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The Management and Treatment of Sex Offenders

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The Management and Treatment of Sex Offenders

Report of the Working Group

Sex Offender Treatment Review

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Executive Summary

Sexual offending is an enormously complex phenomenon, and there are no magical solutions to the problem. Throughout Canada there are dedicated professionals who are doing valuable work in the field. Although there are many unanswered research questions surrounding etiology, assessment, typology and efficacy of treatment, there is a substantial body of knowledge and ongoing activity on which to build policy and programs.

There is no single "cause" of sexual offending; there are many factors which may contribute to an individual's sexual offending, and there are demonstrated treatment approaches that are useful in addressing these factors. While no approach can offer total success, various approaches have shown some success. The practitioners in this field do not claim to "cure"; the treatment strategy is to manage the risk of reoffending (relapse prevention).

Sex offenders often deny their offence and are initially reluctant to participate in treatment. There is an onus on treatment providers to make the prospect of treatment attractive and a responsibility on the system to establish incentives to participate in treatment.

Continuity of treatment from the institution to the community is critical, and currently problematic. Programs tend to operate in isolation; there is a need for greater co-ordination among the various organizations involved in the treatment of sex offenders. There is also a need to improve the transfer of case-specific information among parties.

There are not enough experts to meet the demand for programs, and not adequate training opportunities to allow individuals to develop the expertise required to manage and treat sex offenders. There is a need for more and diverse programs. Outcome research is lacking.

While there is an appreciation of the value of treatment for sex offenders, there is a recognition of the limitations of treatment. Sex offenders with a deviant sexual preference that includes sadism, a history of violence and substance abuse related to their violent behaviour are considered poor prospects for change. The risk of future dangerous behaviour must be addressed as a separate issue from the issue of progress in treatment.

On the one hand, there is a great deal that needs to be done; on the other hand, there is a great deal that can be done based on what already exists. The view of the working group is that the logical starting point is to establish a framework for undertaking program development in this area.

A number of recommendations consistent with this conceptual framework are presented on pages 29 to 32.

Introduction

The impetus for this review came from a tragic event that occurred in Toronto in January, 1988. A woman was sexually assaulted and killed by an offender who at the time of the incident was in breach of the conditions of a 48 hour temporary absence to a community residential facility. A Board of Investigation (Chair: Jane Pepino) that was established to inquire into the circumstances of the incident presented its findings along with 32 recommendations. Recommendation #30 (Pepino Report) stated:

> *"The Board recommends that the Government of Canada initiate a comprehensive evaluation of the effectiveness of all present sexual offender treatment programs. If such evaluation indicates that there are no effective treatment programs at present, further consideration should be given to ending ineffective programs, and concentrating funds and human resources in those areas where some promise is shown." (p. 25)*

This recommendation was accepted by the Solicitor General of Canada, and a working group was constituted for this purpose. The proposal to undertake an investigation of sex offender treatment programs in Canada was brought to the Heads of Corrections Meeting in June, 1988 and received strong endorsement. Subsequently, contact persons for this project were nominated from all the provinces and territories (listed in Appendix A).

The working group was composed of representatives from the Secretariat (Solicitor General of Canada), the Correctional Service of Canada and the National Parole Board. In addition, the contact person from the Ontario Ministry of Correctional Services served on the working group. A researcher under contract with the Ministry of the Solicitor General provided important assistance to the working group. (Members of the working group are listed in Appendix A.)

The mandate for the working group was to examine existing sex offender treatment programs in Canada, review the evidence concerning the effectiveness of various programs in treating sex offenders, identify promising strategies for research and development in this area, and make recommendations concerning further development of treatment programs for sex offenders.

In retrospect, the "Terms of Reference" for this project (see Appendix B) presumed a more advanced state of affairs in the area than is actually the case. For example, an underlying assumption was that there would be substantial amounts of evaluative data on Canadian programs, and that the results of these evaluations could be examined in order to make specific and detailed recommendations for treatment including "matching" of offenders and programs. One of the findings of our review is that there has been very little formal evaluation of existing programs. However, there is an informative body of research on the topic of sex offender management and treatment as well as an impressive cadre of Canadian experts

active in this area. The research literature and expert opinion have formed the basis of the recommendations in this report.

The working group undertook the following tasks:

- a comprehensive review of the literature on sex offender treatment;
- invitations to the Canadian Psychological Association and the Canadian Psychiatric Association to submit briefs on the subject;
- contact with other federal departments and agencies for pertinent information;
- invitations to provincial and territorial representatives to submit relevant information;
- preparation of a "framework paper" to structure the discussion of issues concerning the management and treatment of sex offenders;
- discussions with practitioners in programs identified by federal and provincial contacts (a list of individuals consulted and programs referred to the working group is provided in Appendix C);
- distribution of a survey to gather additional systematic information on programs under review;
- analysis and integration of findings; and
- preparation of a final report.

The working group considers this report as the beginning of a process that will lead to improved treatment and management of sexual offenders.

Although it has become a subject of intense interest in recent years, the problem of sexual offending and the management of sex offenders is not new. Indeed, previous commissions and inquiries have pointed to the problem, made pertinent observations and put forth recommendations. For example, the Fauteaux Committee (1956), in its general discussion of prison programs and rehabilitation, stated the following about sex offenders:

> *"The problem of the sex offender is equally difficult — but it is primarily a medical problem. There has recently been great public concern in various parts of Canada on this subject because of publicity given to sex offences. When such a crime occurs many proposals, some of them hysterical, are advanced for the solution to 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 population and that intensified research on the problem should be carried out." (p.48)*

The Royal Commission on the Criminal Law Relating to Criminal Sexual Psychopaths (McRuer, 1958), although principally concerned with legislation in respect to sexual offenders, addressed the matter of treatment. The Commission provided an interesting summary statement on the perceptions and prospects of treatment:

> *"Many of the witnesses who appeared before us assumed that a 'sexual psychopath' or 'sexual pervert' suffered from a condition that could be 'cured'. We have heard no medical evidence to warrant this assumption nor have we been referred to any medical authority who would appear to give it substantial support. On the other hand, as we shall later point out, many of the medical witnesses who were in a position to speak with great authority took a pessimistic view of the prospects of obtaining satisfactory results from any known form of treatment. These witnesses emphasized that the public should understand that in the present state of medical knowledge it is not possible to speak with assurance about 'curing' the class of offenders we are considering." (p. 83)*

Among the Commission's 17 recommendations, two specifically addressed treatment:

> *15. The Government of Canada, through special grants to universities and otherwise, develop special research schemes to determine the causes of sexual abnormality and improve methods of treatment.*
>
> *16. Special clinics be set up in co-operation with the courts and penal institutions, to which a person found guilty of any sexual offence may be required to report for study and treatment. (p. 130)*

There has been substantial advance in our understanding of sexual offending since the Fauteaux Committee and McRuer Commission did their work, and this will be evident from the research findings discussed later in this report. This advance has not been restricted to

medical science; behavioural science has also played a major role in contributing to our understanding.

The Parliamentary Sub-committee on the Penitentiary System in Canada (MacGuigan Report, 1977) reported that at the time of their review less than 10% of the sexual offenders in federal penitentiaries were in active, specialized treatment. The sub-committee recommended that "there should be several separate institutions for the treatment of sex offenders since their therapy needs are distinctive from those of other inmates with personality disorders." (p. 142)

The Committee on Sexual Offences Against Children and Youths (Badgley Commission, 1984) conducted a comprehensive study of child sexual abuse in Canada. The Badgley Commission's survey of the prevalence of sexual abuse found that one third of females and one fifth of males had been victimized by a sexual offence. Including non-contact offences (e.g., exhibitionism), the rates increased to 53% for females and 31% for males. These startling figures added momentum to the growing concerns about sexual offences in Canada

As a follow-up to the work of the Badgley Commission, a Special Advisor to the Minister of National Health and Welfare on Child Sexual Abuse is currently conducting consultations with the full range of parties concerned with child sexual abuse. The purpose of these consultations is to contribute to the development of a direction for future federal initiatives to address the problem of child sexual abuse in Canada. A recent Discussion Paper (Rogers, 1988) based on these consultations presented the following major conclusions: a) there is a lack of public awareness regarding the extent and seriousness of child sexual abuse; b) there are many excellent practitioners in the field but they are not receiving adequate support from the systems within which they work; and c) the solution to the problem of child sexual abuse will require commitment at the most senior levels of government and a co-ordinated approach involving government, non-governmental agencies and community-based organizations.

The Report of the Standing Committee on Justice and Solicitor General on its Review of Sentencing, Conditional Release and Related Aspects of Corrections (Daubney Report; August, 1988) recognized the abhorrent nature of sexual offending particularly that involving violence and brutality. The committee also addressed the matter of treatment of sex offenders and recommended that "the Correctional Service of Canada dramatically increase the resources allocated to sex offender treatment programs". (p. 209)

Coroner's inquests (Ontario, 1987; Ontario, 1988) into events surrounding two separate incidents involving in each case a sexual murder committed by a federal offender reported similar findings. Both inquests identified problems regarding the transfer of offender information between components within the criminal justice system, individual assessments and access to treatment, and highlighted a requirement for action within the criminal justice system.

Although there have been important advances in our understanding of sexual offending in the past thirty years, there are no simple solutions to the problem of sexual offending. As noted in the opening paragraph of a brief submitted to the working group by the Canadian Psychological Association:

> *"Policies concerning the treatment of sex offenders are necessarily complex; they must relate simultaneously to sentencing, probation and parole policies, the civil liberties of offenders, community safety, the rights of victims, and issues of treatment efficacy. Programs of treatment for sex offenders must, therefore, be developed in the context of a variety of policies dealing with offender disposition. In addition, sex offenders are often involved with mental health and social service agencies before, after, or instead of their involvement with the criminal justice system. Clearly, therefore, policies pertaining to treatment must be coordinated across a variety of agency and governmental jurisdictions."*

The number of offenders in federal penitentiaries serving sentences for sexual offences has increased in recent years. In 1984, there were 871 offenders, 7.4% of the incarcerated population, serving a sentence for a sexual offence; in 1988, there were 1385, 11.4% of the population (Source: Management Information Services, Correctional Service of Canada). It is not clear whether this increase was due to an actual increase in the number of sexual offences or to changes in reporting of such crimes, police practices, court functioning or sentencing patterns. Nevertheless, it is the case that there has been an increasing number of admissions for sexual offences to the federal correctional system in the past five years, and that this has created greater demands for intervention and control in respect to these offenders. This increase in numbers was frequently mentioned by practitioners in our discussions with them, and it appeared to be a phenomenon occurring in provincial correctional systems as well. Along with the increase in numbers, there has been a heightened sensitivity of the public to sexual offending, and increased expectations that these offenders will be treated.

While the number of offenders incarcerated for sexual offences in federal custody is estimated to be in the vicinity of 1400, the number of spaces available for treatment is less than 200. It is evident that current programs are not adequate to provide treatment to all the sex offenders who require it. However, as will be discussed later in this report, the working group is not recommending simply an expansion of current programs to accommodate greater numbers. What is required is a fundamental re-thinking of policies in light of what we know about the effective management and treatment of these offenders. To foreshadow our findings, it appears that the prevention of sexual offending requires not only effective treatment programs but, more generally, a co-ordinated strategy for monitoring and managing sexual offenders in institutions and in the community.

This re-thinking of federal policies must also be undertaken in the context of certain themes that have emerged in corrections in Canada in recent years. In all jurisdictions there has been a renewed interest in developing correctional programs in institutions and in the community.

In 1986, the National Parole Board undertook a strategic planning exercise that resulted in the articulation of a mission, a statement of values, principles and strategic objectives in support of that mission, and a set of decision policies. The mission establishes the Board's primary objective as the protection of society through the timely reintegration of offenders as law-abiding citizens. The decision policies provide criteria to guide risk assessment and decision-making based on categories of offences. Parole is viewed as a method of managing the transition of offenders from prisons to the community thereby reducing risk to society. The focus is on risk and the participation in programs that are likely to reduce risk. In a similar vein, the Ontario Board of Parole recently published a mission statement, values and principles.

The Correctional Service of Canada recently completed a review of its mission and core values. The CSC mission states that "the Correctional Service of Canada, as part of the criminal justice system, contributes to the protection of society by actively encouraging and assisting offenders to become law-abiding citizens, while exercising reasonable, safe, secure and humane control." The Service recognizes its responsibility to provide programs and opportunities to meet the unique needs of various types of offenders, to assist in changing their criminal behaviour and to assist them in successfully reintegrating into the community.

Some of the major themes and proposals advanced by the CSC Task Force on Institutional and Community Programs are relevant to the development of approaches to the management and treatment of sex offenders. The Task Force report enunciated several principles which would serve as a framework for program development:

> *"1. All activities of the Correctional Service of Canada will support the objective of reducing the risk posed when an offender is released to the community. The Service will use an active interventionist approach to corrections.*
>
> *2. The entire correctional environment, including institutions and community operations, will be oriented towards changing the offenders' criminal behaviour. All staff of the Correctional Service will reinforce this environment.*
>
> *3. The Service will respond to each offender as an individual. Having assessed the risk that the offender presents, the Service will address the problems that lead to the offender's criminal behaviour.*

4. *The community has a responsibility to assist in the reintegration of offenders, and the Correctional Service of Canada will actively seek the support and participation of the community during the sentence and encourage the provision of ongoing support to offenders after the sentence expires.*

5. *Offenders are accountable for their behaviour." (p. i, ii)*

The integrated community-based response to sexual offending, as suggested by Principle # 4 above, is a theme that characterizes recent thinking in the field. An excellent illustration of this is the set of principles enunciated by the Nova Scotia Committee for the Prevention and Treatment of Sexual Abuse. These principles recognize that sexual abuse is a family, social, public health, educational, and criminal justice problem, and that the traditional compartmentalizing of treatment for victims, families and offenders should be replaced with a coordinated approach. Further, the principles state that each participant has a duty to develop programs for prevention, detection, assessment and treatment, and that each participant should be aware of and take into consideration the role of others.

Innovative approaches are being developed in various communities and jurisdictions. There appears to be a clear recognition of the importance of addressing the problem of sexual offending, and a commitment to programs to support offender change in institutional and community settings. The working group concludes that a positive environment for program development exists, and that the challenge to deliver effective programs can be met.

Sex Offender Assessment and Treatment: A Review of the Research

The research literature on sexual offending provides no tidy or conclusive findings that can easily direct the design of correctional treatments. Despite a substantial and steadily growing level of knowledge in the field, there remains considerable speculation about what motivates these individuals to commit their offences, and considerable uncertainty about how best to treat or manage those who seem to pose the greatest risk.

From the points of view of public safety and sound correctional practice, the management and treatment of sexual offenders should aim to reduce their risk of reoffending. Assessment should identify risk factors related to sexual offending, treatment should address those risk factors amenable to change, and effective supervision and management should ensure that whatever risk remains is minimized. This simple conceptualization is a useful starting point. However, effecting and coordinating the steps in the approach is much more complicated. It requires an appreciation of the complex nature of sexual offending and of the diversity that characterizes these kinds of offenders.

The following is a brief review of the state of our knowledge on the assessment and treatment of sex offenders. Others (e.g., Barbaree & Marshall, in press; Furby, Weinrott & Blackshaw, 1989; Prentky & Quinsey, 1988) have provided more exhaustive reviews of the literature; our purpose here is to provide an overview of major research findings.

Assessment of Risk for Sexual Offending

Sexual offenders are not a homogeneous group. This is a fact that experts in the field underscore in any discussion of treatment or prediction of re-offending. Different offender and offence characteristics as well as a number of precipitating circumstances or situational variables have been identified as risk factors in sexual offending (e.g., Finkelhor, 1984; Howells, 1981; Langevin, 1983; Quinsey, 1984; 1986). No single risk factor has been identified as underlying or causal, or as inherent in all types of sexual offending. Nonetheless, the research does point consistently to the relative importance of particular factors.

The risk factors with the strongest empirical support are historical factors, especially information about previous offences. These include prior sexual offences, prior non-sexual offences, multiple sexual deviancies, use of force, boy victims, young victims, strangers as victims and exhibitionism. These historical offence-related factors are important primarily because they have been linked with risk of reoffending. As such, they should be addressed systematically in establishing priorities for intervention and in deciding on the nature and level of controls required to minimize risk following treatment. They are important as well in designing treatment strategies; although these historical factors cannot be altered by treatment, their presence can suggest that there are other risk factors that can be targeted in

treatment. For example, a history of sexual offending against young boys strongly suggests the presence of deviant sexual preferences.

The risk factors in sexual offending that can be addressed by particular treatment or supervision regimes have not been as clearly defined. A listing of some of these factors is provided in Table 1. They are grouped as follows: 1) individual dispositions that may motivate sexual offending; 2) factors that can serve to block the opportunity for normal sexual gratification; 3) factors that can disinhibit and thereby promote acting upon deviant sexual fantasies; and 4) factors that can inhibit deviant sexual arousal.

Table 1

Factors contributing to sexual offending that are potential targets for intervention.

motivators	sexual desire; deviant sexual desire, cerebral basis for sexual pleasure, emotional needs and conflicts, e.g., dominance, hatred, acceptance, aggression, nurturance, etc.
blocks to legal sexual outlets	low IQ, unattractive, unassertive, low social skills, restrictive views on sexuality, low sex knowledge, sexual dysfunction, unavailability of appropriate sex partners, marital discord.
disinhibitors	alcohol/drug abuse, pornography use, models (childhood victimization), cognitive distortions, deviant sexual attitudes (rape myths, victim blaming), attitudes supportive of violence, antisocial lifestyle, psychopathy, psychosis, brain injury/pathology.
inhibitors	moral values, empathy for victims, aversion to violence, fear of consequences, legal penalties, incarceration, unavailability of potential victims, resistance of victims.

Sex offenders can differ considerably in terms of the number and severity of these risk factors or needs that can be identified as targets for intervention. For example, an offender with normal sexual orientation, extensive sexual outlets, little empathy, and an antisocial lifestyle may opportunistically rape a woman during a robbery. In contrast, a man who has a sexual preference for boys, low social skills, deviant sexual values, and an aversion to

violence may lure children into long term sexual relationships that the offender perceives as consenting.

Deviant sexual preferences are commonly assessed by interview, sexual history, and by phallometry (i.e., a physiological measurement of sexual arousal). Self-report and phallometric measures do not always coincide, and research typically recommends collecting information from several sources (e.g., Wormith, 1986). Although not immune to conscious manipulation, the use of phallometry is generally considered to be important in the assessment of sexual offenders (Freund, Watson & Rienzo, 1988; Quinsey & Chaplin, 1988; Quinsey & Marshall, 1983).

A variety of established measures are available to assess such factors as social skills, attitudes towards sexual aggression and violence, and other values and beliefs that may be related to sexual deviancy (e.g., victim blaming). The essential point is that the research literature would seem to support assessment that is comprehensive and able to tap a range of relevant and treatable risk and need factors.

There are numerous case studies that have illustrated the contribution of each of the risk factors to sexual offending (Langevin, 1983). Although there have been relatively few research studies designed to isolate the relative importance of these factors in sex offender recidivism, the evidence is mounting. A notable example is Frisbie's (1969) follow-up of sexual offenders that was conducted in California. Frisbie found recidivism to be associated with excessive use of alcohol, desire for physically immature children as sexual objects, unorthodox ethical values, and grave difficulties establishing meaningful relationships with adult females. Other researchers have focused particularly on the assessment of changes in deviant sexual preferences as a result of treatment. Several studies have shown that those offenders who are more likely to recidivate following treatment have not achieved expected reductions in measured deviant arousal (Lang, Lloyd, & Fiqia, 1985; Quinsey, Chaplin & Carrigan, 1980). However, this kind of phallometric assessment of deviant arousal is not without problems and some studies have found deviant sexual arousal patterns to be unrelated to recidivism (Barbaree & Marshall, in press; Gordon & Bergen, 1988).

There are other complications since not all of these factors are easily treatable. For example, offenders with low intelligence or those who suffer from psychosis or brain injury may not benefit from many of the talk-oriented and cognitively-based group therapies. Sexual recidivism is clearly linked to psychopathy (Abel, Mittelman, Becker, Rathner & Rouleau, 1988; Fitch, 1962; Tracy, Donnelly, Morgenbesser & Macdonald, 1983; Wormith & Ruhl, 1986), but psychopathy is itself extremely difficult to treat. In any case, treatment programs should be sufficiently comprehensive that they are likely to address most of the problematic concerns for most of the offenders referred.

Many of the risk or need factors listed in Table 1 are not unique to sexual offenders. Alcohol abuse, marital difficulties, poor social skills and even histories of sexual abuse are frequently found in both inmate and mental health populations. The two factors that are quite

particular to sexual offenders are deviant sexual preferences, and cognitive distortions that support their deviant sexuality (Barbaree & Marshall, 1988). The treatment of these specific factors has received the greatest attention in the research literature. Some of the major findings on treatment effectiveness are examined in the following sections.

Organic Treatments for Deviant Sexual Preferences

Several organic treatments have been proposed for treating deviant sexual impulses. These include antiandrogen medications, castration, and psychosurgery (Bradford, 1985, 1988a). Psychosurgery has been used rarely since the need for such an invasive procedure has been questioned on ethical grounds. Castration was used extensively in Northern Europe (Le Maire, 1956). Denmark, in 1929, was the first to introduce legislation for the involuntary castration of sexual offenders. Some reviews (Bradford, 1985, 1988a; Cheney, 1986) have concluded that castration is a highly effective method for ensuring low risk of re-offending. Others (e.g., Barbaree & Marshall, in press; Heim & Hursch, 1979) have questioned its usefulness, suggesting that other approaches can be equally effective. Castration is thought to work by lowering testosterone levels, since the testes are responsible for 95% of the production of testosterone (Bradford, 1985). Castration often results in significant side effects including obesity, osteoporosis, and gynaecomastia (Bradford, 1985). Due to its invasiveness and controversial efficacy, it is unlikely to be widely used.

A more promising approach is "temporary castration" achieved through antiandrogen medication. There are two main drugs used for this purpose: medroxyprogesterone acetate (MPA), and cyproterone acetate (CPA) (Cooper, 1986). There has also been preliminary research using a luteinizing-hormone-releasing-hormone agonist (LHRH-A) plus the antiandrogen Flutamide (Rousseau, Couture, Dupont, Labrie and Couture, in press).

Both MPA and CPA block the activity of endogenous androgens and reduce serum testosterone (Bradford, 1988b). Most research with these compounds has been of the case study type, such as that reported by Berlin and Meinecke (1981). These researchers observed that sex offenders on MPA had few re-offences. However, ten of the 11 offenders who terminated MPA treatment prematurely committed new offences.

One problem with the use of compounds such as MPA is the reluctance of offenders to continue treatment. For example, Langevin and his colleagues (1979) found that the dropout rate for the subjects treated with MPA was extremely high, but decreased if medication was supplemented with other treatments. Hucker, Langevin and Bain (1988) found that of 100 sexual offenders approached, only 11 completed a 3 month drug trial of MPA or placebo. The major side effects of MPA include sleepiness, mild diabetes, weight gain, fatigue, loss of body hair, and mild depression (Cooper, 1986). These side effects tend to be minimal during short term use; long term effects are not known.

As with MPA, uncontrolled case studies using CPA typically report reductions in sexual deviancy (Cooper, 1986). Cooper (1981), in a placebo controlled study, found CPA to be an effective treatment for hypersexuality. Preliminary results from a well controlled double-blind study by Bradford (1988b) found that CPA decreased sexual hormones, sexual interest, and sexual arousal. There appeared to be a rebound effect, however, when CPA was abruptly withdrawn. Bradford and Pawlak (1987) reported a case study in which CPA effectively eliminated deviant sexual arousal, but arousal to consensual heterosexual activity was maintained. The short term side effects of CPA include loss of body hair, decreased serum production, and gynaecomastia. The results of prolonged use of CPA have not been established (Cooper, 1986).

Investigators tend not to make any direct link between testosterone levels and frequency of sexual activity in human males (Barbaree & Marshall, in press; Cooper, 1986; Langevin, 1983). Instead, a minimum level appears to be required. Above that level, sexual activity is thought to be primarily motivated by personality and social factors.

However, there is a small group of males who have extremely high levels of testosterone which appears to lead to hypersexual behaviour. For these cases, an antiandrogen medication would be indicated. The diminished self-reported arousal observed with antiandrogen medication may be related to central nervous system effects more than to effects on serum testosterone (Cooper, 1986). Antiandrogen medications can diminish sexual motivation, but there is only little evidence that they can change the direction of deviant sexual interests (Bradford, 1985, 1988b). Cooper comments that MPA and CPA are most likely to be effective when participation is truly voluntary, and when the patients are non-psychopathic, non-personality disordered hypersexuals.

Psychological Treatments for Deviant Sexual Preferences

Most experts agree that many of the risk factors for sexual offenders, such as deviant sexual preferences, cannot be completely eliminated, but at best can be controlled or managed. Consequently, treatment should not focus on short-term efforts to "cure" sexual offenders; instead, it should focus on developing ongoing strategies for identifying and managing risk for reoffending (relapse prevention). This understanding was reflected in a summary comment by Richard Laws in the Proceedings of the New York Academy of Sciences Conference on sexual aggression:

> *"Most important, perhaps, is the recognition that it is what happens after the delivery of the treatment package that is critical. Consequently, long-term follow-up is now considered essential. Sexual deviation can be managed, but it is unlikely to go away. There is no 'technofix' for this problem. As one of the presenters put it, therapy may formally end, but 'maintenance is forever'."*
> *(Prentky and Quinsey, 1988)*

Modification of deviant sexual interests and attitudes are important proximal goals of treatment. Most behavioral and psychological programs that focus on effecting change in these areas are multimodal in orientation, addressing various aspects of the offenders' functioning. The evaluation of these programs has been limited, but the available research can, nevertheless, provide some direction concerning program effectiveness.

The programs can be characterized generally as cognitive-behavioral programs (e.g., Barbaree & Marshall, in press; Abel et al., 1981), relapse prevention programs (e.g., Pithers, Marques, Gibat & Marlatt, 1983), and guided self-help programs (e.g., Saylor, 1979). The cognitive-behavioural programs are typically relatively short term programs that involve sex education, social skills training and techniques for managing deviant arousal and fantasies. In relapse prevention programs, offenders identify risk indicators associated with their crime cycle, and then learn techniques to avoid and/or manage high risk situations. The guided self-help programs typically aim to increase the offenders' insight and awareness into the cause of their deviant behaviour. The primary vehicle for this self-exploration is some form of group therapy. In-patient programs, such as the Fort Steilacoom Program in Washington, combine extensive group experience with milieu therapy (Saylor, 1979). Out-patient programs often involve weekly group meetings (e.g., Romero & Williams, 1983).

Many of these cognitive-behavioural programs are designed to reduce deviant sexual arousal. Various behaviour therapy techniques have been used to obtain short term change in deviant sexual responsiveness. These techniques include covert sensitization (Barlow, Leitenberg, & Agras, 1969; Brownell, Hayes, & Barlow, 1977; Maletzky, 1980), aversive conditioning (Callahan & Leitenberg, 1973), biofeedback (Laws, 1980), and satiation (Marshall, 1979). Although the ability of these procedures to effect long-term change in arousal patterns is unclear, there is substantial supportive evidence. For example, Kelly's (1982) review of 32 behaviourally oriented treatment studies found reduction in urges to molest children in 95 of the 121 offenders for whom this was attempted. Analysis of the procedures used for the behavioural treatment of arousal suggests that they can be construed as techniques for identifying and gaining self-control of sexual impulses (Laws, 1980). As such they should not be seen as one-time treatments that can effect permanent change.

Attempts to change some of the distorted beliefs and attitudes of sexual offenders is another common component of behaviourally oriented programs (Abel, Becker & Cunningham-Rathner, 1984; Langevin & Lang, 1985; Scully & Marolla, 1981). These attitudes include, for example, that children can consent to sex with an adult, that fondling does not constitute sexual abuse, and that victims are responsible for being sexually assaulted. Such attitudes are frequently targeted for change (Abel, Becker, Cunningham-Rathner, Rouleau, Kaplan & Reich, 1981; Barbaree & Marshall, 1988; Giarretto, 1982; Langevin & Lang, 1985) and, during the course of treatment, offenders will often express less deviant attitudes and more personal responsibility for their offences (Gordon & Bergen, 1988; McCaghy, 1967; Sagatun, 1982). A persistent complication,

however, is that offenders are motivated to modify their account to meet the expectations of their therapists in order to look cured and be released from treatment (McCaghy, 1967; 1980; Taylor, 1972). Sagatun (1982) noted that offenders directed to attend treatment by court order expressed more responsibility for their offences than the offenders in treatment voluntarily. Quinsey (1987) found that sex offenders did not differ from non-offenders in their explanations of sexual offending. Nevertheless, considering Frisbie's (1969) finding that unorthodox ethical values were related to recidivism, deviant sexual attitudes are probably an important focus for treatment.

Treatment and Sex Offender Recidivism

Outcome research on sex offender treatment programs is a difficult undertaking. The most informative research designs (e.g., random assignment to treatment) are unethical with high risk populations, as is providing high risk offenders the opportunity to re-offend by releasing them to the community. Another approach is to evaluate the recidivism rate of the treatment group against the base rate expected in an appropriate comparison group.

Major studies of sex offender recidivism have been conducted in Great Britain by Fitch (1962) and by Gibbens, Soothill, and Way (1978; 1981; Gibbens, Way & Soothill, 1977; Soothill & Gibbens, 1978; Soothill, Jack & Gibbens, 1976), in Denmark by Christiensen, Elers-Nielsen, Le Maire, and Sturup (1965), and in Norway by Grunfeld and Noreik (1986). These studies involved long term follow-up (10 to 24 years) of sexual offenders who generally did not receive any systematic therapy.

Of the 4,347 offenders examined in these studies, 570, or 13% were reconvicted for a sexual and/or violent offence. The number of reoffences tended to gradually increase over a 10 year period. The pattern of results appeared reasonably consistent across studies. Of those offenders who had no prior sexual offences, 9% were reconvicted for a sexual and/or violent offence. For those with prior sexual offences, the recidivism rate was 28%. Child molesters tended to have a lower recidivism rate (14%) than did rapists (21%). Offenders against boys, however, had a relatively high recidivism rate (40%) although this finding was based on a limited number of offenders (62). In general, recidivists tended to repeat the offence for which they were originally convicted.

Recidivism rates based on reconviction are likely to underestimate the rate of sexual reoffending. Many sexual offences, especially offences against children, go unreported. Marshall and Barbaree (1988) found that reoffence rates based on unofficial sources were 2.5 times higher than reconviction rates. Many pedophiles report hundreds of offences for which they were never charged (Abel, Becker, Mittelman, Cunningham-Rathner, Rouleau & Murphy, 1987).

Table 2

Treatment programs for sexual offenders

Program	Population	Follow-up	Recidivism
Abel et al. (1988) behavioural, 6-12 months out-patient	mixed 35% drop-out	1 year self-report	12.2% (12/98)
Marshall & Barbaree (1988) behavioural, 4 months out-patient	child molesters untreated comparison group	44 months	14.1% (9/64) 32.0% (17/53)
Cabeen & Coleman (1961) milieu, group, family visits, in-patient	MDSO released as safe	8 months	3.8% (3/79)
Davidson (1984) behavioural, 5 months in-patient	child molesters untreated comparison group	5 years	est. 6.2% (2/36) est. 28.1% (10/36)
Gordon & Bergen (1988) behavioural, 5 months inpatient	mixed (Federal)	22 months	12.3% (16/130)
Lang et al. (1988) Alberta Hospital	incest/hetero-pedophiles	3 years	11.8% (6/51)
Maletzky (1980) behavioural, 6 months and follow-up, out-patient	child molesters exhibitionists	36 months	11.0% (11/100)
Nutbrown & Stasiak (1987) O.C.I., correctional treatment facility	violent sexual offenders matched controls	3 years (any offense)	22.0% (13/59) 54.5% (6/11)
Pithers et al. (1988) relapse prevention in and out-patient	mixed (no sex killers)	> 1 year	4.0% (5/124)
Quinsey et al. (1980) behavioural, in-patient	child molesters	29 months	20.0% (6/30)
Romero & Williams (1983) group, out-patient	mixed comparison group (probation)	10 years	13.5% (20/148) 7.2% (6/83)
Steffy & Gauthier (1976) behavioural, 5 month in-patient,	child molesters 33% 1st offenders 64% male victims untreated comparison group	5-8 years	10.4% (12/125) 24.4% (11/45)

Program	Population	Follow-up	Recidivism
Atascadero			
1. Dix (1976) milieu, group 18 months, in-patient	MDSO released as safe	7 years	20.8% (5/24)
	comparison groups 1. MDSO, treated, not safe		16.7% (1/6)
	2. MDSO not amenable		11.8% (2/17)
	3. not MDSO		14.3% (1/7)
2. Frisbie (1969) milieu, group 18 months, in-patient	MDSO released as safe	3-4 years	24.4% (41/168)
	comparison groups 1. not MDSO or not amenable		9.5% (8/84)
	2. prison, not assessed		16.9% (13/77)
	3. probation, not assessed		10.1% (29/288)
3. Frisbie & Dondis (1965) milieu, group 18 months, in-patient	MDSO released as safe	6 years	20.0% (385/1921)
4. Sturgeon & Taylor (1980) milieu, group 18 months, in-patient	MDSO released as safe	5 years	11.7% (21/180)
	comparison groups 1. MDSO, treated, not safe		23.8% (19/80)
	2. not MDSO		24.6% (30/122)
Fort Steilacoom			
1. Saylor (1979) milieu, group, 22 months, in-patient	mixed successful graduates 65% 1st offenders 18% male victims 23% rape	6 to 72 months	22.1% (89/402)
2. Hall (1988)	MDSO released as safe	5 years	20.4% (19/93)
	MDSD, treated, not safe		24.4% (20/82)

Note. MDSO is a "mentally disordered sex offender" as classified by California or Washington State law.

Five studies were located that used comparison groups to evaluate the effectiveness of treatment. Three of these programs (Marshall & Barbaree, 1988; Davidson, 1984; Steffy & Gauthier, 1976) were comprehensive cognitive behavioural programs, one (Romero & Williams, 1983) involved out-patient group therapy for probationers, and one (Nutbrown & Stasiak, 1987) examined a treatment institution for provincial offenders (O.C.I.). Only Romero and Williams (1983) used random assignment to treatment; consequently, the selection of the comparison groups in the other studies involved some form of compromise. An additional 13 studies were located that provided follow-up data on offenders treated with a variety of methods. Four of these studies examined offenders treated at Atascadero State Hospital in California (Dix, 1976; Frisbie, 1969; Frisbie & Dondis, 1965; Sturgeon & Taylor, 1980), and two followed patients of the Fort Steilacoom program in Washington State (Hall, 1988; Saylor, 1979). The remaining studies followed patients from various behavioural programs (Abel et al., 1988; Gordon & Bergen, 1988; Maletsky, 1980; Quinsey et al., 1980), a relapse prevention program (Pithers, Kashima, Cumming, Beal & Buell, 1988), and two other treatment programs (Cabeen & Coleman, 1961; Lang, Pugh & Langevin, 1988). An outline of these studies is provided in Table 2.

The three cognitive-behavioural programs that used comparison groups all showed significant treatment effects. Averaged across the three studies, the sexual recidivism rate for the treated offenders was 10.2%, while the rate for the comparison group averaged 25%. Twenty-two percent of the violent sexual offenders treated at O.C.I. (Nutbrown and Stasiak, 1987) were reconvicted for any offence (including non-sexual and non-violent offences), which was significantly fewer than the 54.5% rate for the comparison group. Of the studies that used a comparison group, only Romero and Williams (1983) failed to find treatment effects. The sexual reoffence rate was low for both the offenders in out-patient group therapy (13.5%) and those on probation (7.2).

The remaining studies to be discussed did not involve a comparison group. Consequently, their recidivism rates need to be compared with the rates found in other studies. One comparison is with the base rate for sexual and/or violent reoffences found in the untreated groups in the previous studies - about 25%. This rate is similar to the base rate for untreated repeat offenders (approximately 28%).

The largest follow-up of treated offenders was conducted on those released from Atascadero Hospital in California (Dix, 1976; Frisbie, 1969; Frisbie & Dondis, 1965; Sturgeon & Taylor, 1980). Patients treated at Atascadero were retained as mentally disordered sex offenders (MDSO) and could be held for an indefinite term. To be classified as an MDSO, two psychiatrists had to judge that an offender had a disorder that predisposes him to commit further sexual offences. Most of the MDSO's were men convicted of non-violent sexual offences against children. Approximately 50% had no prior convictions for sexual offences (Dix, 1976). In practice, most of the men admitted spent an average of eighteen months in the program, which primarily involved milieu and relatively unstructured group therapy. If an offender was judged to be an MDSO, but was not amenable to treatment,

he was returned to the courts and often received a 2-4 year prison sentence. Averaged across the four studies, the reoffence rate for MDSOs treated and then released as safe was 19.7% (N = 2,293). The reoffence rate for offenders identified as MDSOs but judged not to have benefitted from treatment was 19.4% (N = 180).

Clinicians at the Fort Steilacoom program similarly had difficulty identifying offenders who would be likely to reoffend (Hall, 1988). The reoffence rate for patients judged to be successfully treated (21.8%) was not significantly different from the 24.4% reoffence rate for offenders judged to be treatment failures (Hall, 1988; Saylor, 1979). Hall (1988) argues that the clinicians' inability to predict recidivism suggests problems with the "moral" model on which the program was based. He argues instead for a relapse prevention model, such as that operated by Pithers et al. (1988). Preliminary data from the Pither's relapse prevention program shows reoffence rates of 4.0%. Atascadero has also recently turned to a relapse prevention model in an attempt to identify a successful treatment approach (Marques, 1988).

With the exception of Quinsey et al. (1980), who found a 20% reoffence rate, all of the remaining studies (Abel et al., 1988; Cabeen & Coleman, 1961; Gordon & Bergen, 1988; Lang et al., 1988; Maletzky, 1980) found reoffence rates less than 15% (an average of 11%). The reoffence rates for the treated offenders in these studies appears to be lower than the expected base rates, even for Quinsey et al. (1980), who treated particularly disturbed individuals.

Conclusion

A reasonable conclusion from the available literature, then, is that treatment can be effective in reducing sexual recidivism from about 25% to 10-15%. No approach can guarantee complete success. Antiandrogen medication (MPA, CPA) appears to be effective, but treatment strategies must address compliance issues and the management of the offender when the medication is discontinued. The approaches currently considered especially promising are structured programs that address a range of sexual offenders' risk factors/needs and include relapse prevention components.

Findings

The working group's discussions with those involved in treating sexual offenders yielded considerable information on the existing treatment programs in Canada. Formal evaluations of these programs were limited, but our contacts were most helpful in indicating promising directions for program development, and in identifying obstacles that have hindered effective program delivery. Some concerns were limited to specific communities. There were other issues, however, that were identified in many, if not all, of the regions surveyed. This section of the report outlines the working group's observations in ten important areas, along with general conclusions of the major needs or problems suggested by these findings.

1. Information for Assessment

Detailed background information was considered important for the assessment and management of sexual offenders. Difficulties were frequently encountered in obtaining such information. Sexual offenders often deny and distort their history, especially the violent offenders. Clinicians tended to have little knowledge of how to access juvenile records and of relevant provisions of the Young Offenders Act. Information about juvenile offences was often informally obtained, but was not systematically provided. Many involved in offender treatment indicated that inmates frequently disclosed information about the offences that was not part of any official records.

While it was usually possible to obtain previous assessments and police records, special effort was needed to obtain such information. Our survey indicated that about 50% of the offenders had been assessed as sexual offenders prior to assessment at the treatment program. The respondents generally found these assessments to be helpful; however, they were only available about 60% of the time.

Information transfer between agencies tended to be slow and incomplete. Reports of previous treatment and/or assessments were often undetected if the offender failed to disclose the existence of such records. There was also concern that some men who committed a sexual offence (but were convicted for a lesser offence, e.g., assault) might not be identified as sexual offenders.

There appears to be a need for a more orderly transfer of information among justice, corrections, health and social service agencies than is currently the case.

Assessments of sexual offenders can be improved by systematic transfer of information among the agencies involved in their identification, treatment and management.

2. Recruitment into Treatment

A problem that was consistently raised in our discussions with practitioners concerned the matter of recruitment into treatment. Denial is a major issue in dealing with sex offenders. At the outset, few will admit their offences or openly recognize the need for treatment.

There are many reasons why sexual offenders are often reluctant to seek treatment. Being identified as a sex offender in an institution is a major problem because other inmates are often hostile toward sexual offenders. Other factors that may contribute to denial include shame about their offence(s), unwillingness to forfeit the gratification associated with their offence(s), discouragement about the possibility of change, and misunderstandings regarding the nature of treatment.

In our discussions on this point with practitioners there was strong agreement that sex offenders must be actively encouraged to participate in treatment, and that attempts should be made to overcome the initial resistance to treatment. Consistent with the principle of informed consent, it was considered an important professional responsibility to explain to the offender the benefits and risks of participating in treatment, as well as those of not participating in treatment.

Denial of sexual offending is a serious problem, and recruiting sexual offenders into treatment poses a particular challenge to professionals working in this field.

3. Professional Communication

Our meetings with professionals working with sexual offenders revealed that there is considerable expertise in Canada for treating sexual offenders, and that there are many dedicated clinicians in this field. It was also evident, however, that this expertise is not well distributed throughout the different communities. Specific programs have put extensive effort into developing treatment approaches that are unknown in other treatment facilities. This isolation is most noticeable between programs operating in different jurisdictions (e.g., provincial mental health and federal corrections), but it was also evident between the treatment facilities within CSC. One therapist commented that she had borrowed a certain technique from another program after learning about the technique through an offender who had been treated in that program, not through her professional colleagues. In general, treatment staff expressed a strong need for information and professional development opportunities.

Several factors seem to be contributing to the separation between programs. One of the most basic problems is that the relatively few people working in this field are separated by large geographical distances. In the major population areas, it is rare to find more than one program for treating sexual offenders. If any treatment is available in the outlying communities, it is typically provided by a single individual working in professional isolation.

Clinicians interested in other treatment programs are often hindered by the lack of program descriptions. Such documentation is often considered a low priority in light of the considerable service delivery demands. Information exchange is also limited in some cases by rivalries and competitiveness between programs. The lack of communication has led to inaccurate perceptions of other programs, which, in turn, may serve to reinforce the rivalries.

The development of sexual offender treatment programs is hindered by a lack of communication and cooperation between such programs.

4. Range of Programs

There appears to be special knowledge required for the treatment of sexual offenders that is not part of the routine training in any one discipline. Psychiatrists, psychologists, social workers, nurses, and correctional workers all have shown competency in the treatment of sexual offenders. Programs which appeared to be most effective are those which have a well-motivated team and a clear program focus.

Although the practitioners in this field come from various disciplines, we are aware of one educational program which is specifically designed to train specialists in sexology. The University of Quebec at Montreal offers a program that provides five years of study of human sexuality, and graduates of this program are uniquely prepared for work in this area.

It is generally recognized that different offenders have different needs such that all offenders cannot be treated in the same program. The management of sexual offenders in some regions, however, is limited by the lack of treatment options. When only one program is operating, there is a tendency to have offenders attend the program even when it is not appropriate to their needs. The rationale for such placement was rarely articulated, but seemed based on the belief that some treatment was better than no treatment. It was apparent that offenders were requesting admission to whatever program was available within their region rather than be transferred to another region for a program that may have been more appropriate. This placed pressure on the program, as well as on the staff who considered participation in these cases to be inappropriate. The view was also expressed however that treating offenders in inappropriate programs can increase the risk to the public due to false perceptions that the offender is at decreased risk because he attended treatment.

Another observation is that the placement of offenders into institutional treatment programs appeared to be driven more by the offenders' mandatory supervision release date than by priorities based on needs and risks.

The lack of treatment opportunities is leading inmates to create self-help groups with no professional support or involvement. In desperation, this is sometimes considered to be treatment even though the content of the group activities is totally unknown.

CSC regions tend to focus on one program type, which is inappropriate due to the diverse needs of sex offenders. Within each region, a wide range of treatment options and expertise is required to address the diverse needs of sexual offenders.

5. Native Offenders

In June, 1988, an estimated 16% of the total number of federal offenders incarcerated for a sexual offence were native. Based on this review, we are unable to provide particular findings with respect to treatment programs for Native sexual offenders. The one treatment program that we reviewed that was sponsored by a Native organization was a newly implemented cognitive-behavioural program, and while promising, was just receiving its first group of offenders. While there is concern among professionals that current treatment programs are not effectively addressing the needs of Native sexual offenders, we are unable to reach specific conclusions regarding the treatment of these offenders.

6. Continuity and Follow-up

There was a clear consensus that follow-up in the community is crucial to the effective treatment of sexual offenders. This is consistent with the literature which strongly supports the need for relapse prevention. The results of the survey revealed that 10 of the 17 experts who responded to a question concerning the need for follow-up indicated that 100% of even successfully treated sexual offenders require follow-up. Yet, the procedures for providing such follow-up were not well established. Only about 29% of the offenders received follow-up from their original treatment programs. An estimated 14% received follow-up from a program other than the one in which they were originally treated.

CSC has few mechanisms for providing ongoing treatment for sexual offenders released from institutional programs. Institutional treatment programs had difficulty linking offenders to community resources following discharge. In some cases, offenders maintain contact with professionals informally, and phone institutional staff to discuss problems. The therapists are frustrated by the limited support they can offer released offenders. Indeed, some staff were eager to set up community-based programs as a follow-up to an institutional program.

Part of the difficulty derived from a lack of resources. A lack of coordination between treatment programs was also identified as a concern. Offenders are treated by many different institutions, including mental health, corrections, and child welfare agencies. The long term management of sexual offenders requires a degree of co-ordination among such programs that is rarely found.

The CSC parole offices in B.C. have developed one promising approach to providing follow-up. All sexual offenders released on federal parole or mandatory supervision in B.C. are supervised by specially trained parole officers, and are required to attend weekly sessions

with contract psychologists. Although not subject to any formal evaluation, this program appears to be addressing the offenders' needs, and is considered desirable by correctional workers and the Parole Board. Offenders are reported to be initially hesitant to attend the weekly group meetings, but later consider the sessions to be personally valuable.

Continuity of treatment for sexual offenders is hindered in many communities by a lack of resources and coordination among the available treatment providers.

7. Risk Assessments

A distinction was frequently made between assessments done for measuring progress in treatment and those done for determining dangerousness. It was accepted practice that the former be done by those who delivered the program.

The assessment of dangerousness of sexual offenders was recognized as a difficult task. It was generally agreed that risk assessments based on multiple perspectives were preferable to assessments provided by a single individual. There was specific debate over whether therapists were able to provide accurate risk assessments on individuals whom they had treated. Some experts argued that therapists are in an optimal position to assess risk due to their extensive contact with the offenders. Others argued that therapists would have difficulty providing objective risk assessments since: 1) there is little evidence that progress in therapy is related to reoffending (most of the known risk predictors are based on the offender's history), and 2) therapists may be inclined to be overly sympathetic to offenders because of their role as advocates.

Risk assessments conducted by experts not directly involved in program delivery are desirable for all offenders; they are considered especially valuable for high risk offenders.

8. Limitations of Treatment

A persistent theme in our discussions with experts was that it was inappropriate to talk about a "cure" for sexual offenders. There was a strong emphasis on long term management in the community. In this regard, it was suggested that consideration be given to reviewing current law which stipulates that a prison sentence given in conjunction with a probation order cannot exceed two years (Section 737.(1)(b) of the Canadian Criminal Code).

There was general agreement that some sexual offenders remain at high risk for reoffending despite the best known treatment. While treatment is considered to reduce the risk of recidivism in most offenders, it was not clear that it sufficiently reduces the risk of some very high risk offenders to consider them safe for release into the community. In this regard, the submission from the Canadian Psychological Association stated that "it cannot be expected that very serious sexual offenders, such as serial murderers, will or should be viewed as less of a risk as a result of progress in a treatment program." (p. 5) Experts recognized the difficulties in predicting dangerousness, but they generally agreed that high

risk offenders could be identified from the offenders' documented histories (especially their previous offences).

There were many professionals who expressed frustration that potentially very dangerous offenders were being released, some at expiration of sentence. Some of these offenders had been referred for certification under provincial Mental Health Acts, and released because they did not meet the legal requirements.

There were several proposals for alternative methods of protecting the public from high risk offenders, in addition to the existing Dangerous Offender legislation. One proposal was to develop a mechanism for monitoring sexual offenders similar to the procedures used for monitoring individuals under a Lieutenant Governor's Warrant (i.e., persons found mentally unfit to stand trial or not guilty by reason of insanity). Electronic monitoring of such offenders was also suggested as an alternative to indefinite incarceration.

Treatment, by itself, is insufficient to protect the public from some sexual offenders and other strategies should be pursued.

9. Evaluation and Research

There is a recognized need for continued development of sexual offender treatment programs and the need for systematic investigations to increase our knowledge in this area. Many programs are new, and the established programs typically have changed considerably since their inception. Most of these changes, however, have not been directed by documented program outcomes, or by clear theoretical rationales. In fact, adequate program evaluation, including assessment of intermediate gains in treatment as well as the impact of treatment gains on outcomes, is rarely done. Outcome evaluations are difficult due to the relentless pressure to direct resources to meet demands for service, the necessity of long follow-up periods (at least five years), and problems with the reliability of measures of recidivism. As well, research and evaluation have been underfunded and not encouraged by some of the settings in which the programs operated. One notable exception where there has been an active effort to measure program impact as well as to conduct long term follow-up of offenders following release is the Clearwater program at the Regional Psychiatric Centre (Prairies). However, for other programs, even readily available information, such as reconvictions of program graduates, was not known to the staff of these programs. One therapist commented that he only knew of treatment failures when he read about them in the local newspaper. With such unsystematic sources of information, the presence or absence of a single dramatic case could falsely determine the assessment of the program's effectiveness.

The development of sexual offender treatment programs is hindered by the lack of adequate research and evaluation.

10. National Strategy

The programs within CSC exist in the absence of any national plan which would ensure optimal use of resources for the management and treatment of sex offenders. Currently, the efforts and resources are heavily concentrated within institutions. Given the critical importance of community-based management and treatment, there is a need to seriously examine the strategies for intervention and the distribution of resources. These programs are isolated from one another; there is limited opportunity for those involved to exchange information and foster innovation. There is extreme pressure on program staff to process offenders through these programs, while at the same time resources are being diverted from treatment to respond to the growing demand for assessments.

There is no CSC national strategy for the management and treatment of sex offenders, nor is there a single office in NHQ which is responsible for the direction, policy and programs for sex offenders.

Framework for Sex Offenders Programs

No single approach has emerged as the standard treatment for sexual offenders; nevertheless, there is substantial consensus on the general structure of programs that are likely to reduce recidivism. These features do not inhibit the innovations necessary in this nascent field, yet set clear guidelines for the development and evaluation of treatment programs. These factors concern: 1) recruitment of offenders into treatment, 2) assessment, 3) treatment, 4) post-program assessment, 5) risk assessment, 6) discharge and follow-up, and 7) program evaluation. Each of these is outlined separately in the following.

Recruitment into Treatment

The initial component of a treatment program is the manner in which offenders are recruited into treatment. Sexual offenders are often reluctant to seek treatment due to concerns such as fear of being identified as a sexual offender, shame about their offence, unwillingness to forfeit the gratification associated with their offence(s), discouragement about the possibility of change, and misunderstandings regarding the nature of treatment. Treatment without the offender's consent is ethically problematic, and contrary to professional codes of ethics for health care professionals, except under very limited circumstances. However, there is a responsibility to educate the offender regarding the potential benefits and risks of treatment, and to design treatment programs to be as attractive to offenders as possible. The problem of untreated sexual offenders is not going to be solved by a proliferation of programs that offenders refuse to attend, or complete.

Assessment

The assessment of sexual offenders is crucial to effective treatment. Assessment should identify factors that contribute to sexual offending for each offender. While there is no standard assessment procedure for sexual offenders, experts generally agree on broad areas that need to be assessed. These areas include sexual history, sexual preference, hormonal (testosterone) levels, sexual attitudes, substance abuse, cognitive abilities, interpersonal skills, and potential for violence. Detailed, corroborated information on the offence(s) is essential. Phallometric assessment (i.e., a physiological measurement of sexual arousal), although not immune to deliberate faking, is essential for identifying deviant sexual arousal and useful for planning and monitoring treatment.

Treatment

The treatment that the offenders receive should address the risk factors identified during assessment. Each offender presents a particular combination of needs which may be addressed through relevant group programs. Such treatment should be based on prior empirical research or on a theoretical rationale that would be considered acceptable by experts in the field. Treatment programs have a responsibility to articulate what they are

intending to treat, and how they intend to treat it. As well, the treatment should be delivered by adequately trained staff. Treating sexual offenders requires special skills and knowledge that is not obtained through routine training in any particular discipline. Treatment does not have to be delivered in a conventional institution; it can occur in a variety of institutional and community settings.

Post-program Assessment

It is not reasonable to assume that participation in a program will adequately address an offender's needs or the risk that the offender may present on completion of the program. Post-program assessments are needed to determine the effectiveness of treatment for each of the targeted treatment goals. The risk for reoffending must also be explicitly addressed in this post-program assessment.

Risk Assessment

Post-treatment assessments are also required to a) identify the risk factors that need to be monitored and addressed during follow-up, and (b) establish plans for the management of the offender after leaving the treatment program. This assessment must provide the basis for ongoing offender management.

Discharge and Follow-up

In addition to identifying appropriate discharge plans, effective programs need to actively facilitate the orderly transition of offenders from the treatment program to follow-up services. Links among programs are critical to ensure that the follow-up is provided.

Evaluation

Ongoing evaluation is an integral part of effective treatment programs. The available literature indicates that treatment reduces recidivism, but some men still reoffend after treatment. Programs have a responsibility to monitor program integrity and to create new knowledge concerning both treatment effectiveness and risk prediction. For such evaluations to be conducted, adequate documentation is required on the offenders (e.g., pre- and post-assessments) as well as on the treatment that the offenders receive. Knowledge of post-treatment recidivism is also crucial for developing a rational approach to program development and risk prediction.

Recommendations

Continuity, Community and Co-ordination

1. It is recommended that treatment for sexual offenders begin while the offender is in the institution and continue following release to the community.

The minimum goals in the institution should include:

- identification of the individual as a sex offender;
- having the individual recognize his need for treatment;
- educating the offender about treatment options available;
- treatment as appropriate;
- comprehensive release plans; and
- notification of appropriate community officials in cases of high risk releases.

Information regarding risk factors which are identified prior to release should be documented and communicated to those responsible for community follow-up.

The minimum goals in the community should include:

- monitoring the offender's behaviour with particular attention to risk factors (relapse prevention);
- ensuring that the offender is aware of treatment options in the community;
- encouraging the offender to participate in treatment as appropriate; and
- re-incarcerate if necessary.

2. It is recommended that CSC seek to strengthen its links with other governmental and non-governmental agencies and community-based organizations involved in the treatment of sex offenders in order to co-ordinate its activities with those of others in the field and to establish a continuity of treatment from the institution to the community. It is important that CSC participate, in collaboration with other organizations responsible for corrections, health and social services, in the full range of community development activities from problem identification to community-based strategies.

3. It is recommended that mechanisms be established to ensure the efficient transfer of case-specific information among agencies involved in the identification, assessment and management of sex offenders. Information about the offender's background, including previous assessments and treatment, should be communicated. Closer links to the community agencies will facilitate information exchange.

Program Development

4. Recognizing the problem of denial among sexual offenders, it is recommended that a) sex offenders be actively encouraged to participate in treatment by stressing with them the importance of addressing the problem of their sexual offending; b) challenging them with factual information; c) approaching them periodically to participate in treatment if they decline in the first instance; d) building in incentives to participate in programs; and e) include participation in treatment as a release condition where appropriate.

5. Given that public safety is the paramount concern in the treatment and management of sexual offenders, and given the present lack of specialized community resources, it is recommended that the development of community-based programs be a first priority. Secondly, a sufficient number and range of institutional-based programs should be developed in each region to ensure that all sex offenders have access to appropriate and timely treatment. These programs should be developed along lines consistent with the framework described earlier in this report. Every program must include strategies for a) recruiting sex offenders into the program; b) pre-treatment assessment of factors related to sexual offending; c) a rationale linking assessment to treatment; d) post-treatment assessments; and e) follow-up and evaluation.

Alternative programs must be developed to meet the needs of sex offenders whose limitations in intellectual functioning prevent them from benefitting from ordinary programs.

6. It is recommended that support be provided for research, particularly in the following areas: a) descriptive studies of the number and characteristics of sex offenders; b) the development and refinement of measures of risk indicators for sexual offenders; c) development and evaluation of special treatment components for addressing specific needs/risks indicators; and d) the examination of how changes as a result of treatment relate to the likelihood of re-offending.

Strategies for strengthening research and program development activities might include arranging internships, creating a university "chair" and establishing research networks.

Multi-site studies, involving researchers and practitioners in programs operating within various social systems (i.e., corrections, mental health, social services, etc.) across Canada, have particular promise because they would increase the number of subjects for group

comparisons, encourage collaboration on standards for measures, and enhance information transfer among programs.

7. It is recommended that mechanisms be established for the communication of professional knowledge regarding programs and research findings.

Such mechanisms might include organizing workshops and conferences as well as linking through computerized "bulletin boards". This information must be communicated within the criminal justice system as well as with mental health, social services and academia, nationally and internationally.

Risk Assessment and Release

8. It is recommended that independent assessments (external to the treatment program) to determine risk of release to the community in cases where the nature of the sexual offending suggests a high level of risk, be conducted and provided to NPB. Specific policies for the identification and assessment of such cases should be developed jointly by CSC and NPB.

9. It is recommended that the NPB review its decision policies in terms of categories, assessments and release conditions for high risk sex offenders.

Training and Standards

10. It is recommended that human resource planning in CSC should facilitate the development of expertise among staff, and that models whereby parole officers who have responsibility for supervising sexual offenders are linked to a treatment program, be developed further and evaluated.

11. It is recommended that training in the management of sex offenders be provided to a broad range of front line staff and that more intensive training be provided to case management staff who show a special interest in working with sex offenders.

12. It is recommended that more comprehensive programs of education related to sexual deviance and sexual offending be developed and made available to offenders, CSC staff and the NPB.

13. It is recommended that further work be undertaken to develop standards for practice, qualifications and training in respect to pre- and post-treatment assessments, assessments of risk, and treatment of sex offenders.

Focus and Direction

14. It is recommended that a position of special advisor to the Deputy Commissioner, Correctional Programs and Operations be established for a specified period to co-ordinate and facilitate the development of sex offender management strategies within the Correctional Service of Canada, to advise on future directions, policy and programs in respect to sex offenders, and to oversee the evaluation of existing programs.

Major tasks for the special advisor would be to lead CSC in the development of a national strategy for the assessment, treatment and management of sex offenders. The strategy must focus on:

- the identification of specific risk factors which relate to the sexual offending;
- the assignment of treatment priority to sub-groups of sex offenders, based on the risk they represent and the likelihood of treatment effectiveness;
- treatment strategies, including what will be undertaken in institutions and in the community;
- the management of those offenders who will not participate in programs or those for whom no known intervention would reduce risk to an acceptable level for release into the community.

The special advisor should constitute a "committee of experts" to advise on program development, program implementation, training issues, and implementation of the recommendations of this report. This committee would operate at the national level, with links to local levels. The membership of the committee of experts would not be fixed; the composition would vary according to the particular expertise required for specific tasks.

The individual appointed to the position of special advisor would need to be someone who commands respect from professionals in the field, has the skills to direct a complex policy and program initiative and is able to deal effectively with people from various disciplines and perspectives. Such an appointment might best be made through executive interchange (Interchange Canada).

This position should be created for a period of three years, and the progress of the initiative evaluated at the end of that time to determine if it has been effective, and what further steps are indicated.

Appendix A

Working Group Members

Dr. Bob Cormier, Ministry of the Solicitor General (Chair)
Dr. Frank Porporino, Correctional Service of Canada
Ms. Cathy Gainer, National Parole Board
Dr. Steve Wormith, Ontario Ministry of Correctional Services
Dr. Karl Hanson, Research Consultant

Provincial/Territorial Representatives

Newfoundland:	**Ms. Wanda Lundrigan,** Department of Justice
Prince Edward Island:	**Mr. John Bruce,** Department of Justice & Attorney General
Nova Scotia:	**Mr. Bob Lutes,** Department of the Attorney General
New Brunswick:	**Ms. Brenda Thomas,** Department of the Solicitor General
Québec:	**Ms. Lynn Carter,** Ministère de Sécurité Publique du Québec
Ontario:	**Dr. Steve Wormith,** Ontario Ministry of Correctional Services
Manitoba:	**Ms. Jean Kopstein,** Department of the Attorney General
Saskatchewan:	**Mr. Garth King,** Ministry of Justice
Alberta:	**Mr. John Pascoe,** Ministry of the Solicitor General
British Columbia:	**Mr. Henry Mathias,** Ministry of the Attorney General
Yukon:	**Mr. Larry Saidman,** Corrections and Law Enforcement
Northwest Territories:	**Mr. Doug Friesen,** Social Services

Appendix B

Sex Offender Treatment Review Terms of Reference

1. Review the international literature with a particular focus on evaluation research and outcome data;
2. Describe and assess Canadian treatment programs focusing on:
   A) Needs assessment - (What kinds of sex-offenders do we have, in what numbers and what is their amenability to treatment?)
   B) Program specialization - (to what specific needs and offender types are programs aimed?)
   C) Assessment procedures, generally and especially for those who pass an initial screening and are to receive treatment;
   D) Treatment methods;
   E) Follow-up and evaluation data (what criteria for success/failure have been established and what outcome data are available);
   F) What after-care programs are there? Who offers them to whom, under what conditions, and with what effects?
3. Develop recommendations for treatment of federal offenders and ongoing data collection for evaluative purposes (in some detail and with realistic cost estimates).
4. Develop recommendations to maximize the effective matching of offenders and programs.
5. Draft a final report in consultation with federal and provincial participants.
6. Report to the Minister with realistic action options and plans.

Appendix C

Individuals Contacted by the Working Group

J.	Aubut	l'Institut Philippe Pinel
M.	Bamboyne	CSC (Quebec)
H.	Barbaree	Queen's University
A.	Bell	CSC (Atlantic)
E.	Beltrami	Université de Québec à Montréal
H.	Bergen	RPC (Prairies), Saskatoon
R.	Berry	Thistletown Regional Centre
K.	Bita	Clarke Institute of Psychiatry, Toronto
E.	Black	Alberta Hospital, Edmonton
L.	Boon	Stave Lake Correctional Centre, B.C.
L.	Boudreau	Université de Moncton
J.	Bourque	CSC (Pacific)
J.	Bradford	Royal Ottawa Hospital
L.	Cargill	Alberta Hospital, Edmonton
L.	Casey	CSC (Atlantic)
M.	Cheslock	Community & Youth Correctional Services, Manitoba
J.	Cliche	Sécurité Publique, Québec
C.	Cloutier	CSC (Quebec)
N.	Connacher	RTC (Ontario), Kingston
W.	Coombs	Alberta Hospital, Edmonton
M.	Couture	Centre Hospitalier Robert Giffard
N.	Couture	Centre Hospitalier Robert Giffard
P.	Crookall	CSC (Atlantic)
H.	Davidson	CSC (Atlantic)
J.G.	Desrosiers	CSC (Quebec)
B.	Deurloo	CSC (Ontario)
J.	Earle	CSC (Atlantic)
J.	Eastabrook	RTC (Ontario), Kingston
D.	Eaves	B.C. Forensic Psychiatric Services
L.	Ellerby	Native Clan Organization, Winnipeg
E.	Ellis	University of Manitoba
S.	Ferguson	NPB (Ontario)
R.	Fontaine	CSC (Atlantic)
J.	Fransblow	RPC (Pacific) Abbotsford, B.C.
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J.	Frost	CSC (Pacific)
O.	Gaudet	CSC (Atlantic)
N.	Gerard	l'Institut Philippe Pinel

W.	Glackman	Simon Fraser University
L.	Glancy	RPC (Pacific), Abbotsford, B.C.
A.	Gordon	RPC (Prairies), Saskatoon
K.	Graham	CSC (Atlantic)
J.	Greene	Emmanuel House, St. John's
D.	Harder	Therapist, Saskatoon
M.	Harris	B.C. Forensic Psychiatric Services
R.	Hartry	E.A.P., Province of Manitoba
D.	Hawken	RTC (Ontario), Kingston
G.	Helm	CSC (Atlantic)
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T.	Ho	CSC (Ontario)
J.	Homer	CSC (Pacific)
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S.	Hucker	Clarke Institute of Psychiatry, Toronto
R.	Johnson	CSC (Pacific)
V.	Kelman	Special Committee on Child Abuse, Toronto
M.	Kitchur	Child and Family Services, Winnipeg
L.	Kitts	CSC (Prairies)
T.	Kozak	Child and Family Services, Brandon
R.	Kuncoewicz	Marymound Family Centre, Winnipeg
N.	Ladha	Memorial University of Newfoundland
B.	Lamoureux	l'Institut Philippe Pinel
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R.	Lang	Alberta Hospital, Edmonton
R.	Langevin	Clarke Institute of Psychiatry, Toronto
R.	LaTorre	B.C. Forensic Psychiatric Services
D.	Lavigne	RTC (Ontario), Kingston
J.G.	Leger	RTC (Ontario), Kingston
K.	Leinweber	South East Specialized Supervision Unit, Vancouver
G.	Lowrey	Central Toronto Youth Services
S.	Lyth	Carleton Centre, Halifax
F.	Madryga	Therapist, Kamloops, B.C.
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C.	Manuge	CSC (Atlantic)
W.	Marshall	Queen's University, Kingston
F.	Matthews	Central Toronto Youth Services
L.	McClung	CSC (Quebec)
M.	McCormack	Department of Social Services, Newfoundland
A.	McKibben	l'Institut Philippe Pinel
A.	McManaman	Ontario Correctional Institute, Brampton
M.	Middleton	B.C. Forensic Psychiatric Services

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R.	Morris	Adolescent Health Counseling Service, St. John's
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R.	Rockstro	CSC (Atlantic)
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K.	Skinner	CSC (Prairies)
C.	Smiley	RPC (Pacific), Abbotsford, B.C.
D.A.	Solway	Hinton Social Services, Alberta
C.	Sparling	CSC (Ontario)
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L.E.	Stermac	Clarke Institute of Psychiatry, Toronto
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C.	Taylor	Acadia University
P.	Thauberger	Alberta Solicitor General
G.	Thomas	CSC (Pacific)
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S.	Williams	RTC (Ontario),Kingston
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Probation Service Sexual Offenders Group Program, Winnipeg, Manitoba.
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Fresh Start Group, Brandon, Manitoba.
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South East Specialized Supervision Unit, Vancouver, B.C.
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