

**Current Practices in  
Canadian Sexual Abuser  
Treatment Programs: The  
Safer Society 2009 Survey**

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This report is a summary of the Canadian findings of the 2009 Safer Society Survey: Current Practices and Emerging Trends in Sexual Abuser Management (McGrath, Cumming, Burchard, Zeoli, & Ellerby, 2010). Copies of the full report are available for download, free of charge, from [www.saferociety.org](http://www.saferociety.org).

Specialized treatment for sexual offending is a relatively new field, having its origins in the late 1970s. Early programs used a trial and error method of determining what worked until research could provide additional insight into the aetiology of sexual offending and effective treatment of it. To help programs exchange information and to build on one another's successes, Safer Society Foundation began surveying United States programs in 1986. Since then the survey has been conducted every two to six years. The survey provides a wide-angle snapshot of assessment and treatment practices which can now be compared with research findings to determine whether they reflect current best practices. In 2009, the survey was conducted for the ninth time and for the first time included Canadian programs.

### **Method**

Treatment providers completed an online survey that asked them to provide information about several components of their programs. A program was defined as treating only one age group (adult, adolescent, or child) and one gender, and was classified as either a community or institutional program. Several organizations distributed information about the survey to providers on their mailing lists. Organizations that assisted with distribution in Canada included the Association for the Treatment of Sexual Abusers (ATSA), Correctional Service of Canada (CSC) and Safer Society Foundation (SSF). Data was collected between April 13, 2009 and May 24, 2009. Usable data from 72 Canadian programs located in nine provinces were received. Of the 72 programs, 32 (44.5%) provided treatment to adults, 24 (33.3%) to adolescents, and 16 (22.2%) to children. Services were provided to 3,020 individuals in 2008, of whom 222 (7.4%) were female. The majority of the clients served were adults (78.6%), while adolescents represented 12.7 percent of the client population and children accounted for the remaining 8.6 percent. Most programs were community based (81.9%) and these programs served 62.1 percent of the clients. Institutionally-based programs accounted for 18.1 percent of the sample and served 37.9 percent of the clients. Due to low response rates, results are reported for only community-based programs and adult male institutional programs.

The survey results were compared with research identified best practices in the delivery of services to sexual offenders.

### **Key Findings**

The results of this survey suggest a large percentage of programs follow practices shown to be effective in reducing reoffending. Survey results also highlight areas where practice differs from findings in the research literature and may be helpful in assisting programs to consider their structure and content. Overall, it is encouraging that sexual abuser treatment programs in Canada are conforming to what is currently considered best practice in the field.

#### *Staff Training*

An advanced degree indicates a minimum level of advanced professional training. More than a third of all providers held a doctorate degree, while more than 70 percent of treatment providers held either a doctorate or a master's degree. Additionally, many programs reported providing clinical supervision and on-going training to their staff. Over three-quarters of institutional programs and nearly half the community-based programs provided clinical supervision for staff. Ongoing training primarily involved attendance at national conferences, attendance at local or regional trainings and in-house training. About a quarter of adult male programs and half the adult female programs identified attending to staff wellness issues as part of professional development.

### *Program Models*

The survey asked respondents to select from a list of thirteen theories the three that best described their treatment approaches. Over 60 percent of adult and adolescent programs selected the cognitive-behavioural model as a top three choice. This model was most often selected as the primary model by all program types. The cognitive-behavioural approach is arguably the most investigated and empirically supported approach with this population.

The risk, need, and responsivity model forms the cornerstone of national adult sex offender treatment programs in several countries, including Canada. A majority of treatment providers, however, did not select this model as a top three choice. : Of particular note, only 16 percent of adult male community-based programs, which serve the largest number of clients, choose this model as a top three choice.

Relapse prevention has been a standard approach to sexual offender treatment. More recently, however, considerable criticism has been levelled by practitioners and researchers against this approach. Criticisms include that it describes only one pathway to offending, overemphasizes avoidance as opposed to approach goals, and has little support in the treatment outcome literature. Relapse prevention was the second most endorsed model overall, but was chosen by less than 16 percent of programs as the primary theory.

The self-regulation and good lives models attempt to address the perceived failings of the relapse prevention model. Seventy-five percent of the adult institutional programs selected the self-regulation model as a top three choice, and over 20 percent of the adult and adolescent community-based programs also selected it as a top three choice. The relatively recent good lives model appears to be garnering popularity and was identified as a top three choice for 75 percent of the adult female programs, 50 percent of the adult male programs and 20 percent of all adolescent programs.

The most common theoretical bases for programs serving children are the cognitive-behavioural, family systems, sexual trauma, and psycho-social educational models.

### *Assessment Methods*

The research literature has identified the importance of using evidenced-based risk assessment methods and the number of programs doing so in Canada is high. Sex offender specific actuarial risk assessment instruments were nearly universally employed in adult male programs, with only one program not reporting their use. The most commonly used actuarial instrument is the Static-99. Use of dynamic risk assessment measures is also common, with 87.5 percent of institutional adult male programs and 63 percent of adult male community-based programs reporting their use. The Stable 2007 and Acute 2007 are the most widely used measures. Three structured risk assessment instruments, the ERASOR, J-SOAP-II, and JSORRAT-II are in common use with adolescent males. Two-thirds of programs serving this population report using one or more of these instruments.

Psychophysiological instruments can also be used for assessment. The polygraph is employed post-conviction to verify treatment and supervision compliance. The use of polygraph was rare in Canadian programs with no institutional programs for adult males using this procedure and 10.5 percent of the adult male community-based programs reporting polygraph testing. Penile plethysmography measures penile tumescence, typically with a strain gauge, as an individual attends to slides, audio-tapes or video-tapes depicting various appropriate and inappropriate sexual stimuli. Over three-quarters (87.5%) of adult male institutional programs use the penile plethysmograph. Use of the penile plethysmograph was reported by 37 percent of the adult male community-based programs and by 20 percent of adolescent male community-based programs.

Viewing time measures compute the length of time an individual views slides of males and females of different ages. Response times reflect an individual's sexual interests. Twenty-five percent of adult male institutional programs reported use of viewing time measures. Community-based programs for males used

it less frequently, with 10.5 percent of adult programs and 13.3 percent of adolescent programs reporting its use.

### *Treatment Targets*

Over the past decade a series of meta-analyses have identified the types of problems abusers have that are linked to their risk for sexual re-offending. These problems, commonly referred to as criminogenic needs, are believed to be the most important treatment targets for reducing recidivism. Survey respondents' reported treatment targets, however, are often at odds with this research. Offence responsibility and victim empathy, for example, are targeted by at least half of programs for adult and adolescent abusers yet, little evidence exists that focusing on these issues in treatment results in reduced reoffending rates. In contrast, sexual abusers who show evidence of offence-supportive attitudes and who display problems controlling their sexual arousal (e.g., sexual obsessions and deviant sexual interests) have increased rates of sexual reoffending. A comparatively smaller percentage of programs, however, report targeting these issues in treatment. Some caution in the interpretation of these findings is needed since survey respondents were asked whether they targeted a particular issue, not how much emphasis they placed on it.

Three-quarters of all adult programs target intimacy/relationship skills, emotional regulation, and social skills. The most common treatment targets for adolescent and child programs are victim awareness and empathy, intimacy/relationship skills, problem solving, social skills, and family support networks.

In contrast to community based programs, a majority (75%) of adult male institutional programs reported attending to arousal control. Covert sensitization, a procedure in which an individual imagines successfully dealing with situations linked to reoffending, is the most common method used by both community-based and institutional programs. Medications are sometimes used to treat abusers' sexual arousal control problems and reduce their sexually obsessive thoughts. For these purposes, the most commonly used medications are SSRI's, a class of commonly used antidepressants. Physicians prescribed them to abusers in 47 percent of adult male community-based programs and 75 percent of adult male institutional programs. Programs also use antiandrogens, testosterone-lowering medications. Approximately 30 percent of adult male programs use one or more antiandrogen medications. Medications to control arousal are used by 75 percent of institutional programs for adult males, and 63 percent of community-based programs. Only one-quarter of adolescent male programs and adult female programs use these medications and no programs for children did so.

### *Treatment Dosage*

Treatment dose refers to the type, amount, frequency, and duration of treatment services. Wide variations exist in treatment dose among program types. Group treatment is the most common treatment modality for adult males. All of the community-based programs reported using it, as do 88 percent of the institutional programs. Among all community-based programs, individual treatment is the most commonly used modality, with all but one adult male program reporting its use. Half of the institutional programs for adult males also use individual treatment. At least 85 percent of all programs for children and adolescents provided family therapy to their clients. Less than 30 percent of adult community-based programs provided family or couples treatment.

The average number of treatment hours needed to complete a treatment program ranged from 183 hours for adolescent males in community-based programs to 33 hours for female children in community-based programs. The average number of months required to complete treatment programs ranged from five for adult males in institutional programs to twelve for adolescent males and females in community-based programs. Most programs reported providing aftercare or step-down services to their clients, although the practice is not universal. More than half of all Canadian community programs identified providing aftercare and step-down services. Respondents were asked to estimate what percentage of clients who began their program completed it. Completion rates range from 89 to 96 percent.

## **Comparison of Treatment Delivery Between Canada and United States Programs**

Overall, sexual abuser treatment programs in Canada and the United States report very similar practices. A few noteworthy differences were found however. Canadian community programs are more often operated by public organizations and thus are funded by provincial and federal payments. United States community programs are generally operated by private organizations, and are funded by client self-payment.

As noted above, polygraph testing to verify treatment and supervision compliance is not common in Canada. In the United States this practice is common, and data indicates the practice continues to increase. Seventy-nine percent of the adult programs in the United States reported using polygraphs, and 50 percent of adolescent programs reported doing so. In 2002, 70 percent of the adult programs reported using polygraph, as did 44 percent of the adolescent programs. The continuing increase in use of the polygraph is noteworthy given that its use has not been shown to reduce sexual reoffending.

In addition to asking if programs targeted offence responsibility, they were also asked what level of offence disclosure was required for successful program completion. None of the Canadian programs required clients to fully disclose their sexual offending behaviour for successful program completion. One-quarter of the community-based programs and one-third of the institutional programs for adults do not require any offence disclosure to complete their programs. In contrast, about one-third of adult programs and one-quarter of adolescent programs in the United States require nearly full disclosure for successful program completion. Less than 10 percent of adult and adolescent programs in the United States did not require any disclosure for successful completion.

The treatment dose in Canada is typically much lower than that in the United States. For example, adult male institutional programs in Canada provide a median dose of 100 hours of treatment over five months. Programs for this population based in the United States have a median dose of 348 hours delivered over 18 months. An issue the survey did not address is whether abusers were enrolled in other treatments, such as cognitive skills and substance-abuse programs, a common practice in Canada. It is not known if treatment programs took these additional methodologies into account when calculating treatment dose.

## **Conclusions**

Fortunately, considerable research evidence now exists about the types of treatment programs that are most effective in reducing reoffending among sexual abusers (Hanson, Bourgon, Helmus & Hodgson, 2009). The results of this survey suggest a large percentage of programs in Canada are following the best practices identified in this literature. The survey results also identify areas for programs to consider in contrasting their practices with the current state of the research literature in the field. For the most part Canadian and US programs are similar in their practices however some interesting and noteworthy difference did emerge which warrant further consideration and exploration. Given the overall practices identified in the survey, individuals who have sexually offended, their families, victims, program funders, policy makers, and the public can have increased confidence in services delivered in accordance with evidence-based practice. Through these types of efforts and continued research into effective treatment and management practices, reductions in sexual victimization can occur so that we can all contribute to making our society safer.

## References

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