Current Practices and Emerging Trends in Sexual Abuser Management

The Safer Society 2009 North American Survey

Robert J. McGrath • Georgia F. Cumming • Brenda L. Burchard
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We contacted the presidents of all of the state and regional ATSA associations and are grateful for all they did in passing along information about the survey to their members. In addition, we greatly appreciate the assistance of Sarah Lopez of Abel Screening, Inc., and the staffs of Behavioral Technology, Inc. and Limestone Technologies, Inc., for their willingness to forward information about the survey to their customers.

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Executive Summary

This 2009 Survey is the ninth survey of sexual abuser treatment programs and models conducted by the Safer Society Foundation (SSF). It reports on data collected from programs throughout the United States, and for the first time, on data from Canadian programs. The survey presents a wide-angle snapshot of current practice patterns in North America, identifies trends in the field and offers recommendations for improving the delivery of services.

This is the first SSF survey conducted on the Internet. Results are reported for twelve types of programs. The survey defined a *program* as treating only one age group (i.e., adult, adolescent, or child) and one gender, and was classified as either a community or a residential program. Due to low response rates, the data on Canadian residential programs is only reported for adult males.

The report contains the responses of 1,379 sexual abuser treatment programs and represents all 50 states, the District of Columbia, and nine Canadian provinces. During calendar year 2008, the United States programs provided services to 53,811 individuals who committed sexual offenses and the Canadian programs served 3,020 individuals.

Chapters in the report are organized around best practices that guide the delivery of services to this population. Programs that follow best practices use evidence-based models of change. They use trained staff. They adhere to the risk, need, and responsivity principles. In other words, the programs match the intensity of services to the client's risk level (risk principle). They focus treatment on problems that are directly linked to offending behavior (need principle). The programs use effective methods, typically cognitive-behavioral and skills-based interventions matched to the learning style of the individual (responsivity principle). They provide aftercare services. Staff collaborate with other professionals, such as probation and parole officers, to coordinate services. Finally, the programs monitor and evaluate their effectiveness and are committed to continuous quality improvement.

KEY FINDINGS

The results of this report suggest a large percentage of programs in the United States and Canada are following practices shown to be effective in reducing reoffending.

Program Setting

Over 80 percent of programs responding to the survey are community based. This is an encouraging finding because the general correctional literature on adolescents who commit criminal offenses indicates that community treatment is typically more effective than treatment delivered in residential settings. For adults who have sexually offended, some studies have found a similar benefit for community treatment, whereas other studies find no difference in outcomes based on setting. Of course, community treatment is typically much less expensive than residential treatment.

Funding

The survey data do not provide information on the stability of programs' funding streams but do provide information on the nature and diversity of profit status and funding sources. In the United States, private organizations operate about 90 percent of the community programs, whereas in Canada, public organizations operate about 60 percent of the community programs. Community programs typically have diverse funding sources. In the United States, the most common funding source is client self-pay; in Canada, it is provincial and federal funding. Throughout North America, most residential sexual abuser services for adults are provided through prison programs that are operated by the government.

Staff Training

Although having an advanced degree does not ensure competence as a treatment provider, it does indicate a minimum level of advanced professional training. Survey results reveal that Canadian treatment staff typically have a higher level of formal education than those in the United States. Overall, more than a third of Canadian providers hold doctorate degrees whereas less than 15 percent of United States providers do. In community programs in both countries, more than 70 percent of treatment staff have a masters or doctorate degree. In residential programs for children and adolescents in the United States, 50 percent or more of treatment staff have a bachelors' level education or less. Most programs report that they provide clinical supervision and ongoing training to their staff.

Program Models

To indentify programs' primary treatment model, respondents were asked to rank, from a list of thirteen theories, the three theories that best describe their approach. The cognitive-behavioral model was selected most often by programs, typically by a wide margin regardless of country, program setting, age, or gender of clients served. In the United States, 86 percent or more of programs for adults and adolescents selected the cognitive-behavior model as one of the top three choices with a slightly lower percentage of Canadian programs selecting it. The cognitive-behavioral model is an empirically supported approach for working with these populations.

Relapse prevention was the second most endorsed model, typically by more than 50 percent of programs. The number of United States respondents endorsing it as an influential theory has decreased since the 2002 survey for all program types. These decreases, many of which are statistically significant, likely reflect the considerable criticism leveled by practitioners and researchers against relapse prevention in recent years. 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.

The self-regulation and good lives models attempt to address the perceived failings of the relapse prevention model. Both were included in the 2009 survey for the first time. About one-third of United States adult and adolescent programs selected the good lives model as a top-three choice and about one-quarter of these programs selected the self-regulation model. One-half or more of the Canadian adult programs listed the good lives model among their top-three choices.

This is the first survey in which the risk, need, and responsivity model was listed as a theory choice. Despite the fact that it forms the cornerstone of national adult sex offender treatment programs in several countries, including Canada, England, Scotland, and Hong Kong, it was typically selected by less than a third of the programs.

Among programs for children in the United States, the sexual trauma model is endorsed much more now (39%) than in the 2002 survey (23%).

This change may reflect an increasing awareness about the impact of trauma on children. Although multisystemic therapy, an approach that involves the client's family and natural support system, is one of the most empirically supported treatments for adolescents who sexually offend, only 17 percent or fewer of the North American programs for this population list it as a top-three choice. Almost all of these programs, however, do provide family therapy, which is important because most youth who sexually offend live with their families or will return to them following residential treatment.

Assessment Methods

The percentage of programs using evidence-based risk assessment methods continues to increase. United States adult male programs that use one or more of several established actuarial risk instruments have increased from about three-fifths of the programs in 2002 to almost nine-tenths in the current survey. All but one Canadian program report using a sex offender specific actuarial risk instrument. Across North America, the Static-99 is the most commonly used actuarial instrument, by a large margin.

Forty-five percent or more of sexual abuser programs for adult males in North America now use one of three dynamic risk assessment measures listed in the survey. The most commonly used are the Stable 2007 and the Acute 2007.

For adolescent males, three structured risk-assessment instruments are now in common use, ERASOR, J-SOAP-II, and JSORRAT-II. In the United States, programs' use of one or more of these instruments has increased significantly from about two-fifths of the programs in 2002 to over three-quarters in the current survey. In Canada, two-thirds of programs report using one or more of these instruments.

The survey also examined trends in the use of five psychophysiolgical assessment instruments: the penile plethysmograph, vaginal plethysmograph, viewing time measures, polygraph, and voice stress testing.

The penile plethysmograph is a measure of sexual arousal for males. It measures penile tumescence, typically with a strain gage, as an individual attends to slides, audio-tapes, or video-tapes that depict various appropriate and inappropriate sexual stimuli. The percentage of United States programs reporting use of the penile plethysmograph has remained relatively constant over the last two decades. In the present survey, 28 percent of adult community programs and 37 percent of adult residential programs use it. The penile plethysmograph is used by 9 percent of both community and residential adolescent programs. Canadian practice patterns differ only among adult male residential programs where seven out of eight programs (88%) report using the penile plethysmograph.

The vaginal plethysmograph uses a small glass photodetector to measure vaginal blood flow, an indicator of sexual arousal in women. Only two programs for adult females in North American report using this assessment procedure and no adolescent program reports its use.

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. In United States' adult male community programs, the use of viewing-time measures increased from 32 to 46 percent of programs between the 2002 and 2009 surveys. Viewing-time measures are now used more often than the penile plethysmograph in United States programs for adult males and in community programs for adolescent males. Fifteen percent of all Canadian programs report using a viewing-time measure.

Programs employ the polygraph post-conviction to verify treatment and supervision compliance. Polygraph use continues to increase in the United States, from 30 percent of adult programs

in 1996, to 63 percent in 2000, 70 percent in 2002 and 79 percent in the current survey. During this same time period, adolescent programs' use of the polygraph rose from 22 percent in 1996 to 50 percent in the current survey. Less than 10 percent of programs in Canada use the polygraph. These dramatic increases in the United States are particularly noteworthy given that polygraph use has not been shown to reduce sexual reoffending.

Voice stress testing is reported to be an alternative to polygraph testing but fewer than 2 percent of North American programs use it.

Treatment Targets

Over the past decade a series of meta-analyses have identified the types of problems abusers have that are linked to their sexual offending. These problems, commonly referred to as criminogenic needs, are believed to be the most important treatment targets for reducing sexual offending. Survey respondents' reported treatment targets, however, are often at odds with this research. Offense responsibility and victim empathy, for example, are targeted in almost all 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 offense-supportive attitudes and who display problems controlling their sexual arousal (e.g., sexual obsessiveness and deviant sexual interests) have increased rates of sexual reoffending. A comparatively smaller percentage of programs, however, report that they target 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. In addition to asking if programs targeted offense responsibility, respondents were asked additional questions about this same issue. In the United States, about one-quarter of adolescent programs and one-third of adult programs require clients to make near complete disclosure of their sexual offending behavior for successful program completion. Few, less than 10 percent, required no offense disclosure to complete the program. In contrast, no Canadian programs responding to the survey require abusers to fully admit their sexual offending behavior in order to successfully complete treatment. In fact, nearly one-third of Canadian programs for adults do not require any offense disclosure to complete their program.

In the United States in 2009, over half of all programs for adult and adolescent males use one or more behavioral sexual arousal control techniques. Covert sensitization, a procedure in which an individual practices imagining successfully dealing with situations linked with reoffending, is the most common technique. Community programs for adult and adolescent males and females showed a significant increase since the 2002 survey in the use of minimal arousal conditioning, a variation of covert sensitization. In Canada, three-quarters of residential programs for adult males use behavioral sexual arousal control techniques, but only about a third of community programs for adult males do so.

Programs sometimes use medications 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 or more of United States and Canadian programs for adult males. Programs use antiandrogens, testosterone-lowering medications, much less and the use of that type of drug appears to be declining in the United States. Between 2000 and 2009, the use of the antiandrogen, Provera, in adult community programs dropped from 31 to 17 percent and, in residential programs for this same population, from 41 to 18 percent. Antiandrogen medications are very

expensive and the decline in usage may be attributable to decreased program funding.

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 in both community and residential programs for adult males, and is used in 88 percent or more of these programs. For all other program types, individual treatment is the most commonly used modality, being used by 90 percent or more of programs. As noted in previous SSF surveys, some programs report providing individual treatment because they do not have enough clients to conduct group treatment. Programs for adult and adolescent female sexual abusers typically find themselves in this situation. Across all types of programs, the younger the client, the more likely treatment is to involve family members.

Reported treatment dosage in United States sexual abuser programs typically is much greater than in Canada. For example, in adult male residential programs in the United States, core treatment is a median of 348 hours over 18 months. In Canadian programs for this population, the dose is 100 hours over five 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 consideration when calculating treatment dose. Regardless, psychological and medical treatments can help individuals improve their behavior, contribute to them choosing worse behaviors, or make no difference. The appropriate treatment dosage for various abuser risk and need levels should be an important research agenda.

Specialized Services

In both the United States and Canada, one half or more of all program types offer specialized services to sexual abusers who have developmental disabilities. A similar percentage of programs offer services to individuals with psychiatric disabilities. Few programs surveyed provide services to hearing-impaired clients.

Aftercare and Support Services

Most programs report providing aftercare or step-down services to their clients, although the practice is far from universal. For each population, fewer residential programs reported providing aftercare services than did their community-based counterparts. How often other organizations provide aftercare services to clients released from residential programs is unclear. Arguably, clients returning to the community from a residential facility often need considerable transitional support services.

In the United States, 88 percent or more of programs serving adolescents and children report involving family members or significant others in the treatment process. Almost 80 percent of community programs for adults involve support people in treatment but less than half of adult residential programs do so. In Canada, more than 71 percent of programs serving adolescents and children report involving either family members or significant others in the treatment process. None of the Canadian residential programs for adult males responding to these questions report providing these types of supports.

Collaboration Among Service Providers

In order to facilitate communication between service providers, most programs require clients to sign a waiver of confidentiality as a condition of program admission. Almost all programs serving

adolescent and adult males and females in the community report exchanging information with probation and parole officers and caseworkers.

The practice of probation and parole officers and caseworkers visiting treatment groups occurs in about half of community programs for adult males (53%) and adult females (45%). This practice is much less common in Canadian programs for adult males (17%) and females (0%). Co-therapy teams of treatment providers and probation and parole officers or caseworkers are relatively rare in United States community programs for adult males (9%) but more common in Canada (28%). Most respondents to the survey said their programs do not exchange information with victim advocates.

Monitoring and Evaluation

Programs should monitor and evaluate their services and work to continually improve their quality. Many programs seek accreditation or certification by outside organizations which provides for regular reviews by external consultants. Some programs also utilize less formal external review processes. In the United States, 8-14 percent of community programs and 21-35 percent of residential programs report that they utilize such external consultants. In Canada, 0-33 percent of programs report using external consultants.

Respondents also were asked to estimate what percentage of clients who begin their program also complete it. In the United States, residential programs for adult males have the lowest average completion rate, at 71 percent. Program completion rates for all other types of programs are slightly higher and remarkably similar to each other, ranging from 77-89 percent. Adolescent and children's programs have slightly higher completion rates than adult programs. Canadian treatment programs report the highest completion rates, ranging from 89-96 percent.

Provider Opinions about Sex Offender Legislation

For the first time, the survey examined providers' views about the impact of recent sex offender legislation, namely registration, community notification and residency restrictions for both adolescents and adults. Overall, respondents report they have little confidence that these laws enhance community safety and many providers report they believe the laws actually reduce community safety. The only exception is that 51 percent of United States providers report they believe adult registration laws enhance community safety.

CONCLUSIONS

Fortunately, considerable research evidence now exists about the types of treatment programs that are most effective in reducing reoffending among sexual abusers. The results of this report suggest a large percentage of programs in North America are following the best practices identified in this literature. 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, reductions in sexual victimization can occur so that we can all contribute to making our society safer.

We express our appreciation to the numerous sexual abuser treatment providers who took the time to complete this survey. We also look forward to the Safer Society Foundation having the opportunity to periodically update the survey in order to document changes in methods and models used by programs throughout North America. Readers are invited to recommend further areas of inquiry and to make suggestions for future Safer Society surveys.

Tables and Figures

Most tables have two versions; one that reports data on United States programs, signified by the suffix "a," and the other on Canadian programs, signified by the suffix "b."

1 Introduction and Overview

This 2009 survey is the ninth survey of sexual abuser treatment programs and models conducted by the Safer Society Foundation[1]. As with past surveys, it reports on data collected from programs throughout the United States and, for the first time, includes data on Canadian programs. The survey contains the responses of 1,379 sex offense specific treatment programs representing all 50 states and the District of Columbia and nine Canadian provinces. During calendar year 2008, the United States respondents provided services to 53,811 male and female adults, adolescents and children in residential and community settings. The Canadian respondents provided services to 3,020 individuals.

The survey presents a wide-angle snapshot of current practice patterns in the United States and Canada and compares them to the findings of previous surveys. It identifies trends in the field and reports on current best practice in assessing, treating, and managing sexual abusers. Lastly, this report offers recommendations for improving the delivery of services crucial to successful treatment outcomes for this population.

HISTORY OF THE SURVEY

In 1976, under the direction of its founder, the late Fay Honey Knopp, the Safer Society Foundation (SSF) began tracking the development of specialized sexual abuser treatment programs. As a Quaker and prison reformer, Ms. Knopp became certified as a "recorded Quaker minister" so that she could visit inmates in prisons throughout the United States. In that work, she became concerned by the lack of specialized treatment services available for sexual abusers. She began developing a database of programs, and SSF soon became a referral source for abusers, their families, professionals, and others. Her primary motive for tracking and advocating for expanded and high quality specialized sexual abuser services was to further her goal of creating a safer society. Through this effort, as well as through her writing and other advocacy activities, she became perhaps the most influential early champion for the development and improvement of programs and services for individuals who commit sexual offenses.

Ms. Knopp published the Safer Society Foundation's first nationwide survey in 1986 (Knopp, Rosenberg, & Stevenson, 1986). The survey has been repeated at two-to-six-year intervals, but it has evolved and changed over the years. The initial two-page survey questionnaire was designed to collect relatively limited data focusing on adult and adolescent programs. In 1994, the survey began collecting data about programs that served children with sexual behavior problems. This and other expansions of the survey reflect efforts to provide a more comprehensive and detailed examination of this highly specialized and evolving intervention field.

Results of previous SSF surveys are referenced throughout this report and, for simplicity, are identified by the year in which the survey was con-

Table 1.1 Safer Society nationwide surveys, 1986-2009		
Survey Year	**Authors**	**Publication Year**
1986	Knopp, Rosenberg and Stevenson	1986
1988	Knopp and Stevenson	1989
1990	Knopp and Stevenson	1990
1992	Knopp, Freeman-Longo and Stevenson	1992
1994	Freeman-Longo, Bird, Stevenson and Fiske	1995
1996	Burton, Smith-Darden, Levins, Fiske and Freeman-Longo	2000
2000	Burton and Smith-Darden	2001
2002	McGrath, Cumming and Burchard	2003
2009	McGrath, Cumming, Burchard, Zeoli and Ellerby	2010

ducted. These surveys, the years in which they were conducted, the authors, and publication dates are listed in Table 1.1. Full citations for these surveys are found in the References section of this report.

PURPOSES OF THE SURVEY

Despite changes in the scope of the survey over the last two decades, its primary purposes remain essentially the same. As with past surveys, the purposes of the current survey are four-fold.

1. **Monitoring Trends**. The survey is designed to aid in identifying current assessment, treatment, and management practices in the field and to monitor changes and trends in these practices. These data also can be used to identify important areas for research. In fact, past surveys have been cited often in the research literature and at conference presentations.
2. **Program Development**. Policy makers, program developers and service providers can use the results of the survey to compare their program models and methods with others in the United States and Canada. The results offer a view of accepted and emerging approaches in the field. Of course, what is common practice is not always evidence based or best practice. For this reason, where possible, the research basis for the practices described in the current survey is reported and warrants due consideration.
3. **Networking**. The survey is designed to facilitate communication, professional development and training among service providers. By identifying programs that use specific treatment methods or that treat specialized populations, providers with similar interests easily connect with each other.
4. **Referral**. The survey is used to help maintain a database of specialized treatment programs in the United States by location, setting, and specialty for individuals who commit sexual offenses. This information enables SSF to respond to referral requests from individuals, programs, professionals, and family members seeking these specialized assessment and treatment services.

METHOD

Sample

Treatment professionals returned 597 surveys. Of these, 549 surveys met criteria for inclusion in this survey. Of the 48 unusable surveys, six were excluded because they were from a program lo-

cated outside North America. Forty-two program responses were excluded because they did not provide sex offense specific treatment during 2008. Of the usable surveys, 515 were from programs in the United States and 34 from Canada.The 549 returned useable surveys contained information on 1,379 treatment programs; 1,307 from the United States and 72 from Canada. Represented in the survey results are programs from each of the 50 United States, the District of Columbia, and nine Canadian provinces. During calendar year 2008, the United States programs provided services to 53,811 individuals. The Canadian programs provided services to 3,020 individuals.

Survey Questionnaire

This is the first SSF survey conducted on the Internet. All of the previous SSF surveys were questionnaires done on paper. As with recent SSF surveys, we used a modified version of Dillman's (2007) Tailored Design Method to develop the survey questionnaire. His methods are empirically based and were chosen in an effort to maximize the quantity and quality of responses to the survey.

Survey questions remained largely unchanged from recent SSF surveys. This approach was chosen to allow for comparisons across programs' responses between the current and past surveys. However, some modifications were made. The lists of program theories and assessment instruments were updated, more questions were included that addressed offense denial and minimization, and new sections on staff training and providers' opinions about recent sex offender legislation were added. The 2009 survey questions are reprinted in the Appendix.

A commercial survey company, Apian, Inc., developed and managed the survey web site. The survey used a branching design. That is, respondents' answers to each question determined what question or series of questions they would be asked next. For example, respondents who indicated that they treated only adult males in a community setting would be shown and asked questions only pertaining to that type of program. Those who indicated that they treated both adolescent and adult males in a community setting would be shown and asked questions about both of those types of programs, and so on. Respondents who served individuals in both community and residential programs were asked about the community programs first and then asked about their residential programs. For most respondents, the survey took about 15-20 minutes to complete.

Distribution

Distribution of the survey was also guided by Dillman's (2007) Tailored Design Method. This involved contacting potential respondents on multiple occasions and by multiple methods.

Several organizations agreed to distribute information about the survey to providers on their e-mail lists, and encourage them to complete it. These were the Association for the Treatment of Sexual Abusers (ATSA), Center for Sex Offender Management (CSOM), Correctional Service of Canada (CSC), National Adolescent Perpetrator Network (NAPN), and Safer Society Foundation (SSF). As well, companies that manufactured physiological assessment instruments used in the field, namely, Abel Screening, Inc., Behavioral Technology, Inc., and Limestone Technologies, Inc., agreed to distribute information about the survey to their customers. Lastly, presidents of state and regional ATSA chapters and directors of state sex offender management boards were contacted to encourage their members to respond to the survey if they had not already done so.

Potential respondents had access to the survey website for 45 days between April 13, 2009 and May 24, 2009, during which time they had the option of completing the survey either in a single occasion or through multiple sittings.

The methods and general timeline used to enlist respondents were as follows:

- A ***pre-survey invitation e-mail*** was sent to potential respondents using e-mail lists from the multiple organizations listed above, describing the nature and importance of the survey. Interested individuals were directed to a web page where they were instructed to enter their name and e-mail address in the provided boxes and click the "send button" on the screen to forward their responses to the survey host. Individuals who opted to participate in the survey were informed that they would receive a unique password in a few weeks that would allow them to enter the site and complete the survey.
- A ***survey opt-in e-mail*** was sent when the survey became available providing each individual with a password to access the survey. Each respondent was asked to click on a link to the survey website, enter the assigned password, and complete the survey. Participants were also informed that they would receive a token of appreciation (a $9.00 coupon for SSF shipping charges) by entering a request for it at the end of the survey. The password system was a way to limit access to the survey to legitimate respondents.
- A ***reminder e-mail*** was sent to individuals who had not yet completed the survey about two weeks after the initial opt-in e-mail was sent. The importance of responding was highlighted, assigned passwords were provided again, and participants were offered assistance with completing the survey.
- ***Follow-up e-mail and post cards*** were sent between four and five weeks after the beginning of the survey period. Blast e-mails were sent to the individuals who made up the initial e-mail lists. These e-mails simply thanked again those who had responded and encouraged those who had not yet responded to do so. During this follow-up period, post cards encouraging individuals to complete the survey were sent to individuals on SSF's mailing list of treatment providers.
- ***Final contacts*** were made two weeks before the close of the survey access period via e-mail to the presidents of local and regional ATSA chapters asking them once again to request that their members complete the survey.

Return Rate

As with past SSF surveys, calculating a response rate was very difficult. It is estimated that over 5,000 sexual abuser treatment providers received an e-mail or post card request to complete the survey. Many of these providers work in organizations that employ multiple treatment providers, however, and the instructions to providers asked that only one person from each organization complete a survey. Unfortunately, because a complete and current count of programs existing in the United States and Canada is not available, the percentage of programs submitting a survey cannot be determined.

INTERPRETATION OF RESULTS

The results of the survey are reported in the chapters that follow. The information provided here is intended to assist the reader in understanding and interpreting the findings. It includes definitions of key terms and concepts and an overview of how the survey findings are presented.

Definitions

Sexual Abuser. This report is about programs that treat individuals who have sexually abused others, and the term "sexual abuser" is used through-

out the document. However, many jurisdictions in North America and professionals in the field use other terms to describe this population, such as "sex offender," "adolescent with sexual behavior problems" and "sexually reactive youth." In this report, these terms should be considered synonymous.

Program. Survey results are reported for twelve types of programs.[2] Following the definition used in the 2000 Survey, a *program* is defined as treating only one age group (i.e., adult, adolescent, or child) and one gender, and is classified as either a community or a residential program. The twelve program types are depicted in Tables 2.2a and 2.2b. Furthermore, while a program may have multiple sites, it is counted as one program as long as it remains within the parameters listed above. An individual practitioner may be counted as having one or multiple programs depending upon the number of age groups and genders served. Programs also are classified as either community-based or residential.

Age Group. As noted above, programs are classified as serving adults, adolescents, or children. Survey respondents were asked to identify which age groups they treated and the methods and models used with each age group. The age ranges used by programs to define these three age groups have some variability. For example, some programs that define themselves as treating adolescents accept individuals as old as 20. Similarly, some adult prison programs accept individuals under the age of 18 because they are housed in an adult correctional facility. For the purposes of this survey, respondents were asked to define their programs within the following parameters.

- **Adults** – 18 years old and above
- **Adolescents** – 12-17 years old
- **Children** – 11 years old and under

Research and Statistical Terminology

We have kept statistical and research terminology to a minimum. Terms with which some readers may not be familiar are explained here.

Missing Data. If a respondent did not answer a question, the data were considered "missing data" and were eliminated from the analysis of that question. The number of programs providing information for each question is identified (*n*=) at the top of each column of the data tables.

Meta-analysis. Many of the research studies referenced in this report are meta-analytic studies. Meta-analysis is a statistical method of combining and reviewing the results of several studies, enabling researchers to obtain more accurate estimates of the effect of an intervention than are obtained when relying on the results of single studies.

Mean. The mean, sometimes called the arithmetic average, is reported in several of the tables in this report. It is the sum of all of the data in a list of responses (i.e., numbers) to a question, divided by the number of items in the list.

Median. The median is the "middle" value in a list of numbers. For example, if the median number of individuals programs treated in 2008 was 100, this means that half the programs treated more than 100 individuals and half treated less than 100 individuals.

Standard Deviation. The standard deviation is included in parentheses in some of the tables. It is a measure of how closely programs' responses to a question are clustered around the mean of all the responses to that question, or the extent to which the responses "deviate" from the overall mean. When programs' responses are closely clustered, the standard deviation is small. When the responses are widely varied, the standard deviation is relatively large. If programs' responses are in a normal bell-curve pattern, then 99.74 percent of the responses to the question are within the ±3 standard deviations of the average, 95 percent of the responses are within

two standard deviations of the mean, and 68 percent of the responses fall within one standard deviation of the mean. If, for example, the average number of individuals treated in programs in 2008 is 100, and the standard deviation 20, then 99.74 percent of the programs treated between 40 and 160 abusers; 95 percent of the programs treated between 60 and 140 individuals; and 68 percent of the programs treated between 80 and 120 individuals.

Statistical Significance. Some findings in the survey are described as being "statistically significant." This means that they were unlikely to have occurred by chance. To illustrate, if someone flips a coin several times, it should come up heads about half the time and tails about half the time. If someone flips a coin and it comes up heads six of the first ten times; that is, 60 percent of the time, this imbalance may well have occurred by chance. However, if someone flips a coin 400 times and it comes up heads 60 percent of the time, then these results are likely not the result of chance and some irregularity in the coin or how it was flipped likely exists. In the results reported in this study, something will be described as statistically significant if statistical tests (e.g., chi-square) indicate a 95 percent or greater level of confidence that a result did not happen by chance. In the Tables, * and $p < .05$ means a 95 percent or greater level of confidence, ** and $p < .01$ means a 99 percent or greater level of confidence, and *** and $p < .001$ means a 99.9 percent or greater level of confidence.

BEST PRACTICE

The chapters in this report are organized around components of "best practice" in the assessment, treatment, and supervision of individuals who have committed sexual offenses. Defining best practice is, of course, a difficult matter. It is predicated on the belief that certain types of practices are more effective than others.

For areas in which sexual abuser-specific research exists to inform practices, the service models, methods, and trends identified in the survey are contrasted against the interventions and strategies empirically demonstrated to be most effective. Where such research does not exist, other relevant bodies of literature, primarily the general correctional rehabilitation literature described below, are used to help define what constitutes best practices, analyze the data collected, and organize the results.

Sexual Abuser Literature

The knowledge base regarding assessment, treatment, and supervision of sexual abusers has many limitations, but significant advances in the field continue to take place. For example, some treatment models have been found to be more effectiveness than others (e.g., Hanson, Bourgon, Helmus, & Hodgson, 2009; Murphy & McGrath, 2008; Reitzel & Carbonell, 2006; St. Amand, Bard, & Silovsky, 2008) and considerable advancements have taken place in the area of risk assessment (Craig, Browne, & Beech, 2008; Hanson & Morton-Bourgon, 2009). Additionally, several entities and organizations have incorporated the available research literature and expert consensuses into various practice standards and guidelines. These resources include publications by the American Academy of Child and Adolescent Psychiatry (1999), the Association for the Treatment of Sexual Abusers (2005, 2006), the National Adolescent Perpetrator Network (1993), and the National Offense-Specific Residential Standards Task Force (1999). Additionally, several national bodies that oversee treatment services for sex abusers have published thoughtful, research-based practice standards (Correctional Service of Canada, 2000; Home Office Communication Directorate, England, 2000; Scottish Prison Service, 2003).

Correctional Rehabilitation Literature

Providers, programs, and jurisdictions must make decisions about how to deliver services, in spite of limitations in our knowledge base. One way to address this challenge is to draw on the much larger general correctional rehabilitation literature. Fortunately, a considerable amount of research is available that details the types of programs that are most effective in reducing the incidence of criminal behavior (e.g., Andrews & Bonta, 2006; Lipsey & Cullen, 2007; McGuire, 2002; Motiuk & Serin, 2001). This body of research is commonly referred to as the "What Works" literature. This general correctional literature is referenced frequently throughout this report when we compare current practice patterns in North America against these benchmarks and suggest ways to apply these principles and practices to sexual abuser programs. Because many sexual offenders also commit non-sexual crimes (Hanson & Bussière, 1998; Langan, Schmitt, & Durose, 2003), and because some of the risk factors that are linked to recidivism among non-sexual abusers are also linked to recidivism among sexual abusers, it is believed that the general correctional literature is applicable to the theory, assessment, treatment, and supervision of sexual abusers.

Three empirically based principles form the cornerstone of effective correctional services. These are the risk, need, and responsivity principles. Correctional programs that adhere to these principles are found consistently to be more effective than those that do not (e.g., Andrews, 2008; Andrews & Bonta, 2006; Andrews, Bonta, & Hoge, 1990; Andrews, Zinger, Hoge, Bonta, Gendreau, & Cullen, 1990; Harland, 1996; Pealer & Latessa, 2004). Effectiveness is measured by the degree to which services reduce criminal offending. More recently, Hanson and his associates (Hanson & Bourgon, 2008; Hanson, Bourgon, et al., 2009) found that these three principles apply equally as well in reducing sexual reoffending among sex offenders. These principles provide a "who, what, and how" framework for informing assessment, treatment, and supervision decisions in programs.

Risk Principle. The risk principle is founded on research demonstrating that treatment interventions are most effective when they match the level of reoffending risk presented by an individual (Andrews & Bonta, 2006). In other words, people who present a significant risk of reoffending, ideally assessed by validated assessment measures, require the most intensive and extensive services. In contrast, individuals assessed as low-risk require minimal or even no interventions. This principle was first recognized in the general correctional rehabilitation literature twenty years ago (e.g., Andrews, Bonta, & Hoge, 1990; Andrews, Zinger, et al., 1990). Studies in the general field of criminology with adults (e.g., Lowenkamp, Latessa, & Holsinger, 2006) and juveniles (e.g., Pealer & Latessa, 2004) have found continued support for this principle. Recently studies of sex offense specific treatment have yielded positive support, as well (e.g., Friendship, Mann, & Beech, 2003; Hanson, Bourgon, et al., 2009: Lovins, Lowenkamp, & Latessa, 2009). In sum, the risk principle helps programs decide “who” should receive the most intensive services. By using the risk principle, programs can allocate often scarce or limited treatment and supervision resources to those individuals who present the greatest risk to reoffend, and for whom services are most likely to have the greatest impact on reducing victimization rates. Conversely, by using the risk principle, staff can identify lower-risk individuals, for example, those for whom intensive interventions, such as incarceration, may be contraindicated, and preserve the most expensive, and often limited resources for those who present the greatest risk (Gendreau, Goggin, & Cullen, 1999; Gendreau, Goggin, Cullen, & Andrews, 2001).

Need Principle. Research results also have demonstrated that interventions are most effective when they address those factors that are associated

with reoffense risk or what is commonly referred to in the criminology literature as "criminogenic needs" (e.g., Andrews & Bonta, 2006). Said another way, the need principle helps providers decide "what" types of problems to treat. For individuals who have sexually offended, these problems include pro-offending attitudes towards women and children, deviant sexual interests, intimacy deficits, and impulsivity (Hanson & Morton-Bourgon, 2004; 2005). For quite some time, in the general correctional rehabilitation literature, there has been strong evidence that programs can enhance their effectiveness by maximizing the number of criminogenic needs they target and minimizing efforts to target non-criminogenic needs (Andrews, 2001; Andrews & Bonta, 2006; Andrews, Dowden, & Gendreau, 1999). Recently the same has been found to be true in treatment programs for individuals who have sexually offended, as well (Hanson & Bourgon, 2008; Hanson, Bourgon, et al., 2009)

Responsivity Principle. In accordance with the responsivity principle, programs should be offered in a format in which individuals can most successfully respond (Andrews & Bonta, 2006; Kennedy, 2001). The responsivity principle focuses on "how" to deliver services. Broadly, programs delivered using a cognitive-behavioral format appear to be the most effective for adults and some adolescents. Specific responsivity issues concern delivering services that match such areas as an individual's motivation, intellectual abilities, gender, culture, and personality characteristics. In addition, programs that encourage and facilitate involvement of the client's natural support systems generally appear to be most effective with many adolescents and children (Hanson, Bourgon, et al., 2009; Reitzel & Carbonell, 2006; St. Amand et al., 2008). The importance of supportive others who can serve as members of a client's safety team appears to extend to adults, as well (e.g., Wilson, Picheca, & Prinzo, 2005).

COMPARISON OF RESULTS BETWEEN SURVEYS

As a final introductory note, some caution should be used in interpreting the current survey data and comparing the results of this survey with those of the eight previous SSF surveys.

First, it is not known to what extent programs that responded to this or previous surveys are representative of programs in the United States and Canada. Further, the survey has been conducted in a variety of ways over the years and this discrepancy may have affected the nature of the participents' responses. For example, the current survey was Internet based whereas previous surveys were distributed by hard copy and completed by hand. Also, the number of potential respondents who received surveys over the years has varied considerably as have the number of programs submitting data. Consequently, whether the number of respondents to this survey or the previous surveys accurately reflects the actual number of programs in various jurisdictions is unknown.

Second, data from surveys prior to 2000 are not reported using the 12 program types used here. Earlier surveys reported combined data for age groups, genders and/or program settings, making direct comparisons between this survey and previous ones difficult. As a result, in many instances, comparisons among survey variables on gender, age, and program setting are not possible.

Third, efforts to improve the survey and to respond to the evolution of the field have led to survey questions being asked in different ways at different times. This has created the difficulty of sometimes "comparing apples to oranges" when examining data from two or more survey years.

Last, definitions were not provided for the various program models and methods that formed the basis for many questions in this as well as previous

surveys. It would be naïve to assume that every provider who filled out the survey defined terms in the same way. Therefore, the extent to which respondents' individual assumptions and interpretations affected their responses is unknown.

Overall, it is encouraging that a large number of long-standing and geographically diverse programs collectively providing services to thousands of abusers responded to the survey. Taken together, the findings from the current survey along with findings from SSF's eight other national surveys provides an important and interesting chronicle of how the field of sexual abuser assessment, treatment, and management has changed and hopefully improved over the past two decades.

NOTES

[1]The Safer Society Foundation, Inc., a non-profit agency, is a national research, advocacy, and referral center for the prevention and treatment of sexual abuse. It was founded in 1964 as the Prison Research Education Action Project (P.R.E.A.P.) by Fay Honey Knopp. P.R.E.A.P. evolved into the Safer Society Program in 1985, and became the Safer Society Foundation, Inc. (SSF) in 1995. The SSF provides a variety of services related to the prevention and treatment of sexual abuse.

[2]For Canadian programs, data on the number of programs and clients treated are reported for all 12 program types in Chapter Two. In subsequent chapters, however, only data on Canadian community programs and residential programs for adult males are reported. This is because few, or in some cases none, of the other types of residential programs submitted responses to the survey.

2 Number and Geographic Distribution of Programs

This chapter is divided into four sections. The first section reviews the research on the effectiveness of treatment for individuals who commit sexual offenses and in doing so provides a rationale about why these services are important. The second section describes the number and types of programs identified in the 2009 survey and compares them with previous SSF surveys. The third section examines the number of offenders treated by age, setting, and gender, and the fourth and final section examines the geographic distribution of programs.

IMPORTANCE OF ACCESS TO TREATMENT

The effectiveness and cost of sexual abuser treatment programs has been the topic of much research, debate, and public interest. Programs that are successful in reducing sexual recidivism rates make a significant contribution to their communities. These positive contributions happen especially when programs provide services to a substantial proportion of abusers in their jurisdictions, allowing the success achieved to outweigh the financial costs.

During the early years of the field's development, research on treatment effectiveness was not encouraging. Two of the largest, most often cited, and influential studies concluded there was no evidence that sexual abuser treatment reduced recidivism (Furby, Weinrott, & Blackshaw, 1989; United States General Accounting Office, 1996). Yet, these older reviews investigated many treatment programs that used interventions no longer considered best practice. These early reviews, as well as more recent ones, also highlight the need for studies with stronger research designs that could better evaluate program effectiveness, such as by randomly assigning individuals to treatment and comparison groups (Kenworthy, Adams, Brooks-Gordon, & Fenton, 2004; Rice & Harris, 2003).

Nevertheless, confidence in the efficacy of treatment has risen in recent years as newer treatment methods have been tested and analyses of outcome studies have become more sophisticated. Several recent large-scale, meta-analytic studies of treatment for adult male sexual abusers have shown positive outcomes, primarily for cognitive-behavioral treatment (Aos, Miller, & Drake, 2006a; Gallagher, Wilson, Hirschfield, Coggeshall, & MacKenzie, 1999; Grossman, Martis, & Fichtner, 1999; Hanson, Gordon, Harris, Marques, Murphy, Quinsey & Seto, 2002; Hanson, Bourgon, et al., 2009; Lösel & Schmucker, 2005; Polizzi, MacKenzie, & Hickman, 1999; Schmucker & Lösel, 2008).

The largest of these meta-analyses made 80 independent comparisons between treated and untreated groups and included more than 22,000 sex offenders (Lösel & Schmucker, 2005; Schmucker & Lösel, 2008). Overall, findings indicate that the sexual recidivism rate of the treated offenders was 11.1 versus 17.5 percent for those who were untreated. This represents an absolute reduction in sexual recidivism of 6.4 percent (17.5% minus

11.1% equals 6.4%) and a relative reduction in recidivism of 36.6 percent (6.4% divided by 17.5% equals 36.6%).

The most recent of these meta-analyses (Hanson, Bourgon, et al., 2009) examined 23 studies and found a similar positive impact of treatment. The sexual recidivism rate of the treated offenders was 10.9 versus 19.2 percent for those who were untreated or who received a comparison treatment. This statistic represents an absolute reduction of 8.3 percent in the sexual recidivism rate (19.2% minus 10.9% equals 8.3%) and a relative reduction in recidivism of 43.2 percent (8.3% divided by 19.2% equals 43.2%). The analyses found even greater reductions in sexual reoffending rates among programs that adhered to the correctional principles of risk, need, and responsivity. The Hanson, Bourgon, et al. (2009) study and the Lösel and Schmucker (2005) and Schmucker & Lösel, (2008) studies found that sex offender treatment reduces non-sexual criminal reoffense rates as well.

For treatment involving adolescent male sexual abusers, Reitzel and Carbonell's 2006 meta-analysis of nine studies found that the sexual reoffense rate of treated adolescents was 7.4 versus 18.9 percent for the untreated adolescents. This figure represents an absolute reduction of 11.5 percent in the sexual recidivism rate (18.9% minus 7.4% equals 11.5%) and a relative reduction in the recidivism rate of 60.8 percent (11.5% divided by 18.9% equals 60.8%). Similarly, Walker, McGovern, Poey and Otis (2004) analyzed ten studies and found a significant treatment effect for adolescent sexual abusers, especially for those who received cognitive-behavioral treatment. In addition, systemic treatments targeting a youth's current life problems in the areas of family, school, and peer relationships have evidenced positive results (Aos et al., 2006a; Borduin, Schaeffer, & Heiblum, 2009; Hanson et al., 2002). Notably, regarding interventions that target the treatment needs of youths in a systemic way (i.e., Multisystemic Therapy), randomized clinical trials show positive treatment outcomes of multisystemic therapy with juvenile sex offenders (e.g., Borduin et al., 2009) and are arguably some of the most well-designed and convincing studies in the field.

With respect to children with sexual behavior problems, a task force convened by the Association for the Treatment of Sexual Abusers (2006) reviewed the literature on assessment, treatment, and management of this population. They concluded that treatment that employs cognitive-behavioral interventions and involves parents and caregivers is more effective than unstructured supportive treatments. Likewise, the recent St. Amand et al. (2008) meta-analysis of 11 studies found that teaching parents and other caregivers to set appropriate rules about sexual behavior was the key element to successful intervention.

Treatment outcome for female sexual abusers of any age is much less studied (Center for Sex Offender Management, 2007). The relatively small number of females who enter the criminal and juvenile justice system for sexually abusive behavior, who are arrested and convicted, and who enter specialized gender-responsive treatment programs for sexual abusers, as well as their relative low observed recidivism rates, are among the factors that contribute to the limited research-based understanding of treatment outcomes for this population.

When examined from a cost-benefit ratio perspective, treatment of individuals who commit sexual offenses appears to be a sound financial investment. Recently, an independent research group in the United Kingdom analyzed 14 outcome studies and concluded that sex offenders who received treatment in prison were 35 percent less likely to reoffend after release than those who received only prison sentences. This led to a savings of £35,213 (about $57,000 U.S. dollars or about $62,000 Canadian dollars) over an offender's lifetime for tax

payers and savings of £130,576 (about $210,000 U.S. dollars or about $229,000 Canadian dollars) when victim costs were included (Matrix Knowledge Group, 2007).

An independent research group in the United States, the Washington State Institute for Public Policy, has conducted two studies that examined the comparative costs and benefits of several crime reduction programs (Aos, Miller & Drake 2006b; Aos, Phipps, Barnoski & Lieb, 2001). In 2001, the group concluded that cognitive-behavioral treatment for adult sexual abusers, when compared to no treatment, saves more money than it costs. The estimated benefit-to-cost ratio is $4.13 dollars saved for every dollar spent on treatment services. Likewise, cognitive-behavioral treatment for juveniles who have committed sexual offenses also was found to have a positive impact, with a benefit-to-cost ratio of $3.38 saved for every dollar spent (Aos et al., 2001). However, in an updated meta-analysis in 2006, they found that prison sex offender treatment followed by community aftercare was associated with reductions in sexual reoffending rates but not enough to find an overall positive financial benefit-to-cost ratio (Aos et al., 2006b).

How well these cost-benefit estimates apply to other jurisdictions depends on factors such as the local costs of investigation, prosecution, incarceration and treatment, as well as sentencing practices. These overall findings, however, are consistent with those of Donato and Shanahan (2001) who examined the cost-effectiveness of treatment involving incarcerated adult child molesters in Australia, with Prentky and Burgess (1990) who examined the cost-effectiveness of treating a similar population in Massachusetts, with Marshall, Marsall, Serran and Fernandez, (2006) who examined the cost effectiveness of their Canadian prison program and with McGrath (1995) who examined the cost-effectiveness of the State of Vermont's network of adult sexual abuser outpatient treatment programs.

The overall positive findings showing treatment effectiveness and positive cost-benefit ratios reflect the importance of providing quality sexual abuser treatment throughout a continuum of community, residential, and institutional settings.

NUMBER OF PROGRAMS IN EACH SURVEY 1986-2009

We begin our review of the 2009 survey results by examining the availability of treatment services in the United States and Canada. As shown in Table 2.1 and Figure 2.1, the number of United States programs responding to this survey was about three-fifths (57.1%) of the number that responded to the previous survey.

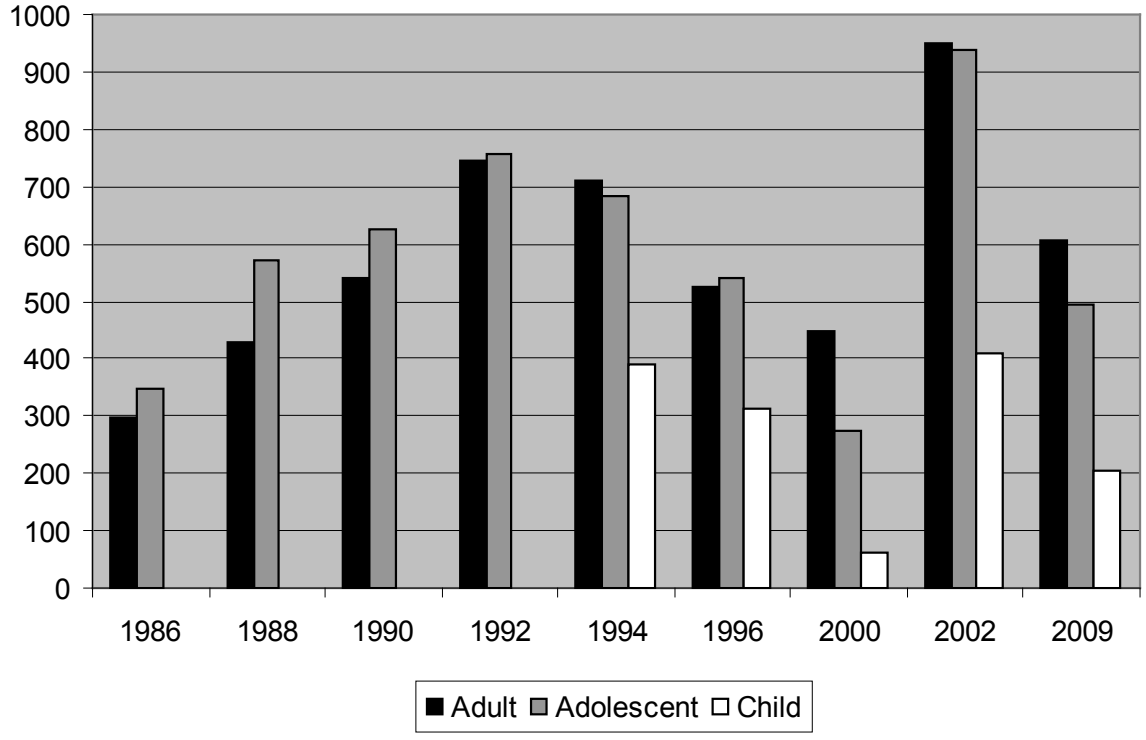
Reasons for the fluctuations in the number of respondents are unclear and may not reflect actual changes in the number of United States programs. The current survey was the first SSF survey conducted on the Internet and this may have affected the response rate. It involved multiple steps to complete. Respondents had to register their names and e-mail addresses on the survey website, wait to be sent passwords, return to the survey website and enter their passwords and then complete the survey. The password system was used to limit survey access to legitimate respondents but this process may have discouraged individuals from signing up for and completing the survey.

As noted in Chapter One, considerable variability in the definition of a program, survey distribution, and follow-up strategies has occurred over the years, making comparisons problematic. Nevertheless, the large number of respondents to the current survey indicates treatment services are available for many sexual abusers in the United States. This is the first time that the survey has solicited Canadian program respondents.

Table 2.1a United States – Number of programs in each survey, 1986-2009				
Year	**Adult**	**Adolescent**	**Child**	**Total**
1986	297	346	N/A	643
1988	429	573	N/A	1,002
1990	541	626	N/A	1,167
1992	745	755	N/A	1,500
1994	710	684	390	1,784
1996	527	539	314	1,380
2000	449	276	62	787
2002	951	937	401	2,289
2009	**608**	**494**	**205**	**1,307**

Table 2.1b Canada – Number of programs in 2009 survey				
Year	**Adult**	**Adolescent**	**Child**	**Total**
2009	32	24	16	72

Figure 2.1a - U.S. Programs Surveyed by Client Population



NUMBER OF PROGRAMS BY SETTING, AGE, AND GENDER

In the United States, of the 1,307 programs responding, 81.6 percent were community-based, and 18.4 percent were residential-based (see Table 2.2a). Almost three-quarters (70.9%) of the programs treated males, and over one-quarter (29.1%) treated females. The percentage of programs treating adults (46.5%) was slightly higher than the percentage treating adolescents (37.8%). Programs that treated children were fewest in number, comprising only 15.7 percent of the programs surveyed.

The Canadian results were very similar to those in the United States. Of the 72 Canadian programs responding, 81.9 percent were community-based, and 18.1 percent were residentially based (see Table 2.2b). Three-quarters (73.6%) of the programs treated males and one-quarter (26.4%) treated females. The percentage of programs that treated adults (44.4%) was slightly greater than the percentage that treated adolescents (33.3%). Programs that treated children were fewest in number comprising only 22.2 percent of the programs surveyed.

Table 2.2a United States – Number of community programs vs. residential programs

	Male			Female			
Type of Program	**Adults**	**Adolescents**	**Children**	**Adults**	**Adolescents**	**Children**	**Total**
Community Programs	330	275	124	174	102	62	1067
Residential Programs	85	98	15	19	19	4	240
Total	**415**	**373**	**139**	**193**	**121**	**66**	**1307**

Table 2.2b Canada – Number of community programs vs. residential programs

	Male			Female			
Type of Program	**Adults**	**Adolescents**	**Children**	**Adults**	**Adolescents**	**Children**	**Total**
Community Programs	19	15	7	4	6	8	59
Residential Programs	8	3	1	1	0	0	13
Total	**27**	**18**	**8**	**5**	**6**	**8**	**72**

NUMBER OF CLIENTS TREATED BY SETTING, AGE, AND GENDER

Tables 2.3a and b show the number of clients treated in the United States and Canada in 2008 by program type, client age, and client gender.

In the United States, survey respondents reported treating 53,811 clients during 2008 (see Table 2.3a). Although 81.6 percent of the programs were community-based, only 66.9 percent of the client population was treated in these programs, with the remaining 33.1 percent receiving treatment in residential programs. Likewise 70.9 percent of the programs surveyed treated males, but they treated 94.5 percent of the clients served in 2008. The greatest difference between client profile and the program profile emerges when examining client ages. Although a similar percentage of programs treated adults as those that treated adolescents, adults comprised a much larger percentage of clients treated in 2008 than adolescents. Almost three-quarters (74.2%) of the client population were adults while adolescents accounted for only 22.5 percent of those treated. Only 3.3 percent of clients treated in 2008 were children.

In Canada, survey respondents reported treating 3,020 clients during 2008 (see Table 2.3b). Although 81.9 percent of the Canadian programs are community-based, only 62.1 percent of the client population was treated in these programs, with the remaining 37.9 percent receiving treatment in residential programs. Likewise, 73.6 percent of the programs surveyed treated males, but they treated 92.6 percent of the clients served in 2008. Although a similar percentage of programs treated adults as treated adolescents, adults comprised a much larger percentage of clients treated in 2008 than adolescents. Over three-quarters (78.6%) of the client population were adults whereas adolescents accounted for only 12.7 percent of those treated. Only 8.6 percent of clients treated in 2008 were children.

Table 2.3a United States – Number of clients treated

Type of Program	Male			Female			Total
	Adults	Adolescents	Children	Adults	Adolescents	Children	
Community Programs	26,639	6,131	962	1,164	624	485	36,005
Residential Programs	11,952	4,947	231	171	388	117	17,806
Total	**38,591**	**11,078**	**1,193**	**1,335**	**1,012**	**602**	**53,811**

Table 2.3b Canada – Number of clients treated

Type of Program	Male			Female			Total
	Adults	Adolescents	Children	Adults	Adolescents	Children	
Community Programs	1,225	325	127	15	48	134	1,874
Residential Programs	1,110	11	0	25	0	0	1,146
Total	**2,335**	**336**	**127**	**40**	**48**	**134**	**3,020**

GEOGRAPHIC DISTRIBUTION OF RESPONDENTS

The United States' state-by-state distribution of programs for males is found in Table 2.4a and for females in Table 2.5a (see pages 18 and 19). Programs from all 50 states and the District of Columbia responded to the survey. As might be expected, states reporting the most programs are among the most populous. California had 101 programs, Texas 87, Pennsylvania 70, New York 65 and Washington State 62.

The Canadian distribution of programs for males is found below in Table 2.4b and for females in Table 2.5b. Programs from 9 of the 13 Canadian provinces responded to the survey. Over one-half of Canadian programs responding were from Ontario.

Table 2.4b Canada – Province distribution of programs for males

Province	Community Programs			Residential Programs			Total
	Adult	Adolescent	Child	Adult	Adolescent	Child	
Alberta	2	1	1	0	0	0	4
British Columbia	2	2	0	1	0	0	5
Manitoba	0	1	0	1	2	0	4
New Brunswick	2	0	0	0	0	0	2
Newfoundland & Labrador	0	0	0	0	0	0	0
Northwest Territories	0	0	0	0	0	0	0
Nova Scotia	2	0	0	0	0	0	2
Nunavut	0	0	0	0	0	0	0
Ontario	8	10	5	6	1	1	31
Prince Edward Island	1	1	1	0	0	0	3
Quebec	0	0	0	0	0	0	0
Saskatchewan	2	0	0	0	0	0	2
Yukon Territory	0	0	0	0	0	0	0
TOTAL	**19**	**15**	**7**	**8**	**3**	**1**	**53**
% of total	**35.8%**	**28.3%**	**13.2%**	**15.1%**	**5.7%**	**1.9%**	**100%**

Table 2.5b Canada – Province distribution of programs for females

Province	Community Programs			Residential Programs			Total
	Adult	Adolescent	Child	Adult	Adolescent	Child	
Alberta	0	1	1	0	0	0	2
British Columbia	0	1	0	0	0	0	1
Manitoba	0	0	0	0	0	0	0
New Brunswick	0	0	0	0	0	0	0
Newfoundland & Labrador	0	0	0	0	0	0	0
Northwest Territories	0	0	0	0	0	0	0
Nova Scotia	1	0	0	0	0	0	1
Nunavut	0	0	0	0	0	0	0
Ontario	1	3	6	1	0	0	11
Prince Edward Island	1	1	1	0	0	0	3
Quebec	0	0	0	0	0	0	0
Saskatchewan	1	0	0	0	0	0	1
Yukon Territory	0	0	0	0	0	0	0
TOTAL	**4**	**6**	**8**	**1**	**0**	**0**	**19**
% of total	**21.1%**	**31.6%**	**42.1%**	**5.3%**	**0.0%**	**0.0%**	**100%**

Table 2.4a United States – State distribution of programs for males

State	Community Programs			Residential Programs			Total
	Adult	Adolescent	Child	Adult	Adolescent	Child	
Alabama	2	2	2	0	4	0	10
Alaska	5	1	1	1	0	0	8
Arizona	13	8	2	0	1	1	25
Arkansas	1	3	2	3	2	0	11
California	34	24	7	3	6	0	74
Colorado	12	9	4	1	7	1	34
Connecticut	1	2	1	2	1	0	7
Delaware	0	2	1	0	0	0	3
DC	1	1	0	0	0	0	2
Florida	15	12	5	5	3	1	41
Georgia	11	12	9	1	4	1	38
Hawaii	6	1	1	2	0	0	10
Idaho	3	3	2	1	4	1	14
Illinois	12	9	5	3	3	0	32
Indiana	9	7	5	3	0	1	25
Iowa	8	4	0	3	2	0	17
Kansas	6	5	0	2	1	0	14
Kentucky	3	4	2	1	1	0	11
Louisiana	1	1	0	0	0	0	2
Maine	2	3	1	1	3	0	10
Maryland	8	7	3	0	2	0	20
Massachusetts	10	6	3	4	4	2	29
Michigan	5	7	6	1	3	1	23
Minnesota	2	5	2	8	4	0	21
Mississippi	1	1	0	0	0	0	2
Missouri	4	5	0	1	3	0	13
Montana	2	1	0	0	0	0	3
Nebraska	3	3	1	1	0	0	8
Nevada	1	1	1	1	0	0	4
New Hampshire	1	1	0	1	1	0	4
New Jersey	7	8	1	1	2	0	19
New Mexico	4	3	2	0	0	0	9
New York	19	14	7	3	1	0	44
North Carolina	10	10	5	2	2	1	30
North Dakota	0	0	0	2	2	0	4
Ohio	7	9	2	2	5	0	25
Oklahoma	3	1	1	1	0	0	6
Oregon	8	8	4	1	2	0	23
Pennsylvania	15	14	6	4	8	2	49
Rhode Island	2	1	1	0	0	0	4
South Carolina	1	3	2	0	1	0	7
South Dakota	2	2	1	1	2	1	9
Tennessee	4	3	2	1	1	0	11
Texas	21	19	9	3	6	1	59
Utah	1	1	0	0	1	0	3
Vermont	12	4	4	2	1	0	23
Virginia	7	8	3	3	0	0	21
Washington	15	10	5	5	2	0	37
West Virginia	1	0	0	0	0	0	1
Wisconsin	6	6	2	5	2	1	22
Wyoming	3	1	1	0	1	0	6
TOTAL	**330**	**275**	**124**	**85**	**98**	**15**	**927**
% of total	**35.6%**	**29.7%**	**13.4%**	**9.2%**	**10.6%**	**1.6%**	**100%**

Table 2.5a United States – State distribution of programs for females

State	Community Programs			Residential Programs			Total
	Adult	Adolescent	Child	Adult	Adolescent	Child	
Alabama	0	0	0	0	0	0	0
Alaska	2	0	0	0	0	0	2
Arizona	6	4	1	0	0	0	11
Arkansas	0	1	1	0	0	0	2
California	18	5	1	2	1	0	27
Colorado	5	5	4	0	2	0	16
Connecticut	0	1	0	1	0	0	2
Delaware	0	0	0	0	0	0	0
DC	0	0	0	0	0	0	0
Florida	11	5	3	0	1	1	21
Georgia	9	5	5	0	0	0	19
Hawaii	2	1	0	2	0	0	5
Idaho	2	1	0	0	1	0	4
Illinois	8	4	2	0	0	0	14
Indiana	3	1	0	0	0	0	4
Iowa	4	1	0	0	0	0	5
Kansas	4	1	0	2	0	0	7
Kentucky	1	1	1	0	0	0	3
Louisiana	0	0	0	0	0	0	0
Maine	0	0	0	0	1	0	1
Maryland	5	1	0	0	0	0	6
Massachusetts	7	2	1	0	1	0	11
Michigan	2	3	3	0	1	0	9
Minnesota	1	0	1	1	1	0	4
Mississippi	0	0	0	0	0	0	0
Missouri	3	2	0	1	0	1	7
Montana	0	0	0	0	0	0	0
Nebraska	1	0	0	0	0	0	1
Nevada	0	1	1	1	0	0	3
New Hampshire	0	0	0	2	0	0	2
New Jersey	6	3	0	0	1	0	10
New Mexico	3	2	3	0	0	0	8
New York	11	5	5	0	0	0	21
North Carolina	4	6	3	0	1	1	15
North Dakota	0	0	0	1	0	0	1
Ohio	3	4	2	0	0	0	9
Oklahoma	3	1	1	0	0	0	5
Oregon	7	4	4	0	0	0	15
Pennsylvania	8	8	5	0	0	0	21
Rhode Island	1	1	1	0	0	0	3
South Carolina	0	0	0	0	3	1	4
South Dakota	1	1	1	0	1	0	4
Tennessee	2	1	0	0	0	0	3
Texas	11	9	4	1	3	0	28
Utah	1	0	0	0	0	0	1
Vermont	1	1	3	0	0	0	5
Virginia	6	3	1	0	0	0	10
Washington	9	7	4	4	1	0	25
West Virginia	0	0	0	0	0	0	0
Wisconsin	2	1	1	1	0	0	5
Wyoming	1	0	0	0	0	0	1
TOTAL	**174**	**102**	**62**	**19**	**19**	**4**	**380**
% of total	**45.8%**	**26.8%**	**16.3%**	**5.0%**	**5.0%**	**1.1%**	**100%**

3 Program Age, Size and Setting

This chapter reviews findings on the average age of programs, size of programs, and the settings in which programs were located.

AGE OF PROGRAMS

Newer correctional programs are typically more effective than older ones. Andrews and Bonta (2006) examined this phenomenon in one of the largest meta-analyses of the general correctional treatment outcome literature to date. Their review of almost 400 adult and juvenile studies found stronger treatment effects among newer versus older programs for the entire sample as well as for the three sub-samples of offenders they examined: young, female, and nonwhite offenders. Similarly, in the sex offender field, the most up-to-date meta-analysis found stronger treatment effects for treatments delivered in recent versus past decades (Hanson, Bourgon, et al., 2009).

Because contemporary sex offender treatment approaches have generally been found more effective than older ones (Alexander, 1999; Hanson et al., 2002; Hanson, Bourgon, et al., 2009; Lösel & Schmucker, 2005), programs need to be sure to incorporate assessment and treatment methods that are supported by current research literature.

In the United States, community-based programs for all sexual offender populations (i.e., adults, adolescents, and children), and residential programs for adult and adolescent males, have been in existence for approximately the same duration (see Table 3.1a). They appear to be relatively well established, with typical average ages of 12 years or longer. The average age of programs in the current survey is typically about two to three years older than for programs in the last SSF survey.

The average age of Canadian programs is very similar to those in the United States (see Table 3.1b), although residential programs for adult males appear to have been in existence for a much longer time than similar programs in the United States: 22 versus 12 years.

Please note: Beginning with Table 3.1b, and continuing throughout the remainder of the report, data on residential programs in Canada is reported only for adult males. This is because, as shown in Table 2.2b, the limited number of responses from residential programs serving adolescents, children, and females does not allow for meaningful analyses. Only three residential programs for adolescent males responded to the survey and one program each responded for male children and adult females, and no programs responded for female adolescents or children.

Table 3.1a United States – Age of programs in years, average and (standard deviation)						
	Male			Female		
Community Programs	Adults n= 326	Adolescents n=269	Children n=124	Adults n=173	Adolescents n=100	Children n=62
Average per program	13.95 (7.97)	13.17 (8.73)	12.57 (8.95)	6.73 (9.59)	12.60 (7.75)	11.77 (8.07)
Residential Programs	Adults n= 78	Adolescents n=88	Children n=15	Adults n=17	Adolescents n=15	Children n=4
Average per program	12.06 (8.58)	14.87 (10.08)	15.13 (10.05)	9.06 (6.80)	14.67 (14.33)	17.50 (16.76)

Table 3.1b Canada – Age of programs in years, average and (standard deviation)						
	Male			Female		
Community Programs	Adults n= 18	Adolescents n=14	Children n=7	Adults n=4	Adolescents n=6	Children n=8
Average per program	16.50 (5.44)	13.86 (4.49)	12.57 (6.65)	13.50 (4.55)	9.63 (5.74)	11.38 (7.03)
Residential Programs	Adults n= 8					
Average per program	22.00 (9.23)					

SIZE OF PROGRAMS

The size of programs, defined by the number of clients treated in 2008, is presented in Tables 3.2a and b. Although the size of most programs tends to be relatively fixed, program size can be an important determinant for best practice and effective treatment. Smaller correctional treatment programs are generally more effective than larger ones. In a meta-analysis by Andrews and Bonta (2006), "small" was defined as sample sizes of 100 offenders or less. These treatment effects hold true whether the programs delivered services to adult males, youth, females, or minorities (Andrews & Bonta, 2006). In their recent meta-analysis of sex offender programs providing services primarily for adolescent and adult males, Lösel and Schmucker (2005) also found that smaller programs had better treatment outcomes. Perhaps when managing the quality of treatment, large programs with numerous clients and many staff is more difficult than in smaller ones with fewer clients and staff. Additionally, maintaining a positive treatment culture in large institutional settings may be especially difficult.

In the present study, the average size of sexual abuser programs in the United States and Canada for adult males was much larger than programs for male adolescents and children, and for females of any age (see Tables 3.2a and b). For all programs, large standard deviations indicate considerable variability in program size. Developers of new programs should take into consideration the research on the relationship between program size and program effectiveness. This research also can be useful for programs in the process of restructuring.

Table 3.2a United States – Program size, average number of clients treated and (standard deviation)						
	Male			Female		
Community Programs	Adults n= 328	Adolescents n=274	Children n=123	Adults n=173	Adolescents n=102	Children n=62
Average per program	81.22 (152.45)	22.38 (35.11)	7.82 (6.93)	6.73 (9.59)	6.18 (11.06)	7.95 (8.69)
Residential Programs	Adults n= 85	Adolescents n=98	Children n=15	Adults n=18	Adolescents n=19	Children n=4
Average per program	140.61 (161.09)	50.48 (71.20)	15.40 (20.75)	9.50 (7.01)	20.42 (22.51)	29.25 (34.46)

Table 3.2b Canada – Program size, average number of clients treated and (standard deviation)						
	Male			Female		
Community Programs	Adults n= 19	Adolescents n=15	Children n=7	Adults n=4	Adolescents n=6	Children n=8
Average per program	64.47 (63.08)	23.21 (41.12)	21.17 (33.95)	3.75 (4.19)	8.00 (14.70)	19.14 (44.48)
Residential Programs	Adults n= 8					
Average per program	138.75 (88.71)					

PROGRAM SETTING

Tables 3.3a & b present detailed data about the settings in which sexual abuser programs deliver services. Clear evidence exists in the correctional literature and emerging evidence in the sexual abuser literature that the setting in which services are delivered influences treatment outcome.

The general correctional literature indicates that community-based interventions are typically more effective than residential-based ones, both for adults (Andrews & Bonta, 2006) and adolescents (Henggeler, Melton, & Smith, 1992; Izzo & Ross, 1990; Skowyra & Cocozza, 2007; Whitehead & Lab, 1989). Andrews (2001) argues that services provided to adolescents in the community are more effective when delivered in the individual's natural environment, such as home or school, than at an agency. Lipsey's (1995) meta-analysis of nearly 400 delinquency treatment studies suggests that services provided to adolescents in the justice system may be less effective than those delivered by other sponsors. Although Lipsey's results are not definitive, and may reflect older models of treatment, he hypothesized that adolescents who are institutionalized or under correctional supervision may have a more negative attitude toward their treatment and, therefore, may be less receptive to it.

In the sex offender literature, the largest meta-analysis to date (Lösel & Schmucker, 2005; Schmucker & Lösel, 2008) found the positive impact of treatment was much greater among outpatient programs than for either prison, hospital, or mixed residential and community programs. Hanson, Bourgon, et al. (2009), however, found that treatment was equally effective regardless of whether it was delivered in the community or an institution.

Of course, the highest risk sexual abusers may be the ones most likely to be placed in residential settings and they may be some of the most difficult individuals to treat. Other factors may impact the treatment of individuals in residential settings as well. Negative peer influence is one reason that residential programs may be less effective than community ones, especially for youth (Dishion, McCord, & Poulin, 1999; Dodge, Dishion, & Lansford, 2006). Prisons and other residential settings for sexual abusers congregate individuals who, by definition, have engaged in antisocial behavior. One of the strongest risk factors for general criminal offending is associating with other criminals (Andrews & Bonta, 2006; Gendreau, Little, & Goggin, 1996). Among sexual abusers, associating with other criminals has also been identified as a significant risk factor for sexual reoffending (Hanson, Harris, Scott, & Helmus, 2007).

As has been shown in Tables 2.2a and b, slightly over 80 percent of programs in both the United States and Canada were located in community settings. Tables 3.3a and b describe in more detail the percentage of programs located in different types of community and residential settings.

In the United States, for each age and gender group, around three-quarters (between 69-78%) of community programs were located in private practices. The next most common community setting location was community mental health centers (between 15-23%). Not surprisingly, about half (48%) of the residential programs for adult male sexual abusers were located in prisons and 23 percent were in civil commitment centers. For adult females about three-quarters (74%) were located in prisons, and only 11 percent in civil commitment centers because very few woman are civilly committed. Most residential programs for male and female children and adolescents were located in residential treatment centers.

In Canada, a comparatively much smaller percentage of community programs are private practices. This difference is because many community treatment programs for sexual abusers are delivered directly by federal (i.e., Correctional Service of Canada, Parole) and provincial government departments (i.e., provincial corrections services, Health, Family Services, and Child Welfare). Of the eight residential programs for adult males, seven were located in prison settings, one in a hospital setting and none in a civil commitment center. Canada does not have civil commitment programs like those now located in over 20 states in the United States and, as a result, such facilities do not exist.

Treatment service options for sexual abusers should be available across a continuum of care as people that offend sexually differ in risk factors and criminogenic needs and individuals themselves demonstrate variability in their level of risk and need areas over time.

Given research on the relationship between program setting and effectiveness, placement of sexual abusers in the least restrictive setting in which their risk can be effectively managed is an important disposition consideration.

Table 3.3a United States – Program setting, percentage						
	Male			Female		
Community programs	**Adults n=329**	**Adolescents n=275**	**Children n=123**	**Adults n=173**	**Adolescents n=102**	**Children n=62**
Community mental health	15.2	18.9	19.5	13.9	22.5	19.4
Court clinic	2.4	3.6	1.6	2.3	2.0	1.6
Hospital	1.2	1.8	1.6	0.5	2.0	3.2
Private practice	78.1	69.5	74.8	78.0	68.6	71.0
Halfway house	3.0	1.1	0.0	2.3	1.0	0.0
Other	12.5	13.1	6.5	11.6	10.8	6.5
Residential programs	**Adults n=84**	**Adolescents n=98**	**Children n=15**	**Adults n=19**	**Adolescents n=19**	**Children n=4**
Prison	47.6	12.2	6.7	73.7	15.8	0.0
Civil commitment center	22.6	0.0	0.0	10.5	0.0	0.0
Hospital	4.8	0.0	0.0	5.3	5.3	0.0
Halfway house	3.6	0.0	0.0	0.0	0.0	0.0
Group home	3.6	6.1	6.7	5.3	5.3	0.0
Residential treatment center	9.5	64.3	53.3	5.3	47.4	75.0
Other	8.3	17.4	33.3	0.0	26.3	25.0

Note: Some programs reported being based in more than one setting so some column totals exceed 100%.

Table 3.3b Canada – Program setting, percentage						
	Male			Female		
Community programs	**Adults n=19**	**Adolescents n=15**	**Children n=4**	**Adults n=4**	**Adolescents n=6**	**Children n=8**
Community mental health	15.8	26.7	42.9	25.0	33.3	50.0
Court clinic	5.3	6.7	0.0	0.0	0.0	0.0
Hospital	21.1	6.7	0.0	50.0	0.0	0.0
Private practice	36.8	4.0	42.9	0.0	33.3	37.5
Halfway house	10.5	0.0	0.0	0.0	0.0	0.0
Other	31.6	33.3	14.3	50.0	33.3	12.5
Residential programs	**Adults n=8**					
Prison	87.5					
Civil commitment center	0.0					
Hospital	12.5					
Halfway house	0.0					
Group home	0.0					
Residential treatment center	0.0					
Other	0.0					

Note: Some programs reported being based in more than one setting so some column totals exceed 100%.

4 Client Profiles

This chapter reports on the types of clients served in programs. Respondents were asked to identify whether they treated sexual abusers from six categories: rapist, incest abuser (intrafamilial), child abuser (extrafamilial), statutory rapist (i.e., engaged in illegal cooperative sex with a similar age peer who was under the age of consent), non-contact abuser (e.g., exhibitionists, voyeurs and obscene phone callers) and child pornography exclusive offender. These abuser types are commonly used to categorize adult and adolescent sexual abusers (Gordon, Harris, Murphy, Seto, Hanson, Marques, & Quinsey, 1998). Children who engage in sexually abusive behavior are not included in these specific analyses, as they are not typically categorized in this manner.

Ideally, the distribution of abuser types in community and residential programs should be related to some rational decision-making process, such as the risk and need principles. Setting aside issues of punishment and other non-rehabilitative sentencing objectives, residential services ideally should be reserved for sex offenders with a higher reoffense risk and offenders whose treatment needs are more extensive, whereas community placements are more appropriate for sexual abusers with a lower reoffense risk and fewer treatment needs (Andrews & Bonta, 2006; McGrath, 1991).

Although validated risk instruments are the most reliable way to assess risk (see Chapter 8), offense type also is related to adult male sexual abusers' risk to sexually reoffend (Hanson & Bussière, 1998). Much less is known about risk factors for male adolescent and child sexual abusers (Calder, 2002) and female sexual abusers of all ages (Center for Sex Offender Management, 2007). However, many of the risk factors for general criminal recidivism for adult males and adult females in the correctional system are similar (Andrews & Bonta, 2006; Andrews & Dowden, 1999).

Among adult male sexual abusers, incest abusers have the lowest rates of sexual reoffense and non-contact abusers, such as exhibitionists, have the highest re-offense rates (Hanson, Morton, & Harris, 2003; McGrath, 1991). Of course, non-contact offenders, by definition, do not commit physically abusive acts.

As shown in Tables 4.1a and b, the majority of programs in the United States and Canada treat most types of sexual abusers. Although the survey did not ask respondents to identify the percentage of each abuser type treated in their programs during the survey period, data from the 2002 survey showed a rational method of placement. In 2002, rapists represented a higher proportion of clients in residential programs than in community programs, probably due to the level of violence of their offenses. Non-contact abusers made up a higher proportion of clients in community programs than residential programs, likely as a result of their generally low violence level. Incest abusers, a low-reoffense risk group, were appropriately found at a

higher percentage in community programs and at a lower percentage in residential programs. Future SSF surveys should collect data similar to the 2002 survey that allowed for examination of placement decisions based on abuser type.

Table 4.1a United States – Client offense types served, percentage

	Male		Female	
Community Programs	Adults n=328	Adolescents n=273	Adults n=172	Adolescents n=101
Rapists	79.3	65.9	52.9	49.5
Incest abusers (intrafamilial)	96.3	95.2	90.1	99.0
Child abusers (extrafamilial)	93.6	92.7	84.9	89.1
Statutory rapists	87.5	81.3	72.7	59.4
Child pornography exclusive abusers	90.5	61.9	54.7	48.5
Other non-contact abusers	86.3	74.0	64.5	68.3
Residential Programs	Adults n=83	Adolescents n=97	Adults n=17	Adolescents n=19
Rapists	95.2	77.3	70.6	47.4
Incest abusers (intrafamilial)	97.6	97.9	94.1	100
Child abusers (extrafamilial)	98.8	96.9	88.2	100
Statutory rapists	80.7	82.5	52.9	47.4
Child pornography exclusive abusers	71.1	43.3	47.0	47.4
Other non-contact abusers	73.5	74.2	47.1	63.2

Table 4.1b Canada – Client offense types served, percentage

	Male		Female	
Community Programs	Adults n=19	Adolescents n=15	Adults n=4	Adolescents n=6
Rapists	89.5	66.7	50.0	50.0
Incest abusers (intrafamilial)	100	100	100	100
Child abusers (extrafamilial)	100	100	50.0	100
Statutory rapists	73.7	73.3	50.0	83.3
Child pornography exclusive abusers	100	73.3	75.0	66.7
Other non-contact abusers	94.7	86.7	50.0	100
Residential Programs	Adults n=8			
Rapists	100			
Incest abusers (intrafamilial)	100			
Child abusers (extrafamilial)	100			
Statutory rapists	62.5			
Child pornography exclusive abusers	87.5			
Other non-contact abusers	87.5			

5 Program Funding

This chapter reports survey findings on programs' financial organization. Best practice in this area is simply that programs maintain stable funding to ensure the smooth delivery of services. Unfortunately, the survey data do not provide information on the stability of programs' funding streams. The data does, however, provide information on the nature and diversity of programs' funding sources and their profit status.

PROGRAM PROFIT STATUS

In the United States, the profit structure for community programs is quite consistent across each of the six program types (see Table 5.1a). Private organizations operate about 90 percent of community programs. Between two-thirds and three-quarters (64.7-74.5%) of all community programs are private, for-profit, while only 16.1-22.3 percent are private, not-for-profit organizations. Only about 10 percent are operated by public organizations.

The profit structure of residential programs in the United States is more diverse. About 60 percent of residential programs for adult males and adult females are within the public sector. Since most residential sexual abuser services for adults are provided in prison settings (see Tables 3.3a and b), this result is expected. Most of the residential programs providing services to adolescents and children are private, not-for-profit organizations.

In Canada, the profit structure of community programs is the reverse of what it is in the United States as Canadian programs for sexual abusers are often operated by federal and provincial government. About 60 percent of Canada's community programs are operated by public organizations (see Table 5.1b). As in the United States, most residential sexual abuser services for adults are provided in prison and are operated by the government.

Table 5.1a United States – Program profit status, percentage

	Male			Female		
Community Programs	Adults n=329	Adolescents n=274	Children n=121	Adults n=173	Adolescents n=102	Children n=62
Private, not-for-profit	16.1	22.3	19.8	17.9	17.6	19.4
Private, for-profit	74.5	66.7	70.2	73.4	64.7	69.4
Public	9.4	11.0	9.9	8.6	17.6	11.3
Residential Programs	Adults n=84	Adolescents n=98	Children n=15	Adults n=19	Adolescents n=19	Children n=4
Private, not-for-profit	16.7	51.0	60.0	21.1	26.3	50.0
Private, for-profit	25.0	26.5	26.7	15.8	36.8	25.0
Public	58.3	22.4	13.3	63.2	36.8	25.0

Table 5.1b Canada – Program profit status, percentage						
	Male			Female		
Community Programs	Adults n=19	Adolescents n=15	Children n=7	Adults n=4	Adolescents n=6	Children n=8
Private, not-for-profit	5.3	6.7	14.3	0.0	16.7	12.5
Private, for-profit	31.6	33.3	28.6	0.0	16.7	25.0
Public	63.2	60.0	57.1	100	66.7	62.5
Residential Programs	Adults n=8					
Private, not-for-profit	12.5					
Private, for-profit	12.5					
Public	75.0					

PROGRAM FUNDING SOURCES

Most programs have diverse funding sources (see Tables 5.2a and b). In the United States, client self-pay was the most common funding source reported for all community programs (see Table 5.2a). Ninety percent of community programs serving adult males and females received some funding from client self-pay. About three-quarters of the programs serving each of the other four populations also reported self-pay as a funding source. Private insurance was the next most common funding source for all community programs.

In the United States, state appropriations were identified as the most frequent funding source for residential programs for adults, many of which were prison-based. State grants were the most common funding source for residential treatment programs for adolescents and children.

In Canada, provincial grants, followed by federal grants and contracts, were the most common funding source for community programs. Client self-pay is considerably less common than in the United States (see Table 5.2b). This difference is because federal and provincial governments are the primary funders of community treatment programs for sexual abusers. Federal grants and contracts are the most common funding source for residential programs for adult males.

Table 5.2a United States – Program funding sources, percentage						
	Male			Female		
Community Programs	Adults n=330	Adolescents n=275	Children n=124	Adults n=174	Adolescents n=101	Children n=62
Federal grants & contracts	25.2	11.3	10.5	18.4	11.9	11.3
State grants & contracts	40.3	40.4	41.9	37.9	45.5	48.4
Local grants & contracts	27.6	41.5	46.8	27.6	52.5	46.8
Insurance, private	45.5	51.3	69.4	42.5	56.4	71.0
Insurance, public	19.4	43.3	57.3	27.0	44.6	53.2
Client self-pay	90.3	78.9	77.4	90.8	74.3	72.6
Other	6.7	10.5	12.9	8.0	13.9	14.5
Residential Programs	Adults n=81	Adolescents n=96	Children n=15	Adults n=18	Adolescents n=19	Children n=4
Federal grants & contracts	8.6	17.7	20.0	11.1	15.8	50.0
State grants & contracts	74.1	64.6	53.3	72.2	57.9	50.0
Local grants & contracts	14.8	41.7	66.7	5.6	26.3	50.0
Insurance, private	4.9	28.1	40.0	5.6	31.6	50.0
Insurance, public	12.3	45.8	66.7	11.1	42.1	100
Client self-pay	13.6	29.2	46.7	16.7	42.1	50.0
Other	18.5	20.8	46.7	38.9	26.3	50.0

Note: Most programs selected multiple funding sources so many column totals exceed 100%.

Table 5.2b Canada – Program funding sources, percentage						
	Male			Female		
Community Programs	Adults n=19	Adolescents n=15	Children n=7	Adults n=4	Adolescents n=6	Children n=8
Federal grants & contracts	21.1	6.7	0.0	0.0	16.7	0.0
Provincial grants & contracts	57.9	73.3	57.1	25.0	83.3	62.5
Local grants & contracts	15.8	26.7	42.9	0.0	16.7	37.5
Insurance, private	5.3	13.3	28.6	0.0	16.7	25.0
Insurance, public	21.1	13.3	0.0	75.0	0.0	0.0
Client self-pay	21.1	33.3	28.6	0.0	33.3	12.5
Other	26.3	33.3	42.9	50.0	50.0	37.5
Residential Programs	Adults n=8					
Federal grants & contracts	62.5					
Provincial grants & contracts	25.0					
Local grants & contracts	12.5					
Insurance, private	0.0					
Insurance, public	0.0					
Client self-pay	0.0					
Other	12.5					

Note: Most programs selected multiple funding sources so many column totals exceed 100%.

6 Staff Education, Training and Support

This chapter reports on staff educational backgrounds, opportunities for continuing education, and availability of clinical supervision and supports. Respondents were asked to identify the number of staff who provide treatment services in their program by educational degree and the types of continuing education and clinical supervision and support the staff receive.

The engagement style by which staff deliver services is arguably the most important contributor to effective programs. In the general psychotherapy literature, up to 30 percent of client improvement is attributable to therapeutic relationship factors (Lambert, 1992; Lambert & Barley, 2001). This finding is consistent with those found in the literature on treating general correctional clients (Andrews & Bonta, 2006; Dowden & Andrews, 2004; Florsheim, Shortorban, Guest-Warnick, Barratt, & Hwang, 2000). As well, therapist style has also been found to be critically important in the effective delivery of sexual abuser services (Beech & Fordham, 1997; Marshall et. al. 2006; Rothman, 2007). In these recent studies in the sexual abuser field, maximal positive change in treatment is found when therapists deliver services in a respectful, warm, genuine, directive and empathetic manner. Therapist treatment styles that are cold, hostile, shaming and deceptive have been shown to have no therapeutic benefit and typically have a negative effect on clients achieving treatment goals. Overall, Marshall et al. (2006) report that therapist style accounts for between 40 and 60 percent of the variance among indicators of treatment benefits in their studies examining the effectiveness of sex offender treatment.

Consequently, training and supervising staff are critically important. In the general correctional literature, programs that provide training and ongoing clinical supervision to their staff yield lower rates of criminal reoffending than those that do not (Andrews & Bonta, 2006). Although staff training and supervision have been less studied in the sexual abuser treatment field, there is no reason to believe that these process-related variables would not be applicable.

Staff treating sexual abusers also confront special challenges in working with this difficult client population. Burnout is a very real occupational hazard (Cumming & McGrath, 2005; Edmunds, 1997). This is the first SSF study in which respondents have been queried about whether they provide wellness programs for their staff.

STAFF EDUCATION

Tables 6.1a and b report on the educational background of staff that provide treatment services in programs. It is important to note that "treatment services" was not defined in the survey questionnaire and programs may vary in how they interpret this term.

In community programs in the United States, doctoral level staff accounted for about one-fifth or less (19.9-5.2%) of treatment providers and master's level staff typically accounted for around three-

quarters (61.6-85.3%) of all the treatment providers (see Table 6.1a). Few providers with bachelor's level training or less delivered services in community programs.

Residential programs employed a higher number of staff per program than community programs and delivered services using fewer individuals with advanced degrees. For most program types, the highest formal education of the majority of staff that provided services to sexual abusers was a bachelor's degree or less. The one exception is that over one-half of staff that provided services in residential programs to adult males had a master's or doctorate degree.

In Canada, staff who delivered services to sexual abusers typically had a higher level of formal education than staff in the United States (see Table 6.1b). Over a third or more of staff in all but one type of community program held a doctorate degree and about one-third to two-thirds were master's level trained. Staff in the eight Canadian residential programs for adult males had the highest levels of advanced education; about half (47.9%) held a doctorate degree and almost one-third (29.2%) were trained at the master's level.

Table 6.1a United States – Number of program treatment staff by educational degree and (percentage)

	Male			Female		
Community Programs	Adults n=327	Adolescents n=275	Children n=124	Adults n=174	Adolescents n=101	Children n=62
Doctorate	51 (5.2)	161 (17.3)	68 (17.6)	100 (18.7)	62 (16.7)	42 (19.9)
Master's	830 (85.3)	619 (66.6)	291 (75.4)	410 (76.5)	229 (61.6)	157 (74.4)
Bachelor's	76 (7.8)	121 (13.0)	20 (5.2)	22 (4.1)	27 (7.3)	8 (3.8)
No Bachelor's	16 (1.6)	29 (3.1)	7 (1.8)	4 (0.7)	54 (14.5)	4 (1.9)
Total	973 (100)	930 (100)	386 (100)	536 (100)	372 (100)	211 (100)
Residential Programs	Adults n=84	Adolescents n=95	Children n=15	Adults n=19	Adolescents n=19	Children n=4
Doctorate	198 (15.7)	100 (5.1)	7 (3.8)	6 (5.6)	23 (6.1)	0 (0.0)
Master's	572 (45.4)	459 (23.2)	54 (29.2)	46 (43.0)	70 (18.7)	10 (12.8)
Bachelor's	297 (23.6)	848 (42.9)	85 (45.9)	5 (4.7)	124 (33.1)	32 (41.0)
No Bachelor's	192 (15.3)	569 (28.8)	39 (21.1)	50 (46.7)	158 (42.1)	36 (46.2)
Total	1,259 (100)	1,976 (100)	185 (100)	107 (100)	375 (100)	78 (100)

Note: Some staff members were counted more than once because they provided treatment to clients in more than one type of program in their organization.

Table 6.1b Canada – Number of program treatment staff by educational degree and (percentage)						
	Male			Female		
Community Programs	Adults n=19	Adolescents n=15	Children n=7	Adults n=4	Adolescents n=6	Children n=8
Doctorate	27 (35.1)	26 (38.8)	8 (26.7)	8 (47.1)	12 (34.3)	10 (25.0)
Master's	28 (36.4)	31 (46.3)	17 (56.7)	7 (41.2)	19 (54.3)	20 (50.0)
Bachelor's	21 (27.3)	8 (11.9)	4 (13.3)	2 (11.8)	4 (11.4)	6 (15.0)
No Bachelor's	1 (1.3)	2 (3.0)	1 (3.3)	0 (0.0)	0 (0.0)	4 (10.0)
Total	77 (100)	67 (100)	30 (100)	17 (100)	35 (100)	40 (100)
Residential Programs	Adults n=8					
Doctorate	23 (47.9)					
Master's	14 (29.2)					
Bachelor's	9 (18.8)					
No Bachelor's	2 (4.2)					
Total	48 (100)					

Note: Some staff members were counted more than once because they provided treatment to clients in more than one type of program in their organization.

STAFF TRAINING AND SUPPORT SERVICES

Staff training and supervision data have not been reported upon in previous surveys but as noted above have important implications for the delivery of effective services. The relatively low overall level of advanced graduate school training attained by staff in residential programs makes ongoing staff training and supervision in these settings even more critical. This is especially true given that staff in residential settings generally treat the most difficult and highest risk clients.

In addition, exposure to sexually explicit trauma related material during the course of delivering services can be difficult for professionals working in the field (Ellerby, 1997, 1998; Ennis & Horne, 2003; Farrenkopf, 1992, Moulden & Firestone, 2007). Attending to issues of staff wellness therefore is an important area for attention in staff selection, training, supervision, and ongoing support.

In the United States, almost all programs provided some type of ongoing staff training, the most common of which was local or regional trainings (see Table 6.2a). In terms of providing clinical supervision to staff, over half (52.5-66.0%) of community programs did so, as did about three-quarters or more of residential programs. We suspect that these differences are accounted for by the fact that many community programs are located in private practices and by the fact that staff seek clinical supervision or peer consultation at their discretion,

whereas most residential programs are operated by agencies or organization that require their staff to receive clinical supervision.

Canadian programs report similar rates of clinical supervision but slightly lower rates of training opportunities (see Table 6.2b).

In the United States, staff wellness services appear to operate in only about one-fifth or less of community programs and in about one-third of residential programs. The rates are slightly higher in Canada. Staff wellness services include employee assistance programs and staff training on burnout, secondary trauma, and healthy coping strategies. However, "wellness services" was not defined in the survey questionnaire and programs may have varied in how they interpreted this term.

Table 6.2a United States – Staff development, percentage

	Male			Female		
Community Programs	Adults n=322	Adolescents n=269	Children n=118	Adults n=171	Adolescents n=100	Children n=61
Clinical supervision	52.5	55.8	60.2	53.8	66.0	63.9
Staff wellness services	14.9	14.9	17.8	18.1	19.0	19.7
In-house training	42.5	44.6	44.1	44.4	52.0	47.5
Local and regional training	87.9	87.7	83.1	83.6	88.0	85.2
National conferences	68.0	65.1	72.9	66.7	72.0	67.2
Residential Programs	Adults n=84	Adolescents n=98	Children n=15	Adults n=17	Adolescents n=19	Children n=4
Clinical supervision	70.2	82.7	73.3	70.6	78.9	100
Staff wellness services	32.1	31.6	26.7	17.6	52.6	75.0
In-house training	84.5	84.7	86.7	76.5	78.9	100
Local and regional training	91.7	85.7	100	88.2	89.5	100
National conferences	70.2	62.2	53.3	58.8	73.7	50.0

Table 6.2b Canada – Staff development, percentage

	Male			Female		
Community Programs	Adults n=19	Adolescents n=14	Children n=7	Adults n=4	Adolescents n=6	Children n=8
Clinical supervision	47.4	50.0	42.9	25.0	50.0	50.0
Staff wellness services	26.3	14.3	14.3	50.0	33.3	12.5
In-house training	52.6	50.0	42.9	25.0	50.0	50.0
Local and regional training	47.4	28.6	14.3	50.0	50.0	25.0
National conferences	68.4	71.4	42.9	50.0	83.3	25.0
Residential Programs	Adults n=8					
Clinical supervision	87.5					
Staff wellness services	25.0					
In-house training	50.0					
Local and regional training	62.5					
National conferences	75.0					

7 Program Theory

This chapter examines the theories on which respondents' programs were based. It also compares the rates of endorsement of theories in the current survey with past surveys.

Considerable best practice literature exists on program theory models. Recent meta-analytic studies of the adult male sexual abusers treatment outcome literature provide the most support for cognitive-behavioral interventions (Aos et al., 2006a; Gallagher et al., 1999; Grossman et al., 1999; Hanson et al., 2002; Hanson, Bourgon, et al., 2009; Lösel & Schmucker, 2005; Polizzi et al., 1999; Schmucker & Lösel, 2008).

Cognitive-behavioral treatment for adolescent male sexual abusers also has shown evidence of effectiveness (Walker et al., 2004; Reitzel & Carbonell, 2006), as have family and other systemic treatments targeting sex offense specific issues as well as youths' current life problems in the areas of family, school and peer relationships (Aos et al., 2006b; Borduin et. al., 2009; Hanson et al., 2002).

For children with sexual behavior problems, treatment involving parents and caregivers appears essential and cognitive-behavioral therapies appear more effective than non-directive approaches (Association for the Treatment of Sexual Abusers, 2006; St. Amand et al., 2008)

Treatment outcome for female sexual abusers of any age is much less studied (Center for Sex Offender Management, 2007).

In the current survey, respondents were asked to rank order, from among 13 choices, the three theories that best describe their approach. Although it is understood that many of the models listed overlap with each other and some models might be better described as treatment "philosophies," this more inclusive list was retained in order to survey as broadly as possible how program providers in the field describe the ways they make sense of what they do. Definitions of each model (which were not provided to respondents) are listed here in alphabetical order for the interested reader.

- *Bio-medical*. The primary focus is on the medical model and disease processes. Medication, such as antiandrogens and selective serotonin reuptake inhibitors, is a major treatment emphasis.
- *Cognitive-Behavioral*. This method blends two approaches. Cognitive therapy is based on the premise that how individuals think largely determines how they act and that changes in behavior can be accomplished by changing one's patterns of thinking. Behavior therapy is founded on the premise that behavior is learned and that it can be changed by a variety of conditioning methods.
- *Family Systems*. In this model, the family system is viewed in the context of how it may have contributed to and maintained problematic sexual behavior. The family is the primary unit of treatment and the goal is to change maladaptive relationship patterns.

- *Good Lives*. This model focuses on helping individuals achieve in socially acceptable ways the primary human goods sought by all humans. The goal is to help the individual develop a good life that is inconsistent with offending. It deemphasizes a focus on traditional risk management and avoidance strategies.
- *Harm Reduction*. This way of looking at treatment recognizes that the ideal outcome is preventing reoffending, but considers any reduction in the magnitude of a reoffense as worthwhile.
- *Multisystemic*. Multisystemic approaches use a broad-based array of treatment interventions to influence the client in his or her natural environment. Services are often provided in the home, neighborhood, school, and community in an effort to change the client's "ecological context."
- *Psychodynamic*. This model emphasizes the importance of understanding the unconscious forces that shape human sexual behavior and other behaviors.
- *Psycho-Socio-Educational*. This model emphasizes education as a method of helping sexual abusers change their behavior. Group classes and social skills practice are typically included.
- *Risk-Need-Responsivity*. These are called the three principles of effective correctional services. Programs employing this model focus services on moderate- and higher-risk offenders, target for change those characteristics of offenders that are directly linked to reoffending and are responsive to offenders' learning styles, and focus on social learning and cognitive-behavioral treatment approaches.
- *Relapse Prevention*. Relapse prevention is a multi-modal, cognitive-behavioral approach. Emphasis is on helping abusers learn self-management skills to prevent relapse and teaching others how to supervise the abuser and assist him or her in successfully using these relapse prevention skills. Relapse prevention can be used as an overarching framework for providing treatment and supervision services to abusers.
- *Self-regulation*. This is a model of the relapse process that has identified four pathways to offending and that recommends treatment approaches relevant for each. It is an alternative to the traditional relapse prevention model.
- *Sexual Addiction*. Sexual abusers who commit certain types of sexually abusive behavior are viewed as having a sexual addiction. Treatment includes attendance in a 12-Step program such as Sexaholics Anonymous or Sex and Love Addicts Anonymous.
- *Sexual Trauma*. Sexual trauma models posit that being sexually abused as a child is a major explanatory factor as to why some sexual abusers commit their offenses. Helping abusers resolve their sexual trauma is considered a critical treatment component.

Programs' responses to questions about the theories on which their programs are based are contained in several tables. Tables 7.1a and b identify the percentage of programs in the United States and Canada that choose each of 13 theories, listed in alphabetical order, as best describing their approach. Tables 7.2a and b identify how often each of these 13 theories was included as one of the three top theories that respondents reported as best describing their work with sexual abusers. Tables 7.3, 7.4 and 7.5 compare the rates of endorsement of the most commonly selected theories in United States programs in the current survey with the 2002 Survey. The data is presented in these tables first for United States programs and then for Canadian programs.

In the United States, when programs were asked to rank order the three top theories that best described their work with sexual abusers, their most common first choice was the cognitive-behavioral model (see Table 7.1a). Respondents selected this primary theory by a large margin, regardless of setting or age or gender of clients served.

Table 7.2a identifies how often respondents included each theory as one of their three top theories for describing their work with this population. This means, for example, that among community programs for adult males, 92.0 percent of the 324 respondents identified cognitive-behavioral as one of their top three choices. Cognitive-behavioral was a top-three selection for between 86.0-95.0 percent of all programs for adult and adolescent males and females, and relapse prevention was the next most common selection among these programs. For children's programs, between 55.8-80.0 percent of programs selected cognitive-behavioral as a top-three approach. Despite the recognized importance of family and caretaker involvement in effective services for children and adolescents who engage in problematic sexual behavior, it was surprising and of some concern that a much lower percentage of programs serving children and adolescents listed family systems or multisystemic therapy in their list of top-three theories that inform delivery of services in their programs.

Tables 7.3a, 7.4a and 7.5a, representing one table for each age group, compare the percentages of program theories endorsed by respondents in the 2002 Survey with those in the current survey. Only the most frequently endorsed theories are listed in these tables; they are listed in descending order (i.e., most common to least common). Several interesting changes in the trends for programs' driving theories emerge when examining these data. As indicated in these tables, many of the changes are statistically significant.

For example, although the relapse prevention model continues to be influential in the field, especially in programs for adult and adolescent sexual abusers, its use appears to be declining (see Tables 7.3a, 7.4a and 7.5a). Fewer respondents are endorsing it now as a major influential theory than in 2002. These changes may be because practitioners and researchers have leveled considerable criticism against the relapse prevention model in recent years (Laws, Hudson, & Ward, 2000; Ward, Polaschek, & Beech, 2006; Yates, 2007). A major concern is that it describes only one pathway to offending. It also overemphasizes avoidance as opposed to approach goals. That is, it focuses on what abusers should not do rather than focusing on helping them develop prosocial interests, activities and relationships that are incompatible with offending (Cumming & McGrath, 2005; Ellerby, Bedard, & Chartrand, 2000). Two models that attempt to address perceived failings of the relapse prevention model are the self-regulation and good lives models (Ward et al., 2006), both of which were included in the survey for the first time. As a top-three choice among programs for adult and adolescents, about one-third of programs endorsed the good lives model and about one-quarter reported using the self-regulation model.

This survey is the first one in which the risk, need, and responsivity model was listed as a theory choice. That model is the cornerstone of national adult sex offender treatment programs in several countries, including Canada, England, Scotland, and Hong Kong, and more research supports it than other models listed in this chapter (Andrews & Bonta, 2006; Hanson, Bourgon, et al., 2009). Therefore, the low percentage of programs that endorsed it as a top-three choice is striking, especially for programs in Canada.

In addition to the cognitive-behavioral and relapse prevention models, the psycho-socio-education model has also had prominence in the field. In the 1988 Survey, adolescent programs most often selected it as their primary model. A greater percentage of adult and adolescent programs in the

1988 and 1992 Surveys selected it as their primary model than selected relapse prevention. The psychosocio-education model is now endorsed much less frequently than in past surveys, especially among programs for adults (see Table 7.3a). This shift may reflect a trend among providers in conceptualizing intervention with sexual abusers more as "treatment" than "education."

Among programs for children, the sexual trauma model is endorsed much more now than in the 2002 survey. This change may reflect an increasing awareness about the impact of traumatic experiences on children and trauma's potential etiological significance for sexual behavior problems, in return, on children. Despite the previously noted concerns that family systems and multisystemic models were not more popular with programs serving youthful abusers, over three-quarters of all programs for children and adolescents provide family therapy to their clients, as will be seen in Chapter 10 (see Table 10.1a). Most youthful sexual abusers live with family members or will return to their families following residential treatment; positive family and significant-other support is critical to many young abusers' treatment success.

In Canada, as in the United States, when programs were asked to rank order the three top theories that best described their work with sexual abusers, their most common first choice was the cognitive-behavioral one (see Table 7.1b). Table 7.2b identifies how often respondents included each theory as one of the three top choices for describing their work with sexual abusers. Relapse prevention continues to be an influential model in community programs for adult and adolescent sexual abusers in Canada, but much less so within the small number of residential programs for adult males. The good lives model is being embraced in a larger percentage of Canadian than United States programs. Half or more of Canadian programs for adult males and females list the good lives model among their top three choices.

Table 7.1a United States – Primary theory that best describes program, percentage						
	Male			Female		
Community Programs	Adults n=324	Adolescents n=268	Children n=120	Adults n=171	Adolescents n=100	Children n=60
Bio-medical	0.6	0.4	0.0	0.0	0.0	0.0
Cognitive-behavioral	65.1	63.8	35.8	70.2	65.0	30.0
Family systems	0.6	4.5	23.3	2.3	3.0	20.0
Good Lives	5.2	3.7	1.7	4.7	4.0	0.0
Harm Reduction	0.3	0.0	0.8	0.0	0.0	1.7
Multisystemic	3.1	6.0	8.3	2.9	4.0	5.0
Psycho-dynamic	1.5	0.8	1.7	1.2	1.0	0.0
Psycho-socio-educational	1.5	4.5	7.5	1.8	6.0	10.0
Relapse prevention	14.8	9.7	2.5	9.4	4.0	3.3
Risk-need-responsivity	3.1	3.0	3.3	2.9	5.0	1.7
Self-regulation	1.2	1.9	2.5	0.6	2.0	3.3
Sexual addiction	0.9	0.4	0.0	0.0	0.0	0.0
Sexual trauma	0.3	0.4	8.3	2.9	5.0	16.7
Other	1.5	1.1	4.2	1.2	1.0	8.3
Total	100%	100%	100%	100%	100%	100%
Residential Programs	Adults n=79	Adolescents n=96	Children n=15	Adults n=19	Adolescents n=19	Children n=4
Bio-medical	0.0	1.0	0.0	0.0	5.3	0.0
Cognitive-behavioral	65.8	69.8	40.0	63.2	63.2	25.0
Family systems	0.0	2.1	6.7	0.0	5.3	0.0
Good Lives	2.5	5.2	0.0	5.3	0.0	0.0
Harm Reduction	0.0	0.0	0.0	0.0	0.0	0.0
Multisystemic	0.0	2.1	20.0	5.3	0.0	0.0
Psycho-dynamic	0.0	1.0	0.0	0.0	0.0	0.0
Psycho-socio-educational	2.5	5.2	6.7	0.0	5.3	25.0
Relapse prevention	12.7	4.2	6.7	5.3	5.3	25.0
Risk-need-responsivity	10.1	4.2	6.7	21.1	5.3	0.0
Self-regulation	2.5	3.1	0.0	0.0	0.0	0.0
Sexual addiction	0.0	0.0	0.0	0.0	0.0	0.0
Sexual trauma	0.0	1.0	6.7	0.0	5.3	25.0
Other	3.8	1.0	6.7	0.0	5.3	0.0
Total	100%	100%	100%	100%	100%	100%

Note: The list of program theories has varied somewhat between surveys. Several theories were added for the first time in the current survey, namely, good lives, harm reduction, risk/need/responsivity and self-regulation.

Table 7.2a United States – Top three theories that best describes program, percentage						
	Male			Female		
Community Programs	Adults n=324	Adolescents n=268	Children n=120	Adults n=171	Adolescents n=100	Children n=60
Bio-medical	2.2	0.7	0.8	1.8	2.0	1.7
Cognitive-behavioral	92.0	86.9	55.8	91.2	86.0	60.0
Family systems	8.3	34.3	64.2	12.3	34.0	55.0
Good Lives	28.7	16.4	6.7	27.5	18.0	5.0
Harm Reduction	2.5	2.2	4.2	2.3	2.0	6.7
Multisystemic	8.6	18.7	24.2	11.7	17.0	20.0
Psycho-dynamic	5.2	6.0	7.5	7.0	5.0	3.3
Psycho-socio-educational	30.2	35.4	34.2	27.5	34.0	38.3
Relapse prevention	66.7	51.5	25.0	57.9	36.0	20.0
Risk-need-responsivity	18.5	13.1	13.3	16.4	14.0	10.0
Self-regulation	22.2	22.8	26.7	18.1	19.0	18.3
Sexual addiction	9.3	1.9	0.8	4.1	0.0	0.0
Sexual trauma	3.7	8.6	33.3	21.1	29.0	51.7
Other	1.9	1.5	3.3	1.2	4.0	10.0
Residential Programs	Adults n=79	Adolescents n=96	Children n=15	Adults n=19	Adolescents n=19	Children n=4
Bio-medical	3.8	2.1	0.0	5.3	5.3	0.0
Cognitive-behavioral	95.0	88.5	80.0	89.5	89.5	75.0
Family systems	0.0	21.9	6.7	0.0	15.8	0.0
Good Lives	32.9	20.8	20.0	36.8	15.8	0.0
Harm Reduction	2.5	3.1	6.7	5.3	0.0	0.0
Multisystemic	5.1	14.6	26.7	5.3	26.3	50.0
Psycho-dynamic	0.0	4.2	13.3	0.0	5.3	0.0
Psycho-socio-educational	32.9	43.8	46.7	26.3	57.9	75.0
Relapse prevention	67.1	47.9	33.3	57.9	21.1	50.0
Risk-need-responsivity	31.6	19.8	20.0	36.8	15.8	0.0
Self-regulation	22.8	14.6	6.7	26.3	10.5	0.0
Sexual addiction	2.5	5.2	0.0	0.0	0.0	0.0
Sexual trauma	0.0	10.4	33.3	10.5	31.6	50.0
Other	3.8	3.1	6.7	0.0	5.3	0.0

Note: The list of program theories has varied somewhat between surveys. Several theories were added for the first time in the current survey, namely, good lives, harm reduction, risk/need/responsivity and self-regulation.

Table 7.3a United States – Top three theories that best describes programs for adults 2002 and 2009, percentage				
Adults	**Male**		**Female**	
Community Programs	2002 n=458	2009 n=324	2002 n=252	2009 n=171
Cognitive-behavioral	91.9	92.0	94.4	91.2
Relapse prevention	79.7	66.7***	81.0	57.9***
Psycho-socio-educational	46.7	30.2***	43.3	27.5***
Good lives	-	28.7	-	27.5
Self-regulation	-	22.2	-	18.1
Risk-need-responsivity	-	18.5	-	16.4
Residential Programs	2002 n=80	2009 n=79	2002 n=31	2009 n=19
Cognitive-behavioral	92.5	95.0	87.1	89.5
Relapse prevention	85.0	67.1**	83.9	57.9
Psycho-socio-educational	48.8	32.9	48.4	26.3
Good lives	-	32.9	-	36.8
Self-regulation	-	22.8	-	26.3
Risk-need-responsivity	-	31.6	-	36.8

Note: The list of program theories has varied somewhat between surveys. Several theories were added for the first time in the current survey, namely, good lives, harm reduction, risk/need/responsivity and self-regulation.
**The change in the percentage of programs selecting this model is significant at $p < .01$.
*** The change in the percentage of programs selecting this model is significant at $p < .001$.

Table 7.4a United States – Top three theories that best describes programs for adolescents 2002 and 2009, percentage				
Adolescents	**Male**		**Female**	
Community Programs	2002 n=418	2009 n=268	2002 n=182	2009 n=100
Cognitive-behavioral	90.9	86.9	90.1	86.0
Relapse prevention	75.1	51.5***	70.9	36.0***
Psycho-socio-educational	43.8	35.4***	42.3	34.0
Family systems	30.0	34.3	32.4	34.0
Self-regulation	-	22.8	-	19.0
Multisystemic	21.8	18.7	25.8	17.0*
Sexual trauma	5.5	8.6	7.1	29.0***
Residential Programs	2002 n=165	2009 n=96	2002 n=28	2009 n=19
Cognitive-behavioral	97.0	88.5	96.4	89.5
Relapse prevention	75.8	47.9***	67.9	21.1**
Psycho-socio-educational	40.6	43.8	28.6	57.9
Family systems	22.4	21.9	35.7	15.8
Self-regulation	-	14.6	-	10.5
Multisystemic	20.6	14.6	28.6	26.3
Sexual trauma	5.5	10.4	17.9	31.6

Note: The list of program theories has varied somewhat between surveys. Several theories were added for the first time in the current survey, namely, good lives, harm reduction, risk/need/responsivity and self-regulation.
* The change in the percentage of programs selecting this model is significant at $p < .05$.
**The change in the percentage of programs selecting this model is significant at $p < .01$.
*** The change in the percentage of programs selecting this model is significant at $p < .001$.

Table 7.5a United States – Top three theories that best describes programs for children 2002 and 2009, percentage				
Children	**Male**		**Female**	
Community Programs	2002 n=182	2009 n=120	2002 n=113	2009 n=60
Cognitive-behavioral	76.4	55.8***	75.2	60.0
Relapse prevention	47.8	25.0***	40.7	20.0**
Psycho-socio-educational	41.2	34.2	44.2	38.3
Family systems	50.5	64.2	54.0	55.0
Multisystemic	27.5	24.2	29.2	20.0*
Sexual trauma	20.9	33.3*	25.7	51.7***
Residential Programs	2002 n=16	2009 n=15	2002 n=5	2009 n=4
Cognitive-behavioral	93.8	80.0	80.0	75.0
Relapse prevention	56.3	33.3	60.0	50.0
Psycho-socio-educational	25.0	46.7	0.0	75.0
Family systems	31.3	6.7	20.0	0.0
Multisystemic	25.0	26.7	20.0	50.0
Sexual trauma	25.0	33.3	40.0	50.0

Note: The list of program theories has varied somewhat between surveys. Several theories were added for the first time in the current survey, namely, good lives, harm reduction, risk/need/responsivity and self-regulation.
* The change in the number of programs selecting this model is significant at $p < .05$.
** The change in the number of programs selecting this model is significant at $p < .01$.
*** The change in the number of programs selecting this model is significant at $p < .001$.

Table 7.1b Canada – Primary theory that best describes program, percentage						
	Male			Female		
Community Programs	Adults n=19	Adolescents n=15	Children n=7	Adults n=4	Adolescents n=5	Children n=8
Bio-medical	5.3	6.7	0.0	25.0	0.0	0.0
Cognitive-behavioral	47.4	60.0	28.6	25.0	20.0	25.0
Family systems	0.0	0.0	28.6	0.0	0.0	37.5
Good Lives	10.5	13.3	0.0	25.0	20.0	0.0
Harm Reduction	0.0	0.0	0.0	0.0	0.0	0.0
Multisystemic	5.3	13.3	14.3	0.0	20.0	12.5
Psycho-dynamic	0.0	0.0	0.0	0.0	0.0	0.0
Psycho-socio-educational	5.3	0.0	0.0	0.0	20.0	0.0
Relapse prevention	15.8	6.7	0.0	0.0	0.0	0.0
Risk-need-responsivity	5.3	0.0	0.0	25.0	0.0	0.0
Self-regulation	5.3	0.0	14.3	0.0	0.0	12.5
Sexual addiction	0.0	0.0	0.0	0.0	0.0	0.0
Sexual trauma	0.0	0.0	14.3	0.0	20.0	12.5
Other	0.0	0.0	0.0	0.0	0.0	0.0
Total	100%	100%	100%	100%	100%	100%
Residential Programs	Adults n=8					
Bio-medical	12.5					
Cognitive-behavioral	50.0					
Family systems	0.0					
Good Lives	0.0					
Harm Reduction	0.0					
Multisystemic	0.0					
Psycho-dynamic	0.0					
Psycho-socio-educational	0.0					
Relapse prevention	0.0					
Risk-need-responsivity	0.0					
Self-regulation	37.5					
Sexual addiction	0.0					
Sexual trauma	0.0					
Other	0.0					
Total	100%					

Table 7.2b Canada – Top three theories that best describes program, percentage

	Male			Female		
Community Programs	Adults n=19	Adolescents n=15	Children n=7	Adults n=4	Adolescents n=5	Children n=8
Bio-medical	15.8	6.7	0.0	25.0	0.0	0.0
Cognitive-behavioral	63.2	86.7	57.1	75.0	80.0	62.5
Family systems	0.0	20.0	57.1	0.0	20.0	62.5
Good Lives	52.6	20.0	14.3	75.0	20.0	25.0
Harm Reduction	5.3	6.7	0.0	0.0	0.0	0.0
Multisystemic	15.8	20.0	14.3	0.0	40.0	12.5
Psycho-dynamic	5.3	0.0	14.3	0.0	0.0	12.5
Psycho-socio-educational	21.1	33.3	42.9	0.0	40.0	37.5
Relapse prevention	73.7	40.0	0.0	75.0	40.0	0.0
Risk-need-responsivity	26.3	26.7	28.6	50.0	20.0	25.0
Self-regulation	21.1	26.7	14.3	0.0	0.0	12.5
Sexual addiction	0.0	0.0	0.0	0.0	0.0	0.0
Sexual trauma	0.0	13.3	57.1	0.0	40.0	50.0
Other	0.0	0.0	0.0	0.0	0.0	0.0
Residential Programs	Adults n=8					
Bio-medical	12.5					
Cognitive-behavioral	100					
Family systems	0.0					
Good Lives	50.0					
Harm Reduction	0.0					
Multisystemic	12.5					
Psycho-dynamic	0.0					
Psycho-socio-educational	0.0					
Relapse prevention	12.5					
Risk-need-responsivity	37.5					
Self-regulation	75.0					
Sexual addiction	0.0					
Sexual trauma	0.0					
Other	0.0					

8 Assessment Methods

This chapter examines the percentage of programs utilizing various assessment methods. This current SSF survey is only the second one (the first being the 2002 survey) in which data on the use of assessment instruments other than the penile plethysmograph and polygraph is reported. This chapter also compares the current rates of reported use of these physiological instruments with past rates.

Assessment-driven decision making is a best practice in the field, and it forms the foundation for effective sexual abuser services. Assessments illuminate case-by-case differences among sexual abusers so that programs can make placement, treatment, supervision and other service delivery decisions based on individuals' risk level, treatment needs, and responsivity factors (Andrews & Bonta, 2006; Hanson, Bourgon, et al., 2009; Harland, 1996). Assessment continues to be the focus of much research in the field (e.g., Craig et al., 2008). Practice patterns in assessment, as identified in this survey, have changed significantly over the last six years.

Assessment methods surveyed in this study focus primarily on specialized instruments used to evaluate reoffense risk and treatment needs among sexual abusers. The most extensively researched risk and need instruments are those used with adult males. To a lesser degree, advances have been made in risk assessment instruments specifically for adolescent males who have engaged in sexually abusive behavior. No validated sex offender risk instruments exist for female sex offenders.

Sexual abuser treatment providers also use general psychological tests and inventories commonly used in the mental health field to assess a range of cognitive, psychological, behavioral, and other potential problem areas. The assessment of an array of psychological and behavioral factors can be important for ensuring treatment methods are responsive to individual needs and learning styles, but these instruments were too numerous to include in our survey questionnaire.

RISK ASSESSMENT

The optimal risk assessment approach is an actuarial method, a statistical approach that has proven more effective than clinical judgment in making risk determinations (Grove & Meehl, 1996; Hanson & Morton-Bourgon, 2009). An abuser's risk is assessed by determining how similar he or she is to other groups of abusers for whom the reoffense risk is known. The evaluator obtains data on several characteristics of the individual that are known risk factors for reoffending, such as criminal history and victim gender. Each characteristic is weighted, and these weights are added in a prescribed manner yielding a risk score. The risk score translates to a risk level and the actual percent reoffense rate of individuals in the normative sample who obtained the same score. Insurance companies use this approach to determine insurance rates for different populations of insurees based on the statistical likelihood they will file a certain type of claim.

The actuarial approach is relatively easy to learn. It provides objectivity, uniformity, consistency, and equality in the decision-making process. It does, however, have some limitations. Actuarial assessments focus on general predictors and often ignore case-specific factors. When used as a stand-alone instrument, they lack the comprehensiveness common to a thorough clinical assessment. Additionally, base rates of reoffending in the population being evaluated may differ from the samples on which the instrument was normed.

Nevertheless, acceptance of actuarial risk assessment for sexual abusers is generally well established. For example, the Association for the Treatment of Sexual Abusers (2005) practice standards and guidelines for adult male sexual abusers state, "Members conducting risk assessments use an appropriate actuarial risk assessment instrument for the client population being evaluated" (p. 12).

As is shown in the several assessment sections that follow, it is encouraging that the percentage of programs using evidence-based assessment instruments continues to increase.

SEXUAL RECIDIVISM RISK ASSESSMENT INSTRUMENTS FOR ADULT MALES

Several actuarial instruments are available for adult male offenders. In the 2002 Survey, we noted that Langton and his associates (Langton, 2003; Langton, Barbaree, & Seto, 2002) identified five sex-offender specific instruments for adult males that have acceptable inter-rater reliability, have moderate predictive validity, are cross-validated, and can be scored by trained correctional staff, as well as clinicians. Included in the present survey are these same five instruments, in addition to the more recently developed Static-2002 (see Table 8.1).

Notably, each of these instrument is comprised primarily or entirely of static risk factors. Static risk factors are unchangeable historical variables, such as number of prior sexual offense convictions, history of non-sexual criminal activity, and victim gender. As described above, static risk instruments are valuable in assessing the long-term reoffense risk of offenders. Yet, because they are composed of unchangeable risk factors, they do not account for factors that may reduce risk. Static assessment instruments do not help service providers identify relevant treatment targets that may reduce risk or assess how successful abusers have been in addressing risk relevant factors and, consequently, reducing their likelihood of reoffending. Instruments that exclusively measure changeable risk factors are examined in the next section. Here, a brief description of each of these six primarily static risk instruments follows:

- *MnSOST-R*. The MnSOST-R (Minnesota Sex Offender Screening Tool – Revised; Epperson, Kaul, & Heselton, 1999) is designed to assess sexual reoffense risk among adult rapists and extra-familial child molesters. It is composed of 16 static and dynamic items. Scores fall into one of four levels reflecting the probability of sexual reoffending within six years post-release from prison.
- *RRASOR*. The RRASOR (Rapid Risk Assessment for Sex Offense Recidivism; Hanson, 1997) is designed to assess sexual re-offense risk among adult sex offenders. It is comprised of four static items. Scores fall into one of six levels reflecting the probability of sexual reoffending at five- and ten-year intervals.
- *Static-99*. The Static-99 (Hanson & Thornton, 1999; Harris, Phenix, Hanson & Thornton, 2003) includes the four items that comprise the RRASOR as well as six other static items. The resulting 10-item actuarial risk measure

is used in a manner similar to the RRASOR. Scores fall into one of seven levels reflecting the probability of sexual and violent reoffending at five-, ten-, and 15-year intervals.

- *Static-2002*. The Static-2002 (Hanson, Helmus, & Thornton, in press; Phenix, Doren, Helmus, Hanson, & Thornton, 2009) was designed to be an improvement of the Static-99. It is composed of 14 static risk factors and is used for evaluating the probability of sexual and violent reoffending at five- and ten-year intervals.
- *SVR-20*. The SVR-20 (Sexual Violent Risk-20) (Boer, Hart, Kropp, & Webster, 1997) was designed to assess sexual reoffense risk among adult male sex offenders. It is composed of 20 static and dynamic risk items. Originally designed as an empirically guided risk-assessment instrument, research has found that scores on the instrument correlate with the probability that an individual will sexually reoffend (e.g., Langton, 2003).
- *VASOR*. The VASOR (Vermont Assessment of Sex-Offender Risk) (McGrath & Hoke, 2001) is a risk assessment scale for adult male sex offenders that has two scales. The reoffense risk scale includes 13 static and dynamic risk factors. Scores fall into one of three levels reflecting the probability of sexual reoffending within five years. The six-item violence scale assesses the nature of an individual's violence history and offense severity.

In the United States, the use of one or more of these instruments has increased significantly from about three-fifths of the programs in 2002 to almost nine-tenths in the current survey (see Table 8.1a). This increase largely is accounted for by statistically significant and dramatic increases in the use of the Static-99 in community and residential programs from 2002 to 2009. The Static-99 continues to be the most commonly used of these instruments by a wide margin, followed by its predecessor, the RRASOR. The Static-2002 has only been available for a few years, but given that the authors report it has better predictive accuracy than the Static-99, as well as other advantages (Hanson, Helmus, & Thornton, in press), its use may increase substantially over the next few years.

Four of the six instruments (i.e., RRASOR, Static-99, Static-2002 and SVR-20) listed in Tables 8.1a and b were developed in Canada where their use is well-established. As shown in Table 8.1b, all but one of the 27 Canadian programs for adult males that responded to the survey used one or more of these instruments. Just as is true in the United States, the Static-99 is by far the most commonly used instrument in Canada.

Table 8.1a United States – Sexual recidivism risk assessment instruments used in adult male programs 2002 & 2009, percentage				
	Community Programs		Residential Programs	
Instruments	2002 n=520	2009 n=330	2002 n=93	2009 n=85
MnSOST-R	20.2	23.0	23.7	31.8
RRASOR	35.0	31.2	31.2	29.4
Static-99	54.0	71.2***	48.4	80.0***
Static-2002	n/a	22.1	n/a	16.5
SVR-20	9.0	8.5	9.7	3.5
VASOR	5.8	11.8**	3.2	7.1
Use one or more of the above	63.3	87.9***	55.9	87.1***

**The change in the percentage of programs using this instrument is significant at $p < .01$.
***The change in the percentage of programs using this instrument is significant at $p < .001$.

Table 8.1b Canada – Sexual recidivism risk assessment instruments used in adult male programs, percentage		
	Community Programs	Residential Programs
Instruments	2009 n=19	2009 n=8
MnSOST-R	0.0	0.0
RRASOR	10.5	25.0
Static-99	68.4	87.5
Static-2002	42.1	25.0
SVR-20	26.3	25.0
VASOR	0.0	0.0
Use one or more of the above	94.7	100

DYNAMIC RISK ASSESSMENT INSTRUMENTS FOR ADULT MALES

To identify targets for supervision and treatment intervention, as well as measure change in reoffense risk, assessment of dynamic risk factors, sometimes called criminogenic needs (e.g., Andrews & Bonta, 2006), is required. Dynamic risk factors are potentially changeable offending-related aspects of an individual's functioning or their situations or circumstances and are commonly labeled as either "stable" or "acute." Stable dynamic risk factors are relatively ingrained behavioral and personality characteristics that are rather constant over time but that, potentially, are amenable to intervention. Examples are pro-offending attitudes and offense-related sexual interests. Acute dynamic risk factors are those that can change rapidly. Examples of acute dynamic risk factors include current access to potential victims and substance abuse. Acute risk factors potentially are more responsive to supervision and treatment interventions than are stable dynamic factors. Sexual abuser programs that focus on helping clients change problems linked to the offending behavior are more effective in reducing recidivism than those that do not (Hanson, Bourgon, et al., 2009).

Research on dynamic risk factors, as well as the development of dynamic risk assessment instruments for use with sexual abusers, has been a rela-

tively recent development and, consequently, supporting research is much more limited than research on static risk measures. A few promising dynamic instruments exist, however. Three were included in the survey and are described below.

- *Stable 2007 and Acute 2007*. The Stable 2007 and Acute 2007 (Hanson, Harris, Scott, & Helmus, 2007) were designed to enable probation and parole officers, as well as clinicians, to assess and track changes in the risk status of adult sex offenders over time. The Stable-2007 is composed of 16 stable dynamic risk factors and the Acute-2007 is composed of seven acute dynamic risk factors. These instruments were designed to be used in combination with the Static-99.
- *SRA*. The SRA (Structured Risk Assessment; Knight & Thornton, 2007; Thornton, 2002) is a clinician-scored, dynamic, risk-assessment instrument comprised of 16 risk factors that are grouped into four broad need domains. It is designed to be used in conjunction with the Static-99 or the RM-2000, a static risk instrument used commonly in the United Kingdom.
- *TPS*. The TPS (Sex Offender Treatment Needs and Progress Scale; McGrath & Cumming, 2003; McGrath, Cumming, & Livingston, 2005) is 22-item dynamic risk instrument designed to aid clinicians, correctional caseworkers, and probation and parole officers in identifying and monitoring treatment and supervision needs and progress of adult male sexual abusers.

As shown in Table 8.2a, almost half of programs for adult male sexual abusers in the United States report using one or more of these instruments. An even higher percentage of programs in Canada use one or more of these instruments (see Table 8.2b). The most commonly used instruments in both countries are the Stable 2007 and the Acute 2007. Given the importance of dynamic risk assessment, as described in the earlier discussion of the principles of effective correctional treatment, programs that include dynamic risk and progress assessments may be more effective at reducing reoffending.

Table 8.2a United States – Dynamic sexual abuser risk assessment instruments used in adult male programs, percentage

Instruments	Community n=330	Residential n=85
SRA – Structured Risk Assessment	9.1	12.9
Stable 2007 and Acute 2007	34.5	36.5
TPS – Sex Offender Treatment Needs and Progress Scale	18.5	2.4
Use one or more of the above	48.5	45.9

Table 8.2b Canada – Dynamic sexual abuser risk assessment instruments used in adult male programs, percentage

Instruments	Community n=19	Residential n=8
SRA – Structured Risk Assessment	15.8	0.0
Stable 2007 and Acute 2007	57.9	87.5
TPS – Sex Offender Treatment Needs and Progress Scale	10.5	0.0
Use one or more of the above	63.3	87.5

GENERAL RISK ASSESSMENT INSTRUMENTS FOR ADULTS

While the instruments in Tables 8.1 and 8.2 were designed primarily to assess the likelihood that a sexual abuser will commit another sexual offense, the instruments listed in Tables 8.3a and b and described here were designed to assess the risk of other types of criminal reoffending.

- *LSI-R*.. The LSI-R (Level of Service Inventory-Revised; Andrews & Bonta, 1995) is a well-established risk/need instrument used extensively with male and female adult offenders in the general correctional population. Built on 54 static and dynamic risk factors, its scores fall into one of four risk/need categories predicting reincarceration rates at one year following release. Total and Subscale scores are used to guide placement, treatment, and supervision planning. The LSI-R does not predict sexual reoffending particularly well, but Simourd and Malcolm (1998) found it predicted general criminal reoffending among sex offenders. The authors also have published a short version of this instrument (LSI-R:SV) and one that focuses on case planning and management (LS/CMI).
- *VRAG*. The VRAG (Violence Risk Appraisal Guide; Quinsey, Harris, Rice, & Cormier, 2006) is a 12-item actuarial instrument comprised of static risk factors. Scores fall into one of seven "bins" or groups that predict the probability of violent reoffending, which includes sexual reoffending, among adult males at seven- and 10-year intervals.
- *SORAG*. The SORAG (Sex Offender Risk Appraisal Guide; Quinsey, Harris, Rice, & Cormier, 2006) is a version of the VRAG designed for use with adult sex offenders. It has 14 static items. As with the VRAG, scores fall into one of seven "bins" that predict violent reoffending, which includes sexual reoffending, among adult males at seven- and 10-year intervals.

As shown in Tables 8.3, a relatively small percentage of programs in both the United States and Canada reported using the LSI-R, VRAG or SORAG. This result is surprising given that many sexual abusers also commit non-sexual crimes and the goals of most sexual abuser programs include preventing all types of reoffending.

Table 8.3a United States – General risk assessment instruments used in programs for adults 2002 & 2009, percentage

	Male		Female	
Community Programs	2002 n=520	2009 n=330	2002 n=289	2009 n=174
LSI-R (Level of Service Inventory - Revised)	5.8	10.9	5.2	11.5
VRAG (Violence Risk Appraisal Guide)	n/a	11.8	n/a	12.6
SORAG (Sexual Offense Risk Appraisal Guide)	n/a	13.6	n/a	14.4
VRAG or SORAG (combined in 2002 Survey)	16.9	n/a	10.7	n/a
Residential Programs	2002 n=93	2009 n=85	2002 n=35	2009 n=19
LSI-R (Level of Service Inventory - Revised)	13.9	22.4	17.1	36.8
VRAG (Violence Risk Appraisal Guide)	n/a	7.1	n/a	10.5
SORAG (Sexual Offense Risk Appraisal Guide)	n/a	9.4	n/a	10.5
VRAG or SORAG (combined in 2002 Survey)	17.2	n/a	2.9	n/a

Table 8.3b Canada – General risk assessment instruments used in programs for adults, percentage		
	Male	**Female**
Community Programs	Adults n=19	Adults n=4
LSI-R (Level of Service Inventory - Revised)	31.6	0.0
VRAG (Violence Risk Appraisal Guide)	31.6	0.0
SORAG (Sexual Offense Risk Appraisal Guide)	26.3	25.0
Residential Programs	Adults n=8	
LSI-R (Level of Service Inventory - Revised)	25.0	
VRAG (Violence Risk Appraisal Guide)	25.0	
SORAG (Sexual Offense Risk Appraisal Guide)	37.5	

SEX OFFENSE SPECIFIC RISK ASSESSMENT INSTRUMENTS FOR ADOLESCENT MALES

The evolution of sexual recidivism risk assessment instruments for adolescent males has been slower than for adult males. Research on predictive accuracy of risk assessment among this population is still in the early stage. The ERASOR and J-SOAP-II are two empirically guided risk instruments for adolescent males, and the JSORRAT-II is a relatively new actuarial measure for adolescents.

- *ERASOR*. The ERASOR (Estimate of Risk of Adolescent Sexual Offender Recidivism; Worling & Curwen, 2001) is a 23-item checklist using static and dynamic risk factors. It is designed to aid in assessing sexual reoffense risk among male sexual abusers ages 12 through 18.
- *J-SOAP-II*. The J-SOAP-II (Juvenile Sex Offender Assessment Protocol-II; Prentky & Righthand, 2003) is a 28-item checklist comprised of static and dynamic risk factors. It is designed to aid in assessing sexual and nonsexual reoffense risk among male sexual abusers ages 12 through 18.
- *JSORRAT-II*. The JSORRAT-II (Juvenile Sexual Offense Recidivism Risk Assessment Tool; Epperson, Ralston, Fowers, & DeWitt, 2005), comprised of 12 static risk factors, is a sexual recidivism risk assessment tool designed for juvenile male sexual offenders ages 12 through 18.

In the United States, use of one or more of these instruments has increased significantly from about two-fifths of the programs in 2002 to over three-quarters of the programs in the current survey (see Table 8.4a). These increases are accounted for by the statistically significant and dramatic increases in the use of the ERASOR and J-SOAP-II in community and residential programs from 2002 to 2009. The newest of the three instruments, the JSORRAT-II, is the least commonly used. In Canada, two-thirds of programs reported using one or more of these instruments (see Table 8.4b), slightly less than in the United States.

Table 8.4a United States – Sex offense specific risk assessment instruments used in adolescent male programs 2002 & 2009, percentage				
	Community Programs		Residential Programs	
Instruments	2002 n=477	2009 n=275	2002 n=187	2009 n=98
ERASOR	21.0	53.1***	20.9	43.8***
J-SOAP-II	30.4	61.1***	31.0	58.2***
JSORRAT-II	n/a	18.5	n/a	18.4
Use one or more of the above	39.2	81.1***	43.1	76.5***

***The change in the percentage of programs using this instrument is significant at $p < .001$.

Table 8.4b Canada – Sex offense specific risk instruments used in adolescent male programs 2009, percentage	
	Community Programs
Instruments	2009 n =15
ERASOR	60.0
J-SOAP-II	26.7
JSORRAT-II	0.0
Use one or more of the above	66.7

OTHER PAPER-AND-PENCIL ASSESSMENT INSTRUMENTS

Treatment providers and researchers who reviewed earlier drafts of the survey questionnaire recommended inclusion of other assessment instruments commonly used with adults, adolescents and children with illegal sexual behaviors and these are described below and listed in Tables 8.5.

- *CBCL*. The CBCL (Child Behavior Checklist; Achenbach, 1991) is designed to assess "social competence" and "behavior problems" in children ages 4 to 18. It consists of 118 items related to behavior problems which are scored on a three-point scale ranging from not true to often true of the child. Multiple versions of the CBCL (i.e., parent, teacher, and youth versions) enable the evaluator to obtain a more well-rounded assessment of the youth.
- *CSBI*. The CSBI (Child Sexual Behavior Inventory; Friedrich, 1997) is a parent report (mother or primary female caregiver) measure of sexual behavior in children ages 2-12 years. It is intended for use with children who have been or who may have been sexually abused.
- *MSI-II*. The MSI-II (Multiphasic Sex Inventory-II; Nichols & Molinder, 1996) is a 500-item self-report questionnaire designed to assess a wide range of psychosexual characteristics of sexual offenders, including denial, cognitive distortions, and motivation for treatment. Versions exist for adult and adolescent males and females.
- *PCL-R*. The PCL-R (Psychopathy Checklist-Revised; Hare, 2003) is a 20-item clinical-rating scale that provides an estimate of the extent to which an individual has characteristics associated with psychopathy.

- *PCL:YV*. The PCL:YV (Psychopathy Checklist: Youth Version; Forth, Kosson, & Hare, 2003) is the youth version of the PCL-R clinical rating scale. It measures interpersonal, affective, and behavioral features related to psychopathy.
- *YLS/CMI*. The YLS/CMI (Youth Level of Service/Case Management Inventory; Hoge & Andrews, 2003) is the youth version of the LSI-R and LS/CMI. It is a risk/needs assessment and a case management tool that assesses risk for nonsexual reoffending among juveniles with sexual and nonsexual offense histories.

Table 8.5a United States – Other assessment instruments, percentage

	Male			Female		
Community Programs	Adults n=330	Adolescents n=275	Children n=124	Adults n=174	Adolescents n=102	Children n=62
CBCL	n/a	39.3	62.1	n/a	43.1	59.7
CSBI	n/a	32.7	55.6	n/a	35.3	66.1
MSI-II	30.6	n/a	n/a	33.9	n/a	n/a
PCL-R	29.1	n/a	n/a	20.7	n/a	n/a
PCL:YV	n/a	10.9	n/a	n/a	11.8	n/a
YLS/CMI	n/a	5.5	2.4	n/a	6.9	1.6
Residential Programs	Adults n=85	Adolescents n=98	Children n=15	Adults n=19	Adolescents n=19	Children n=4
CBCL	n/a	40.8	60.0	n/a	42.1	100
CSBI	n/a	27.6	26.7	n/a	31.6	75.0
MSI-II	31.8	n/a	n/a	26.3	n/a	n/a
PCL-R	43.5	n/a	n/a	26.3	n/a	n/a
PCL:YV	n/a	7.1	n/a	n/a	5.3	n/a
YLS/CMI	n/a	12.2	6.7	n/a	10.5	0.0

Table 8.5b Canada – Other assessment instruments, percentage

	Male			Female		
Community Programs	Adults n=19	Adolescents n=15	Children n=7	Adults n=4	Adolescents n=6	Children n=8
CBCL	n/a	40.0	100	n/a	66.7	100
CSBI	n/a	26.7	85.7	n/a	33.3	87.5
MSI-II	10.5	n/a	n/a	0.0	n/a	n/a
PCL-R	47.4	n/a	n/a	25.0	n/a	n/a
PCL:YV	n/a	13.3	n/a	n/a	0.0	n/a
YLS/CMI	n/a	13.3	n/a	n/a	16.7	0.0
Residential Programs	Adults n=8					
MSI-II	0.0					
PCL-R	25.0					

POLYGRAPHY

This section reports on the percentage of adult and adolescent programs using the polygraph. It is rarely used with children. Typically, programs employ the polygraph post-conviction to motivate abusers to be truthful about their sexual offending history, to follow treatment and supervision rules, and to verify that they have complied with those rules. Three types of post-conviction polygraph examinations are used for these purposes.

- *Full Disclosure or Sexual History Exam*. This type of examination is used to verify that the abuser has honestly and completely detailed his or her entire sexual offending history to service providers. Staff usually refer an abuser for this type of exam after he or she has been in treatment for three to six months.
- *Specific Issue Exam*. This type of examination is used to verify the details of a specific concern. A typical specific issue exam, for example, would focus on whether an individual actually committed the sexual offense for which he or she was convicted.
- *Maintenance or Monitoring Exam*. These types of polygraph examinations are used to verify whether an offender has been compliant with his or her treatment and supervision requirements. A typical exam question might be, “Other than what you have already told me, since your release to the community on parole have you had any contact with your victim?" These exams are administered on a periodic basis, usually not more than once every six months.

Research in this area indicates that polygraphed sex offenders, compared to non-polygraphed offenders, are found to admit to committing more past sexual offending behavior (Ahlmeyer, Heil, McKee, & English, 2000; Hindman & Peters, 2001) and more high-risk behavior during community supervision (Grubin, Madsen, Parsons, Sosnowski, & Warberg, 2004). This information is believed to help providers more precisely target rehabilitation services (Grubin et al., 2004; Kokish, 2003). As a result, surveys of providers commonly report that they believe the polygraph is a useful management tool (Kokish, 2003; McGrath, Cumming, Hoke, & Bonn-Miller, 2007). A primary perceived value of polygraph is the belief that individuals who commit sexual offenses may be deterred from reoffending when they know they will be tested regularly so that they fear detection (Abrams & Abrams, 1993). On the other hand, mandated polygraphs may affect the therapeutic alliance, and former clients, once they are not required to comply with polygraphs, may be less likely to turn to treatment providers when in need.

Most scientific reviews conclude that polygraph tests that focus on specific, narrow and concrete issues commonly yield accuracy rates well above chance (National Research Council, 2002; Raskin & Honts, 2001). A common concern of critics, though, is the negative impact on examinees of even a small number of inaccurate test results (Cross & Saxe, 2001). Different types of post-conviction sex offense polygraph exams are prone to varying degrees of error (Branaman & Gallagher, 2005). Exams that focus on whether an individual committed a specific sexual offense for which he has already been found guilty are likely to be the most accurate although still not perfect. An example of such an exam question would be, "Did you touch the victim's breast last Monday?" Least accurate are those that focus on wide-ranging issues, such as in Sexual History or Full Disclosure Exams. An example of a broad question would be, "Have you told me about every deviant sexual act that you have committed since you were a child?" In all cases, polygraph tests are prone most to false positive errors, that is, falsely judging someone who is

telling the truth to be deceptive (Branaman & Gallagher, 2005).

Unfortunately, the important question of whether polygraph-induced disclosures to treatment providers and correctional supervision staff are associated with lower reoffense rates has not been well studied. We are aware of only one published study that has addressed this issue. McGrath et al. (2007) compared a group of sex offenders who received community cognitive-behavioral treatment, correctional supervision, and periodic polygraph compliance exams with a matched group of offenders who received the same type of treatment and supervision services but no polygraph exams. At fixed, five-year follow-up periods, the number of individuals in the polygraph group charged with committing a new non-sexual violent offense was lower than in the no-polygraph group, but there were no differences in the number of individuals charged with new sexual or other type of criminal offenses.

Survey results indicate the polygraph continues to be commonly used in sexual abuser programs throughout the United States (see Table 8.6a). Not surprisingly, however, community programs used the polygraph more often than residential programs in every age and gender category. The highest reported use of the polygraph was in community programs for adult males (79.4%) and those for adult females (77.0%). More adult programs than adolescent programs use the polygraph, regardless of setting or gender.

In marked contrast to practice patterns in the United States, use of the polygraph in Canadian programs appears much less common (see Table 8.6b). Only community programs for adult males reported using the polygraph. Of these programs, only 2 of 19 (10.5%) reported using this technology.

Programs' responses to another survey question concerning the polygraph are detailed in the next chapter (see Table 9.3a and b). The question asks whether programs require abusers to pass a disclosure polygraph test in order to successfully complete treatment and the results of those responses, therefore, are contained in the section on treatment targets and offense denial and minimization.

Table 8.6a United States – Polygraph use by programs, percentage

	Male		Female	
Community Programs	Adults n=330	Adolescents n=275	Adults n=174	Adolescents n=102
Polygraphy, disclosure tests	67.0	46.6	69.5	44.1
Polygraphy, monitoring or maintenance tests	74.5	42.5	72.4	41.2
Polygraphy, special issues tests	60.6	42.5	64.4	41.2
Use one or more of the above	79.4	50.5	77.0	49.0
Residential Programs	Adults n=85	Adolescents n=98	Adults n=19	Adolescents n=19
Polygraphy, disclosure tests	52.9	38.8	52.6	26.3
Polygraphy, monitoring or maintenance tests	38.8	27.6	26.3	31.6
Polygraphy, special issues tests	41.2	35.7	36.8	31.6
Use one or more of the above	56.5	49.0	52.6	31.6

Table 8.6b Canada – Polygraph use by programs, percentage				
	Male		Female	
Community Programs	Adults n=19	Adolescents n=15	Adults n=4	Adolescents n=6
Polygraphy, disclosure tests	5.3	0.0	25.0	0.0
Polygraphy, monitoring or maintenance tests	10.5	0.0	25.0	0.0
Polygraphy, special issues tests	10.5	0.0	25.0	0.0
Use one or more of the above	10.5	0.0	25.0	0.0
Residential Programs	Adults n=8			
Polygraphy, disclosure tests	0.0			
Polygraphy, monitoring or maintenance tests	0.0			
Polygraphy, special issues tests	0.0			
Use one or more of the above	0.0			

SEXUAL INTEREST MEASURES

Assessing and treating offense-related sexual interests is perhaps what most sets apart sexual abuser rehabilitation efforts from those for other types of offenders. At least as far back as Freud's (1953) initial formulations of psychoanalytic theory, abusive sexual fantasy has been linked with abusive sexual behavior. This connection between abusive sexual fantasy and behavior similarly forms the cornerstone of early behavioral theories about sexual offending (McGuire, Carlisle, & Young, 1965). Behavioral conditioning theory posits that offense-related sexual interests are developed in childhood when deviant sexual stimuli are paired with sexual arousal. Sexual abusers maintain their offense-related sexual interests by continuing to pair abusive sexual fantasies with sexual arousal during masturbation. Some researchers challenge these theories (Marshall, Anderson & Fernandez, 1999) but assessment and modification of sexual interests is an integral component in a large number of programs for adult male sexual abusers (Marshall, Fernandez, Hudson, & Ward, 1998).

Deviant sexual interest is clearly a stable dynamic risk factor. Adult male sexual abusers, with a greater sexual interest in children than adults, have higher sexual reoffense rates than those who do not (Hanson & Morton-Bourgon, 2004; 2005; Mann, Hanson, & Thornton, 2008). A recent, large-scale meta-analysis found that sexual abusers with a greater interest in coercive sexual activities than in cooperative ones also have higher sexual reoffense rates than those who do not (Mann, Hanson & Thornton, 2008).

Several methods are used to assess an individual's sexual interests and preferences, ranging from relatively simple to more complex. Simple approaches include clinical interviews and self-report measures (e.g., Abel & Becker, 1985; Nichols & Molinder, 1996) but these methods are quite vulnerable to deception and socially desirable responding. Evaluators also can make educated inferences about an abuser's sexual interests based on the individual's relationship history, sexual offending and victim selection history (Seto & Lalumiere, 2001) and pornography use (Seto, Cantor, & Blanchard, 2006). More complex methods involving the use of the psycho-physiological assessment instruments can employed but even these techniques can be subject to deception. These methods are listed in Table 8.7 and described below.

- *Penile Plethysmograph*. The penile plethysmograph measures penile tumescence, typically with a strain gage, as the subject attends to slides, audio-tapes, or video-tapes depicting various appropriate and inappropriate sexual stimuli. The magnitude of the individual's erection response to a category of stimuli is considered an indication of his sexual interest in that behavior or in persons of that age and gender (Marshall & Fernandez, 2003; Murphy & Barbaree, 1994).
- *Vaginal Plethysmograph*. The vaginal plethysmograph uses a small glass photodetector to measure vaginal blood flow, an indicator of sexual arousal in women. In a process similar to penile plethysmographic assessment, measurements are taken while the woman views or listens to stimuli depicting appropriate and inappropriate sexual activities (Greer, Morokoff, & Greenwood, 1974).
- *Viewing Time Measures*. Viewing time measures compute the length of time an individual views slides of males and females of different ages. Individuals in the slides are typically clothed. Response times on this test are believed to reflect an individual's sexual interests (Abel, Huffman, Warberg, & Holland, 1998; Gress, 2005; Letourneau, 2002).

Tables 8.7a and b list the percentage of programs reporting use of the various psycho-physiological measures of sexual interest.

Children's programs are not included here because these measures are rarely used with this population. The infrequent use of the penile plethysmograph by adolescent programs is probably warranted, as the significance of phallometrically measured sexual arousal in adolescents is less clear than in adults. Arousal patterns of adolescents appear less set (Becker & Hunter, 1997). Additionally, some adolescents may be impacted negatively by being exposed to deviant sexual materials during phallometric testing.

In the United States, almost three-fifths (58.8%) of programs for adult males report using the penile plethysmograph, viewing-time measures or both. Among adult male programs, the penile plethysmograph is more commonly used in residential programs (36.5%) and viewing-time measures are more commonly used in community programs (45.8%). Among community and residential programs for male adolescents, slightly less than 10 percent used the penile plethysmograph, whereas slightly over one-third used viewing time measures. Among programs for females, use of viewing time measures ranged from a low of 10.5 percent in residential programs for adults to a high of 43.7 percent in community programs for adults. Only two programs in the survey reported using the vaginal plethysmograph.

In Canada, viewing time measures appear to be used much less than in the United States, whereas seven out the eight (87.5%) adult male residential programs responding report using the penile plethysmograph.

The sexual-interest measures described here can have value with adults even though they are relatively expensive to use compared to paper-and-pencil measures and clinical interview approaches. Marshall and Fernandez's (2003) recent conclusions about the usefulness of phallometric assessments may apply equally well to viewing-time testing. They opine that objective measures of sexual interest can be useful for predicting risk, assessing treatment needs, and evaluating treatment response.

Table 8.7a United States – Sexual interest measures, percentage

	Male		Female	
Community Programs	Adults n=330	Adolescents n=275	Adults n=174	Adolescents n=102
Penile plethysmography (PPG)	27.9	9.5	n/a	n/a
Viewing time measures (VTM)	45.8	34.5	43.7	25.5
Use PPG, VRT, or both	58.8	39.3	n/a	n/a
Vaginal plethysmography	n/a	n/a	1.1	0.0
Residential Programs	Adults n=85	Adolescents n=98	Adults n=19	Adolescents n=19
Penile plethysmography (PPG)	36.5	9.2	n/a	n/a
Viewing time measures (VTM)	28.2	34.7	10.5	36.8
Use PPG, VTM, or both	48.2	38.8	n/a	n/a
Vaginal plethysmography	n/a	n/a	0.0	0.0

Table 8.7b Canada – Sexual interest measures, percentage

	Male		Female	
Community Programs	Adults n=19	Adolescents n=15	Adults n=4	Adolescents n=6
Penile plethysmography (PPG)	36.8	20.0	n/a	n/a
Viewing time measures (VTM)	10.5	13.3	25.0	36.8
Use PPG, VRT, or both	42.1	26.7	n/a	n/a
Vaginal plethysmography	n/a	n/a	0.0	0.0
Residential Programs	Adults n=8			
Penile plethysmography (PPG)	87.5			
Viewing time measures (VTM)	25.0			
Use PPG, VRT, or both	87.5			
Vaginal plethysmography	n/a			

Table 8.8a United States – Voice stress measures, percentage

	Male		Female	
Community Programs	Adults n=330	Adolescents n=275	Adults n=174	Adolescents n=102
Voice Stress	1.5	2.2	1.7	2.0
Residential Programs	Adults n=85	Adolescents n=98	Adults n=19	Adolescents n=19
Voice Stress	1.2	1.0	0.0	0.0

Table 8.8b Canada – Voice stress measures, percentage				
	Male		Female	
Community Programs	Adults n=19	Adolescents n=15	Adults n=4	Adolescents n=6
Voice Stress	0.0	0.0	0.0	0.0
Residential Programs	Adults n=8			
Voice Stress	12.5			

VOICE STRESS MEASURES

Computer-based voice stress analysis programs are designed to measure changes in voice patterns that are thought to be associated with deception. The programs are commercially available and proponents argue that they are an alternative to traditional polygraph testing. A recent research review reports low rates of accuracy in detecting deception (Damphousse, 2008). As shown in Tables 8.8a and b, very few programs use this technology in either the United States or Canada.

TRENDS IN PSYCHOPHYSIOLOGICAL ASSESSMENT METHODS IN THE UNITED STATES 1986-2009

Tables 8.9 and 8.10 reveal some interesting patterns in the percentage of programs that have used psychophysiological assessment methods over time. The percentage of programs using the penile plethysmograph has remained relatively stable over the past two decades. Programs for adult males use this technology at slightly higher rates than those for adolescent males.

An alternative to the use of the penile plethysmograph is the viewing time measure. Use of viewing time measures increased in community programs for adults from 31 percent in 2002 to 45 percent in 2009. In community programs for adolescents, the increase was from 25 to 31 percent and in residential programs from 17 to 31 percent.

The most dramatic increase in use of psychophysiological assessment instruments is in the area of polygraphy. The 1992 Survey began tracking programs' use of the polygraph. Since that time, polygraph use more than doubled in community adult programs (29 to 79%) and more than tripled in residential programs for adults (16 to 56%). During the same time period, the percentage of adolescent community programs using the polygraph doubled, going from 25 to 50 percent and the percentage of adolescent residential programs using it more than doubled, increasing from 19 to 46 percent. Despite this striking rise in its use, it is arguably a very intrusive measure, and its scientific merit continues to be questioned (e.g., National Research Council, 2002). Further, treatment providers have surprisingly little guidance about its appropriate application. Current Association for the Treatment of Sexual Abuser (2005) practice guidelines speak more to standards about the technical aspects of conducting an examination than about how to use the results of the examination. The field would benefit greatly from additional guidelines and standards in this important area.

Table 8.9 – Psychophysiological assessment methods used with adults in the United States 1986-2009, percentage									
Community Programs	1986	1988	1990	1992	1994	1996	2000	2002	2009
Penile plethysmograph	27	28	32	31	32	20	28	25	28
Polygraph				29	29	30	63	70	79
Viewing time measures								31	45
Voice stress measures									2
Residential Programs	1986	1988	1990	1992	1994	1996	2000	2002	2009
Penile plethysmograph	27	22	30	27	27	28	45	34	37
Polygraph				16	16	17	37	36	56
Viewing time measures								24	25
Voice stress measures									1

Note: Data on use of the penile plethysmograph represent the responses of programs for males. Data on the polygraph and viewing time measures represent the combined responses of programs for both genders. Data on polygraph use by programs in 2000 is based on unpublished raw data from the 2000 Survey.

Table 8.10 – Psychophysiological assessment methods used with adolescents in the United States 1986-2009, percentage									
Community Programs	1986	1988	1990	1992	1994	1996	2000	2002	2009
Penile plethysmograph	13	16	22	24	24	9	11	10	10
Polygraph				25	25	22	33	44	50
Viewing time measures								25	31
Voice stress measures									2
Residential Programs	1986	1988	1990	1992	1994	1996	2000	2002	2009
Penile plethysmograph	8	11	19	18	18	11	15	9	9
Polygraph				19	19	11	24	30	46
Viewing time measures								17	35
Voice stress measures									1

Note: Data on use of the penile plethysmograph represent the responses of programs for males. Data on the polygraph and viewing time measures represent the combined responses of programs for both genders. Data on polygraph use by programs in 2000 is based on unpublished raw data from the 2000 Survey.

9 Treatment Targets and Methods

This chapter reviews what programs target in treatment and the methods they use to do so. It also examines how programs provide treatment when clients deny and do not accept responsibility for their offenses. Lastly, this chapter examines practice patterns with respect to behavioral and pharmacological treatment interventions that are specifically designed to help clients address sexual arousal and interest problems.

Consistent with the need principle, targets of treatment in sexual abuser programs should focus primarily on dynamic risk factors associated with offending, that is, criminogenic needs. Programs that focus services on criminogenic needs have greater reductions in reoffending rates than those that do not (Andrews & Bonta, 2006; Hanson, Bourgon, et al., 2009).

Further, effective programs not only target the problems of abusers that are criminogenic but address as many of those problems as possible. As Andrews and his colleagues (Andrews, 2001; Andrews & Bonta, 2006; Andrews, Dowden, & Gendreau, 1999; Dowden & Andrews, 2000) identified in their meta-analyses, the effectiveness of correctional treatment programs increases as the number of criminogenic needs addressed increases and the number of non-criminogenic needs decreases. Hanson, Bourgon, et al. (2009) found this inverse relationship holds true in programs for sex offenders as well.

A series of sex-offense-specific meta-analyses have examined the criminogenic needs of adult and adolescent sex offenders (Hanson & Bussière, 1998; Hanson, & Morton-Bourgon, 2004, 2005; Mann et al, 2008; McCann & Lussier, 2008). Major criminogenic risk factors identified in these studies include sexual preoccupation, deviant sexual interests, attitudes supportive of offending, intimacy deficits, emotion regulation problems, lifestyle impulsivity, poor problem-solving skills, negative social influences, and resistance to supervision. These studies also identified several factors that are common targets of treatment in sex offender programs, but which appear to have little or no relationship with sexual recidivism. These factors include offense denial and minimization, low self-esteem, poor victim empathy, having been sexually abused as a child, and general psychological problems.

Nevertheless, some treatment targets are important for effective sex offense specific treatment even if they are not criminogenic. These targets typically are factors that can enhance treatment responsivity, and include such elements as the facilitation of the therapeutic alliance and encouraging better engagement in treatment. For example, while low self-esteem has generally not been found to be a criminogenic need (Hanson & Bussière, 1998), targeting this problem in treatment may enhance clients' beliefs in their capacity to change (Marshall et al., 2006).

In addition to reporting survey results pertaining to core sex-offense specific treatment targets, treatment interventions are examined in this chapter. As has been noted in previous chapters, treatment methods under the rubric of cognitive-behavioral therapy have the greatest empirical support for

adults. With adolescents, cognitive-behavioral and multisystemic treatments show the best outcomes.

CORE TREATMENT TARGETS

The treatment targets included in the current survey and listed in Tables 9.1a and b are primarily those examined in previous SSF surveys. In our experience, they are also the most common core treatment targets addressed in programs throughout the United States and in most other jurisdictions around the world. Each is commonly identified in the practice guidelines of several professional groups for adult male sexual abusers (Association for the Treatment of Sexual Abusers, 2005; Correctional Service of Canada, 2000; Home Office Communication Directorate, 2000), as well as for adolescent male sexual abusers (American Academy of Child and Adolescent Psychiatry, 1999; National Adolescent Perpetrator Network, 1993). To what extent they are important for female adults and adolescents and young children with sexual offenses remains an empirical question. As already noted, not all of the surveyed treatment targets are criminogenic.

In the survey, respondents were ask to "check" a box to signify which of the treatment targets listed in Table 9.1 their programs addressed. The survey did not define these treatment targets or ask how much treatment time was devoted to each target. Each target is described here.

- *Arousal Control*. Sexual preoccupation, hypersexual behaviors, and deviant sexual interests are risk factors for committing sexually abusive acts. Behavior therapies and medication are employed to help selected clients with persistent arousal control problems manage their abusive sexual fantasies and urges in appropriate ways and, in some cases, replace them with more appropriate ones.
- *Emotional Regulation*. Marked deterioration of mood is linked to imminent risk of sexual reoffending. Thus improved emotional regulation is a common and appropriate target in treatment. The goal is to help the client recognize, monitor, understand, and appropriately mange emotions.
- *Family Support Networks*. An informed network of family and friends can provide much-needed positive social support that helps reduce reoffense risk. Pro-social support persons can reinforce pro-social attitudes, help clients secure and maintain stable employment, avoid and cope with high-risk situations, and develop lifestyles incompatible with sexual offending.
- *Intimacy and Relationship Skills*. Problems in developing and maintaining satisfying intimate relationships with friends of a similar age are related to some sexual abusers' tendencies to seek out sexual relationships with children and non-consenting adults. Intimacy and relationship skill development, therefore, can be an important treatment target.
- *Offense Responsibility*. Traditionally, one of the first steps in sexual abuser treatment has involved asking clients to describe and accept responsibility for their sexually abusive behavior. Many providers argue that treatment interventions rely on the abuser's ability to identify and address offense precursors, which is difficult to do if he or she denies committing the sexual offense. Given that the relevance of offense denial and responsibility as a treatment target has received increased attention in recent years and has been debated actively since the last survey, the current survey included more questions on this topic and addresses them in a separate section in this chapter.

- *Offense Supportive Attitudes*. Sexual abusers typically use irrational or rationalizing thought processes to support or justify their sexually abusive behaviors. Cognitive restructuring is used to help them identify and counter these distorted thought processes.
- *Problem Solving*. Poor problem solving is linked to increased sexual reoffense rates among sexual abusers. It may be that offenders who do not have skills to solve problems and meet their sexual and life needs in prosocial ways attempt to meet their needs in ways that are sexually abusive.
- *Self-monitoring*. Self monitoring refers to an individual's ability to be aware of and manage his or her internal processes. In the area of sexual abuser treatment, this includes recognition and management of the thoughts, attitudes, feelings, situations, and sexual interest and arousal that were linked to offending.
- *Social Skills*. Sexual abusers often have a variety of social skills deficits. These can include impairment in the areas of conflict resolution, conversational skills, parenting, and use of leisure time. Sometimes these problems are related to mental health disorders for which treatment is also required.
- *Victim Awareness and Empathy*. Treatment efforts designed to teach sexual abusers about the detrimental effects of sexual victimization, about how to see situations from another's perspective, and about how to understand and value others are common in most programs. As has been noted in the introduction to this chapter, however, research has not identified poor victim empathy as a criminogenic risk factor.

As shown in Tables 9.1a and b, a high percentage of programs, in each category, address most of these treatment areas. The emphases, however, often are at odds with what the research has indicated are the most important criminogenic treatment targets. Offense responsibility as well as victim awareness and empathy are some of the most endorsed treatment targets among adult and adolescent programs in spite of limited or complete lack of evidence indicating that addressing these treatment targets results in reduced reoffending rates. In contrast, sexual abusers who evidence offense-supportive attitudes and problems controlling their arousal (e.g., sexual preoccupation and deviant sexual interests) have increased rates of sexual reoffending, but a comparatively small percentage of programs report they address these issues in treatment. Offense responsibility and arousal control are examined in more detail in later sections of this chapter.

In United States programs, no significant shifts in practice patterns are evident when comparing the results in Table 9.1a with the results of the 2002 survey.

Table 9.1a United States – Core treatment targets, percentage						
	Male			Female		
Community Programs	Adults n=329	Adolescents n=272	Children n=121	Adults n=171	Adolescents n=101	Children n=62
Arousal control	68.5	57.5	n/a	58.6	53.9	n/a
Emotional regulation	65.7	65.8	66.1	64.7	71.3	64.5
Family support networks	77.2	94.0	94.1	77.8	96.0	93.3
Intimacy/relationship skills	91.2	86.8	45.5	91.9	85.1	43.5
Offense responsibility	91.8	88.2	57.0	85.5	86.1	45.2
Offense supportive attitudes	54.4	51.8	33.1	49.7	55.4	29.0
Problem Solving	79.9	86.0	73.6	78.0	83.2	74.2
Self-monitoring	56.2	54.0	38.0	47.4	49.5	29.0
Social skills training	87.5	94.1	89.3	86.1	94.1	88.7
Victim awareness and empathy	92.7	92.6	76.0	94.8	93.1	69.4
Residential Programs	Adults n=79	Adolescents n=95	Children n=15	Adults n=17	Adolescents n=18	Children n=4
Arousal control	58.8	61.2	n/a	36.8	36.8	n/a
Emotional regulation	64.6	76.8	86.7	86.7	77.8	100
Family support networks	46.7	89.6	93.3	41.2	88.2	100
Intimacy/relationship skills	83.5	87.4	80.0	100	66.7	75.0
Offense responsibility	91.1	93.7	86.7	88.2	72.2	100
Offense supportive attitudes	54.4	45.3	66.7	64.7	44.4	25.0
Problem Solving	78.5	90.5	100	88.2	94.4	100
Self-monitoring	49.4	57.9	73.3	41.2	55.6	75.0
Social skills training	91.1	98.9	100	100	88.9	100
Victim awareness and empathy	87.3	94.7	93.3	82.4	94.4	100

Note: Percentages in the "Arousal control" rows are taken from the “Uses one or more of the above” sections in Table 9.5a and those in the "Family support networks" rows are taken from the “Family educated to be part of the client’s support network” from Table 12.2a.

OFFENSE DENIAL AND RESPONSIBILITY

The importance of offense denial and responsibility in the treatment of sexual abusers has received considerable attention over the last several years. Many abusers deny committing the sexual offenses for which they have been convicted and, often, this denial has been viewed as a serious challenge to providing them treatment (Barbaree, 1991; Maletsky, 1991; Marshall, 1994). Therefore, conventional wisdom encouraged having clients describe and accept responsibility for their sexually abusive behavior early in treatment. The idea was that someone must admit to having a problem before treatment to modify that problem could be successful. Furthermore, some argue that treating an individual for an unacknowledged problem is unethical.

Recent research indicates that offense denial and minimization may not be as important treatment targets as once thought. In a series of influential meta-analyses conducted over the last decade, offense denial and minimization were not predictive of sexual recidivism (Hanson & Bussière, 1998; Hanson, & Morton-Bourgon, 2004, 2005; Mann et

Table 9.1b Canada – Core treatment targets, percentage						
	Male			Female		
Community Programs	Adults n=19	Adolescents n=15	Children n=7	Adults n=4	Adolescents n=6	Children n=8
Arousal control	36.8	53.3	n/a	0.0	66.7	n/a
Emotional regulation	78.9	66.7	71.4	75.0	66.7	75.0
Family support networks	50.0	71.4	83.3	75.0	83.3	71.4
Intimacy/relationship skills	94.7	86.7	85.7	100	100	75.0
Offense responsibility	78.9	86.7	57.1	50.0	66.7	62.5
Offense supportive attitudes	57.9	53.3	42.9	50.0	66.7	37.5
Problem Solving	73.7	86.7	85.7	75.0	100	87.5
Self-monitoring	52.6	60.0	71.4	50.0	66.7	62.5
Social skills training	78.9	86.7	85.7	75.0	100	87.5
Victim awareness and empathy	89.5	93.3	100	75.0	100	87.5
Residential Programs	Adults n=8					
Arousal control	75.0					
Emotional regulation	87.5					
Family support networks	0.0					
Intimacy/relationship skills	87.5					
Offense responsibility	50.0					
Offense supportive attitudes	62.5					
Problem Solving	50.0					
Self-monitoring	37.5					
Social skills training	50.0					
Victim awareness and empathy	75.0					

Note: Percentages in the "Arousal control" rows are taken from the “Uses one or more of the above” sections in Table 9.5b and those in the "Family support networks" rows are taken from the “Family educated to be part of the client’s support network” from Table 12.2b.

al., 2008). These findings are not without challengers. Lund (2000), for example, contested the results of the earliest of these meta-analyses, noting that the definitions of denial varied considerably among the studies examined. Complete deniers were excluded in some of the studies, and it was unclear if deniers at the beginning of treatment were still in denial at the end of treatment. More recently, some research groups have found that the relationship between denial and recidivism is rather complex and may be an important risk factor for some types of sex offenders but not others. For example, Nunes, Hanson, Firestone, Moulden, Greenberg and Bradford (2007) found incest offenders who were in categorical denial reoffended at higher rates than those who were not. Langton, Barbaree, Harkins, Arenovich, Mcnamee, Peacock et. al. (2008) found that minimization of sexual offending behavior was a significant predictor of sexual recidivism among a sample of high-risk sex offenders. Yates (2009) has recently reviewed much of the relevant literature in this area and has outlined the various arguments in this debate.

Most programs continue to require clients to admit some or all of their sexual offending behavior in order to be accepted into and complete treatment, although a small number of programs do not require any admission of guilt to enter or complete treat-

ment (see Tables 9.2a and b and 9.3a and b). Proponents of this latter approach argue that treatment of sex offenders in categorical denial nonetheless can be quite effective (Marshall, Thornton, Marshall, Fernandez, & Mann, 2001).

Among professionals believing that denial is not a criminogenic need, many still argue that it is an important treatment target. They label it a responsivity issue and maintain that admitting at least some sexual offending behavior makes it easier to examine and modify the precursors of offending.

Whereas Tables 9.1a and b simply report whether respondents targeted offense responsibility in their program, Tables 9.2a and b and Tables 9.3a and b examine how much emphasis programs place on this issue as a requirement of program completion. Data in Tables 9.2a and b is based on respondents' answers to the following question, for which they were asked to select one of the four following responses:

> In general, what level of sexual offense disclosure must an abuser make to successfully complete your program?
>
> - Disclose a sexual offense history that is very consistent with official records.
> - Disclose a sexual offense history that is reasonably consistent with official records.
> - Disclose at least some sexual offense history, even if it is inconsistent with official records.
> - Does not need to disclose committing a sexual offense.

In the United States, one-third (33.4%) of adult programs and one-quarter (26.9%) of adolescent programs require near full disclosure for successful program completion. Less than 10 percent of programs did not require any offense disclosure to complete the program.

In contrast, no Canadian programs responding to the survey require individuals to fully admit their sexual offending behavior in order to successfully complete treatment. In fact, one-quarter (26.3%) of community programs and just over one-third (37.5%) of residential programs for adults do not require offense disclosures to complete their program.

Table 9.2a United States – Level of offense disclosure required to successfully complete program, percentage

	Male		Female	
Community Programs	Adults n=329	Adolescents n=271	Adults n=173	Adolescents n=100
Very consistent	33.4	26.9	33.0	27.0
Reasonably consistent	48.0	51.7	47.4	50.0
Inconsistent, but some	12.5	14.4	12.7	15.0
None required	6.1	7.0	6.9	8.0
Residential Programs	Adults n=82	Adolescents n=97	Adults n=18	Adolescents n=19
Very consistent	36.6	38.1	38.9	21.1
Reasonably consistent	42.7	44.3	33.3	57.9
Inconsistent, but some	14.6	8.2	27.8	15.8
None required	6.1	9.3	0.0	5.3

Table 9.2b Canada – Level of offense disclosure required to successfully complete program, percentage				
	Male		Female	
Community Programs	Adults n=19	Adolescents n=15	Adults n=4	Adolescents n=6
Very consistent	0.0	0.0	0.0	0.0
Reasonably consistent	36.8	53.3	50.0	50.0
Inconsistent, but some	36.8	33.3	25.0	33.3
None required	26.3	13.3	25.0	16.7
Residential Programs	Adults n=8			
Very consistent	0.0			
Reasonably consistent	12.5			
Inconsistent, but some	50.0			
None required	37.5			

As previously shown in Table 8.6a, programs in the United States commonly administer disclosure polygraphs to adult and adolescent sexual abusers. Table 9.3a shows that half of community programs for adult males and females require their clients pass a disclosure polygraph to successfully complete treatment. The percentages for adolescent clients are lower but still significant. Few programs in Canada used the polygraph and of those that do, none had such a requirement (see Table 9.3b).

Table 9.3a United States – Disclosure polygraph test required to successfully complete treatment, percentage				
	Male		Female	
Community Programs	Adults n=328	Adolescents n=269	Adults n=171	Adolescents n=99
Required	50.0	26.8	54.4	27.3
Not required	28.0	34.2	29.8	32.3
Does not use polygraph	22.0	39.0	15.8	40.4
Residential Programs	Adults n=83	Adolescents n=97	Adults n=18	Adolescents n=19
Required	34.9	15.5	38.9	10.5
Not required	25.3	40.2	33.3	47.4
Does not use polygraph	39.8	44.3	27.8	42.1

Table 9.3b Canada – Disclosure polygraph test required to successfully complete treatment, percentage				
	Male		Female	
Community Programs	Adults n=19	Adolescents n=15	Adults n=4	Adolescents n=6
Required	0.0	0.0	0.0	0.0
Not required	36.8	33.3	25.0	16.7
Does not use polygraph	63.2	66.7	75.0	83.3
Residential Programs	Adults n=8			
Required	0.0			
Not required	0.0			
Does not use polygraph	100			

Tables 9.4a and b give the percentage of programs providing separate groups for deniers and also shows the percentage of those programs that integrate into groups abusers who admit their offenses with those that do not. In general, separate groups for deniers are relatively uncommon. Whether due to treatment philosophy or because few programs have enough deniers to form specialized groups for this population, programs in both the United States and Canada commonly treat admitters and deniers in the same group.

Some programs may ultimately decide to terminate or exclude clients from treatment when they remain in denial, but good-faith efforts should first be made to assist clients with this problem (Association for the Treatment of Sexual Abusers, 2005; National Adolescent Perpetrator Network, 1993). McGrath (1990) and Winn (1996) suggest several individual treatment strategies for working with clients in denial. O'Donohue and Letourneau (1993) and Schlank and Shaw (1996) report success using time-limited group psycho-educational modules with deniers. Marshall (1994) describes effective strategies for working with deniers who are in mixed treatment groups with abusers who admit their offending behavior.

Table 9.4a United States – Specialized services for deniers, percentage						
	Male			**Female**		
Community Programs	Adults n=283	Adolescents n=215	Children n=82	Adults n=128	Adolescents n=78	Children n=12
Separate group for deniers	10.2	5.5	1.2	6.3	7.7	0.0
Admitters/deniers in same group	56.2	47.4	15.9	46.9	28.2	50.0
Residential Programs	Adults n=73	Adolescents n=85	Children n=12	Adults n=12	Adolescents n=16	Children n=3
Separate group for deniers	13.7	4.7	8.3	8.3	6.3	0.0
Admitters/deniers in same group	46.6	78.8	75.0	33.3	81.3	100

Note: Columns do not add up to 100% because some programs refuse to treat deniers or provide them individual treatment, rather than operating a separate group for them or placing them in the same group with admitters.

Table 9.4b Canada – Specialized services for deniers, percentage						
	Male			Female		
Community Programs	Adults n=14	Adolescents n=12	Children n=4	Adults n=2	Adolescents n=5	Children n=5
Separate group for deniers	21.4	8.3	0.0	50.0	20.0	0.0
Admitters/deniers in same group	50.0	16.7	25.0	50.0	20.0	0.0
Residential Programs	Adults n=8					
Separate group for deniers	37.5					
Admitters/deniers in same group	37.5					

Note: Columns do not add up to 100% because some programs refused to treat deniers or provide them individual treatment, rather than operating a separate group for them or placing them in the same group with admitters.

BEHAVIORAL SEXUAL AROUSAL CONTROL TREATMENTS

Sexual abusers with sexual arousal control problems (e.g., sexual preoccupation, deviant sexual arousal, or compulsive or hypersexual behaviors) should receive treatment to address these difficulties. Sexual-arousal problems concern sexual abusers' sexual interests and sex drive. Some abusers are more aroused to coercive sexual behavior than to appropriate, consensual sexual activities, while others are not at all aroused to appropriate sexual behavior. Some abusers have a very high sex drive and have difficulty controlling and not acting on their sexually intrusive thoughts.

Treatment for arousal control problems has two goals. The first goal is to help sexual abusers control, reduce, or eliminate abusive sexual interests and behavior. The other goal is to help abusers develop, maintain, and strengthen appropriate sexual arousal and interests. Several behavioral therapy techniques can help clients achieve these goals. Although none has undergone extensive empirical evaluation, the literature reports some success for each method in treating adult males (Laws, 1995, 2001; Maletsky, 1991; Marshall et al., 1999). Their effectiveness in treating adolescent males is less documented (Hunter & Lexier, 1998) and their effectiveness in treating females of any age or male children is largely unexamined and may not be appropriate.

Behavioral sexual arousal control treatments surveyed in the study and listed in Tables 9.5a and b are described here.

- *Aversive behavioral rehearsal*. The abuser role-plays his sexual offense in the presence of others, often while it is video-taped. This aversive procedure compels the abuser to see what he looks and sounds like while abusing someone. Because the procedure is quite intrusive, it has several potential negative side effects (Mann, Daniels, & Marshall, 2002; Webster, Bowers, Mann & Marshall, 2005; Wickramaserka, 1980).
- *Covert sensitization*. The sexual abuser imagines performing the chain of behaviors that led to his sexual offending or that might lead to some high-risk situation. Prior to committing an offense or engaging in high-risk behavior in his imagination, the abuser interrupts the chain by imagining an aversive consequence or by imagining successfully escaping the situation (Maletsky, 1991; McGrath, 2001).
- *Masturbatory satiation*. In this extinction procedure, the client masturbates while repeatedly

verbalizing his abusive sexual fantasies until their sexually arousing properties are extinguished through boredom. Typically, the client is instructed to masturbate to orgasm to an appropriate fantasy before beginning the procedure. In doing so, the client pairs arousal to an appropriate image and begins the satiation procedure when his sexual arousal is already low (Laws, 1995; Maletsky, 1991).

- *Minimal arousal conditioning*. This procedure is similar to covert sensitization except that the abuser interrupts the chain of behaviors sooner. The abuser interrupts the chain as soon as he or she experiences any type of mentally or physically sexually arousing thoughts or feelings (Gray, 1995; Jensen, 1994).
- *Odor aversion*. In this procedure, the abuser uses a foul odor, such as ammonia or spoiled meat, to interrupt sexually deviant urges or thoughts (Laws, 2001; Maletsky, 1991). This approach can be done during treatment sessions or in real-life situations in the community.
- *Orgasmic conditioning*. In this overt, positive conditioning procedure, the abuser pairs appropriate sexual fantasies with masturbation and orgasm (Maletsky, 1991; McGrath, 2001). It is designed to increase an abuser's interest in age-appropriate, consenting sexual behavior.
- *Verbal satiation*. Verbal satiation is carried out in the same manner as masturbatory satiation except that the client does not masturbate while verbalizing his abusive sexual fantasies (Laws, 1995; Maletsky, 1991; McGrath, 2001).

In the United States in 2009, over half of all programs for adult and adolescent males used one or more of the behavioral sexual arousal control techniques listed in Table 9.5a, as did more than half of community programs for adult and adolescent females. Covert sensitization was the most commonly used behavioral arousal control technique among all program types, typically by a large margin. Few programs for children use these techniques and therefore that data is not reported here.

Table 9.5a also contains data from the 2002 survey; some changes in practice patterns are evident since that last survey. The most striking finding is that residential programs for adolescents have shown a statistically significant increase in the use of behavioral methods (percent using "one or more of above"), namely, an 8.1 percent change among programs for males and 16.7 percent for females. As also shown in this table, the techniques that are being used more by these two program types are covert sensitization, and a similar procedure, minimal arousal conditioning. Interestingly, community programs for adult males and also females have shown a statistically significant rise in the use of minimal arousal conditioning.

In Canada, three-quarters (75.0%) of residential programs for adult males use one or more of the behavioral sexual arousal control techniques listed in Table 9.5b, but only about a third (36.8%) of community programs for adult males use them.

Table 9.5a United States – Behavioral sexual arousal control treatments 2002 and 2009, percentage				
Adults	**Male**		**Female**	
Community Programs	2002 n=522	2009 n=330	2002 n=287	2009 n=174
Aversive behavioral rehearsal	22.8	22.4	14.3	12.1
Covert sensitization	48.9	54.2	36.2	40.8
Masturbatory satiation	24.3	17.6	10.5	5.2
Minimal arousal conditioning	18.4	27.3**	12.2	20.1*
Odor aversion	25.3	29.1	15.0	17.8
Orgasmic conditioning	15.7	14.2	11.1	2.9**
Verbal satiation	15.5	14.5	10.8	6.9
Uses one or more of above	63.3	68.5	49.5	58.6
Residential Programs	2002 n=93	2009 n=85	2002 n=35	2009 n=19
Aversive behavioral rehearsal	18.3	14.1	2.9	0.0
Covert sensitization	48.4	44.7	20.0	21.1
Masturbatory satiation	19.4	14.1	0.0	0.0
Minimal arousal conditioning	18.3	23.5	0.0	15.8
Odor aversion	18.3	15.3	2.9	5.3
Orgasmic conditioning	19.4	15.3	2.9	10.5
Verbal satiation	14.0	9.4	5.7	10.5
Uses one or more of above	59.6	58.8	25.7	36.8
Adolescents	**Male**		**Female**	
Community Programs	2002 n=471	2009 n=275	2002 n=227	2009 n=102
Aversive behavioral rehearsal	14.6	16.4	10.6	13.7
Covert sensitization	34.8	43.6**	25.6	40.2**
Masturbatory satiation	12.5	14.5	8.4	6.9
Minimal arousal conditioning	9.8	17.5**	5.3	14.9**
Odor aversion	10.2	12.7	5.7	5.9
Orgasmic conditioning	8.3	8.0	5.7	2.0
Verbal satiation	10.6	12.0	8.4	9.8
Uses one or more of above	49.4	57.5*	37.2	53.9**
Residential Programs	2002 n=187	2009 n=98	2002 n=33	2009 n=19
Aversive behavioral rehearsal	18.2	17.3	6.1	5.3
Covert sensitization	39.0	40.8	36.4	21.1
Masturbatory satiation	15.5	12.2	12.1	5.3
Minimal arousal conditioning	18.2	22.4	18.2	15.8
Odor aversion	4.8	6.1	6.1	5.3
Orgasmic conditioning	8.0	5.1	0.0	0.0
Verbal satiation	15.0	10.2	6.1	10.5
Uses one or more of above	56.4	61.2	48.5	36.8

*The change in the percentage of programs using this treatment is significant at $p < .05$.
**The change in the percentage of programs using this treatment is significant at $p < .01$.

Table 9.5b Canada – Behavioral sexual arousal control treatments, percentage				
	Male		Female	
Community Programs	Adults n=19	Adolescents n=15	Adults n=4	Adolescents n=6
Aversive behavioral rehearsal	10.5	13.3	0.0	0.0
Covert sensitization	31.6	46.7	0.0	66.7
Masturbatory satiation	15.8	6.7	0.0	0.0
Minimal arousal conditioning	10.5	6.7	0.0	0.0
Odor aversion	10.5	0.0	0.0	0.0
Orgasmic conditioning	5.3	0.0	0.0	0.0
Verbal satiation	10.5	6.7	0.0	16.7
Uses one or more of the above	36.8	53.3	0.0	66.7
Residential Programs	Adults n=8			
Aversive behavioral rehearsal	0.0			
Covert sensitization	62.5			
Masturbatory satiation	25.0			
Minimal arousal conditioning	12.5			
Odor aversion	25.0			
Orgasmic conditioning	62.5			
Verbal satiation	37.5			
Uses one or more of the above	75.0			

PHARMACOLOGICAL SEXUAL AROUSAL CONTROL TREATMENTS

Behavioral sexual arousal control treatments are not always effective or desirable for clients. In such cases, medication can help some sexual abusers gain control over their sexually abusive fantasies and urges. Pharmacological interventions are not stand-alone treatments and are best used in conjunction with psychological treatments. Medications commonly used to treat sexual abusers help regulate mood, reduce sex drive, and reduce sexually obsessive thoughts (Grubin, 2000: Kafka, 2000). Four medications commonly prescribed in North America are described below.

- *SSRI's* (Selective Serotonin Reuptake Inhibitors). These commonly used antidepressants (e.g., Paxil, Prozac, Serzone, and Zoloft) are effective in decreasing the sex drive and sexually obsessive thoughts of some sexual abusers (Kafka, 2000; Greenberg & Bradford, 1997). Additionally, they may be helpful to offenders who have mood disorders.
- *Lupron* (Luprolide Acetate). This relatively new type of antiandrogen medication has fewer side effects than other antiandrogens commonly used with sexual abusers (Krueger & Kaplan, 2001). It acts by lowering testosterone levels and assists clients by decreasing the intensity and frequency of sexual thoughts and urges.
- *Provera* (Medroxyprogesterone Acetate). Provera is an antiandrogen medication and, like Lupron, reduces the testosterone level and sex drive in males (Prentky, 1997). It has the advantage of costing much less than Lupron, but has more side effects.

- *Cyproterone acetate*. Cyproterone acetate is another antiandrogen medication (Grubin, 2000). It is used in Canada but is not available in the United States currently.

SSRI's are the most commonly used medications (see Tables 9.6a and b) in both the United States and Canada, probably because they are less expensive and have fewer side effects than antiandrogens. Antiandrogens are rarely used with adolescents and children. This reserve is warranted because the effects of antiandrogens on the normal growth and development of youth are not known. The American Academy of Child and Adolescent Psychiatry (1999) recommends use of antiandrogens be limited to the most severe cases and discourages their use with youth under the age of 17.

Table 9.6a also contains data on medication use from the 2000 and 2002 Surveys. Although no statistically significant trends were evident in programs' practice pattern between the 2002 and the present survey, some significant reductions in use of medications among programs for males were found between the 2000 and present survey. Use of Provera has declined, perhaps due to decreases in funding for programs. Antiandrogen medications, in particular Provera, are very expensive. Some program types also evidenced a decline in the use of SSRI's, many of which are relatively inexpensive. Use of these medications in Canada appears to be much greater than in the United States.

Table 9.6a – Pharmacological sexual arousal control treatments in the United States 2000-2009, percentage

Adult	**Male**			**Female**		
Community Programs	2000 n=237	2002 n=522	2009 n=330	2000 n=162	2002 n=291	2009 n=174
SSRI's	57.0	53.6	50.3	41.0	38.1	32.2
Lupron	11.0	9.0	13.0	2.0	2.4	0.6
Provera	31.0***	23.2	16.7***	6.0	4.5	1.7
Residential Programs	2000 n=49	2002 n=93	2009 n=85	2000 n=13	2002 n=35	2009 n=19
SSRI's	78.0*	45.2	55.3*	38.0	31.4	15.8
Lupron	14.0	21.5	15.3	0.0	0.0	0.0
Provera	41.0**	30.1	17.6**	15.0	2.9	0.0
Adolescent	**Male**			**Female**		
Community Programs	2000 n=118	2002 n=478	2009 n=275	2000 n=72	2002 n=229	2009 n=102
SSRI's	44.0**	33.1	30.2**	38.0*	23.6	20.6*
Lupron	7.0	1.7	2.5	0.0	0.9	0.0
Provera	9.0*	3.1	0.4*	0.0	1.7	0.0
ResidentialPrograms	2000 n=91	2002 n=186	2009 n=98	2000 n=10	2002 n=33	2009 n=19
SSRI's	65.0***	43.5	35.7***	50.0	39.4	31.6
Lupron	8.0	5.4	4.1	0.0	3.0	0.0
Provera	8.0	7.5	1.0	0.0	0.0	0.0

Note: Program data for 2000 is based on unpublished raw data from the 2000 Survey and had previously been rounded to whole numbers.
*The change in the percentage of programs using this medication is significant at $p < .05$.
**The change in the percentage of programs using this medication is significant at $p < .01$.
***The change in the percentage of programs using this medication is significant at $p < .001$.

Table 9.6b Canada – Pharmacological sexual arousal control treatments, percentage						
	Male			Female		
Community Programs	Adults n=19	Adolescents n=15	Children n=7	Adults n=4	Adolescents n=6	Children n=8
SSRI's	47.4	20.0	0.0	25.0	0.0	0.0
Lupron	42.1	13.3	0.0	0.0	0.0	0.0
Provera	21.1	6.7	0.0	25.0	0.0	0.0
Cyproterone acetate	26.3	6.7	0.0	25.0	0.0	0.0
Uses one or more of the above	63.2	26.7	0.0	25.0	0.0	0.0
Residential Programs	Adults n=8					
SSRI's	75.0					
Lupron	75.0					
Provera	50.0					
Cyproterone acetate	50.0					
Uses one or more of the above	75.0					

TREATMENT METHODS

The theory upon which a program is based determines what treatment methods are implemented. For example, cognitive-behavioral programs use cognitive and behavioral techniques. Programs that are based on bio-medical models use medication, although usually in conjunction with psychosocial interventions. Programs built on trauma theories might be more likely to use Eye Movement Desensitization and Reprocessing (EMDR) as a treatment method than programs built on other theories, but like the bio-medical models, may use other treatment strategies as well. Below, we will provide survey findings about what treatment methods programs use.

Given that the most common treatment model in sexual abuser programs in the United States and Canada is cognitive-behavioral, it is not surprising that the most common treatment methods include cognitive restructuring, relapse prevention and the assault cycle or offense chain (see Tables 9.9a and b). It is noteworthy that despite the recognition of the importance of treatment engagement, therapeutic alliance and motivation (e.g., Mann, 2000; Marshall, Anderson & Fernandez, 1999), less than half the community programs in the United States and Canada report using motivational interviewing.

The degree to which programs focus on skill development was not examined in the survey, but is an important issue. Effective programs do more than simply help clients acquire new insights and information. Correctional programs that emphasize skill development are more effective than those that do not (Andrews & Bonta, 2006; Lipsey, 1995; Lösel, 1995). Skill development involves helping abusers establish new patterns of prosocial thinking and behaving, using treatment strategies such as modeling, practicing, and performance feedback.

Table 9.7a United States – Treatment methods, percentage						
	Male			Female		
Community Programs	Adults n=329	Adolescents n=272	Children n=121	Adults n=173	Adolescents n=101	Children n=62
Art therapies	8.8	25.0	53.7	8.1	27.7	58.1
Assault cycle or offense chain	92.1	84.2	33.9	82.7	80.2	25.8
Client's victimization/trauma	77.8	84.9	79.3	86.1	89.1	77.4
Cognitive restructuring	89.7	83.5	55.4	95.4	87.1	51.6
Drama therapy	6.7	6.6	9.1	7.5	5.9	9.7
EMDR	10.3	8.8	3.3	12.1	14.9	11.3
Family reunification	59.6	77.2	72.7	62.4	82.2	79.0
Motivational interviewing	45.9	41.9	18.2	43.9	42.6	16.1
Relapse prevention	95.7	90.4	52.1	94.2	86.1	32.3
Schema therapy	11.2	8.5	3.3	8.7	5.9	1.6
Sex education	74.8	90.1	74.4	78.0	91.1	79.0
Therapeutic community	14.0	18.4	10.7	8.1	11.9	3.2
Victim clarification	68.7	74.7	43.8	65.3	93.1	45.2
Victim restitution	31.0	38.6	24.0	27.7	38.6	22.6
Residential Programs	Adults n=79	Adolescents n=95	Children n=15	Adults n=17	Adolescents n=18	Children n=4
Art therapies	26.6	40.0	40.0	17.6	38.9	25.0
Assault cycle or offense chain	92.4	91.6	73.3	94.1	72.2	75.0
Client's victimization/trauma	59.5	92.6	93.3	58.8	83.3	100
Cognitive restructuring	91.1	88.4	100	88.2	88.9	75.0
Drama therapy	10.1	10.5	0.0	0.0	11.1	25.0
EMDR	10.1	20.0	26.7	5.9	27.8	25.0
Family reunification	20.3	98.7	86.7	17.6	61.1	100
Motivational interviewing	60.8	57.9	60.0	58.8	44.4	50.0
Relapse prevention	92.4	90.5	80.0	100	94.4	75.0
Schema therapy	8.9	4.2	6.7	11.8	5.6	0.0
Sex education	72.2	93.7	93.3	70.6	83.3	100
Therapeutic community	46.8	51.6	53.3	17.6	44.4	75.0
Victim clarification	39.2	69.5	66.7	47.1	72.2	100
Victim restitution	19.0	45.3	40.0	5.9	50.0	50.0

Table 9.7b Canada – Treatment methods, percentage						
	Male			Female		
Community Programs	Adults n=19	Adolescents n=15	Children n=7	Adults n=4	Adolescents n=6	Children n=8
Art therapies	5.3	13.3	28.6	0.0	16.7	50.0
Assault cycle or offense chain	84.2	73.3	0.0	75.0	83.3	0.0
Client's victimization or trauma	68.4	73.3	100	50.0	83.3	100
Cognitive restructuring	78.9	86.7	71.4	75.0	100	62.5
Drama therapy	0.0	6.7	28.6	0.0	16.7	25.0
EMDR	0.0	6.7	14.3	0.0	33.3	12.5
Family reunification	31.6	60.0	57.1	25.0	100	75.0
Motivational interviewing	47.4	40.0	14.3	50.0	66.7	12.5
Relapse prevention	94.7	100	28.6	100	100	25.0
Schema therapy	5.3	13.3	14.3	0.0	16.7	25.0
Sex education	63.2	93.3	100	75.0	100	100
Therapeutic community	5.3	13.3	28.6	0.0	16.7	12.5
Victim clarification	26.3	60.0	71.4	50.0	100	50.0
Victim restitution	15.8	46.7	42.9	0.0	66.7	37.5
Residential Programs	Adults n=8					
Art therapies	0.0					
Assault cycle or offense chain	62.5					
Client's victimization or trauma	25.0					
Cognitive restructuring	75.0					
Drama therapy	0.0					
EMDR	0.0					
Family reunification	0.0					
Motivational interviewing	62.5					
Relapse prevention	50.0					
Schema therapy	12.5					
Sex education	50.0					
Therapeutic community	12.5					
Victim clarification	0.0					
Victim restitution	0.0					

10 Treatment Dose

This chapter describes the type, amount, frequency, and duration of treatment services that programs provide to the individuals they serve. These variables are referred to collectively as treatment dose. To design treatment interventions in accordance with the risk, need, and responsivity principles, programs must consider each of these variables.

An analogy for understanding the concept of treatment dosage is the treatment of pneumonia. If a virus causes pneumonia, antibiotic treatment is not helpful. It costs money and may cause a dangerous allergic reaction. In this case, antibiotics are contraindicated. However, if the pneumonia is caused by a bacterium, a course of an antibiotic will likely cure the illness. If taken for less than the recommended amount, frequency and duration, the antibiotic may not be effective. When taken longer, it may cause unwanted side effects. If the pneumonia is caused by a drug-resistant bacterium, then one or more atypical antibiotics may need to be taken to cure the infection. And, a small number of types of pneumonia are exceedingly resistant to known treatments.

Similarly, in our field, it is imperative that treatment providers begin by assessing their clients thoroughly to determine what type of treatment or treatments will be most effective, and how much and how often they should be delivered. It also is critical for providers to develop ideas about how long it may take for treatment to be effective. Ideally, treatment would consist of no more than, and no less than, the type and amount of care needed to help clients successfully manage their reoffense risk. Such an approach not only would be cost effective but also would minimize the risk of unintended negative effects or outcomes associated with the treatment.

As in the medical analogy above, sexual abuser treatment has several possible outcomes. Treatment can help individuals who have committed sexual offenses improve their behavior, contribute to them choosing worse behaviors, or make no difference.

To examine the issue of dosage, researchers in England (Beech, Fisher, & Beckett, 1998) studied how much cognitive-behavioral sex offender treatment was required to positively impact client change and whether additional treatment produced increased positive effects. They compared the effectiveness of group treatment for adult male sexual abusers at a lower dose (80 hours) and higher dose (160 hours) of treatment. Abusers with low levels of denial and sexual deviancy benefited from both the low- and high-dose programs, demonstrating considerable overall treatment effect as measured on several pre- and post-measures. The additional 80 hours of treatment for the low-risk group of sexual abusers seemed to have no incremental value. In contrast, the abusers with high levels of denial and sexual deviancy required the higher dose program to achieve significant benefits. This study provides evidence that matching treatment dose to the client's risk and need, rather than requiring the same treatment for all offenders, may be the most cost-effective strategy.

The unintended negative impact of interventions with individuals under correctional control also has been studied. Numerous general correctional rehabilitation studies have shown that intensive services delivered to low-risk offenders often result in increased recidivism compared to matched groups of low-risk offenders who received no or minimal services (Andrews, Bonta et al., 1990; Andrews & Bonta, 2006; Andrews, Zinger et al., 1990; Gendreau, Goggin, Cullen, & Andrews, 2001). More recently in the sex offender field, Lovins et al (2009) found that low risk sex offenders who were placed in an intensive halfway house treatment program reoffended at a higher rate than a group of matched low risk sex offenders that received less intensive services. Conversely, higher risk sex offender can suffer negative effect of an inappropriate treatment dose. For example, several studies indicate that placing high-risk antisocial youth in group treatment settings may reinforce their delinquent attitudes and result in increased rates of reoffense (Dodge et al., 2006; Dishion et al., 1999). It is important to note that these findings do not suggest that individuals who commit sexual offenses should receive no services, rather they highlight the importance of matching the treatment dose to the risk, need, and responsivity issues of each client.

MODES OF TREATMENT

This section examines the percent of programs that use group, individual and family or couples treatment.

Although little research has compared the effectiveness of group interventions with other treatment modes, group treatment is the primary treatment for serving most sexual abusers (American Academy of Child and Adolescent Psychiatry, 1999; Association for the Treatment of Sexual Abusers, 2005; National Adolescent Perpetrator Network, 1993). It has several advantages. Group treatment is more economical than individual, couples, or family therapy. Sexual abusers often feel more comfortable admitting and discussing their offenses in a treatment group where others are modeling openness. Clients often accept feedback about their behavior more willingly from other group members than from therapists. Finally, clients can practice social skills in group treatment settings.

Group treatment does have some risks. Just as group members can be a prosocial influence on each other, they also can influence each other in antisocial ways. The greatest potential for harm is probably to low-risk sexual abusers placed in treatment groups with high-risk offenders (Andrews & Bonta, 2006). As previously noted, especially for youth, placement in settings with antisocial peers may reinforce delinquent attitudes and result in increased rates of reoffense (Dodge et al., 2006; Dishion et al., 1999).

Sole reliance on individual treatment often is contraindicated. Individual treatment is more expensive and does not provide the same opportunities for peer support and social-skills practice as group treatment. In some instances, individual treatment can be appropriate. Canadian researchers (DeFazio, Abrancen, & Looman, 2001) compared the effectiveness of group treatment and individual treatment for high-risk/high-need sexual abusers. Clients with factors such as low cognitive functioning, psychosis, difficulties with daily living skills, and disruptive behavior were referred to individual treatment. The treatment outcome was the same as for the offenders who participated in group therapy. Individual treatment can also augment group treatment. Individual sessions may provide a setting for clients to discuss the details of their sex offenses without exposing others to sexually explicit information they may find sexually arousing, that may fuel their deviant fantasies, and that may violate victim confidentiality. Augmenting group treatment

with individual sessions is a common approach in many sexual abuser programs.

Family and significant-other involvement in treatment appears to be good practice and is essential in many cases. Research findings supporting these types of interventions are detailed in Chapter 12. Of course, victim safety is critical when involving families in treatment. The well-being and protection of children and other potential victims must be a priority. If contact between a child sexual abuser and children in the family occurs, thoughtful timing, monitoring, and supervision is necessary (Cumming & McGrath, 2005). Couples therapy involving sexual abusers may be very valuable, but also should be conducted thoughtfully. It may be contraindicated initially if clients have a history of violence toward their partners.

As shown in Tables 10.1a and b, group treatment is the most commonly used treatment modality in both community and residential programs for adult males, used in 88 percent or more of these programs. For all other program types, individual treatment is the most commonly used modality, used by 90 percent or more of programs. As noted in previous SSF surveys, some programs reported providing individual treatment because they do not have enough clients to conduct group treatment. This situation appears frequent for programs providing treatment for female adult and adolescent sexual abusers. Across all types of programs, the younger the client, the more likely that treatment involves family members.

For the first time, the survey examined the structure of treatment groups that programs used, namely closed, open, or both of these types of groups. In closed groups, all clients begin the treatment group together and progress though the various treatment components as a group. In open or rolling groups, clients work on assignments and issues at their own pace and begin and complete the group at different times. When one member completes the group, space becomes available and a new member is added to the group. As shown in Tables 10.2a and b, programs utilizing group treatment mostly ran open groups.

Table 10.1a United States – Type of treatment sessions, percentage

	Male			Female		
Community Programs	Adults	Adolescents	Children	Adults	Adolescents	Children
Group	n=326	n=271	n=120	n=170	n=100	n=61
	88.0	69.4	29.2	57.7	37.0	23.0
Individual	n=325	n=271	n=122	n=174	n=102	n=61
	84.6	94.8	96.7	87.4	97.1	95.1
Family or couples	n=308	n=266	n=123	n=161	n=101	n=61
	65.3	84.6	95.9	60.2	88.1	95.1
Residential Programs	Adults	Adolescents	Children	Adults	Adolescents	Children
Group	n=85	n=98	n=15	n=19	n=19	n=4
	90.2	95.9	80.0	77.8	89.5	75.0
Individual	n=80	n=98	n=15	n=17	n=18	n=4
	75.0	100	100	82.4	100	100
Family or couples	n=74	n=96	n=15	n=16	n=18	n=4
	35.1	94.8	100	37.5	78.9	100

Table 10.1b Canada – Type of treatment sessions, percentage

	Male			Female		
Community Programs	Adults	Adolescents	Children	Adults	Adolescents	Children
Group	n=18	n=15	n=7	n=4	n=6	n=8
	100	40.0	14.3	0.0	33.3	0.0
Individual	n=18	n=15	n=7	n=4	n=6	n=7
	94.4	100	100	100	100	100
Family or couples	n=17	n=13	n=7	n=4	n=6	n=7
	29.4	84.6	100	25.0	100	87.5
Residential Programs	Adults					
Group	n=8					
	87.5					
Individual	n=8					
	50.0					
Family or couples	n=8					
	12.5					

Table 10.2a United States – Type of treatment groups, percentage

	Male			Female		
Community Programs	Adults n=326	Adolescents n=271	Children n=120	Adults n=170	Adolescents n=100	Children n=61
Open (rolling)	72.1	54.6	14.2	47.6	27.0	6.6
Closed	6.4	6.3	6.7	4.7	4.0	11.5
Both	9.5	8.5	8.3	5.3	6.0	4.9
Does not use group	12.0	30.6	70.8	42.4	63.0	77.0
Residential Programs	Adults n=82	Adolescents n=97	Children n=15	Adults n=18	Adolescents n=19	Children n=4
Open (rolling)	46.3	59.8	60.0	61.1	52.6	75.0
Closed	14.6	8.2	6.7	11.1	5.3	0.0
Both	29.3	27.8	13.3	5.6	31.6	0.0
Does not use group	9.8	4.1	20.0	22.2	10.5	25.0

Table 10.2b Canada – Type of treatment groups, percentage						
	Male			Female		
Community Programs	Adults n=18	Adolescents n=15	Children n=7	Adults n=4	Adolescents n=6	Children n=7
Open (rolling)	44.4	6.7	14.3	0.0	16.7	0.0
Closed	38.9	20.0	0.0	0.0	0.0	0.0
Both	16.7	13.3	0.0	0.0	16.7	0.0
Does not use group	0.0	60.0	85.7	100	66.7	100
Residential Programs	Adults n=8					
Open (rolling)	50.0					
Closed	25.0					
Both	12.5					
Does not use group	12.5					

NUMBER AND LENGTH OF TREATMENT SESSIONS

Data on the number and length of treatment sessions is detailed in Tables 10.3a and b. As indicated by the large standard deviations, wide variations exist among some program types in the number of treatment sessions that they delivered during the specified time periods. This finding is because, even within each of the 12 program types, programs can serve very different populations. For example, among residential programs for adult males in the United States, some jail programs provided one group a week for a few months, although the typical core prison program provided about three groups a week over a period of about two years. A few civil commitment programs for sexually violent predators provided eight or more groups a week over a period in excess of five years. Consequently, Tables 10.3a and b and Tables 10.4a and b, in addition to providing the mean program responses, also include standard deviations and median responses.

With the above caveats in mind, on average, community programs that provide group treatment, for all age groups and genders, deliver about one group session per week. Residential programs provide two-to-four group sessions per week. Adolescents and children of both genders receive the most individual treatment, averaging about one session per week. Children and adolescents in both community and residential programs receive more family sessions per month than do adults. Group sessions for adults and adolescents are commonly 90 minutes long, 60 minutes for children. The length of individual treatment was typically about one hour, as were family and couples' sessions.

Table 10.3a.1 United States – Type, number and length of treatment sessions, average, (standard deviation), and median						
Community Programs	**Male**			**Female**		
Group Treatment	Adults n=284	Adolescents n=190	Children n=38	Adults n=100	Adolescents n=44	Children n=16
Mean # sessions per week	1.06	1.17	1.07	1.00	1.05	0.97
Standard deviation	(0.35)	(0.61)	(0.35)	(0.23)	(0.21)	(0.13)
Median	1	1	1	1	1	1
Length of session, minutes	92.20	81.67	68.12	88.95	81.39	67.00
Standard deviation	(21.40)	(23.92)	(16.30)	(19.58)	(16.24)	(17.61)
Median	90	90	60	90	90	60
Individual Treatment	Adults n=270	Adolescents n=254	Children n=117	Adults n=152	Adolescents n=98	Children n=57
Mean # sessions per month	2.27	3.11	3.68	2.70	3.29	3.55
Standard deviation	(1.60)	(1.56)	(1.17)	(1.55)	(1.39)	(1.27)
Median	2	4	4	4	4	4
Length of session, minutes	54.31	54.17	52.92	54.74	55.40	53.88
Standard deviation	(10.44)	(8.56)	(7.69)	(11.03)	(10.04)	(6.29)
Median	55	55	50	50	50	50
Family-Couples Treatment	Adults n=190	Adolescents n=224	Children n=117	Adults n=78	Adolescents n=89	Children n=59
Mean # sessions per month	0.72	1.39	1.80	0.74	1.33	1.70
Standard deviation	(0.64)	(1.03)	(1.24)	(0.67)	(1.05)	(1.32)
Median	0.5	1	2	0.5	1	1
Length of session, minutes	58.67	57.81	56.09	57.68	57.41	56.98
Standard deviation	(13.35)	(13.68)	(12.39)	(12.61)	(11.31)	(13.28)
Median	60	60	60	60	60	60

Table 10.3a.2 United States – Type, number and length of treatment sessions, average, (standard deviation), and median (continued)						
Residential Programs	**Male**			**Female**		
Group Treatment	Adults n=73	Adolescents n=91	Children n=12	Adults n=15	Adolescents n=17	Children n=3
Mean # sessions per week	4.51	4.45	4.75	3.03	5.00	3.33
Standard deviation	(4.25)	(3.44)	(3.08)	(2.75)	(5.28)	(2.52)
Median	3	4	4	2	3	3
Length of session, minutes	94.10	69.63	67.92	105.77	63.53	45.67
Standard deviation	(34.05)	(17.22)	(18.40)	(36.16)	(15.29)	(2.89)
Median	90	60	60	120	60	45
Individual Treatment	Adults n=60	Adolescents n=97	Children n=15	Adults n=14	Adolescents n=18	Children n=4
Mean # sessions per month	2.82	4.64	5.20	2.50	4.67	6.50
Standard deviation	(2.74)	(2.61)	(2.91)	(1.40)	(2.22)	(3.00)
Median	2	4	4	2	4	6
Length of session, minutes	48.67	51.65	46.67	49.29	50.26	47.50
Standard deviation	(16.34)	(9.59)	(13.32)	(16.85)	(12.30)	(12.58)
Median	45	50	50	50	55	50
Family-Couples Treatment	Adults n=26	Adolescents n=91	Children n=15	Adults n=6	Adolescents n=15	Children n=4
Mean # sessions per month	0.87	1.67	2.14	0.62	1.62	2.25
Standard deviation	(1.02)	(1.11)	(1.54)	(0.44)	(1.21)	(1.89)
Median	0.5	1	1	1	1	1.5
Length of session, minutes	75.19	62.47	62.00	70.83	66.67	62.50
Standard deviation	(25.71)	(16.74)	(19.35)	(28.72)	(25.33)	(18.93)
Median	60	60	60	60	60	55

Note: The number of programs that reported providing each type of treatment modality varied. The “n” at the top of each section represents the number of programs that reported providing each treatment modality.

Table 10.3b.1 Canada – Type, number and length of treatment sessions, average, (standard deviation), and median						
Community Programs	**Male**			**Female**		
Group Treatment	Adults n=18	Adolescents n=7	Children n=0	Adults n=0	Adolescents n=2	Children n=0
Mean # sessions per week	1.06	1.07			1.00	
Standard deviation	(0.24)	(0.19)	---	---	(0.00)	---
Median	1	1			1	
Length of session, minutes	150	132			60	
Standard deviation	(72.76)	(65.73)	---	---	(0.00)	---
Median	120	180			60	
Individual Treatment	Adults n=17	Adolescents n=15	Children n=7	Adults n=4	Adolescents n=6	Children n=7
Mean # sessions per month	2.32	2.80	3.60	2.75	3.83	3.62
Standard deviation	(1.64)	(1.32)	(0.79)	(1.34)	(0.41)	(0.74)
Median	2	3	4	3	4	4
Length of session, minutes	61.11	61.67	58.33	72.50	63.33	55.71
Standard deviation	(18.44)	(9.37)	(6.83)	(28.28)	(13.66)	(7.32)
Median	60	60	60	60	60	60
Family-Couples Treatment	Adults n=5	Adolescents n=11	Children n=7	Adults n=1	Adolescents n=6	Children n=7
Mean # sessions per month	0.32	1.34	1.89	0.50	1.50	1.89
Standard deviation	(0.18)	(0.67)	(1.15)	(0.00)	(0.55)	(1.15)
Median	0.25	1	2	0.5	1.5	2
Length of session, minutes	56.00	70.00	66.00	50.00	75.00	65.00
Standard deviation	(5.48)	(21.21)	(13.42)	(0.00)	(25.10)	(12.25)
Median	60	60	60	50	60	60

Table 10.3b.2 Canada – Type, number and length of treatment sessions, average, (standard deviation), and median (continued)		
Residential Programs	**Male**	**Female**
Group Treatment	Adults n=7	
Mean # sessions per week	3.00	
Standard deviation	(1.91)	
Median	2	
Length of session, minutes	141.43	
Standard deviation	(37.61)	
Median	150	
Individual Treatment	Adults n=4	
Mean # sessions per month	5.5	
Standard deviation	(9.67)	
Median	0.75	
Length of session, minutes	52.5	
Standard deviation	(15.0)	
Median	60	
Family-Couples Treatment	Adults n=1	
Mean # sessions per month	2.00	
Standard deviation	(0.00)	
Median	2	
Length of session, minutes	50	
Standard deviation	(0.00)	
Median	50	

Note: The number of programs that reported providing each type of treatment modality varied. The “n” at the top of each section represents the number of programs that reported providing each treatment modality.

LENGTH OF TREATMENT IN MONTHS

This section examines length of treatment in months. Programs were asked to report the typical average number of months it takes to complete their “core” program and, if they provide less intensive “aftercare” or “step-down” services, the typical average number of months it takes to complete that phase of the program (Chapter 12 further examines “aftercare” or “step-down” services). The large standard deviations for some types of programs indicate wide variations in the programs’ typical lengths. Examination of the data from community programs for males shows that treatment length varies with the client's age (see Table 10.4); a median of 24 months for adults, 14 for adolescents and 10 for children. Other program types have much more variability.

In Canada, programs for adults are much shorter than comparable programs in the United States (see Table 10.4b); a median of eight months for community programs and five months for residential programs.

Table 10.4a United States – Typical number of months to complete core and aftercare program, average, (standard deviation), and median						
	Male			Female		
Community Programs	Adults n=318	Adolescents n=260	Children n=118	Adults n=168	Adolescents n=98	Children n=60
Core program, months	24.71	15.37	10.60	24.35	14.72	10.47
Standard deviation	(13.67)	(6.77)	(5.60)	(20.60)	(6.65)	(6.68)
Median	24	14	10	24	12	8
	n=267	n=206	n=74	n=138	n=73	n=34
Aftercare program, months	14.59	8.00	7.04	13.30	7.45	7.74
Standard deviation	(12.69)	(5.75)	(6.21)	(10.65)	(6.65)	(8.02)
Median	12	6	6	12	6	6
Residential Programs	Adults n=76	Adolescents n=94	Children n=14	Adults n=18	Adolescents n=18	Children n=4
Core program, months	29.93	13.62	15.36	20.50	13.78	13.5
Standard deviation	(28.49)	(4.90)	(6.38)	(25.30)	(5.48)	(5.74)
Median	18	12	16	12	14	15
	n=41	n=53	n=5	n=11	n=9	n=0
Aftercare program, months	18.51	7.08	5.40	13.00	4.89	
Standard deviation	(17.12)	(3.96)	(1.95)	(9.62)	(2.93)	---
Median	12	6	6	12	4	

Note: The number of programs that responded to each question in some columns varied slightly. The "n" at the top of each column represents the minimum number of programs that responded to each question in that column.

Table 10.4b Canada – Typical number of months to complete core and aftercare program, average, (standard deviation), and median						
	Male			Female		
Community Programs	Adults n=18	Adolescents n=15	Children n=7	Adults n=4	Adolescents n=6	Children n=7
Core program, months	12.14	10.03	8.29	7.50	12.33	7.29
Standard deviation	(11.29)	(3.99)	(2.36)	(3.56)	(3.20)	(2.93)
Median	8	12	9	8	12	6
	n=14	n=9	n=4	n=2	n=5	n=5
Aftercare program, months	19.64	5.78	5.00	9.00	5.00	5.20
Standard deviation	(30.42)	(3.73)	(4.69)	(4.24)	(3.94)	(4.09)
Median	12	4	3	8	3	3
Residential Programs	Adults n=8					
Core program, months	4.50					
Standard deviation	(2.27)					
Median	5					
	n=3					
Aftercare program, months	3.33					
Standard deviation	(0.58)					
Median	3					

Note: The number of programs that responded to each question in some columns varied slightly. The "n" at the top of each column represents the minimum number of programs that responded to each question in that column.

AMOUNT OF TREATMENT IN HOURS

The number of months required to complete a program (described above in Tables 10.4a and b) is, by itself, an inadequate measure of comparing treatment dose among programs. Programs that look similar because treatment is completed in the same length of time may be quite different in the amount of service provided. Total number of treatment hours is a simple way to compare treatment doses between programs.

As detailed in Table 10.5, the typical average number of treatment hours clients in community programs receive follows the same pattern as the average length of treatment, with total treatment hours varying with client age. Programs for children have the fewest treatment hours while programs for adults and adolescents have many more treatment hours. Treatment dose in residential programs is typically much greater than in community programs. Following the same pattern as seen in program length, Canadian programs provide a much lower dose of treatment hours than comparable programs in the United States.

Programs can use the information provided in this chapter to compare themselves with the practice patterns of similar programs in North America. Unfortunately, except for rare examples (e.g., Beech et al., 1998), program evaluation research in the sexual abuser field has not explicitly linked outcomes to treatment dose. Consequently, further study in this area is imperative. Such research could help identify optimal treatment dosages for subgroups of sexual abusers and prevent unintended negative consequences of either under- or over-treating clients. Until this research is conducted, evaluators need to use professional judgment to decide what constitutes an appropriate treatment dose to enable a client to make and sustain change.

Table 10.5a United States – Median number of hours to complete "core" program

	Male			Female		
Community Programs	Adults n= 308	Adolescents n=260	Children n=118	Adults n=161	Adolescents n=98	Children n=60
Group	140	82	(39)	140	(70)	(31)
Individual	43	50	36	86	43	29
Family-Couples	11	50	18	11	11	7
Total	194	182	54	237	54	36
Residential Programs	Adults n=74	Adolescents n=94	Children n=14	Adults n=16	Adolescents n=18	Children n=4
Group	316	187	62	187	163	105
Individual	32	43	58	22	50	81
Family-Couples	(8)	11	14	(11)	13	20
Total	348	241	134	209	226	206

Note: The median number of hours to complete the "core" program is the median hours of group, individual and family-couples treatment delivered per month (see Table 10.3a), at 4.33 weeks per month, multiplied by the median number of months to complete the "core" treatment program (see Table 10.4a), multiplied by .90 to account for a 10% cancellation rate of services due to holidays and other therapists' days off. The hours for types of services that less than half of programs reported delivering are in parentheses and are not included in the computation of total hours. Programs' aftercare and step-down service hours are not reflected in this table because survey data lacked sufficient detail to make these calculations.

Table 10.5b Canada – Number of hours to complete "core" program, average						
	Male			Female		
Community Programs	Adults n=17	Adolescents n=13	Children n=7	Adults n=4	Adolescents n=6	Children n=7
Group	62	140	0	0	(47)	0
Individual	25	32	32	22	43	22
Family-Couples	(3)	11	16	(4)	16	11
Total	87	183	48	22	59	33
Residential Programs	Adults n=8					
Group	97					
Individual	3					
Family-Couples	(9)					
Total	100					

Note: The median number of hours to complete the "core" program is the median hours of group, individual and family-couples treatment delivered per month (see Table 10.3) at 4.33 weeks per month, multiplied by the median number of months to complete the "core" treatment program (see Tables 10.3b and 10.4b), multiplied by .90 to account for a 10% cancellation rate of services due to holidays and other therapist days off. The hours for types of services that less than half of programs reported delivering are in parentheses and are not included in the computation of total hours. Programs' aftercare and step-down service hours are not reflected in this table because survey data lacked sufficient detail to make these calculations.

11 Special Needs Services

This chapter reviews findings on the types of services that programs offer sexual abusers with special needs. Two categories are examined: services for abusers with special physical or mental health needs, and statutory rapists.

Programs should design and deliver services to meet clients' special needs because doing so increases the effectiveness of interventions. This concept is the essence of the responsivity principle as defined in Chapter 1. Services should be delivered in a manner that matches an individual's motivation, ability, learning style and personality characteristics (Andrews & Bonta, 2006; Kennedy, 2001). Programs failing to take this principle into consideration may provide services that are not helpful or, worse yet, harmful.

When examining the data in this section, readers should recognize that programs not offering one of the services listed may have referred clients to another program in their jurisdiction that offers the service.

INDIVIDUALS WITH SPECIAL NEEDS

Tables 11.1 presents the percentage of programs offering specialized services to clients with selected special physical, developmental and mental health needs. The survey did not attempt to assess the type and quality of services offered. In both the United States and Canada, one half or more of all program types offer special services to sexual abusers who have developmental disabilities. In general, a similar percentage of programs offer services to individuals with psychiatric disabilities. Few programs surveyed provide services to hearing-impaired clients.

Several resources offer guidance on providing services to sexual abusers with special physical or mental health needs. Specialized assessment and treatment approaches have been detailed for sexual abusers with developmental disabilities in residential settings by Haaven and Coleman (2000) and Haaven, Little, and Petre-Miller (1990). Treatment approaches for this population served in community settings are described by Blasingame (2001), Haaven and Coleman (2000), Keeling, Rose and Beech (2008) and McGrath, Livingston, and Falk (2007a; 2007b). Model program descriptions for sexual abuser services delivered in psychiatric settings are described in Marshall et al. (1998). Dennis and Baker (1998) provide guidance for providers working with hearing-impaired sexual abusers.

Table 11.1a United States – Specialized services for individuals with disabilities, percentage						
	Male			Female		
Community Programs	Adults n=283	Adolescents n=215	Children n=82	Adults n=128	Adolescents n=78	Children n=62
Developmentally disabled	54.1	58.1	75.6	52.3	60.3	50.0
Hearing impaired services	7.4	5.1	7.3	7.8	5.1	4.8
Psychiatrically disordered	45.9	50.2	62.2	51.6	59.0	37.1
Residential Programs	Adults n=73	Adolescents n=85	Children n=12	Adults n=12	Adolescents n=16	Children n=3
Developmentally disabled	69.9	51.8	83.3	75.0	62.5	100
Hearing impaired services	26.0	5.9	16.7	33.3	12.5	33.3
Psychiatrically disordered	68.5	75.3	100	66.7	75.0	100

Table 11.1b Canada – Specialized services for individuals with disabilities, percentage						
	Male			Female		
Community Programs	Adults n=14	Adolescents n=12	Children n=4	Adults n=2	Adolescents n=5	Children n=5
Developmentally disabled	63.3	66.7	75.0	50.0	60.0	100
Hearing impaired services	7.1	8.3	0.0	50.0	0.0	20.0
Psychiatrically disordered	50.0	66.7	50.0	50.0	40.0	60.0
Residential Programs	Adults n=8					
Developmentally disabled	50.0					
Hearing impaired services	25.0					
Psychiatrically disordered	62.5					

STATUTORY RAPISTS

Statutory rape refers to cooperative sexual activity between an individual over the age of consent and a minor under the age of consent. The sexual contact is illegal and the individual over the age of consent can be charged and convicted of a sexual offense. This type of offense appears to be quite common. For example, Leitenberg and Saltzman's (2003) study of female college freshman found about a quarter of these students had sexual intercourse between the ages of 13 and 15 that they considered consensual and, for most, their partners were more than two years their senior. Their partner's age was unrelated to later sexual satisfaction or symptoms of psychological distress.

The difficult best practice issue is what treatment services, if any, should be provided to statutory rapists who are close in age to their victims. On the one hand, some statutory offenders have a pattern of serially and manipulatively preying on vulnerable teenage females. This behavioral pattern or other sexually abusive characteristics certainly would justify referral to traditional sexual abuser treatment services.

On the other hand, people have increasingly questioned the extent to which the behaviors and motivations of some statutory offenders fit the "traditional" definitions of sexual abusers. An example is when an offender is close in age to the minor, and when the offense for which the offender is convicted has been consensual and non-coercive (in spite

of the fact that local laws may prohibit the behavior based on the belief that the victim in such cases is not old enough to truly understand the implications of sexual involvement and to provide consent). Many of these types of offenders need minimal, if any, treatment. For such offenders, what may be most useful are brief psychoeducational interventions that focus on the laws and the reasoning behind the laws, and explanations of how to develop prosocial relationships that are age appropriate and consensual.

No risk-assessment instruments are specifically designed for statutory rapists. In fact, widely used sex offender specific risk instruments (e.g., Static-99 and Static-2002) specifically state that they are not appropriate for use with this population (Harris et al., 2003; Phenix et al., 2009).

Survey recipients were asked if they provide a separate group for statutory rapists. As shown in Tables 11.2a and b, a few programs in the United States did, but no Canadian programs did. Whether programs place low risk/need statutory rapists in "regular" sexual abuser groups, provide individual treatment, or provide no treatment at all is not known. Programs should be thoughtful and match services for statutory rapists to their risk and needs.

Table 11.2a United States – Specialized services for statutory rapists, percentage

	Male		Female	
Community Programs	Adults n=283	Adolescents n=215	Adults n=128	Adolescents n=78
Separate group for statutory rapists	11.0	5.1	3.1	5.1
Residential Programs	Adults n=73	Adolescents n=85	Adults n=12	Adolescents n=16
Separate group for statutory rapists	2.7	4.7	0.0	6.3

Table 11.2b Canada – Specialized services for statutory rapists, percentage

	Male		Female	
Community Programs	Adults n=14	Adolescents n=12	Adults n=2	Adolescents n=5
Separate group for statutory rapists	0.0	0.0	0.0	0.0
Residential Programs	Adults n=8			
Separate group for statutory rapists	0.0			

12 Continuity of Care

This chapter examines findings on continuity of care efforts. Continuity of care refers to community follow-up services provided to sexual abusers upon their release from residential settings as well as step-down sessions, booster sessions, and other support services provided to clients in the community.

Continuity of care services are believed important because programs must make efforts to ensure that clients are successful not just in the short term but over the long term as well. Programs should therefore assist clients in maintaining positive changes achieved during treatment. Progress that sexual abusers make in institutional settings should be reinforced and strengthened by follow-up services in the community. Progress made in community settings also should be reinforced and strengthened by periodic booster sessions and ongoing facilitation of support systems.

AFTERCARE AND STEP-DOWN SERVICES

Continuity of care plans should include both treatment and supervision services. In one of the largest randomized social science studies ever conducted in the United States, the RAND Corporation evaluated intensive supervision programs in 14 jurisdictions in nine states (Petersilia & Turner, 1993a; Petersilia & Turner, 1993b). The study design excluded sex offenders, but given its size, quality, and scope, the results are worth noting. Offenders involved in post-incarceration treatment recidivated at significantly lower rates than those who were not.

More recently, a meta-analysis of 24 studies in the general correctional literature found that intensive surveillance-oriented community supervision programs had no impact on reoffending rates, while those that included a treatment component were associated with a 22 percent reduction in reoffending rates (Aos, et al., 2006a).

In the sexual abuser field, Willis and Grace (2008; 2009) have documented the importance of transitional services to the community that include both sex offender specific treatment and more general resettlement issues such as employment and accommodation. Similar results have been reported by McGrath, Cumming, Livingston, and Hoke (2003).

For sexual abusers in community programs, ending treatment precipitously does not appear to be good practice. Gradually reducing the frequency of sessions, or having clients periodically return for "booster sessions" are two methods some programs use to support clients during the aftercare treatment phase. Such approaches are recommended for both adult and adolescent sexual abusers by leading organizations in the field (Association for the Treatment of Sexual Abusers, 2005; National Adolescent Perpetrator Network, 1993), although the necessity of this approach as a part of sex offense specific treatment has not undergone evaluation. Within the general correctional rehabilitation literature, we are aware of only one meta-analysis that has examined

this issue. No statistically significant differences in recidivism rates were found between programs that provided booster sessions and those that did not (Dowden, Antonowicz, & Andrews, 2003).

As shown in Tables 12.1a and b, although many programs report providing aftercare or step-down services to their clients, it is far from a universal practice. Fewer residential programs report providing aftercare services than each of their community program counterparts, however how often other organizations provide aftercare services to clients released from residential programs is unclear. Arguably, clients returning to the community after being in a residential facility are likely to need support services.

Table 12.1a United States – Aftercare and step-down services, percentage

	Male			Female		
Community Programs	Adults n=316	Adolescents n=262	Children n=115	Adults n=168	Adolescents n=98	Children n=57
	84.8	78.6	64.3	82.1	74.5	59.6
Residential Programs	Adults n=75	Adolescents n=94	Children n=15	Adults n=16	Adolescents n=18	Children n=4
	54.7	56.4	33.3	43.8	50.0	0.0

Table 12.1b Canada – Aftercare and step-down services, percentage

	Male			Female		
Community Programs	Adults n=18	Adolescents n=14	Children n=6	Adults n=4	Adolescents n=6	Children n=7
	77.8	64.3	66.7	50.0	83.3	71.4
Residential Programs	Adults n=5					
	60.0					

FAMILY AND OTHER SUPPORT SYSTEMS

Support systems can be important in helping sexual abusers manage their long-term risk to reoffend. Ongoing informal support from family and friends is critical because most sexual abusers will be in treatment and under formal supervision for only a limited time. An estimated 95 percent of all offenders sentenced to prison will eventually be released back to the community (Bureau of Justice Statistics, 1997). Most offenders placed on supervision in the community eventually will be released from the care and control of community correctional agencies and most treatment programs are time-limited (see Chapter 10). Given that for some clients managing their sexually abusive behavior will be a life-long task (Association for the Treatment of Sexual Abusers, 2005), ongoing natural supports are critically important.

Research evidence for the value of natural supports is strong. Dowden, Antonowicz, and Andrews' (2003) meta-analysis of correctional rehabilitation programs using relapse prevention methods found that training significant others in the relapse prevention model produced a powerful, positive treatment effect. In the sexual abuser literature, this strategy is consistent with the recommendations of Cumming

and McGrath (2000). They describe strategies for enlisting and training family, friends, significant others, and volunteers as part of an abuser's self-management plan. The goal is to provide the abuser with support persons who can help him or her avoid high-risk situations, develop and maintain healthy interpersonal relationships, and cope effectively with life's inevitable challenges. The encouraging results of multisystemic treatment for youthful sexual abusers is likely attributable, in part, to its inclusion of clients' natural supports (Borduin et al., 2009; Borduin, Henggeler, Blaske, & Stein, 1990; Borduin & Schaeffer, 2001; Henggeler, Schoenwald, Borduin, Rowland & Cunningham, 1998).

Many sexual abusers have few ties to the community by the time they are released from incarceration. For these individuals perhaps the most exciting recent advances in bridging services from prison to the community involves the Circles of Support and Accountability approach with high-risk sexual offenders. This aftercare approach involves a small group of volunteers that provide wrap around services to the offender and assist him or her in developing positive social supports. Initial evaluations are very encouraging (Wilson et al., 2005).

Programs' use of several types of natural supports was surveyed and the results are reported in Tables 12.2a and b. In the United States, of programs serving adolescents and children, 88 percent or more reported involving either family members or significant others in the treatment process. Almost 80 percent of community programs for adults do so but less than half of adult residential programs do so.

In Canada, about 70 percent or more of programs serving adolescents and children report involving either family members or significant others in the treatment process. None of the residential programs for adult males responding to these questions reported providing these types of supports.

The large percentage of programs for adolescents and children involving family members in their treatment is very encouraging. Many youth will return to their families after treatment, making family involvement in treatment a priority for these programs. The lower rate of significant-other involvement in residential programs for adults may be due to geographic barriers. Many prison and other residential programs are located considerable distances from clients' families. To address this need, some programs offer family or couples-therapy sessions or educational seminars for significant others on visiting days at their institutions. Adult sexual abusers are often estranged from their families, which also may explain the low rates of family involvement for this population. In these cases, trained community volunteers may be enlisted to provide social supports (Cumming & McGrath, 2000; Heise, Horne, Kirkegaard, Nigh, Derry, & Yantzi, 1996; Wilson et al., 2005).

Table 12.2a United States – Family involvement and other supports, percentage of programs

	Male			Female		
Community Programs	Adults n=283	Adolescents n=215	Children n=82	Adults n=128	Adolescents n=78	Children n=42
Offer a parents/significant others group	30.0	46.5	46.3	32.0	50.0	57.1
Family educated to be part of	n=324	n=268	n=118	n=171	n=98	n=60
client's support system	77.2	94.0	94.1	77.8	96.0	93.3
Community members educated to be part of client's support team	37.0	37.7	42.4	35.7	39.8	38.3
Residential Programs	Adults n=73	Adolescents n=85	Children n=12	Adults n=12	Adolescents n=16	Children n=3
Offer a parents/significant others group	6.8	28.2	25.0	0.0	43.8	66.7
Family educated to be part of	n=75	n=96	n=15	n=17	n=17	n=4
client's support system	46.7	89.6	93.3	41.2	88.2	100
Community members educated to be part of client's support team	21.3	37.5	46.7	25.0	35.3	25.0

Table 12.2b Canada – Family involvement and other supports, percentage of programs

	Male			Female		
Community Programs	Adults n=14	Adolescents n=12	Children n=4	Adults n=2	Adolescents n=5	Children n=5
Offer a parents/significant others group	14.3	16.7	25.0	50.0	40.0	40.0
Family educated to be part of	n=18	n=14	n=6	n=4	n=6	n=7
client's support system	50.0	71.4	83.3	75.0	83.3	71.4
Community members educated to be part of client's support team	44.4	25.6	33.3	25.0	40.0	42.9
Residential Programs	Adults n=8					
Offer a parents/significant others group	0.0					
Family educated to be part of	n=7					
client's support system	0.0					
Community members educated to be part of client's support team	0.0					

13 Collaboration Among Service Providers

This chapter reviews the types of collaborative relationships programs have with probation officers, parole officers, caseworkers, and victim advocates.

Several organizations and entities (Association for the Treatment of Sexual Abusers, 2005; Center for Sex Offender Management, 2008a; National Adolescent Perpetrator Network, 1993) stress the importance of using a team approach for managing sexual abusers in the community. A team approach facilitates exchange of information between service providers, each of whom may have a unique perspective about an abuser's risk, treatment needs, and supervision requirements. For example, treatment providers can provide probation and parole officers and caseworkers with clinical observations and relevant information that can better guide supervision practices and increase community safety. Supervision staff can relay information to treatment providers about how a sexual abuser is functioning in the community or the milieu of a residential setting. Providers can use this information to craft more appropriate treatment plans. Victim advocates involvement is very important for providing input about the victim's needs and the impact of the abuse on the victim and for making recommendations regarding victim contact.

Research supports the importance of a collaborative approach. In recent meta-analyses, Washington State Institute for Public Policy researchers (Aos et al., 2006a; 2006b) found a method that is especially effective for working with juvenile delinquents is a coordinated, multiple-agency approach, sometimes referred to as "wraparound" service programs. Multisystemic therapy treatment for adolescent sexual abusers is probably successful, in part, because collaborative relationships are forged with additional community professionals and supports, such as probation officers, teachers, and so forth, to provide prosocial supports to the young person (Henggeler et al., 1998). Our own and others' analysis of common elements of effective sexual abuser treatment programs indicates close collaboration between treatment and supervision staff is essential (Cumming & McGrath, 2000; 2005; English, Pullen, & Jones, 1996) and may be considered "best practice."

WAIVERS OF CONFIDENTIALITY

Collaboration between service providers requires sharing relevant information. In most circumstances the sexual abuser must consent to this information sharing. A national random survey of community adult sex offender treatment programs by McGrath, Cumming, and Holt (2002) found that 93.7 percent of programs required clients to sign waivers allowing their staff to communicate with probation and parole officers.

In the current survey, programs also were asked if they required their clients, as a condition of program admission, to sign a waiver of confidentiality to allow information sharing between service providers. The majority reported that they did so (see Tables 13.1a and b).

Table 13.1a United States – Confidentiality waiver required for program admission, percentage						
	Male			Female		
Community Programs	Adults n=324	Adolescents n=268	Children n=118	Adults n=171	Adolescents n=98	Children n=60
Confidentiality waiver required	81.8	78.4	72.0	86.0	83.7	63.3
Residential Programs	Adults n=75	Adolescents n=96	Children n=15	Adults n=17	Adolescents n=17	Children n=4
Confidentiality Waiver required	69.3	63.5	80.0	88.2	70.6	75.0

Table 13.1b Canada – Confidentiality waiver required for program admission, percentage						
	Male			Female		
Community Programs	Adults n=18	Adolescents n=14	Children n=6	Adults n=4	Adolescents n=6	Children n=7
Confidentiality waiver required	77.8	64.3	83.3	50.0	83.3	85.7
Residential Programs	Adults n=7					
Confidentiality Waiver required	100					

COLLABORATION WITH PROBATION AND PAROLE OFFICERS AND CASEWORKERS

In the national survey noted above (McGrath et al., 2002), researchers found that treatment providers appeared to value communication with probation and parole officers and exchanged information with them frequently. The vast majority of treatment providers (87.4%) described close communication with probation and parole officers as "essential" for managing their cases effectively. Over four-fifths (82.1%) reported that they "always" inform probation and parole officers when a client is judged as being at increased risk.

The findings from the present survey indicate that almost all sexual abuser programs that responded from the United States (95.9-98.8%)—serving adolescent and adult males and females in the community—report exchanging information with probation and parole officers and caseworkers (see Table 13.2a). Other types of programs report a slightly lower, but still very high rate (70.0-100%) of information exchange.

Among all program categories in the United States, the practice of probation and parole officers and caseworkers visiting treatment groups is most common in community programs for adult males (52.5%) and adult females (45.0%). Group visits can educate supervision staff about sexual abusers and enhance their ability to supervise these individuals. Co-therapy teams of treatment providers and probation/parole officers or caseworkers are relatively rare. This practice is reported in only 8.6 percent of adult community programs, similar to the percentage (8.9%) that McGrath et al. (2002) found six years earlier. Other program types use this practice even less frequently. Programs using or considering using similar co-therapy team approaches should consult the Association for the Treatment of Sexual Abusers (2005) practice standards and guidelines that outline several concerns about this practice.

The survey also inquired about programs' use of "integrated risk management teams." These were defined as providers partnering with mental health,

law enforcement, corrections and social service organizations. In the United States, about half (44.0-58.8%) of all program types report having such teams.

In Canada, the vast majority of responding programs report that they exchange information with probation and parole officers and caseworkers (see Table 13.2b). Although it is a relatively common in the United States for probation and parole officers and caseworkers to visit treatment groups, this practice is very rare in Canada. However, almost one-third of community programs for adult males are co-lead by a probation or parole officer. Between two-fifths and two-thirds of all community programs reported having "integrated risk management teams." None of the seven residential programs for adult males report being part of these teams.

Table 13.2a United States – Collaboration with probation/parole officers and caseworkers, percentage

	Male			Female		
Community Programs	Adults n=324	Adolescents n=268	Children n=118	Adults n=171	Adolescents n=98	Children n=60
Exchange info with PO's or caseworkers	96.3	97.0	79.7	98.8	95.9	70.0
PO's or caseworkers visit groups	52.5	41.8	20.3	45.0	41.8	15.0
PO's or caseworkers co-lead groups	8.6	8.6	3.4	5.3	8.2	3.3
Integrated risk management team	54.9	51.9	50.0	53.8	54.1	55.0
Residential Programs	Adults n=75	Adolescents n=96	Children n=15	Adults n=17	Adolescents n=17	Children n=4
Exchange info with PO's or caseworkers	82.7	94.8	93.3	82.3	94.1	100
PO's or caseworkers visit groups	17.3	30.2	40.0	29.4	35.3	0.0
PO's or caseworkers co-lead groups	2.7	5.2	0.0	0.0	0.0	0.0
Integrated risk management team	44.0	53.1	53.3	52.9	58.8	50.0

Table 13.2b Canada – Collaboration with probation/parole officers and caseworkers, percentage						
	Male			Female		
Community Programs	Adults n=18	Adolescents n=14	Children n=6	Adults n=4	Adolescents n=6	Children n=7
Exchange info with PO's or caseworkers	83.3	85.7	50.0	75.0	83.3	42.9
PO's or caseworkers visit groups	16.7	14.3	0.0	25.0	0.0	0.0
PO's or caseworkers co-lead groups	27.8	0.0	0.0	50.0	0.0	0.0
Integrated risk management team	38.9	50.0	66.7	50.0	66.7	57.1
Residential Programs	Adults n=7					
Exchange info with PO's or caseworkers	71.4					
PO's or caseworkers visit groups	0.0					
PO's or caseworkers co-lead groups	0.0					
Integrated risk management team	0.0					

COLLABORATION WITH VICTIM ADVOCATES

A primary goal of intervention with sexual abusers is to prevent further victimization. Consequently, it makes sense for sexual abuser treatment providers to communicate with victim advocates regarding how to best meet the needs of victims and reduce the likelihood of new offenses (Center for Sex Offender Management, 2000; 2008a). Topics discussed often involve victim safety issues such as limiting an abuser's movement in the community to prevent victim contact. Advocates also can contribute ideas about ways an abuser can make restitution to a victim or help victim groups assist other victims. In some programs, victim advocates assist in delivering victim empathy treatment components (D'Amora & Burns-Smith, 1999).

In the United States, as shown in Table 13.3a, between one-quarter and one-third of community programs indicated that they exchanged information with victim advocates. There was a wider range of involvement in this practice among residential programs. Very few programs report victim advocates visiting their treatment groups. In comparison, Canadian programs report much less involvement with victim advocates.

Table 13.3a United States – Collaboration with victim advocates, percentage						
	Male			**Female**		
Community Programs	Adults n=324	Adolescents n=268	Children n=118	Adults n=171	Adolescents n=98	Children n=60
Exchange information with victim advocates	25.6	28.7	26.3	25.1	35.7	31.7
Victim advocates visit groups	11.7	7.8	7.6	9.9	8.2	3.3
Residential Programs	Adults n=75	Adolescents n=96	Children n=15	Adults n=17	Adolescents n=17	Children n=4
Exchange information with victim advocates	20.0	33.3	40.0	35.3	41.2	25.0
Victim advocates visit groups	10.7	5.2	6.7	17.6	11.8	25.0

Table 13.3b Canada - Collaboration with victim advocates, percentage						
	Male			Female		
Community Programs	Adults n=18	Adolescents n=14	Children n=6	Adults n=4	Adolescents n=6	Children n=7
Exchange information with victim advocates	5.6	21.4	33.3	0.0	16.7	28.6
Victim advocates visit groups	0.0	7.1	0.0	0.0	0.0	0.0
Residential Programs	Adults n=7					
Exchange information with victim advocates	0.0					
Victim advocates visit groups	0.0					

14 Monitoring and Evaluation

This chapter reports on the percentage of programs that use external consultants to help improve the quality of their program. The chapter also reviews findings on program completion rates.

QUALITY IMPROVEMENT ACTIVITIES

Programs should monitor and evaluate their services and continually work to improve their quality. Many programs seek accreditation or certification by outside organizations and thus they are regularly reviewed by external consultants. These reviewers can be private organizations such as the Joint Commission on the Accreditation of Health Care Facilities (JCAHO), the Commission of the Accreditation of Rehabilitation Faculties (CARF) and the American Correctional Association (ACA), but they are not specifically focused on sex offense specific treatment needs.

In contrast, some countries have tied funding for their sex offender treatment programs to an accreditation process. Their goal is to ensure that services are delivered according to best-practice criteria and are cost-effective. Accreditation panels have been in operation in Canada (Correctional Service of Canada, 2000), England (Home Office Communication Directorate, England, 2000), Scotland (Scottish Prison Service, 2003), and Ireland (Lundstrom, 2002). Other jurisdictions and programs have formed treatment advisory boards to regularly review their programs. The Hong Kong Correctional Services sex offender program and some civil commitment programs in the United States, such as Florida and Wisconsin, also have treatment advisory boards.

Cumming and McGrath (2005) and Murphy and McGrath (2008) have summarized criteria that these accreditation and treatment advisory panels commonly use to evaluate and monitor programs. These key areas serve as primary topics for many of the chapters in this publication. In summary, effective sexual abuser programs:

1. Use an evidence-based model of change.
2. Collaborate with the referring and supervising agency.
3. Assess and target criminogenic needs.
4. Assess offender risk.
5. Match treatment intensity to abusers' risk level.
6. Match services to abusers' responsivity issues.
7. Use effective treatment methods.
8. Provide continuity of care.
9. Use trained and competent staff.
10. Monitor and evaluate program delivery.

Tables 14.1a and b report the percentage of programs that use external consultants to help improve the quality of their program. In the United States, between 8.2 and 14.3 percent of community

Table 14.1a United States – External consultants for quality improvement, percentage						
	Male			Female		
Community Programs	Adults n=324	Adolescents n=268	Children n=118	Adults n=171	Adolescents n=98	Children n=60
Have external review	14.2	14.2	11.0	8.2	14.3	10.0
Residential Programs	Adults n=75	Adolescents n=96	Children n=15	Adults n=17	Adolescents n=17	Children n=4
Have external review	32.0	20.8	33.3	23.5	35.3	25.0

Table 14.1b Canada – External consultants for quality improvement, percentage						
	Male			Female		
Community Programs	Adults n=18	Adolescents n=14	Children n=6	Adults n=4	Adolescents n=6	Children n=7
Have external review	11.1	14.3	16.7	0.0	33.3	14.3
Residential Programs	Adults n=7					
Have external review	0.0					

programs and 20.8 to 35.3 of residential programs utilize such external consultants. Programs in Canada report ranges between 0-33.3 percent.

PROGRAM COMPLETION RATE

Another monitoring activity concerns tracking program completion rates. Respondents were asked to estimate what percentage of clients who began their program then completed the program. In the United States, residential programs for adult males have the lowest average completion rate, at 70.9 percent (see Table 14.2a). Program completion rates for all other types of programs were slightly higher and remarkably similar to each other, ranging from 76.5 to 88.6 percent. Adolescent and children's programs have slightly higher completion rates than adult programs.

Canadian treatment programs report slightly higher completion rates than programs in the United States across all program types. They range from 88.7 to 96.4 percent.

Several interesting clinical and policy issues affect program completion rates. For example, as McGrath, Cumming, Livingston and Hoke (2003) noted, programs that place excessively high expectations on participants may have lower completion rates because clients cannot meet these standards. Conversely, those with less stringent expectations may have higher completion rates since clients can more easily achieve the standards. Specific factors that can affect program completion rates include issues such as staff training in how to engage clients in treatment, program duration, level of emphasis on offense denial, and the risk and need level of the clients. An important empirical question is what enrollment and retention standards programs should set in order to achieve the best overall treatment outcomes. Further research should examine how program standards and completion rates are related to recidivism rates among populations of abusers.

Table 14.2a United States – Program completion rates, mean percentage and (standard deviation)						
	Male			Female		
Community Programs	Adults n=312	Adolescents n=254	Children n=111	Adults n=153	Adolescents n=95	Children n=56
	76.49 (19.83)	82.33 (17.73)	85.85 (18.41)	81.60 (20.97)	85.56 (18.59)	83.93 (19.46)
Residential Programs	Adults n=63	Adolescents n=91	Children n=14	Adults n=15	Adolescents n=18	Children n=4
	70.87 (25.45)	81.80 (15.65)	85.93 (17.99)	79.33 (29.51)	88.61 (10.19)	85.50 (10.21)

Table 14.2b Canada – Program completion rates, mean percentage and (standard deviation)						
	Male			Female		
Community Programs	Adults n=17	Adolescents n=13	Children n=6	Adults n=4	Adolescents n=6	Children n=7
	88.65 (8.51)	92.31 (6.96)	95.83 (4.92)	87.25 (22.25)	90.83 (8.61)	96.43 (4.76)
Residential Programs	Adults n=8					
	94.00 (4.44)					

15 Legislation Impact Reported by Providers

This chapter reports on the providers' views about the impact of various types of sex offender legislation. This is the first SSF survey to examine these issues. Although the survey is focused primarily on treatment services for sexual abusers, these legislative initiatives share the same goals as treatment with this population, to reduce reoffending and increase community safety. Consequently, registration, community notification, and registry laws are briefly examined.

In the United States, all 50 states now have some type of sex offender registration and community notification law and over one half have residency restriction laws (Center for Sex Offender Management, 2008b; Council of State Governments, 2008). In Canada, these laws are much less widespread.

Registration laws require convicted sex offenders to provide indentifying information to law enforcement agencies. The agencies use this information to track convicted sex offenders and investigate sex crimes. Community notification laws provide information about registered sex offenders to the public. Notification methods vary markedly among states and include strategies such as media releases, mailed or posted flyers, Internet websites, registration lists, door-to-door law enforcement contacts, and community meetings. Community notification is premised on the idea that an informed public can better protect itself. Residency laws restrict sex offenders from living within a certain distance (this distance ranges from 500 to 2,000 feet) from locations where children congregate, such as schools, play grounds, parks and daycare centers.

Considerable public awareness and support for these types of laws exists (Lieb & Nunlist, 2008; Anderson & Sample, 2008; Levenson, Brannon, Fortney & Baker, 2007) but whether they result in reduced sexual reoffending rates is still a debatable question (Center for Sex Offender Management, 2008b). Sex offenders and their families though report several negative effects of these laws. About a quarter commonly report job loss and exclusion or expulsion from residence. About one-half or more typically report negative psychosocial consequences such as stress, shame, hopelessness and loss of social support. A small percentage report being the target of vigilante attacks (Brannon, Levenson, Fortney, & Baker, 2007; Levenson & Cotter, 2005; Levenson, D'Amora & Hern, 2007; Mercado, Alverez & Levenson, 2008; Tewksbury, 2005; Zevitz & Farkas, 2000a, 2000b).

Mental health professionals who treat sex offenders appear to be skeptical about the benefits of some of these laws. For example, in a nationwide survey, 81 percent of 133 sex offender treatment providers reported that they did not think that posting information about sex offenders on public websites would reduce recidivism and 70 percent felt community notification gives the public a false sense of security (Malesky & Keim, 2001). In another study of sex offender treatment providers, a similar percentage (74%) felt that community notification gives the public a false sense of security, as

did 70 percent of professionals who work with victims of sexual abuse (Levenson, Fortney, & Baker, in press).

The public policy questions were asked of each respondent once, regardless of the number of programs for which they provided data. Unlike other questions in the survey, each provider was asked about policies for both juveniles and adults, without regard to the populations their programs served.

As shown in Tables 15.1a, overall, United States respondents report that they have little confidence that these laws enhance community safety, and many providers report that they believe they actually reduce community safety. The only exception was that slightly over half (51.1%) of United States providers report that they believe adult registration laws enhanced community safety.

As shown in Table 15.1b, Canadian respondents were even more negative about these laws. Fifty percent or more of Canadian respondents opined that registration and community notification for both adults and juveniles reduces community safety.

The reserve that most providers express about these legislative initiatives is probably warranted. Overall, little evidence exists that these legislative initiatives reduce offending rates (Center for Sex Offender Management, 2008b). As well, the studies cited above indicate that unintended consequences of these laws include residence and job instability and difficulty developing or maintaining appropriate social supports. Problems in these areas are reported to be associated with increased risk of reoffending (Andrews & Bonta, 2006; Hanson & Bussière, 1998; Hanson & Morton-Bourgon, 2004, 2005).

While professional organizations within the field, such as ATSA, work to influence the formulation of public policy, additional research on the effectiveness or lack thereof of these policies will be needed. Although complete agreement among treatment professionals is not expected, the field as a whole must strive to find a unified position supported by research in order to have credibility with policy makers and the public. Research and education in this area will continue to be a priority for obtaining our common goal of a safer society for everyone.

Table 15.1a United States – Provider opinion on impact of sex offender legislation, percentage				
Legislation	**n**	**Reduces Community Safety**	**No Effect on Community Safety**	**Enhances Community Safety**
Adult sex offender registration	503	13.3	35.6	51.1
Adult community notification	499	23.6	40.5	35.9
Adult residency restrictions	493	39.1	37.7	23.1
Juvenile sex offender registration	492	25.6	51.6	22.8
Juvenile community notification	484	30.6	52.5	16.9
Juvenile residency restrictions	484	36.2	49.8	14.0

Table 15.1b Canada – Provider opinion on impact of sex offender legislation, percentage				
Legislation	**n**	**Reduces Community Safety**	**No Effect on Community Safety**	**Enhances Community Safety**
Adult sex offender registration	33	27.3	36.4	36.4
Adult community notification	33	63.6	24.2	12.1
Adult residency restrictions	32	50.0	6.3	43.8
Juvenile sex offender registration	31	29.0	58.1	12.9
Juvenile community notification	31	64.5	29.0	6.5
Juvenile residency restrictions	31	51.6	16.1	32.3

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Appendix: North American Treatment Provider Survey Questions (Web-based survey)

Did you provide any specialized sexual offender treatment in 2008? (Select one)

☐ Yes ☐ No

Note: Response of "No" exited the survey.

In what country is your practice located? (Select One)

☐ Canada ☐ United States

☐ Other: (Specify)

Please select the type of services your agency, organization, or practice provides.

- If all of the services provided by this agency, organization, or practice are community based:
  - please select community-based only.
- If the services are entirely residential or institutional:
  - please select residential/institutional only.
- If this agency, organization, or practice provides both community-based AND residential or institutional services:
  - please select both.
- If you provide community-based services on behalf of one agency, organization, or practice, AND residential or institutional services on behalf of a different agency, organization, or practice:
  - please complete two surveys and provide information about the services offered by each agency, organization, or practice separately.

I/We Provide: (Select one)

☐ Community-based services only

☐ Residential/Institutional services only

☐ Both community-based services and residential/institutional

Note: If you selected residential/institutional only, you will skip to Question 30 at this point.

COMMUNITY-BASED SECTION

Please check the populations your community-based program served in 2008. Adult programs are defined as those primarily for individuals age 18 and older, adolescent programs for ages 12 to 17, and children's programs for age 11 and younger.

If you had no clients in a particular population in 2008, please do NOT check that population. (Check all that apply)

☐ Adult Females

☐ Adolescent Females

☐ Female Children

☐ Adult Males

☐ Adolescent Males

☐ Male Children

Note: From this point forward, you will see information for only those populations that you selected in the previous question. If you operate both community-based and residential programs, you will be asked to choose the residential populations you serve later.

1. How many years has each of your community-based programs operated? If 2008 was your first year of operation, please enter 1. (Enter the number)

2. What is the setting of your community-based programs? Check all that apply for each treatment population.

- ☐ Community Mental Health Center
- ☐ Court Clinic
- ☐ Hospital
- ☐ Halfway House
- ☐ Private Practice
- ☐ Other

3. What type of program do you operate? Select one option for each population you treat.

- ☐ Private, not-for-profit
- ☐ Private, for profit
- ☐ Public

4. What are your funding sources? For each population you serve, check all that apply.

- ☐ Federal grants or contracts
- ☐ Insurance, public (e.g. Medicaid)
- ☐ State/provincial grants or contracts
- ☐ Client self-pay
- ☐ Other government grants or contracts (county, city etc.)
- ☐ Insurance, private
- ☐ Other

5. What is the educational level of staff who provide treatment services? Enter the number of staff at each educational level serving each population. A single staff member may be counted more than once. For example, if you hold a doctorate and you work with both adult and adolescent males, you would count yourself as a doctorate level provider in both those categories.

- ☐ Doctorate degree
- ☐ Master's degree
- ☐ Bachelor's degree
- ☐ No bachelor's degree

6. What type of sex offender specific professional development activities has anyone who provides treatment services on behalf of your program (including yourself) participated in during 2008? Please check all that apply.

- ☐ In-house training
- ☐ Clinical supervision by a mental health practitioner
- ☐ Services targeting staff wellness
- ☐ Local/regional training
- ☐ National/international conferences

7. Do you provide services in any language other than English? If yes, please enter the languages in the text box beside the corresponding populations. For example, if you provide services in Spanish to adult males, please enter Spanish in the text box labeled adult males. If you provide languages as needed, please select "yes" and enter "As needed" in the Other Languages text box.

- ☐ Yes ☐ No
- ☐ Other Languages (please separate with commas)

8. What is the approximate number of clients who received any treatment in your program in 2008? (Please enter the number by population.)

9. For each population, please enter the typical average number of months it takes to complete your "core" treatment program. (Do not include the amount of time clients may participate in less intensive "aftercare" or "step-down" services. Information about these services will be collected in the next question.)

10. For each population, please enter the typical average number of months it takes to complete less intensive "aftercare" or "step-down" services. Please enter 0 if you do not provide "aftercare" or "step-down" services.

11. About what percentage of clients who begin the program complete the program? (Please enter the percentage by population.)

12. On average, how many group treatment sessions does a client attend each week? Please enter the number. If clients participate in less than one session per week, please use a decimal to indicate how often group sessions are offered. For example, if a client participates in two sessions per month, please enter '0.5'.

13. What types of groups does your program use? Please select one answer for each population.

- ☐ Open (rolling)
- ☐ Closed
- ☐ Both
- ☐ None, do not use group

14. What is the average length of group treatment sessions in minutes? Please enter the average length or select no group offered for each population.

15. On average, how many individual sessions does a client attend per month? If clients participate in less than one session per month, please use a decimal to indicate how often individual sessions are offered. For example, if a client participates in one session every two months, please enter ‘0.5’.

16. What is the average length of individual sessions in minutes? Please enter the minutes or select no individual sessions for each population.

17. On average, how many family or couple sessions does a client attend per month? If clients participate in less than one session per month, please use a decimal to indicate how often family or couple sessions are offered. For example, if a client participates in one session every two months, please enter ‘0.5’.

18. What is the average length of family or couple treatment sessions in minutes? Please enter the minutes or select no family/couple sessions for each population.

19. Do you provide services to the following populations? Please check all that apply. This information is being collected only for adult and adolescent populations.

- ☐ Rapists
- ☐ Statutory rapist (illegal cooperative sex with similar age peer)
- ☐ Incest abusers (intrafamilial)
- ☐ Child abusers (extrafamilial)
- ☐ Child pornography exclusive abusers
- ☐ Other non-contact abusers

20. Please check each special service your program provides for each population you serve. (Note: Separate group for statutory rapists and separate group for child pornography exclusive offenders are not options for female and male child populations.)

- ☐ Separate group for statutory rapists (illegal cooperative sex with similar age peer)
- ☐ Separate group for child pornography exclusive offenders
- ☐ Separate group for deniers
- ☐ Admitters and full deniers in same group
- ☐ Group for parents or significant others
- ☐ High-risk sexual abuser services
- ☐ Hearing impaired sexual abuser services
- ☐ Developmentally disabled abuser services
- ☐ Psychiatrically disordered abuser services

21. Which three (3) theories best describe your treatment approach? Select one (1) for the theory which best describes your approach, two (2) for the second best theory, and three (3) for the third best theory. You will only be allowed to enter three choices for each population, and they must be rank ordered from one to three. If you select Other as one of your choices, please enter the name of the theory in the text box.

- ☐ Bio-medical
- ☐ Cognitive-Behavioral
- ☐ Family Systems
- ☐ Good Lives
- ☐ Harm Reduction
- ☐ Multi-systemic
- ☐ Psychodynamic
- ☐ Psycho-Socio-Educational
- ☐ Risk, Need and Responsivity
- ☐ Relapse Prevention
- ☐ Self-regulation
- ☐ Sexual Addiction
- ☐ Sexual Trauma
- ☐ Other

22. Please check each instrument that is used, at least occasionally, to assess clients in your program. This information is being collected only for adult and adolescent populations. (Note: For female populations penile plethysmograph is replaced with vaginal photoplethysmograph.)

- ☐ Penile Plethysmograph
- ☐ Polygraph, disclosure tests
- ☐ Polygraph, monitoring/maintenance tests
- ☐ Polygraph, special issues tests
- ☐ Viewing Time Measures, such as Abel Screen or Affinity tests
- ☐ Voice Stress Test

23. Please check each assessment instrument that is used in your program for each population.

Adult Female:

- ☐ LSI-R, LSI-R:SV, or LS/CMI
- ☐ PCL-RVRAG
- ☐ MSI-II
- ☐ SORAG

Adolescent Female:

- ☐ Child Behavior Checklist
- ☐ Child Sexual Behavior Inventory
- ☐ ERASOR-II
- ☐ J-SOAP-II
- ☐ JSORAT-II
- ☐ PCL:YV
- ☐ YLS/CMI

Female Child:

- ☐ Child Behavior Checklist
- ☐ Child Sexual Behavior Inventory
- ☐ ERASOR-II
- ☐ J-SOAP-II
- ☐ JSORAT-II
- ☐ YLS/CMI

Adult Male:

- ☐ LSI-R, LSI-R:SV, or LS/CMI
- ☐ MnSOST-R
- ☐ MSI-II
- ☐ PCL-R
- ☐ RRASOR
- ☐ SO Treatment Needs and Progress Scale
- ☐ SORAG
- ☐ SRA - Structured Risk Assessment
- ☐ Stable and Acute 2007
- ☐ Static-99
- ☐ Static 2002
- ☐ SVR-20
- ☐ VASOR
- ☐ VRAG

Adolescent Male:

- ☐ Child Behavior Checklist
- ☐ Child Sexual Behavior Inventory
- ☐ ERASOR-II
- ☐ J-SOAP-II
- ☐ JSORAT-II
- ☐ PCL:YV
- ☐ YLS/CMI

Male Child:

- ☐ Child Behavior Checklist
- ☐ Child Sexual Behavior Inventory
- ☐ ERASOR-II
- ☐ J-SOAP-II
- ☐ JSORAT-II
- ☐ YLS/CMI

24. Please check each item that is a component of your treatment program for each population you serve.

- ☐ Art therapies
- ☐ Assault cycle or offense chain
- ☐ Client's victimization/trauma
- ☐ Cognitive restructuring
- ☐ Drama therapy
- ☐ EMDR
- ☐ Emotional regulation
- ☐ Family reunification
- ☐ Intimacy/relationship skills
- ☐ Motivational interviewing
- ☐ Offense responsibility
- ☐ Offense supportive attitudes
- ☐ Problem solving training
- ☐ Relapse prevention
- ☐ Schema therapy
- ☐ Self-monitoring training
- ☐ Sex education
- ☐ Social skills training
- ☐ Therapeutic community
- ☐ Victim awareness and empathy
- ☐ Victim clarification
- ☐ Victim restitution

25. In general, what level of sexual offense disclosure must an abuser make to successfully complete your program? Please select one for each population you serve. This information is being collected only for adult and adolescent populations.

- ☐ Disclose a sexual offense history that is very consistent with official records.
- ☐ Disclose a sexual offense history that is reasonably consistent with official records.
- ☐ Disclose at least some sexual offense history, even if it is inconsistent with official records.
- ☐ Does not need to disclose committing a sexual offense.

26. Does an abuser need to pass a full disclosure polygraph exam in order to successfully complete your program? Please select one for each population you serve. This information is being collected only for adult and adolescent populations.

- ☐ Yes ☐ No
- ☐ Does not apply; we do not use disclosure polygraph tests

27. Please check each medication that clients in your program use to help control their sexual arousal.

- ☐ Provera
- ☐ Lupron
- ☐ SSRI's
- ☐ Cyproterone acetate

28. Please check each arousal control technique that is used with each population you treat.

- ☐ Covert sensitization
- ☐ Minimal arousal conditioning
- ☐ Odor aversion
- ☐ Modified aversive behavior rehearsal
- ☐ Masturbatory satiation
- ☐ Orgasmic conditioning or reconditioning
- ☐ Verbal satiation

29. Please check each community and other agency involvement activity that is used by your program.

- ☐ Limits of confidentiality agreement required for admission to program
- ☐ Exchange information with probation/parole officers or caseworkers
- ☐ Probation/parole officers or caseworkers visit group
- ☐ Probation/parole officers or caseworkers co-lead groups with therapists
- ☐ Exchange information with victim advocates
- ☐ Victim advocates visit group
- ☐ Family educated to be part of client's support system
- ☐ Community members educated to be part of client's support system
- ☐ Integrated risk management team (e.g., partnering with mental health, law enforcement, corrections, and social service organizations)
- ☐ External consultants (e.g. treatment advisory board) for quality improvement purposes

Note: This completes the data collection for community-based programs. If you have selected community-based programs only, at this point you will be asked to complete a public policy question before filling our the contact data for your program. You will skip to the question following question 60 and complete the remainder of the survey.

RESIDENTIAL PROGRAMS SECTION

The following questions collect information on residential or institutional programs.

30. Please check the populations your residential/institutional program served in 2008. Adult programs are defined as those primarily for individuals age 18 and older, adolescent programs for ages 12 to 17, and children's programs for age 11 and younger. If you had no clients in a particular population in 2008, please do NOT check that population. (Check all that apply.)

- ☐ Adult Females
- ☐ Adolescent Females
- ☐ Female Children
- ☐ Adult Males
- ☐ Adolescent Males
- ☐ Male Children

Note: From this point forward, you will see information for only those populations that you selected in the previous question.

31. How many years has each of your residential/institutional programs operated? If 2008 was your first year of operation, please enter 1.

32. Please select the setting that most closely describes the setting of each residential/institutional program. If you select other, please enter the setting in the text box.

- ☐ Prison
- ☐ Halfway House
- ☐ Civil Commitment Center (e.g. SVP)
- ☐ Group Home
- ☐ Hospital
- ☐ Residential Treatment Center
- ☐ Other:

33. What type of program do you operate? Select one option for each population you treat.

- ☐ Private, not-for-profit
- ☐ Private, for profit
- ☐ Public

34. What is the educational level of staff who provide treatment services? Enter the number of staff at each educational level serving each population. A single staff member may be counted more than once. For example, if you hold a doctorate and you work with both adult and adolescent males, you would count yourself as a doctorate level provider in both those categories.

- ☐ Doctorate degree
- ☐ Master's degree
- ☐ Bachelor's degree
- ☐ No bachelor's degree

35. What type of sex offender specific professional development activities has anyone who provides treatment services on behalf of your program (including yourself) participated in during 2008? Please check all that apply**.**

- ☐ In-house training
- ☐ Clinical supervision by a mental health practitioner
- ☐ Services targeting staff wellness
- ☐ Local/regional training
- ☐ National/international conferences

36. Do you provide services in any language other than English? If yes, please enter the languages in the text box beside the corresponding populations. For example, if you provide services in Spanish to adult males, please enter Spanish in the text box labeled adult males. If you provide languages as needed, please select "yes" and enter "As needed" in the Other Languages text box.

- ☐ Yes ☐ No
- ☐ Other Languages (please separate with commas)

37. What is the approximate number of clients who received any treatment in your program in 2008? (Please enter the number by population.)

38. For each population, please enter the typical average number of months it takes to complete your "core" treatment program. (Do not include the amount of time clients may participate in less intensive "aftercare" or "step-down" services. Information about these services will be collected in the next question.)

39. For each population, please enter the typical average number of months it takes to complete less intensive "aftercare" or "step-down" services. Enter 0 if you do not provide "aftercare" or "step-down" services.

40. About what percentage of clients who begin the program complete the program? (Please enter the percentage by population.)

41. What are your funding sources? For each population you serve, check all that apply.

- ☐ Federal grants or contracts
- ☐ State/provincial grants or contracts
- ☐ Other government grants or contracts (county, city etc.)
- ☐ Insurance, private
- ☐ Insurance, public (e.g. Medicaid)
- ☐ Client self-pay
- ☐ Other sources

42. Is your program accredited? If yes, please provide the full name of the accrediting organization in the text box.

- ☐ Yes (Enter full name of accrediting organization.)
- ☐ No

43. On average, how many group treatment sessions does a client attend each week? Please enter the number. If clients participate in less than one session per week, please use a decimal to indicate how often group sessions are offered. For example, if a client participates in two sessions per month, please enter '0.5'.

44. What types of groups does your program use? Please select one answer for each population.

- ☐ Open (rolling)
- ☐ Closed
- ☐ Both
- ☐ None, do not use group

45. What is the average length of group treatment sessions in minutes? Please enter the average length or select no group offered for each population.

46. On average, how many individual sessions does a client attend per month? If clients participate in less than one session per month, please use a decimal to indicate how often individual sessions are offered. For example, if a client participates in one session every two months, please enter '0.5'.

47. What is the average length of individual sessions in minutes? Please enter the minutes or select no individual sessions for each population.

48. On average, how many family or couple sessions does a client attend per month? If clients participate in less than one session per month, please use a decimal to indicate how often family or couple sessions are offered. For example, if a client participates in one session every two months, please enter '0.5'.

49. What is the average length of family or couple treatment sessions in minutes? Please enter the minutes or select no family/couple sessions for each population.

50. Do you provide services to the following populations? Please check all that apply. This information is being collected only for adult and adolescent populations.

- ☐ Rapists
- ☐ Statutory rapist (illegal cooperative sex with similar age peer)
- ☐ Incest abusers (intrafamilial)
- ☐ Child abusers (extrafamilial)
- ☐ Child pornography exclusive abusers
- ☐ Other non-contact abusers

51. Please check each special service your program provides for each population you serve. (Note: Separate group for statutory rapists and separate group for child pornography exclusive offenders are not options for female and male child populations.)

- ☐ Separate group for statutory rapists (illegal cooperative sex with similar age peer
- ☐ Separate group for child pornography exclusive offenders
- ☐ Separate group for deniers
- ☐ Admitters and full deniers in same group
- ☐ Group for parents or significant others
- ☐ High-risk sexual abuser services
- ☐ Hearing impaired sexual abuser services
- ☐ Developmentally disabled abuser services
- ☐ Psychiatrically disordered abuser services

52. Which three (3) theories best describe your treatment approach? Select one (1) for the theory which best describes your approach, two (2) for the second best theory, and three (3) for the third best theory. You will only be allowed to enter three choices for each population, and they must be rank ordered from one to three. If you select Other as one of your choices, please enter the name of the theory in the text box.

- ☐ Bio-medical
- ☐ Cognitive-Behavioral
- ☐ Family Systems
- ☐ Good Lives
- ☐ Harm Reduction
- ☐ Multi-systemic
- ☐ Psychodynamic
- ☐ Psycho-Socio-Educational
- ☐ Risk, Need and Responsivity
- ☐ Relapse Prevention
- ☐ Self-regulation
- ☐ Sexual Addiction
- ☐ Sexual Trauma
- ☐ Other

53. Please check each instrument that is used, at least occasionally, to assess clients in your program. This information is being collected only for adult and adolescent populations. (Note: For female populations penile plethysmograph is replaced with vaginal photoplethysmograph.)

- ☐ Penile Plethysmograph
- ☐ Polygraph, disclosure tests
- ☐ Polygraph, monitoring/maintenance tests
- ☐ Polygraph, special issues tests
- ☐ Viewing Time Measures, such as Abel Screen or Affinity tests
- ☐ Voice Stress Test

54. Please check each medication that clients in your program use to help control their sexual arousal.

- ☐ Provera
- ☐ Lupron
- ☐ SSRI's
- ☐ Cyproterone acetate

55. Please check each arousal control technique that is used with each population you treat.

- ☐ Covert sensitization
- ☐ Minimal arousal conditioning
- ☐ Odor aversion
- ☐ Modified aversive behavior rehearsal
- ☐ Masturbatory satiation
- ☐ Orgasmic conditioning or reconditioning
- ☐ Verbal satiation

56. Please check each assessment instrument that is used in your program for each population.

Adult Female:

- ☐ LSI-R, LSI-R:SV, or LS/CMI
- ☐ MSI-II
- ☐ PCL-R
- ☐ SORAG
- ☐ VRAG

Adolescent Female:

- ☐ Child Behavior Checklist
- ☐ Child Sexual Behavior Inventory
- ☐ ERASOR-II
- ☐ J-SOAP-II
- ☐ JSORAT-II
- ☐ PCL:YV
- ☐ YLS/CMI

Female Child:

- ☐ Child Behavior Checklist
- ☐ Child Sexual Behavior Inventory
- ☐ ERASOR-II
- ☐ J-SOAP-II
- ☐ JSORAT-II
- ☐ YLS/CMI

Adult Male:

- ☐ LSI-R, LSI-R:SV, or LS/CMI
- ☐ MnSOST-R
- ☐ MSI-II
- ☐ PCL-R
- ☐ RRASOR
- ☐ SO Treatment Needs and Progress Scale
- ☐ SORAG
- ☐ SRA - Structured Risk Assessment
- ☐ Stable and Acute 2007
- ☐ Static-99
- ☐ Static 2002
- ☐ SVR-20
- ☐ VASOR
- ☐ VRAG

Adolescent Male:

- ☐ Child Behavior Checklist
- ☐ Child Sexual Behavior Inventory
- ☐ ERASOR-II
- ☐ J-SOAP-II
- ☐ JSORAT-II
- ☐ PCL:YV
- ☐ YLS/CMI

Male Child:

- ☐ Child Behavior Checklist
- ☐ Child Sexual Behavior Inventory
- ☐ ERASOR-II
- ☐ J-SOAP-II
- ☐ JSORAT-II
- ☐ YLS/CMI

57. Please check each item that is a component of your treatment program for each population you serve.

- ☐ Art therapies
- ☐ Assault cycle or offense chain
- ☐ Client's victimization/trauma
- ☐ Cognitive restructuring
- ☐ Drama therapy
- ☐ EMDR
- ☐ Emotional regulation
- ☐ Family reunification
- ☐ Intimacy/relationship skills
- ☐ Motivational interviewing
- ☐ Offense responsibility
- ☐ Offense supportive attitudes
- ☐ Problem solving training
- ☐ Relapse prevention
- ☐ Schema therapy
- ☐ Self-monitoring training
- ☐ Sex education
- ☐ Social skills training
- ☐ Therapeutic community
- ☐ Victim clarification
- ☐ Victim awareness and empathy
- ☐ Victim restitution

58. In general, what level of sexual offense disclosure must an abuser make to successfully complete your program? Please select one for each population you serve. This information is being collected only for adult and adolescent populations.

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- ☐ Disclose a sexual offense history that is reasonably consistent with official records.
- ☐ Disclose at least some sexual offense history, even if it is inconsistent with official records.
- ☐ Does not need to disclose committing a sexual offense.

59. Does an abuser need to pass a full disclosure polygraph exam in order to successfully complete your program? Please select one for each population you serve. This information is being collected only for adult and adolescent populations.

- ☐ Yes ☐ No
- ☐ Does not apply; we do not use disclosure polygraph tests

60. Please check each community and other agency involvement activity that is used by your program.

- ☐ Limits of confidentiality agreement required for admission to program
- ☐ Exchange information with probation/parole officers or caseworkers
- ☐ Probation/parole officers or caseworkers visit group
- ☐ Probation/parole officers or caseworkers co-lead groups with therapists
- ☐ Exchange information with victim advocates
- ☐ Victim advocates visit group
- ☐ Family educated to be part of client's support system
- ☐ Community members educated to be part of client's support system
- ☐ Integrated risk management team (e.g., partnering with mental health, law enforcement, corrections, and social service organizations)
- ☐ External consultants (e.g. treatment advisory board) for quality improvement purposes

All respondents will see this question and the following informational screens. If you have only community-based programs, you will skip directly to this section of the survey once you have answered Question 29.

Overall, what do you believe is the impact of the following laws on community safety? (Choose one response for each law.)

- ☐ Reduces community safety
- ☐ Has no effect
- ☐ Enhances community safety

Juvenile Sex Offender Registration

Juvenile Community Notification

Juvenile Residency Restrictions

Adult Sex Offender Registration

Adult Community Notification

Adult Residency Restrictions

CONTACT INFORMATION

Your Full Name:
Your Title:
Agency or Practice Name:

Main Office Information
Address:
City:
State/Province:
Zip/Postal Code:
Country:

- ☐ Canada
- ☐ United States
- ☐ Other:

Phone:
Email:

Satellite Office Information (if applicable)
Address:
City:
State/Province:
Zip/Postal Code:
Country:

- ☐ Canada
- ☐ United States
- ☐ Other:

Phone:
Email:

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If there is anything else you would like to tell us about your program or to comment on answers to your questions, please use the text box below.

Please fill out the information below so that we may e-mail you a coupon worth up to $9.00 off shipping charges on your next Safer Society Press order as a token of our appreciation.

Name
Organization
E-mail

About the Authors

ROBERT J. MCGRATH is Clinical Director of the Vermont Department of Corrections statewide network of three prison and 12 community sex offender treatment programs, and a consultant to the Vermont Department of Developmental Disabilities on sexual abuser issues. He has been an active clinician, researcher and administrator in the field for over 25 years. He co-authored the book *Supervision of the Sex Offender* and has authored or co-authored over three dozen publications in the field. He serves or has served on the treatment advisory boards of several sexual violent predator civil commitment programs in the United States and for the national sex offender treatment programs of Canada, England and Hong Kong. He co-chairs the Association for the Treatment of Sexual Abusers' Practice Standards Committee.

GEORGIA F. CUMMING is Program Director of the Vermont Center for the Prevention and Treatment of Sexual Abuse and has worked in the field of sex offender management for over 25 years. She was formerly a probation and parole officer. She is the co-author of the book *Supervision of the Sex Offender* and has co-authored over two dozen publications in the field. She has presented extensively at workshops throughout North America on sex offender supervision.

BRENDA L. BURCHARD is Executive Director of the Safer Society Foundation. In this position, she oversees the Safer Society publication activities, resource center, library, and research activities. Previously, she worked in both the non-profit sector and the printing industry. Her academic training is in the natural sciences. She received her Bachelor of Science degree from Duke University and her Master of Science in Environmental Science from the School of Public and Environmental Affairs at Indiana University.

STEPHEN ZEOLI is Marketing and Sales Director for Safer Society Press, the publishing program of Safer Society Foundation. Shortly after graduating from the University of Vermont, Steve and three companions spent a year bicycling 13,000 miles around North America, an experience that led to a position with the marketing department of the bicycle manufacturer Cannondale Corporation. After moving permanently to Vermont, Steve spent 12 years in the marketing office of Champlain College in Burlington. In his free time, Steve serves on the board of a local, nonprofit history organization.

LAWRENCE ELLERBY is in private practice at Forensic Psychological Services, Ellerby & Associates where the clinical team conducts forensic assessments and provides institutional and community based treatment for individuals with histories of violent and sexual offending behavior. He is a Lecturer for the Department of Psychiatry at the University of Manitoba, a consultant to the Canadian Child Protection Center and a trainer for the Canadian Police College. He has published articles and book chapters related to offender assessment and treatment issues and given invited addresses on these topics in Canada, the United States and Europe. Lawrence has served two terms as the elected Canadian representative on the Board of Directors for the Association for the Treatment of Sexual Abusers (ATSA) and will assume the position of ATSA President in January 2010.

Safer Society Press

The Safer Society Press is the publishing program of the Safer Society Foundation, Inc., a nonprofit agency dedicated to ending sexual abuse by promoting effective prevention and best-practice treatment for sexual abusers and their victims.

Safer Society Press publishes books for clinicians, clients, families educators, and others.

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