the available records (19.8 per cent).

Location Of Offences	Male Victims (n=129)	Female Victims (n=545)	Multiple Victims (n=21)
	Per Cent	Per Cent	Per Cent
Private places	43.0	47.8	57.1
Public places	30.2	34.3	28.6
Not reported	26.8	17.9	14.3

For cases for which this information was available, the ratios of offences committed in private and public places were generally comparable for male and female victims. However, of offences committed in private places, females were twice (30.0 per cent) as likely as males (14.1 per cent) to have had offences committed against them in their own homes, while the reverse was true of offences occurring in the offender's home. In the latter instance, male victims were twice (26.8 per cent) as likely to have been victimized in an offender's home as females (13.7 per cent). Of convicted offenders having two or more victims, proportionately more of these offences were committed in private places than offenders having a single victim.

The proportional distribution of private to public locations where the offences committed by convicted male offenders occurred is somewhat lower than that documented in the National Police Force Survey. However, this difference may be accounted for by the substantially higher proportion of cases for which the location of the offence was not identified in correctional records. The findings for the two surveys (police and corrections) were comparable in relation to the proportion of victims and offenders living in the same households and the proportion of offenders who were family members or relatives.

In about one in five offences (22.0 per cent), the victim and the convicted offender had been living in the same household when the offence was committed, with this situation having involved twice (24.6 per cent) as many female victims as male victims (12.1 per cent). These results parallel those of the National Police Force Survey in which slightly less than a fifth of the children and suspects were living in the same household or residence. When the experience of victims in all age groups is considered, there was an inverse relationship between their ages and the locations where the offences occurred. The likelihood of the youngest group of victims having been assaulted in their own homes was 33.0 per cent, while for the oldest group, this had happened to only about one in six (16.0 per cent).

In comparison with the findings of other surveys of convicted sexual offenders having both children and adults as victims, it appears, although exactly similar information is not available, that a higher proportion of convicted child sexual offenders commit their crimes in private locations. In 1974, a census was taken of 495 sexual offenders in custody in federal penitentiaries across Canada.[1] This group included offenders having both children and adults as victims; the study included only prisoners incarcerated or under supervision of the federal correctional service. Allowing for these differences between the 1974 Survey of the Canadian Penitentiary Service and the 1982 National Corrections Survey, it was found in the earlier review that about a third (34.9 per cent) of the sexual offences had been committed in private locations in contrast with under half (46.8 per cent) of the offences documented in the present survey.

Types of Sexual Acts

In contrast to the types of sexual acts committed against victims whose experience was documented in other national surveys conducted by the Committee, proportionately more of the sexual acts committed by convicted offenders were of a more serious nature having involved completed or attempted vaginal and anal penetration. Proportionately twice as many sexual acts committed by convicted male child sexual offenders as those documented in the National Police Force Survey had involved vaginal penetration with a penis and anal penetration with a penis against male victims.

Table 38.2

Types of Sexual Acts Committed Against Children by Convicted Male Child Sexual Offenders

Type of Sexual Act Committed Against The Child	Male Victims (n=129)		Female Victims (n=545)	
	No.	Non-Accum. %	No.	Non-Accum. %
Fondling/touching breasts, buttocks	8	6.2	100	18.3
Fondling/touching genital area	46	35.7	120	22.0
Kissing mouth, other parts	7	5.4	42	7.7
Oral-genital	28	21.7	51	9.4
Oral-anal	1	0.8	1	0.2
Attempted vaginal penetration with penis	—	—	54	9.9
Vaginal penetration with penis	—	—	192	35.2
Vaginal penetration with finger	—	—	32	5.9
Vaginal penetration with object	—	—	4	0.7
Attempted anal penetration with penis	6	4.7	7	1.3
Anal penetration with penis	21	16.3	9	1.7
Anal penetration with finger	3	2.3	1	0.2
Anal penetration with object	4	3.1	2	0.4
Bestiality	1	0.8	4	0.7
Exposed genitalia	13	10.0	51	9.4
Exposed nude body	6	4.7	19	3.5

National Corrections Survey. The sexual acts committed by convicted male child sexual offenders having more than one victim are given in the text.

Some form of vaginal penetration had been attempted or completed against half of the female victims (51.7 per cent). Offenders had had sexual intercourse with about one third of the girls (35.2 per cent) and about one in 28

females (3.6 per cent) had been a victim of completed or attempted anal penetration. In contrast, acts of completed or attempted anal penetration had been committed against one in four male victims (26.4 per cent). Male victims were also twice (21.7 per cent) as likely as girls (9.4 per cent) to have been involved in oral-genital contacts and they were more than half again as likely to have had their genitals sexually touched. On the other hand, one in five girls (18.3 per cent) had had her breasts or buttocks sexually fondled with acts of this kind having happened to only one in 16 male victims (6.2 per cent).

In five cases, one involving a boy and four involving girls, the victims had been forced by convicted male sexual offenders to commit acts of bestiality. One of the 21 convicted offenders having two or more victims had also forced children to engage in the act of bestiality. As well, in one of the eight cases involving a convicted female offender, an act of this kind had been committed. Despite the suggestion that "it is difficult to provide a rationale for maintaining the bestiality provision",[2] the findings indicate that in the instance of this survey, acts of this kind had involved about one in a hundred children of convicted sexual offenders.

Only one sexual act had been committed against three in four victims (73.9 per cent). In incidents involving more than one sexual act, proportionately, twice as many girls (26.4 per cent) as boys (14.7 per cent) had been victims.

The findings in Table 38.2 list the sexual acts committed in incidents in which only a single victim had been involved. In addition to this group, the sexual acts committed by the 21 convicted male offenders having two or more victims had involved: vaginal penetration with a penis (3); attempted vaginal penetration (2); anal penetration [penis (1), finger (1)]; oral-genital contact (5); acts of exposure (5); thigh intercourse (3); kissing mouth, other parts of the body (1); and bestiality (1). Proportionately, the convicted offenders having multiple victims in comparison to those having single victims appear to have committed fewer serious sexual acts, but as the findings concerning physical injuries to victims indicate, they were more likely to have hurt children.

The sexual acts of completed and attempted vaginal and anal penetration with a penis were considered in relation to whether convicted offenders had a prior criminal record. Of acts of this kind, those involving completed and attempted sexual intercourse with young female victims accounted for 85.1 per cent of the total; of the remainder involving completed or attempted acts of buggery, three in five (61.4 per cent) were against males, one in three (36.4 per cent) was against a female and one in 50 (2.2 per cent) was committed by offenders having multiple victims.

In the National Corrections Survey, about a third of the offenders (35.2 per cent) were sentenced for having had sexual intercourse with female victims and one in 10 (9.9 per cent) had attempted these acts. The findings indicate that there is a close association between whether offenders were recidivists and whether these types of acts had been committed against victims.

Sexual Acts Committed Against Female Victims	Previous Criminal Record		
	None	Sexual Offences	Other Offences
	Non-Accumulative Percentages		
Attempted vaginal penetration with penis	8.0	8.6	13.2
Vaginal penetration with penis	26.3	34.2	44.2
Attempted anal penetration with penis	0.4	3.8	1.1
Anal penetration with penis	1.2	2.9	1.6

About a third (34.3 per cent) of offenders having no prior record and about two in five sexual recidivists (42.8 per cent) had been sentenced for acts involving completed or attempted vaginal penetration with a penis. In contrast, close to three in five non-sexual recidivists (57.4 per cent) were convicted of sexual offences involving similar acts. These findings, which are congruent with those concerning the use of physical coercion and the extent of physical injuries sustained by victims, indicate that non-sexual recidivists, on average, committed more serious sexual offences and were more dangerous than were either first-time offenders or sexual recidivists. For sexual acts of this kind, the survey's findings suggest that having a prior criminal record is at least if not more significant than the fact of whether recidivism had involved previous convictions for sexual offences.

Sexual Acts Committed Against Male Victims	Previous Criminal Record		
	None	Offences	Other Offences
	Non-Accumulative Percentages		
Attempted anal penetration with penis	4.0	4.3	6.1
Anal penetration with penis	12.0	26.1	9.1

Fewer children had been victims of acts of buggery or attempted buggery. The findings from the National Corrections Survey concerning the distribution of these acts in relation to recidivism are less clearcut than those in this regard involving completed and attempted vaginal penetration with a penis. Fewer first-time offenders than either of two categories of recidivists had attempted acts of anal penetration with a penis. A substantially higher proportion in each category had been sentenced for completed acts of anal penetration with a penis with acts of this kind having been committed by over one in four sexual recidivists (26.1 per cent).

The findings of the National Corrections Survey clearly show that **a substantially larger proportion of female than male victims had more serious sexual offences committed against them by convicted male child sexual offenders.** In the case of male victims, a majority of the sexual acts consisted of touching

the sexual parts of the body, oral-genital contacts or acts of exposure. In contrast, well over half of the sexual acts against female victims involved attempted or completed penetration of the vagina or anus.

In some Canadian research studies on sexual offences, it has been concluded that serious sexual acts are seldom committed against children. In one such study that contributed numerous widely cited publications, it was noted in one report that:

> "... sexual acts with children are usually seen in terms of violence - the rape or murder of a child - although these are extremely rare occurrences. However rare, the very human tendency to fear the worst has created out of these sex-violence cases the archetype for all sexual contacts with children. In actuality, force and coercion hardly ever play a part in pedophilic acts.
>
> ... The great majority of sexual acts in heterosexual pedophilia consist of the same kind of sex-play as is found among prepubertal children, that is, looking, showing, touching, kissing, fondling... Penetration and intra-vaginal coitus is rare among sexual acts with children."[3]

The findings of the National Corrections Survey in relation to the sexual offences committed by convicted male child sexual offenders do not support the observation that serious sexual acts against children are "extremely rare occurrences". A substantial proportion of the offences documented was not only of a serious nature, but as findings given subsequently show, their commission frequently involved threats and the use of force, and a breach of responsibility by persons who were related or in positions of trust to the child.

Use of Threats and Force

In this survey, a similar classification was used as that adopted in the other surveys concerning the types of threats and coercion involved in the commission of sexual offences. Threats included those situations in which a victim submitted because he or she was afraid of the offender. The category "victim was forced" included acts of physical coercion, direct assault and the brandishing or actual use of a weapon.

The use of intimidation and coercion against victims varied in relation to the types of offences for which offenders were currently convicted and whether they had a previous criminal record. While about a third (35.3 per cent) of first-time offenders had used some form of coercion against victims, the proportion resorting to threats and force rose to 45.9 per cent by sexual recidivists and to 50.4 per cent by non-sexual recidivists.

The use of threats and force also varied by the types of sexual acts committed. In this regard, some victims were at considerably greater risk than others in having been threatened or physically attacked before or during a sexual assault. On average, proportionately more female than male victims of convicted male child sexual offenders had been coerced. However, among the different categories of victims, the most vulnerable with respect to having been

threatened or physically assaulted were the female victims of heterosexual recidivists (59.1 per cent) and the male victims (60.6 per cent) of non-sexual recidivists.

Table 38.3

Use of Threats and Physical Force Against Victims of Offences Involving Current Convictions by Previous Criminal Record of Offenders

Prior Criminal Record of Victims Offenders	Victims of Offences who had been Threatened or Physically Forced by Convicted Offenders			
	Male Victims (n=129)	Female Victims (n=545)	Multiple Victims (n=21)	Total (n=695)
	Non-Accumulative Percentages			
None	27.1	36.5	44.4	35.3
Sexual offences	21.7	59.1	12.5	45.9
Other offences	60.6	49.2	25.0	50.4
TOTAL	34.1	45.3	28.6	42.7

National Corrections Survey

In the National Police Force Survey, threats and force were reported to have been used against three in five victims. In the National Corrections Survey, proportionately fewer female victims had been threatened or forced. There was a sharp contrast in the findings of the two surveys in relation to the experience of male victims. In this instance, the proportions were almost exactly reversed. In the corrections survey, about two in three male victims were reported to have been neither threatened nor forced, while in the police force survey, about the same proportion had been threatened or forced. About a quarter of the offenders having multiple victims had used threats or force in committing sexual offences.

In offences in which some type of force had been used, the coercion typically had involved some form of physical restraint of, slapping, or punching the victim. In about one in 14 cases, weapons had been used (7.2 per cent), the child had been strangled or choked (6.2 per cent) or the offender had threatened to kill the child (7.0 per cent).

The Committee's findings on the use of threats and force against victims by convicted child sexual offenders parallel those of two studies conducted during the 1970s of sexual offenders incarcerated in federal penitentiaries, of whom between a half (50.9 per cent) and two-thirds (62.0 per cent) had used threats or force against victims.[4-5] The findings of the three surveys contrast sharply with the assumption prevalent in much of the research literature for this field that "few child molestors are physically dangerous"[6] or that "aggressive attacks on children [which] fortunately are extremely rare".[7]

The findings of the national surveys conducted by the Committee indicate that while only a small proportion of victims was reported to have been physically injured, considerably more had experienced emotional and behavioural harms, and in a substantial number of the offences committed, the child had been threatened or forced to submit to an older person. In submitting to these acts, there is no doubt that many children did so because they were afraid that further force would be used against them or that they would be physically injured.

The different findings obtained in the various studies about the use of force and the extent of the physical injuries sustained by victims may be partially accounted for by the imprecision of the definitions used, the sources of information relied upon and the aegis under which such research was conducted. In many reports reviewed by the Committee, it was found that, while broad generalizations had been reached about the infrequent use of coercion and the minimal harms incurred by young victims, precise documentation about these circumstances was usually notable by its absence.

The general research literature on sexual offenders, for instance, has typically found that relatively few homosexual offenders resort to violence against victims. Few of these studies, however, have assessed the findings obtained in relation to the circumstances of how other types of sexual offences were committed nor have they dealt specifically with homosexual offenders having children and youths as victims. On the basis of information obtained in the National Corrections Survey, the conclusions concerning the non-violent character of homosexual offenders are not confirmed. About one in four first-time offenders and sexual recidivists committing homosexual offences had threatened or physically assaulted victims and some form of coercion had been used against three in five victims of non-sexual recidivists in this group.

Much of the information on these issues in the research literature has come directly from reports provided by offenders themselves who had been charged, were awaiting sentencing, or had been convicted. The professional staff to whom this information was given often included persons under contract or in the employ of enforcement or correctional services. Such persons are in vital positions of authority in relation to decisions which are taken affecting the welfare of offenders. In a situation in which assessment, treatment and the prospect of punishment or discharge are inextricably bound together, it is not surprising, as a number of observers have noted, that some offenders may not be wholly forthright in recounting accurately the circumstances of the offences committed.[8-10] In this regard, a psychiatrist who had assessed dangerous sexual offenders who were in custody in British Columbia noted that:

> "The free flow of communication which is expected to occur in therapy groups is invariably restricted to greater or lesser degree by the unwritten 'contract' and by the group's dependency on the therapist. The patient is extremely aware of the boundaries for self-relevation . . . the patient will quickly perceive certain things are to be kept out of the communication and will reveal only what he wishes to reveal and what he senses the therapist wants to hear . . . the therapist, with his power of reporting and assessment,

has very real power over the inmate's future. The ever-present fear of damaging one's chances for parole naturally inhibits free communication . . . for their day-to-day survival in the institution and to obtain an early release, inmates become adept at numerous games."[11]

On the basis of a broadly undertaken review of the general and Canadian research literature concerning the assessment and treatment of child molesters, a psychologist concluded that:

> "In summary, the psychological test data portray child molesters as unassertive, guarded, moralistic, and guilt-ridden. It is unclear as to what extent the expression of these traits are due to the child molesters' personalities and to what extent they are a result of the child molesters' attempts to convince institutional staff and supervisory personnel of their nondeviance."[12]

While the reasons why such sharp differences occur in the findings of various reports concerning the use of coercion by child sexual offenders may not be fully ascertainable, the Committee concludes on the basis of the findings of the national police and corrections surveys that the use of threats and force are integral elements in a substantial proportion of the sexual offences against children and youths known to the authorities.

Physical Injuries

While the findings concerning the physical injuries sustained by victims of convicted offenders were generally comparable to those obtained in the other national surveys conducted by the Committee, sharp variations occurred in this regard in relation to the types of offences committed and whether offenders had prior convictions. Overall, about one in eight victims (12.4 per cent) had been physically injured. The proportions of victims injured by the types of offences committed were: victims of homosexual offenders, 7.8 per cent; victims of heterosexual offenders, 13.0 per cent; and offenders having two or more victims, 23.8 per cent. The survey's findings also indicate that there was an association between recidivism and the proportion of victims who had been physically injured. The distribution in this regard was: offenders having no previous convictions, 8.8 per cent; sexual recidivists, 10.7 per cent; and non-sexual recidivists, 18.4 per cent.

In comparison to other convicted offenders for whom information was obtained, fewer homosexual offenders having no prior convictions and homosexual recidivists were reported to have physically harmed victims. However, proportionately more victims of homosexual offences had been physically injured by non-sexual recidivists. Although comparable trends occurred in the distribution of victims injured by heterosexual offenders in relation to their prior criminal record, in each instance, proportionately more female victims had been hurt. Proportionately more of the group of offenders having multiple victims had physically injured victims than had other offenders.

Table 38.4

Victims who were Physically Injured by Currently Convicted Offenders in Relation to Previous Criminal Record of Offenders

Prior Criminal Record of Offender	Victims who were Physically Injured by Currently Convicted Offenders in Relation to Previous Criminal Record of Offenders			
	Male Victims (n=129)	Female Victims (n=545)	Multiple Victims (n=21)	Total (n=695)
	Non-Accumulative Percentages			
None	6.0	9.2	11.1	8.8
Sexual offences	4.3	11.4	37.5	10.7
Other offences	15.2	18.8	25.0	18.4
TOTAL	7.8	13.0	23.8	12.4

National Corrections Survey

The findings concerning the hospitalization of victims parallel those for the distribution of victims who were physically injured. On average, 3.9 per cent of victims had been hospitalized. The proportions in relation to recidivism were: offenders having no previous convictions, 1.0 per cent; sexual recidivists, 3.1 per cent; and non-sexual recidivists, 8.3 per cent.

The findings concerning the distribution of physical injuries sustained by victims are consistent with those concerning other aspects of the circumstances of the sexual offences committed against children and youths. Proportionately more recidivists having previously committed sexual and non-sexual offences than first-time offenders had committed more serious sexual acts, had resorted more frequently to coercing victims and had physically injured more victims. While in the review of previous and current convictions of sexual recidivists given in Chapter 40, *Recidivism*, it is noted that there are serious limitations in reaching valid conclusions exclusively from these sources of information, the related findings concerning the sexual acts committed, the use of coercion and the injuries sustained by victims appear to confirm that in the sequence of offences committed by sexual recidivists there is a progression from minor to more serious acts having been committed.

The survey's findings indicate that having a prior criminal record of convictions for sexual offences is not by itself a sufficient measure of determining which types of sexual offenders may be more dangerous than others to victims. On average, non-sexual recidivists had committed more serious acts and used more violence than had sexual recidivists. The findings suggest that having a prior criminal record of any kind is a more accurate measure of the likelihood of violent sexual acts being committed than whether offenders had only previously committed sexual offences.

Sex of Convicted Offenders

Most of the Canadian research on convicted sexual offenders has dealt exclusively with males who have been charged or sentenced. In the National Corrections Survey, eight offenders (1.1 per cent) were women. This gender ratio is about two-fifths lower than that documented in the National Police Force Survey (1.8 per cent, females); it is well less than half of that reported in the National Population Survey (2.8 per cent). The findings suggest that the sex of the assailant may be a selective factor that intervenes between the occurrence of offences and the conviction of offenders.

Of convicted male offenders having single victims, four in five (80.1 per cent) had committed heterosexual offences and one in five (19.9 per cent) had committed a homosexual offence. This distribution is virtually identical to that found in the four national surveys conducted by the Committee in which 80.9 per cent of the offences were heterosexual and 19.1 per cent were homosexual. The gender of the victims of the eight convicted female offenders was: four males, three females, and one case in which victims of both sexes were assaulted.

Because the circumstances of the sexual offences committed by convicted females differ from those of male offenders, these incidents are reported as case studies.

Case Study 1

As a child, this 39 year-old offender was brought up by an aunt and uncle who were reported to have been heavy drinkers. The children in the family included her three natural siblings, a step-brother, a step-sister and an adopted brother. Upon completing Grade 10, she left home, married twice, and when she started committing the offences for which she was later arrested, she was living with her 12 year-old son and was sexually active with a male partner. She held a part-time job.

The sexual offences for which she and her partner were arrested and convicted occurred over a period of about three years. The acts started when her partner invited her and some female friends to engage in a menage-a-trois. On one occasion, the offender brought along her 12 year-old son and a female friend of the same age. Her partner expressed his sexual interest and invited them to return. Soon, the offender had befriended another young girl (eight years-old), and involved her in the relationship. Their sexual acts included: lesbian acts with the girls, including oral sex; intercourse with her son; and attempted intercourse by her partner with one of the female victims. The children's co-operation was obtained by giving them alcohol, drugs and money. The children were shown pornographic films and played with pornographic playing cards during the episodes. Photographs of the nude children were taken by the offender.

Following her arrest and that of her male partner, the offender was convicted on two counts of gross indecency and of having committed incest. She was sentenced to five years' imprisonment, and following admission, she was placed in protective custody. Her medical assessment indicated that she was

addicted to alcohol and heroin. When the case was reviewed, she had not received medical or psychiatric treatment.

Case Study 2

In addition to having completed high school, the offender, a 34 year-old woman, had received two years of training at a business school. She was the middle child in a family of three children, and until she was 16, she lived with her parents and siblings. Following her parents' divorce, and after she had become pregnant, she married a boy of approximately her own age. She had two children with whom she has had no subsequent contact (they were given up for adoption). The offender had one previous offence — theft over $200. She was living with her second husband and her 17 month-old adopted daughter when the offence for which she was currently convicted occurred.

Following an intense argument with her husband, the woman ran upstairs to her child's bedroom and shut the door. When her husband heard the child crying, he entered the room and discovered the offender dripping with blood from her mouth and hands while the child lay bleeding in the genital area. The father immediately took the child to hospital where evidence was found of a bite, bruising and breakage of the skin. It was also discovered that the victim had suffered previous abuse to the genital area.

Charges were laid five days following the incident; the offender was convicted of indecent assault on a female and assault causing bodily harm. She was sentenced to a three month custodial sentence and one year on probation with reporting conditions. Both a pre-sentence report and a psychiatric assessment were ordered. The psychiatric assessment found the offender to be psychotic, schizoid, suicidal, hostile and having signs of inadequate social skills. She was diagnosed as manic depressive. Treatment was recommended, and on sentencing, this was made a condition of probation.

The offender was committed to — , where she served her sentence at her own request. While incarcerated, she was placed in protective custody. Following her release, she received some treatment from the medical staff of the correctional facility, assistance which was also complemented by an external facility specializing in the treatment of deviant sexual behaviour. This treatment included group counselling, individual counselling and drug therapy.

When she was released on probation, the conditions set were that she obtain psychiatric treatment and refrain from seeing the victim without another adult being present. She received individual counselling on a regular basis until she left the province against the advice of her physician. She returned to live with her husband and remained unemployed. The offender was denied custody of the victim who was made a ward of the Crown.

Case Study 3

This 18 year-old woman grew up in an unsettled home in which she is reported to have received little affection from her parents. Her father, an alcoholic, was chronically unemployed and the family was supported by means of provincial welfare. The homes where this woman lived as a child with her 11 siblings were condemned several times by local Departments of Public Health.

Due to parental neglect, the local child protection agency assumed custody when she was age 13 and she was placed in a foster home for a year. Her schooling ended with the completion of Grade 6. When the offence for which she was currently convicted occurred, she was living with her parents and four siblings. Her previous convictions included: damage to property, causing a disturbance, drinking under age and threatening a teacher with a knife.

The offence for which she was convicted of committing an act of gross indecency took place in a hotel room with a group of friends that included two male accomplices and the victim, a 14 year-old boy. The victim was physically restrained by the two accomplices who also threatened him with a broken beer bottle while the offender masturbated. The victim resisted, but suffered no physical injuries. Escaping from the hotel room, he told his grandmother who called the police.

Upon conviction, the offender was sentenced to two years' probation with reporting conditions. She was warned not to contact the victim or his family. While on probation, the offender lived with three of her siblings and one of her siblings' boyfriends. She frequently changed jobs, usually being employed as a waitress.

Case Study 4

This 36 year-old woman was convicted of contributing to juvenile delinquency. An only child, she was raised by a single, unemployed mother who received welfare assistance.

After leaving home, this woman had married twice, the first marriage ending in divorce, and the second involving the death of her husband three weeks after the wedding. Subsequently, she lived alone and supported herself by means of part-time employment as a skating instructor. It was in this capacity that she met a 14 year-old male student. They became lovers and had intercourse. The consensual relationship continued for six months with most of the sexual acts occurring in the woman's home. Their activities were discovered when the boy's parents became suspicious of his extended absences from home. Questioning their son, he told them what had happened.

The boy's parents laid charges against the offender who was arrested and subsequently convicted. The offender was sentenced to one year probation with reporting conditions. Probation conditions included reports to her probation officer and prohibition from association with the victim. The conviction was her first offence.

Following her conviction, the offender violated her probation conditions by contacting the victim and was warned by the court. While on probation, she remarried.

Case Study 5

This 31 year-old offender had completed Grade 10, married and had children, and when the offence for which she was convicted occurred, she was living with her common law husband.

The offender and her husband enticed young boys to their home, and following seduction and coercion, the victims committed acts of anal penetration with a penis on the offender. The offender was convicted of committing bug-

gery and acts of gross indecency involving two 12 year-old male victims. She was sentenced to 18 months' imprisonment.

Case Study 6

When she was a child, this 16 year-old girl was sexually assaulted by her father over a period of years, as were her two sisters. Her father was subsequently charged with incest and received an 18 month sentence and probation. The offender, still a teenager, was living with her mother, father and a 10 year-old brother when the offence was committed.

The offence occurred while the offender was babysitting a four year-old boy in his home. The sexual activity was reported to have been initiated by the victim asking to see the offender naked. The offender then proceeded to fondle and kiss the child and expose her nude body, while the victim, in return, sexually fondled the offender. They were discovered when the victim's seven year-old sister walked into the bedroom and found the victim lying on top of the offender.

The offender was charged with contributing to juvenile delinquency and was sentenced to two years on probation. The conditions of her probation were that she obtain psychiatric counselling, report to her probation officer every two weeks, remain in the jurisdiction, and refrain from being alone with a child under the age of 14 years. While on probation, she lived with her family and had a series of short-term jobs. A warrant was issued for her arrest when on one occasion she failed to report to her probation officer.

Case Study 7

This 31 year-old woman was convicted of four counts of contributing to juvenile delinquency on the basis of sexual offences against five females under the age of 16. When the offences occurred, she was living with her second husband and two children from her previous marriage. Her husband was reported to have had a long criminal record.

The offences committed by the woman and her husband involved approaching young girls on the street, usually in front of bars. The couple took their victims for drives in their car, spoke of sexual acts, and seduced them by giving them alcohol. The victims were reported not to have resisted; no physical injuries were sustained.

The offender was arrested and subsequently convicted. She was sentenced to two years' probation and a $200 fine. The conditions of probation were: remaining within the jurisdiction; prohibition of alcohol consumption; and no involvement with children under 16 years. The offender did not work while on probation. She continued to live with her husband who was under investigation for the sexual abuse of the offender's son.

Case Study 8

As the second of five children, this 29 year-old woman grew up in a family in which relations were assessed as being poor. She completed Grade 10. Her father, a miner, was described as an alcoholic. At age 24, the offender was admitted to hospital for a drug overdose that was diagnosed as an attempted suicide.

When the sequence of sexual offences occurred, the offender was living with her second husband and their three daughters, aged seven, 10 and 11. The victim was the 10 year-old daughter. The offence involved abuse by both the child's mother and her step-father. The step-father initiated and maintained sexual assaults against the child that included acts of fondling, touching the genitals, oral-genital contact, and forced bestiality by the victim with a dog. The offender, described as passive and dependent, felt she could not refuse to assist her husband, nor did she wish to leave him. The offence was discovered when the offender told a child protection worker that she wanted to end the situation.

The offender was charged with indecent assault on a female and sentenced to 18 months in a correctional institution. The court recommended that the offender receive psychiatric treatment. The offender's husband was convicted and sentenced to imprisonment. The child was taken into custody by the Crown.

Following sentencing, the offender was institutionalized. She was severely beaten by other female inmates and was placed in protective custody. The results of a psychological assessment indicated that she was passive, dependent, low in self-esteem and ignorant of sexual matters. It was concluded that her criminal behaviour was a result of a personality disorder combined with her domestic and social circumstances. Her treatment included assertiveness training and personal counselling for low self-esteem and alcohol problems.

While on probation, the offender initiated divorce proceedings against her husband. Following her release, she rarely worked and relied for support on a combination of social assistance and the men with whom she lived.

In five of the eight case studies, the convicted female offender had been involved with male accomplices, usually a husband, common law partner or friend. The accounts suggest that in most instances, the woman complied with the wishes of her male accomplice(s) in sexually assaulting young victims. In the other three cases, one woman was mentally ill, one had been a victim of incest, and one had had a consensual affair with a male adolescent.

In one respect or another, all of the convicted female offenders had come from unstable family backgrounds, several had grown up in poverty, and six in eight had had broken marriages and/or several sexual partners. The victims were strangers in only one case, that involving the luring of girls on the street. Only one of the victims had been physically injured and, in this case, the child's mother had been mentally ill. In several cases in which the use of alcohol or drugs were factors affecting the offender's mental state, no assessment or treatment was reported to have been recommended at any point following the offender's apprehension. Two of the convicted female offenders were recidivists, in both instances, having previous convictions for non-sexual offences.

Age of Convicted Offenders

Although there is a masking effect introduced by the fact that the exact age of the convicted offenders was not obtained in one in five cases (20.3 per

cent), the age distribution of those for whom this information was available represented an expected profile. In contrast with the findings of the National Population Survey and the National Police Force Survey in which about a third of the suspected or known offenders were under age 21, only 14.9 per cent of convicted male offenders were in this age category. Considering the variable age limits established by provincial child welfare legislation and the exercising of discretion in the sentencing of young offenders, it is perhaps surprising that about one in seven convicted offenders was under 21 years-old.

Table 38.5

Age Distribution of Convicted Male Child Sexual Offenders

Age of Convicted Offender	Sex of Victims of Convicted Offenders		
	Male Victims (n=129)	Female Victims (n=545)	Multiple Victims (n=21)
	Per Cent	Per Cent	Per Cent
Under age 21	10.1	16.4	4.8
21 - 30 years	18.6	27.5	33.3
31 - 40 years	23.2	21.1	19.0
41 - 50 years	12.4	10.2	9.5
51 - 60 years	6.2	3.6	14.3
61 and older	4.7	1.6	4.8
Not reported	24.8	19.5	14.3
TOTAL	100.0	99.9*	100.0

National Corrections Survey.

* rounding error

In comparison to the age distribution of offenders in the population and police force surveys, proportionately more convicted offenders were older. In the age category 21-40 years, the respective proportions were: population survey, 43.0 per cent; police force survey, 40.0 per cent; and corrections survey, 47.5 per cent. In the age category 41 years and older, while about one in nine offenders (10.8 per cent) in the population survey was an older male, substantially more offenders in the other two surveys were older persons (police force survey, 18.4 per cent; corrections survey, 17.3 per cent).

Three age-related sub-groupings were identified in the National Corrections Survey. There was a sharp decreasing gradient with age among offenders having committed heterosexual offences. Of offences in which males were victims, a more even age distribution occurred, and for the small group having multiple victims, the age profile was high-low-high. On average, convicted offenders committing homosexual offences were older than those committing heterosexual offences.

In relation to whether offenders had been previously convicted, not unexpectedly, more first-time convicted offenders (25.3 per cent) were under age 21 than were recidivists (8.1 per cent, previous sexual offences; 16.8 per cent, previous non-sexual offences). Substantially fewer offenders having previous convictions for non-sexual offences (14.6 per cent) were 41 years-old or older than the proportion of offenders in the other two categories (24.9 per cent, no previous record; and 26.0 per cent, previous sexual offences).

While the findings on age distribution indicate that a smaller proportion of sexual recidivists than that of the other two categories of offenders was under age 21 and that in other respects they were more comparable to offenders having no prior criminal record, when the types of offences involving current convictions are considered, sharp differences emerge along these lines. For offenders having no prior record and previous sexual offence convictions, substantially more of those convicted of heterosexual offences were younger than those convicted of homosexual offences. Offenders having multiple victims fell in between these two groupings. These sharp age differences, however, disappear among offenders who were previously convicted of non-sexual offences, a majority of whom were younger offenders. These findings suggest that it is the type of offence committed rather than an offender's prior record which accounts for the different age groupings of offenders.

When the findings of the several national surveys are considered together, it is evident that an offender's age is a mitigating factor in relation to charges being laid and convictions imposed. The principle of leniency towards young first-time offenders is well recognized in both civil and criminal legislation and its application is documented in the findings of the national surveys conducted by the Committee. Fewer younger child sexual offenders were convicted than those in this age category who had actually committed offences. A relatively large proportion of the offenders was middle-aged, a fact that by itself indicates the need for an assessment of the capabilities of these males for social adaptation either while under supervision or on probation, and when they return from imprisonment to the community.

Social Background

In the research protocol used to assemble information for the National Corrections Survey, a sizeable number of items was included concerning the social and familial backgrounds of convicted child sexual offenders. Although on the basis of the pretesting of the research protocol it was found that there were substantial gaps in the completion of information for certain items, most of these items were retained since only a few jurisdictions had been involved in this initial phase of the research. However, the results of the pretest were highly accurate in relation to identifying the types of information which it was not feasible to collect from the 10 participating correctional services.

These gaps in missing information were especially prominent concerning the offenders' backgrounds prior to having committed the offences for which they were convicted. In many instances, information of this kind was missing in the available official records for between half and three-quarters of the cases reviewed. To preclude presenting misleading and potentially unrepresentative findings for items for which incomplete information was obtained, only those for which the numerators were somewhat more complete are given.

Of the seven in eight offenders (87.7 per cent) for whom information was available concerning the families in which they had grown up as children, the majority had had both natural parents present during this period of their lives. The members of the nuclear families of these males who were later convicted of sexual offences against children included: natural mothers (93.5 per cent); natural fathers (89.0 per cent); brothers (91.9 per cent); and sisters(92.6 per cent). On average, the convicted offenders had five siblings. At face value, this demographic sketch depicts little that is out of the ordinary, except perhaps for the apparently high level of structurally stable marriages and the larger than average size of the families. This information is barren, however, in relation to providing insights about the emotional dynamics of these families. The findings contrast sharply with those of a number of completed research studies which have found that a relatively high proportion of convicted sexual offenders has grown up in broken homes or has been under the care of someone other than a natural parent(s). In the National Corrections Survey, few of the convicted males had come from totally broken homes and virtually all had brothers and sisters.

A partial measure of the potential instability of the offenders' families is provided by their reported contacts with child protection services. At sometime during their childhood (for reasons for which information was incomplete), one in eight (12.0 per cent) convicted offenders had been removed from his home by a child protection agency. There is no comparative baseline with which this experience can be assessed in relation to that of other types of convicted offenders, or to that of persons who have not been in conflict with the law but who may have been in similar social and economic circumstances.

Either at the time of the conviction or previously, well over half of the convicted child sexual offenders had had an established heterosexual association. In this regard, their experience with broken marriages or common law partnerships was not unusual in relation to that of other Canadian adults.

When they were convicted, two in five convicted male offenders (39.8 per cent) were single, slightly less than three in five (57.4 per cent) were or had been married, and information was not reported for the remainder (2.8 per cent). In relation to their marital status, the experience of convicted male child sexual offenders closely approximated that of sexual offenders having adult and child victims documented in the 1974 federal penitentiary survey.[13]

The marital status of child sexual offenders varied sharply in relation to the gender of their victims. While about three in five offenders having female victims (61.9 per cent) or multiple victims (57.1 per cent) were or had been

Table 38.6

Marital Status of Convicted Male Child Sexual Offenders

Marital Status of Convicted Offender	Sex of Victims of Convicted Offenders		
	Male Victims (n=129)	Female Victims (n=545)	Multiple Victims (n=21)
	Per Cent	Per Cent	Per Cent
Single	58.9	35.5	33.3
Married	19.4	35.2	14.3
Separated/ Divorced	14.7	12.0	33.3
Widowed	—	1.6	—
Common law	5.4	13.1	9.5
Not reported	1.6	2.6	9.5
TOTAL	100.0	100.0	99.9*

National Corrections Survey

* rounding error

married or had had a common law partner, almost an equal proportion of the offenders having male victims (58.9 per cent) had never married.

Because many of the convicted offenders in the survey were either serving sentences or were on parole, the effects of the economic depression of the early 1980s were unlikely to have affected their employment status prior to sentencing. Regardless of the sex or number of their victims, only two in five convicted male child sexual offenders had had full-time employment when they had committed sexual offences for which they were later convicted. About an equal proportion had an unstable job status that included: part-time or seasonal work; unemployment; had never worked; or they were students, disabled, or retired.

In the 1974 Canadian Penitentiary Service Survey of sexual offenders, seven in 10 were unskilled workers, one in nine a skilled worker and the remainder had had an assortment of other types of employment.[14] Despite differences in how the two studies were undertaken, the findings of both are consistent in indicating that **many convicted sexual offenders were on the fringes of the work place, lacked the requisite experience or skills for full-time employment, or had limited job training.** Their work histories suggest that many of the offenders may have subsisted on relatively low incomes. Additional factors which may have affected their employment status, as reported in Chapter 39, *Treatment*, were the high proportion that had at some time been hospitalized for mental illness and that were dependent on alcohol and drugs. In addition to the stigma of having been convicted of a sexual offence against a

child or youth, it can be expected that the social adaptation of these offenders while under supervision or on their return to the community would be sharply hindered by their unstable work careers and limited job skills.

Table 38.7

Employment Status of Male Child Sexual Offenders Prior to Conviction

Prior Employment Status of Convicted Offenders	Sex of Victims of Convicted Offenders		
	Male Victims (n=129)	Female Victims (n=545)	Multiple Victims (n=21)
	Per Cent	Per Cent	Per Cent
Employed	40.3	40.2	38.1
Part-time/ seasonal work	5.4	12.6	4.8
Unemployed	22.5	14.8	9.5
Other	12.4	9.3	19.0
Not reported	19.4	23.1	28.6
TOTAL	100.0	100.0	100.0

National Corrections Survey. 'Other' category includes: never worked, student, disabled, retired.

Type of Association

The classification of the types of association between victims and offenders specified elsewhere in the Report does not refer to the sexual acts committed, but indicates the nature of the relationship between the victim and the offender. Thus, in the category 'relationship of incest', while the blood relatives specified in this sexual offence in the *Criminal Code* are included, sexual acts other than intercourse may have been committed.

Most of the convicted child sexual offenders had known their victims prior to committing the offences. Overall, only one in four offenders (26.9 per cent) was a stranger, with this type of relationship being more common when boys than girls had been victims. In contrast, only one in seven offenders (14.3 per cent) having two or more victims was a stranger.

One in 10 offenders (10.4 per cent) had a legal relationship of incest to the child. Of this group, 63 of 72 were natural fathers. **Fathers — natural, step, foster, adoptive and common law — constituted about one in five of the convicted male child sexual offenders (18.7 per cent).** Of the 17 persons who held positions of trust in relation to the child, four were teachers, 11 were babysitters and two were respectively a youth probation officer and a social worker.

Table 38.8

Type of Association between Victims and Convicted Male Child Sexual Offenders

Type of Association	Male Victims		Female Victims		Multiple Victims	
	No.	%	No.	%	No.	%
Relationship of incest	3	2.3	66	12.1	3	14.3
Other blood relative	4	3.1	21	3.9	3	14.3
Guardianship position	—	—	46	8.4	1	4.8
Other family member	4	3.1	28	5.1	1	4.8
Position of trust	7	5.4	12	2.2	—	—
Friends, acquaintances	27	20.9	106	19.4	4	19.0
Other persons	16	12.4	37	6.8	2	9.5
Strangers	41	31.8	143	26.2	3	14.3
Not reported	27	20.9	86	15.8	4	19.0
TOTAL	129	99.9*	545	99.9*	21	100.0

National Corrections Survey.

* rounding error

Information was not available about the type of association between the victim and offender for one in six cases (16.8 per cent). It is presumed, however, that most of these offenders fell into the 'other' category or were strangers. In general, the types of association between convicted offenders and their victims were comparable to those documented in both the national population and police force surveys. Exceptions included proportionately more persons in positions of trust, and fewer friends and acquaintances who had been convicted. There was a sharp contrast, however, involving the small group of convicted offenders having two or more victims. Two in five of these offenders (38.2 per cent) were relatives or family members (three natural fathers, a step-father, an adoptive father, two uncles and a cousin).Of persons convicted of having committed sexual offences against two or more children, most were either responsible for their welfare or were persons well known to the children.

In the review of the nature of the relationship between the occurrence of recidivism and the type of association between victims and offenders, the categories specifying family members, relatives and persons in guardianship positions were grouped together to provide a single measure of persons responsible for the protection and welfare of the child. The two other categories used were other persons known to victims and strangers.

The survey's findings indicate that there were clearcut differences between the occurrence of recidivism and the type of association between victims and offenders.

Type of Association Between Victim and Offender	Previous Criminal Record of Convicted Offenders		
	None	Sexual Offences	Other Offences
	Per Cent	Per Cent	Per Cent
Family member	33.2	16.4	24.6
Known to victim	46.0	44.6	48.6
Stranger	20.8	39.0	26.8
TOTAL	100.0	100.0	100.0

Regardless of the type of sexual offence committed, a majority of offenders (79.2 per cent) having no prior criminal record had been known to victims. By the types of offences committed, the proportions in this category were: 75.5 per cent, homosexual offenders; 79.5 per cent, heterosexual offenders; and 88.9 per cent, offenders having multiple victims. On average, somewhat fewer non-sexual recidivists (73.2 per cent) were known to victims but sharper variations occurred in this regard in relation to the types of sexual offences committed. While about three in four offenders having multiple victims (75.0 per cent) and those having committed heterosexual offences (76.4 per cent) were known to victims, only over half (54.5 per cent) of non-sexual recidivists who had committed homosexual offences were previously known to the male victims of the offences for which they were currently sentenced.

In contrast to first-time convicted offenders and non-sexual recidivists, proportionately more sexual recidivists, about two in five (39.0 per cent) were strangers to victims. In relation to the types of offences committed, the proportions of offenders who were strangers were: 30.4 per cent, homosexual offenders; 44.8 per cent, heterosexual offenders; and 12.5 per cent, offenders having multiple victims.

In comparison to whether offenders were known to victims, the relationship between recidivism and the type of association was even more pronounced in the instance of offences committed by offenders who were family members. Offenders who were in a familial position of trust to the child constituted one in six sexual recidivists (16.4 per cent), one in four non-sexual recidivists (24.6 per cent) and one in three offenders (33.2 per cent) having no prior criminal record. The survey's findings indicate clearly that **in comparison to offenders convicted for the first time and non-sexual recidivists, substantially fewer sexual recidivists were family members and proportionately more of them were strangers.**

Assaults by Groups

About one in 14 of the convicted child sexual offenders (7.3 per cent) had had one or more accomplices in committing sexual offences against children (7.1 per cent, female victims; 8.5 per cent, male victims). Although the proportion of gang sexual assaults was comparable to that found in the cases reported to public services (8.1 per cent; police, hospitals, child protection services), there was an inversion in the findings obtained in the National Corrections Survey in relation to the sex of the victims.

In the National Corrections Survey, one in 12 convicted offenders (8.5 per cent) had had one or more accomplices in offences committed against male victims in contrast to one in 22 suspected or known offenders (4.5 per cent) who had come to the attention of the police, hospitals or child protection services. This finding is noteworthy since it indicates that group homosexual offences are not an isolated occurrence and that attacks of this kind are likely to be considered serious aggravating factors on sentencing. The gravity with which offences of this kind are seen appears to be further confirmed by the finding that while in cases known to public services group sexual assaults involved proportionately twice as many female as male victims, among convicted child sexual offenders, such offences against male victims for which male offenders had been convicted occurred about a fifth more often than those against females.

In the National Corrections Survey, two in five of the accomplices (40.6 per cent) were the convicted offenders' friends and one in five (18.8 per cent) was a brother. Charges were laid in nine in 10 cases of this kind (90.6 per cent); four in five of the accomplices (81.3 per cent) were subsequently convicted. Twenty-one of the 695 convicted male child sexual offenders (3.0 per cent) had committed sexual offences against two or more victims. In this group, there was one instance in which two or more offenders had sexually assaulted two or more victims.

Summary

1. Of 703 convicted child sexual offenders, 695 were males and eight were females. Of male offenders, 545 had female victims, 129 had male victims and 21 had multiple victims. About one in three offenders (37.7 per cent) had no prior criminal record and one in four (25.8 per cent) was a sexual recidivist. Recidivism varied in relation to the types of offences committed, respectively: 21.5 per cent, heterosexual offenders; 39.5 per cent, homosexual offenders; and 52.4 per cent, offenders having multiple victims.

2. Male victims, on average, were younger than female victims. With the exception of the female victims of sexual recidivists, the male victims of homosexual offenders were younger than the female victims of first-time offenders and non-sexual recidivists.

3. Less than half of the sexual offences were committed in private locations and about a third in public locations. Females were twice as likely as males to have been victimized in their own homes, and there was a *greater likelihood of offences committed in the home having younger victims*.

4. In comparison to the sexual acts committed against children and youths documented in the other national surveys conducted by the Committee, proportionately more sexual offences committed by convicted offenders had involved attempted and completed acts of vaginal and anal penetration. For half of the females, some form of vaginal penetration had been attempted or completed. Attempted or completed anal penetration had been committed against one in four male victims.

   On average, proportionately more serious sexual acts were committed against female victims than against male victims and acts of this kind were more frequently committed by non-sexual recidivists than by either sexual recidivists or first-time convicted offenders.

5. Two in five victims had been threatened or physically forced by convicted offenders with this happening more frequently to female victims than to male victims. The use of threats and coercion varied in relation to the offenders' prior criminal record being used respectively by: a third of first-time offenders; less than half of the sexual recidivists; and half of the non-sexual recidivists.

6. One in eight victims had been physically injured by convicted offenders. The distribution of victims who were injured varied in relation to the types of offences committed and whether offenders had previous convictions. There was a sharp gradient in relation to recidivism with non-sexual recidivists being more dangerous in this regard than sexual recidivists.

7. Virtually all convicted child sexual offenders were males with 1.1 per cent being females.

8. In comparison with the findings of the other national surveys, proportionately more of the convicted offenders were older, and in this regard, homosexual offenders, on average, were older than heterosexual offenders. In relation to recidivism, the findings suggest that the type of offence committed rather than prior convictions is more likely to account for subgroupings of age differences among convicted offenders.

9. Nine in 10 offenders had grown up in homes having both natural parents and siblings, about one in eight had been taken into custody by a child protection agency, and about three in five were, or had been, married. Prior to having committed the offence, two in five offenders had had some form of full-time employment.

10. Fathers — natural, step, foster, adoptive and common law — constituted about one in five convicted offenders. The majority of offenders were known to their victims with only one in four having been a stranger. In contrast to first-time offenders and non-sexual recidivists, proportionately more sexual recidivists were strangers to victims. A third and a quarter respectively of first-time offenders and non-sexual recidivists were in a familial position of trust to the child.

11. About one in 14 convicted offenders had had one or more accomplices in committing the offences.

In undertaking the National Corrections Survey, the Committee identified several dimensions of how service statistics are typically assembled by the Canadian correctional system. While there is usually uniformity in respect to the types of records maintained within each correctional jurisdiction, several services do not have computerized record systems. Where these systems have been established, the information so transferred is assembled to expedite administrative functions. There is no common basis between correctional systems across Canada in regard to the collection of similar types of information about offenders. **For Canada as a whole, there is no single inventory or register that permits the identification of convicted sexual offenders in relation to the age and sex of victims. Accordingly, there is now no means available to determine on a national basis how many convicted persons are child sexual offenders, rapists of girls or adult women, or sentenced for other types of sexual offences.** In this regard, and in the absence of documentation, it is widely assumed that conditions in federal penitentiaries are harsher for inmates and less conducive to their successful return to the community than detentions served in provincial prisons. However, at least with respect to convicted child sexual offenders, this assumption is a matter of informed opinion, or conjecture, rather than one founded on documentation of the outcomes of different types of incarceration or supervision.

The correctional information systems in use across Canada are offender, not victim-oriented. In this respect, it is not apparent how a sufficient assessment can be made of the relative effectiveness of different sentences or treatments provided unless more complete and comprehensive information is available on a routine basis than is currently the case about these offenders and their victims. As clearly shown elsewhere in the Report, the charges laid or the sentences imposed are imprecise means to serve as a basis of assessing the actual types of sexual offences committed. Many of the sexual offences in the *Criminal Code* are neither age nor sex-specific. In this respect, information relying exclusively on reported sexual offences is wholly inadequate to serve as a means of identifying victims.

In assembling its findings, the Committee found that basic information concerning offenders contained in existing correctional records systems was invariably more detailed and complete than the service statistics which were derived from these case reports. What has evolved, however, in the assembling of these statistics is the collation of haphazardly collected information that is not systematically reviewed in relation to: its completeness; its relevance concerning the efficacy of treatment; the follow-up of offenders on parole; and its utility in regard to documenting the occurrence and consequences of recidivism.

In identifying these deficiencies in the information systems of Canadian correctional services, the Committee reiterates concerns that have been voiced for over a century. Speaking in the House of Commons in 1875 concerning the

need for detailed statistics concerning matters of criminal jurisprudence, Mr. Dymond of North York is reported to have said:

> "... it did certainly seem extraordinary that while since Confederation we had consolidated the criminal laws, and whilst during every session measures had been introduced altering or amending the criminal law, we had no evidence upon which to base conclusions as to whether these amendments were necessary or not. In our present state of darkness we had no information that enabled us to ascertain what crimes were increasing or decreasing ..."[15]

In speaking to the Second Reading of the *Bill to Provide for the Collection and Registration of Criminal Statistics* in 1876, the Honourable Mr. Blake cited:

> "... the importance of our obtaining such statistics as may inform the minds of us who are responsible for those laws which proscribe what are crimes, the penalties for them, the criminal procedure, and the general effect of the laws upon the criminal class, as might enable us, per chance with wisdom, to amend them."[16]

As noted in Chapter 13, *Historical Statistical Trends*, a system of collecting information concerning convicted offenders in custody or under supervision of federal correctional services was established during this period. Since shortly after its inception, however, the federal correctional information system has been the target of severe criticism both in Parliament and in reports of advisory inquiries. In a discussion of the utility of these statistics, Mr. Mills observed in Parliament in 1884 that "it has really no value whatever, the information is altogether unreliable and the classification very imperfect."[17] Almost two decades later, speaking in 1902 on the same issue in Parliament, Mr. Clancy observed "I know no more dangerous thing than a service which stands still. It seems to be seized with dry rot."[18]

Similar conclusions have subsequently been reached in several reports of inquiries appointed to review federal correctional services. The 1938 *Report of the Royal Commission to Investigate the Penal System of Canada* (Archambault Report) observed that "... we find that there is a great lack of uniformity in the compilation of statistics respecting crime in Canada; so much so that it would be dangerous to draw definite conclusions from the present statistical material."[19] The 1938 Royal Commission recommended that "a complete revision of the method of preparing statistical information"[20] be undertaken. These recommendations were reiterated in the reports of federal inquiries issued respectively in 1956 (*Fauteux Report*)[21] and 1958 (*McRuer Report*).[22]

These issues were also addressed in the 1969 *Report of the Canadian Committee on Corrections* (Ouimet Report). This Report concluded:

> "The corrections field in Canada as in most countries has suffered from a lack of comprehensive, continuous and long-term planning based, as far as possible, on empirical information. Planning has tended to be sporadic or limited in scope and little use has been made of research ..."[23]

> The primary need in relation to criminological research is a conviction on the part of both government authorities and the public that research findings are essential in determining policy and in operating the law enforcement, judicial and correctional services. Until recently, policy-making has been based exclusively on common sense and on the impressions picked up by individuals in the course of their work. This is in sharp contrast to what is done in matters involving the physical and biological sciences.[24]
>
> It is also important that research findings be published . . . Publication makes research findings available to other workers for checking. Also, publication of research material enables the public to judge effectiveness of the services.[25]
>
> . . . if research is to have its maximum effect, there should be organized and continuous procedures to ensure that the findings of research will be implemented.[26]
>
> . . . there are limits on the kind and scope of research a public service can conduct. Government research workers are not normally free to publish research findings that are in conflict with government policy. There is often a split in jurisdiction between departments. This makes comprehensive study of a problem difficult. A third handicap suffered by the government research worker is the need to keep up with day-to-day problems faced by the present operating services. This does not leave much time or many facilities for basic research."[27]

Although advised by some senior administrators and experienced criminological researchers before it started its review that it was not feasible to obtain the information being sought and that most jurisdictions would likely be uncooperative, the Committee in fact received valuable and effective assistance from federal and provincial correctional services in the design of the research protocol and the implementation of the National Corrections Survey. While the Committee fully recognizes that more indepth research conducted over a longer period of time is required to provide fuller documentation concerning the difficult issues reviewed, the undertaking of the survey leaves no doubt that it is feasible to conduct such research on a national scale. Those persons who believe that there are insuperable obstacles precluding such research either have apparently not attempted such an undertaking, or they have been prematurely deterred by their preconceptions of what they believed the difficulties to be.

The Committee fully endorses the recommendations of earlier federal inquiries concerning the need for establishing a more effective correctional information records systems concerning problems of national importance such as convicted offenders who have committed sexual offences against children and youths. In the Committee's judgment, there is a need in relation to convicted child sexual offenders to establish a correctional record system that incorporates basic information on:

1. ***The Offender(s).*** **Age, sex, education, job skills, work experience, family background, marital status, physical and mental state.**
2. ***The Victim(s).*** **Age, sex, relationship to offender.**

3. *Current Conviction.* Listing of specific sexual acts committed, use of threats/force, injuries to victims, accomplices, offences resulting in convictions, sentencing decisions.

4. *Previous Criminal Record.* Specifying convictions, age and sex of previous victims, court disposition, subsequent charges known to have been laid.

5. *Services Provided.* Provision of medical, psychiatric, psychological, vocational, educational services.

In the implementation of this minimum standard correctional information record system, the Committee believes that its requisite components should incorporate the following elements:

6. *National in Scope.* Information about convicted child sexual offenders should be obtained from all jurisdictions — federal, provincial and territorial.

7. *Computerized Storage.* For purposes of efficiency in management and retrieval of information.

8. *Updating of Information.* Upon discharge from custody, completion of probation or parole.

9. *Periodic Review by Participating Jurisdictions.* To assess the more effective operation of the information system.

As specified in Chapter 3, *Recommendations*, the Committee calls for the establishment of a standard national correctional information records system in relation to convicted child sexual offenders and that the development and operation of this system be undertaken jointly by federal, provincial and territorial correctional services.

References

Chapter 37: Convicted Offenders

[1] Searle, C.A., *A Study of Sexual Offenders in Canada and a Proposal for Treatment*, Ottawa: Canadian Penitentiary Service, 1974 (mimeo).

[2] Canada. Law Reform Commission of Canada. Working Paper 22. *Criminal Law - Sexual Offences*. Ottawa: Supply and Services Canada, 1978, p. 35.

[3] Gigeroff, A.K., J.W. Mohr and R.E. Turner, Sexual Offenders on Probation: II. Heterosexual Pedophiles. *Federal Probation*, 32 (4): 17, 1968.

[4] Searle, C.A., *op. cit.*

[5] Christie, M.M., W.L. Marshall and R.D. Lanthier, *A Descriptive Study of Incarcerated Rapists and Pedophiles*, Kingston: Canadian Penitentiary Services, 1977 (mimeo), pp. 27-28.

[6] Quinsey, V.L., The Assessment and Treatment of Child Molesters: A Review, *Canadian Psychological Review*, 18: 218, 1977.

[7] Gigeroff, A.K., *op. cit.*, p. 20.

[8] Quinsey, V.L., *op. cit.*, pp. 212-213.

[9] West, D.J., C. Roy and F.L. Nichols, *Understanding Sexual Attacks*, London: Heineman, 1978.

[10] Marcus, A.M. and C. Conway, Dangerous Sexual Offender Project, *Canadian Journal of Corrections*, 11: 198-205, 1969.

[11] Marcus, A.M. and C. Conway, A Canadian Group Approach Study of Dangerous Sexual Offenders, *International Journal of Offender Therapy*, 15: 60-61, 1971.

[12] Quinsey, V.L., *op. cit.*, pp. 212-213.

[13] Searle, C.A., *op. cit.*

[14] *Ibid.*

[15] Canada. *Debates of the House of Commons of the Dominion of Canada, Second Session, Third Parliament*, Ottawa, 1875, p. 214.

[16] Canada. *Debates of the House of Commons of the Dominion of Canada, Third Session, Third Parliament*, Ottawa, 1876, p. 189.

[17] Canada. *Debates of the House of Commons of the Dominion of Canada, Second Session, Fifth Parliament*, Ottawa, 1884, pp. 1089-90.

[18] Canada. *Debates of the House of Commons of the Dominion of Canada, Second Session, Ninth Parliament*, Ottawa, 1902, p. 335.

[19] Canada. *Report of the Royal Commission to Investigate the Penal System of Canada*. Ottawa: King's Printer, 1938, p. 174.

[20] *Ibid.*, p. 359.

[21] Canada. Department of Justice. *Report of a Committee Appointed to Inquire into the Principles and Procedures followed in the Remission Service of the Department of Justice of Canada*. Ottawa: Queen's Printer, 1956.

[22] Canada. *Report of the Royal Commission on the Criminal Law Relating to Criminal Sexual Psychopaths*. Ottawa: Queen's Printer, 1958.

[23] Canada. Department of the Solicitor General. *Report of the Canadian Committee on Corrections*. Ottawa: Queen's Printer, 1969, p. 423.

[24] *Ibid.*, pp. 423-24.

[25] *Ibid.*, p. 424.

[26] *Ibid.*, p. 426.

[27] *Ibid.*, p. 427.