

IMPAC

Inter-ministerial Provincial Advisory Committee

Service Issues for Adolescents Who Sexually Offend

June 2005

The Inter-ministerial Provincial Advisory Committee would like to acknowledge the work of Neill Carson, Dual Diagnosis Resource Service, Centre for Addiction & Mental Health, Rick Owens, Community Family Support Services, Griffin Centre, Dr. James Worling, Consultant Psychologist, Sexual Abuse: Family Education & Treatment Program, Thistletown Regional Centre, and Peter Hoag and Bill Kent from the Office of Child & Family Service Advocacy in the collection of material and writing of the following report. Also IMPAC would like to acknowledge the generosity of the Provincial Centre of Excellence for Child and Youth Mental Health at the Children's Hospital of Eastern Ontario in providing financial support, the Griffin Centre for administering the funds and to Tracey Curwen as the researcher responsible for presenting the survey and compiling the data that was used to support the Addendum report. Their dedicated effort in guiding this project to completion is appreciated by the Committee.

Jamie Emerson
Chair

June 2005

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Executive Summary

Between 1997 and 2004, five hundred and twenty-four Ontario youth identified with sexual offending behaviour were referred to the Office of Child and Family Service Advocacy. Twenty three percent of these young people were developmentally disabled. In each of these cases, the communities in which they lived, whether they were rural or urban, lacked the resources to provide the services these youth required. These youth reflect systemic deficits in service provision in Ontario and the absence of provincial standards or best practice guidelines for effective intervention with youth who sexually offend.

Fifty percent of incarcerated adults who have sexually offended report that they began offending when they were teenagers, and 25% of sexual offences in Canada are committed by teenagers. Untreated sexual offenders who elude detection can have hundreds of victims over their lifetime. The effects for victims – both children and adults – can be profound and lifelong, with the impact extending into their families and communities.

While it is encouraging to note that advances in the assessment and treatment of youth who sexually offend have resulted in the reduction of recidivism by as much as 73%¹, the lack of funding and co-ordination of services in Ontario has meant that most agencies and communities have been left to improvise and to redirect resources from core mandate.

What is needed is a strategy whereby resources are targeted to develop the capacity of communities across the Province to address the risks and needs of these youth. Building on existing models and programs, best practice standards must be set and met, agencies must be empowered to attend to these youth in a timely manner, and cooperation fostered between the constituent groups who are involved with these youth. This would include those who work in the youth justice, child welfare, developmental services and children's mental health sectors. Working together, and with the appropriate resources and supports, Communities can reduce sexual offending and make Ontario safer.

A review of the original survey materials of the treatment programs still in existence was initiated in June 2005 by contacting 34 treatment providers. The attached report supports the identified issues collected from data since 1997. These are identified as a lack of coordination between treatment services, a lack of standards and guidelines, a lack of appropriate training, a lack of research and most importantly a lack of dedicated funding to serve this population.

Recommendations

The Inter-ministerial Provincial Advisory Committee (IMPAC), respectfully submits the following recommendations:

1. That the Ministry of Children and Youth Services addresses the serious problem of adolescent sex offending by creating a network of dedicated treatment resources for adolescents who have offended sexually, to ensure the safety of children in the care of youth justice, children's mental health, and child welfare and to promote the safety of the communities in which such settings are located.
2. A panel of experts with a provincial perspective should be convened to assist in the identification and implementation of Provincial standards and strategies. This group should review existing best-practice guidelines (such as those developed by the Association for the Treatment of Sexual Abusers²) and the Provincial strategies and policies that already exist in Nova Scotia and British Columbia. This panel should recommend to the Government of Ontario a set of standards and mechanisms for their implementation and monitoring that would be workable in this province.
3. The Province of Ontario should strike an inter-ministerial task group comprised of representatives from the Ministry of Community and Social Services, the Ministry of Children and Youth Services, the Ministry of Health and Long Term Care, the Ministry of Education and the Ministry of the Attorney General to review the assessment, treatment, custody/detention and residential needs and existing capacities of communities across the Province.
4. Lead agencies in each region should be identified and funded to provide comprehensive specialized assessment, treatment and residential services to youth with an intellectual disability and/or complex mental health needs. Wherever possible, these agencies should be those with proven leadership and expertise in this area. In the absence of an existing specialized program, service providers with expertise in either intellectual disabilities or sexual offence-specific treatment should be identified as resources to develop the necessary cross-disciplinary expertise.
5. Community panels made up of representatives of each of the constituent groups (e.g. child welfare, youth justice services, children's mental health, police, the courts, residential service providers, etc.) involved with the continuum of responses and services to these youth should be formed in each region. Building on the example of the *Continuum of Services for Adolescents Who Sexually Offend* in Toronto, these panels would coordinate and support the implementation of best-practice standards and provide training and consultation to those who intervene with these youth. These community panels should also coordinate with local service resolution mechanisms to ensure that complex service issues are addressed before they become larger jurisdictional matters.
6. The Ontario government should support a coordinated program of research to examine the efficacy of both community-based and residential treatment for adolescents who have sexually offended. This is particularly important given the fiscal cost of interventions and the current paucity of empirical knowledge regarding treatment outcome for this population. Further, a province-wide research project could provide the Ministry with information for program development and implementation regarding critical issues such as provincial incidence rates, risk assessment protocols, impact of sibling-incest family reunification, professional training, specialized assessment tools, and the implementation of best-practice guidelines.

Background

In October 2002, the Office of Child and Family Service Advocacy (Advocacy Office) initiated a review of the services provided in Ontario to adolescents who sexually offend. This process was endorsed by the Inter-ministerial Provincial Advisory Committee (IMPAC). The review came as a result of the identification of a significant number of Advocacy Office cases that involved service provision issues for this population. In a review of the Advocacy Office data between April 1997 and March 2004, 524 cases were identified as having sex-offending behaviour as a prominent feature. Of those, there were a significant number where no appropriate community resources were available (see Appendix A & B). IMPAC had, over the same timeframe, reviewed a number of hard-to-serve cases where the appropriate sexual-offence-specific services were not readily available to meet the needs of clients. Also of concern was that of the 524 cases brought to the Advocacy Office, 123 or 23.5% were developmentally disabled. These cases were over-represented in the cases that required review by IMPAC.

In the general population, although only 3% of the population have an intellectual disability³, they represent as much as 15% of individuals who are convicted of sexual offences⁴ and a higher percentage of those who perpetrate sexual offences⁵. As noted above, the higher representation of this group in the cases referred to the Advocacy Office underlines an additional service gap.

As a consequence, service providers from across the province were invited to participate in a review of services for adolescents who offend sexually, with the goal to identify and make recommendations on the current status of services in the province of Ontario. The agencies involved represented a wide range of services including treatment facilities, community service agencies, and young offender services. Provincial Ministries also were directly involved in the work of the committee (see Appendix C).

In December 2004 the Inter-ministerial Provincial Advisory Committee (IMPAC) submitted a briefing outlining the provincial needs and deficits related to the assessment and treatment of sexually offending adolescents in Ontario. Following the briefing submission, funding was attained from The Provincial Centre of Excellence for Child and Youth Mental Health at the Children's Hospital of Eastern Ontario to provide detailed information on the *current* functioning of treatment programs for sexually offending adolescents including; an annotated bibliography, issues related to diversity: isolated, rural and aboriginal communities, a meta analysis of outcome based research of established programs in Canada, a review of at existing models in Nova Scotia and British Columbia, and a review of the original survey materials.

The Issues

Sexual victimization leads to a number of emotional, social, and psychological difficulties for many child and adolescent victims including sexualized behaviours, depression, anxiety, academic difficulties, self-harm, and social withdrawal⁶. These effects can be life lasting with extensive repercussions to the individual and their community. Adult victims may experience interpersonal difficulties, loss of employment, substance use issues, depression and a range of trauma and anxiety related symptoms.

The Youth Court Survey for 2003 indicated that in Canada, 961 youth were charged with a total of 2188 sexual assault charges and that youth in Ontario accounted for almost half of this: 466 Ontario youth were charged (48.5%) with 1172 charges (53.6%). As for other sexual offences, 453 youth in Canada accumulated 1218 other sexual offence charges with Ontario accounting for approximately half with 219 youths (48.3%) and accumulating 650 other sexual offence charges (53.4%). Individuals aged 13 through 17 are significantly more likely to be charged with a sexual offence compared to any other age group in Canada.⁷

Although most victims of sexual assault never disclose their abuse to authorities, police in Ontario reported 8,877 sexual assaults in 2002.⁸ This represents one reported sexual assault every hour each day.

In Ontario, provincial government recognition of the importance of this issue has been inconsistent. As a result, communities and organizations have sought to develop offender specific resources in isolation from one another. They have worked mainly from core funding and without a specific mandate. This environment promotes experimentation. It does not ensure that accepted standards of practice are pursued. There is no mechanism at present to ensure that the assessment and treatment of adolescents who have offended sexually is both clinically sound and attentive to the appropriate standards of community safety. At the same time, it is important to note that the Government of Ontario recognized the need for specialized services for families affected by sexual abuse, and that it supported the establishment of the Sexual Abuse: Family Education and Treatment (SAFE-T) Program, 20 years ago. In addition to services for child and adolescent victims and children with sexual behaviour problems, this community-based resource in Toronto provides specialized assessment and treatment services to approximately 40 adolescents each year who have committed a sexual offence.

The assessment and treatment of individuals who commit sexual offences is recognized internationally as a clinical specialty, as there are many differences between general delinquency and sexual offending. Indeed, best-practice guidelines have been developed specifically to address the assessment and treatment of individuals who commit sexual offences⁹, and many programs throughout North America provide service under these guidelines. It is interesting to note that much of the leading international research regarding the assessment and treatment of adults who offend sexually has been produced in Ontario. It should be noted that there are province-wide policies and funding in both Nova Scotia and British Columbia to address youth that offend sexually.

One of the few follow-up studies that have compared best-practice treatment to a comparison group was conducted at a provincially operated program in Ontario. With follow-up data spanning almost 10 years, the authors found that only 5% of those adolescents who received specialized treatment re-offended sexually, compared to

almost 18% of those adolescents who did not receive the specialized treatment. Furthermore, the comprehensive treatment also significantly reduced the rate of nonsexual re-offending¹⁰.

As the issue of sexual offending is not adequately recognized in Ontario, there are no expectations to follow accepted best-practice guidelines, and this results in a number of problems for both the adolescents who offend sexually and the community. For example, it is well established that “generic” delinquency counseling will have little impact on reducing the risk of re-offending sexually. Furthermore, there is convincing research that traditional, correctional-milieu treatment for adolescents will actually increase the risk of recidivism overall. In many parts of the province, however, specialized services are not available (either residential or community-based); thus, adolescents receive only generic, non-specialized treatment.

Resource limitations also lead to many parts of the province offering only very brief (e.g. 10 weeks) community-based treatment that is limited to group-therapy interventions, the efficacy of which is, at best, quite limited. In North America, the average length of specialized, community-based treatment is 18 months. Furthermore, although group therapy can be a powerful intervention for some adolescents, it is well established that placing some adolescents in a group with other adolescents who have committed sexual assaults may actually lead to increased risk of re-offense¹¹.

It is also a well-recognized best practice to ensure that a comprehensive assessment of risk and treatment need is conducted before treatment is provided. This is to ensure that (a) those clients who have the highest clinical needs and present with the highest risk to reoffend receive the most intensive treatment, (b) treatment is tailored specifically to the adolescent’s unique strengths and risk factors, (c) the limited treatment resources are allocated appropriately according to risk and need, and (d) to maximize community protection. Unfortunately, as in the case of treatment, there are no province-wide standards for assessment. As such, there are many programs in Ontario in which some form of treatment is provided without a comprehensive assessment, a consequence of which is that some high-risk adolescents receive little or no appropriate treatment, and some low-risk/low-need adolescents receive intensive treatment.

Since 1981, specialized residential and community-based programs have been developed throughout the United States specifically for adolescents who commit sexual offences. Indeed, there are several hundred such programs presently in the U.S¹². If an adolescent requires residential treatment; he or she would be placed in a residential facility that works specifically with juveniles who commit sexual offences. The staff in these institutions have specialized training to work with this population of teens, and the mandate of the state-licensed institutions is to reduce the risk of recidivism. In Ontario, however, due to a lack of province-wide standards that address the placement of these youth, most adolescents who commit sexual offences in Ontario who require a residential placement, are housed in generic group homes or custody settings – without specialized treatment.

The lack of accepted provincial standards also leads to a number of significant inconsistencies throughout Ontario, including the following examples:

- In the absence of resources and regional protocols specific to risk assessment and intervention, adolescents in some parts of the province, who sexually offend against

siblings are not removed from their homes (at least for the duration of the assessment) and continue to reside, untreated, with their victims.

- Most programs including youth justice facilities do not have services tailored for special populations of adolescents who commit sexual offences, such as adolescents with intellectual disabilities or adolescent females.
- Some programs will conduct a clinical assessment before the adolescent has even been convicted in a youth court. These “pre-adjudication” assessments raise a number of ethical and legal issues, such as having the adolescent reveal clinical information that could be used against them in court. Pre-adjudication assessments are also often used inappropriately to try to establish guilt or innocence, and yet there is no known assessment device or procedure that is valid for this purpose. Best-practice guidelines note that it is ideal to conduct assessments post-adjudication and prior to sentencing if at all possible.
- Treatment and assessment services are provided at many locations across the province by individuals without specialized training and supervision.
- Recent advances in risk assessment have informed best-practice standards for formulating risk statements. Presently, statements of risk to reoffend are made, in many agencies in Ontario, by individuals without the appropriate training and supervision.
- There are agencies in Ontario that use intrusive, and potentially harmful assessment and treatment procedures (e.g., plethysmographic assessment, aversive conditioning) without appropriate training and/or informed consent procedures.
- In some jurisdictions in the province, judges are able to order and receive Section 34 (YCJA) assessments to assist with sentencing and community access, yet in other jurisdictions, offence specific assessments are difficult to obtain, despite federal legislation.
- The Province has not yet committed to establishing sex-offence specific diversion measures
- Some high-risk youth in Ontario are provided with no specialized, sexual offence-specific services while some low-risk youth are provided with unnecessarily intrusive, lengthy, and expensive out-of-home, specialized services.
- Adolescents and families discharged from one agency are re-assessed at another agency.
- Co-residents of inappropriately housed offenders are placed at risk to be victimized.
- The adult provincial correctional system has a 190-bed facility designed to treat adult sex offenders. No such facility exists for youth.
- Due to the stigma attached to this group, youth are often advised to conceal their charges, or reasons for placement, making milieu therapy for offenders impossible.

Service Provision Issues for Youth with Intellectual Disabilities¹³

Between January 1997 and June 2004, the Office of Child and Family Service Advocacy responded to 524 referrals of young people with complex needs and a history of sexual offending. Of this total, 144 or 27% had a diagnosis reflective of intellectual disability or other cognitive impairment. On February 15, 2000 an 18-year-old intellectually disabled man named Joshua died of a reaction to neuroleptic medication while in an adult detention centre in the Province of Ontario¹⁴. Joshua had a history of mental health problems, sexual victimization, and sexual offending behaviour, and had lived in multiple placements. He never received treatment that combined expertise in intellectual disability, mental health and sexual offending. Although Joshua's death was unusual, the circumstances that preceded his death and that resulted in his incarceration were by no means unique. Despite the frequency with which service providers and communities across the province are confronted with high risk youth with complex needs, the Coroner's Jury recommendation that "[t]he Ministry of Community and Social Services establish specialized residential services dedicated to addressing the complex needs of developmentally handicapped sex offending youth"¹⁵ has never been implemented. Consequently, intellectually disabled youth who sexually offend continue to be treated and placed in settings that are inadequate or unsuited to their risks and needs, thus endangering the youth, the staff and the community.

As noted previously while only 3% of the population have an intellectual disability¹⁶, they represent as much as 15% of individuals who are convicted of sexual offences¹⁷ in the general population and over 23% of the offending youth referred to the Advocacy Office.

Relative to non-disabled youth in the criminal justice system who have sexually offended, intellectually disabled youth:

- confess and plead guilty more frequently,
- plea bargain and appeal findings less often,
- serve longer sentences.¹⁸

Intellectually disabled youth who sexually offend are often not charged by (well-meaning) police who recognize the vulnerability of these individuals within the criminal system, and so:

- the number of victims of sexual assault increases while youth that offend go untreated.
- individuals who would benefit from treatment don't get it, continue to offend and eventually suffer more severe consequences and greater exposure to a criminal justice system that does not have the resources to respond to their special needs.

The findings of the Legal Issues Committee of the Continuum of Services for Youth Who Have Sexually Offended¹⁹ suggest that these tendencies are due in part to the persistent and pervasive failure to ensure that accused youth with intellectual disabilities understand

what is happening to and around them at the time of arrest, trial and sentencing. Concepts such as guilt, intent and wilfulness are not readily comprehensible for most youth, but are especially problematic for those with cognitive limitations. In addition, the adversarial nature of the mainstream criminal justice systems is neither intuitive nor familiar for most people, and can be overwhelming at the best of times.

- Although they tend to have fewer victims²⁰, sexual offending youth with intellectual disabilities have a greater tendency to offend against strangers²¹, and so may be reported to authorities more often.
- Because of their cognitive limitations, these youth are less adept at planning, perpetrating and concealing their offences to avoid detection²².
- These youth tend to live highly supervised lives and do not have the same opportunities for age-appropriate sexual development. With disturbing frequency efforts at appropriate intimacy are restricted and even censured and teaching about healthy relationships is absent. By preventing the development of pro-social sexual identities, restrictions of this sort effectively compound the risk of further offending²³.
- These youth can be more awkward in their efforts to initiate sexual intimacy or may simply take advantage of perceived opportunities.
- Disabled youth are considerably more vulnerable to abuse and sexual victimization²⁴, which, while not a causal factor in sexual offending, may form a part or even the bulk of sexual experience from which a youth has to draw when contemplating and initiating intimate relationships.
- They are more likely than their non-disabled peers to be diverted to group homes rather than custodial settings.
- They are more likely to have their charges dropped.²⁵ When they are not formally charged, they are less likely to receive the appropriate treatment.
- Anecdotal evidence in the Toronto region suggests that many youth who do offend are excused from taking responsibility by victims, authority figures and police, in the mistaken belief that either the offending youth did not know what he or she was doing (or that what they were doing was wrong), or that they are 'unfit' to participate in the youth justice process.
- It is also worth noting, though, that many youth with intellectual disabilities are adept at and invested in concealing their disability and, therefore, are not identified as such at the time of arrest.²⁶

Finally, it is worth noting that the numbers cited herein may significantly under-represent the numbers of sexual offences committed by youth who have an intellectual disability.

Service Delivery Challenges in the Province of Ontario:

Due to a lack of assessment and treatment standards, non-intellectually delayed adolescents who sexually offend and their intellectually delayed counterparts face similar treatment issues.

- While providers may be prepared to accept these adolescents, they often have difficulty responding appropriately to their needs. There is no mechanism to establish what standards of assessment and treatment should be applied, or to establish their efficacy.
- While there may be agencies in the province that claim to provide service to sexually offending youth, few are both equipped and willing to work with the complex constellations of risks and needs intellectually disabled youth present. Where treatment is offered, it is frequently not specialized for this population.
 - Intellectually disabled individuals are exposed to treatment modalities designed for non-impaired people. This elevates anxiety and significantly undermines treatment efficacy, which may contribute to increased risk for re-offending.
 - A view is perpetuated that cognitively impaired individuals are not amenable to treatment when, in fact, the literature indicates that appropriately modified cognitive-behavioural approaches are effective with this population.²⁷
- Given the relative dearth of valid and proven assessment and treatment resources, existing materials used for non-disabled youth and adults must be adapted. Consequently, assessment and treatment processes for intellectually disabled youth who sexually offend take considerably longer.²⁸

There is one agency in Toronto that provides specialized comprehensive services (i.e. residential treatment, day/school programs, and offence-specific treatment in a variety of modalities) for intellectually disabled youth who have sexually offended – the Griffin Centre – yet it receives no funding for this specialized service, and it is restricted to serving Toronto area youth. There are several privately operated, non-specialized residential programs for this population, but what is missing is a funding mechanism to purchase the offence-specific services these youth need. Outside of the large urban areas, the shortage of specialized resources is even more pronounced.

The effects of under-funding are compounded by the absence of Provincial support for evidence-based standards of practice, creating obstacles to positive treatment outcomes:

- Individuals are often subject to risk assessments that are not conducted post-adjudication in accordance with best practice-guidelines. Sometimes performed in the absence of a finding of guilt, these assessments are then used to inform decisions about the liberties of those deemed to pose a risk, effectively jailing youth who are forced to comply with the demands of service providers anxious about their responsibility for community safety.

- Other dangerous individuals are treated as if their behaviour is not serious and provided with sex education, supportive psychotherapy and anger management while remaining unsupervised and with access to additional victims.
- Intellectually disabled individuals are more prone to physical and mental illness than their non-disabled counterparts. Treatment for offending youth can be undermined by undiagnosed and untreated psychiatric or physical disorders.
- For those intellectually disabled youth who sexually offend and are caught during their middle to late adolescent years, offence-specific services that exist are usually found in children's mental health services funded by the Ministry of Children and Youth Services. Treatment for these youth usually requires 2 to 4 years to complete and often continues as the individual passes out of adolescence into adulthood. This requires the transfer of services into an adult system where treatment has one funding source for mental health services (the Ministry of Health and Long-Term Care) and another for developmental services (the Ministry of Community and Social Services). Consequently, transitional aged youth who offend, face significant challenges with accessing service packages that integrate both mental health and developmental components to properly meet their needs.

This brief and incomplete survey of service delivery challenges for intellectually disabled sexual offenders in the Province of Ontario provides some explanation for the over-representation of cases brought before the IMPAC committee. From their first contact with investigators to their last session in treatment, these youth require levels of specialization and expertise that are difficult to find, even in ostensibly resource-rich urban centres. In essence, these youth represent the hardest to serve of all youth who have sexually offended, a population that is already underserved throughout the province. Failure to attend to the needs of these youth serves only to perpetuate the risk for recidivism, and robs these youth of appropriate opportunities to take responsibility for their behaviours and in so doing, become capable of experiencing healthy, pro-social intimacy.

Recommendations

The Inter-ministerial Provincial Advisory Committee (IMPAC), respectfully submits the following recommendations:

1. The Ministry of Children and Youth Services address the serious problem of adolescent sex offending by creating a network of dedicated treatment resources for adolescents who have offended sexually to ensure the safety of children in the care of youth justice, children's mental health, and child welfare and to promote the safety of the communities in which such settings are located.
2. A panel of experts with a provincial perspective should be convened to assist in the identification and implementation of Provincial standards and strategies. This group should review existing best-practice guidelines (such as those developed by the Association for the Treatment of Sexual Abusers²⁹) and the Provincial strategies and policies that already exist in Nova Scotia and British Columbia. This panel should recommend to the Government of Ontario a set of standards and mechanisms for their implementation and monitoring that would be workable in this province.
3. The Province of Ontario should strike an inter-ministerial task group comprised of representatives from The Ministry of Community and Social Services, the Ministry of Children's and Youth Services, the Ministry of Health and Long Term Care, the Ministry of Education and the Ministry of the Attorney General to review the assessment, treatment, custody/detention and residential needs and existing capacities of communities across the Province.
4. Lead agencies in each region should be identified and funded to provide comprehensive specialized assessment, treatment and residential services to youth with an intellectual disability and/or complex mental health needs. Wherever possible, these agencies should be those with proven leadership and expertise in this area. In the absence of an existing specialized program, service providers with expertise in either intellectual disabilities or sexual offence-specific treatment should be identified as resources to develop the necessary cross-disciplinary expertise.
5. Community panels made up of representatives of each of the constituent groups (e.g. child welfare, youth justice services, children's mental health, police, the courts, residential service providers, etc.) involved with the continuum of responses and services to these youth should be formed in each region. Building on the example of the *Continuum of Services for Adolescents Who Sexually Offend* in Toronto, these panels would coordinate and support the implementation of best-practice standards and provide training and consultation to those who intervene with these youth. These community panels should also coordinate with local service resolution mechanisms to ensure that complex service issues are addressed before they become larger jurisdictional matters.
6. The Ontario government should support a coordinated program of research to examine the efficacy of both community-based and residential treatment for adolescents who have sexually offended. This is particularly important given the fiscal cost of interventions and the current paucity of empirical knowledge regarding treatment outcome for this population. Further, a province-wide research project could provide the Ministry with critical information for program development and implementation regarding critical issues such as provincial incidence rates, risk assessment protocols, impact of sibling-incest family reunification, professional training, specialized assessment tools, and the implementation of best-practice guidelines.

June 2005

Appendix A – Terms of Reference

The Provincial Inter-ministerial Adolescent Sex Offender Committee is a broad based provincial committee composed of service providers from across the province and representatives from Ministry of Health, Ministry of Corrections and the Ministry of Community and Social Services (on a consultative basis). The Committee was initiated in 1997 by the Inter-Ministerial Provincial Advisory Committee (IMPAC) as a result of a significant number of complex cases, which were presented to the committee (IMPAC) over the past two years. Each of these cases raised a number of issues about resources, service standards, and most importantly, inter-ministerial collaboration and planning.

The purpose of the committee is as follows:

1. To review the range of adolescent sex offender services in Ontario. This would include:
 - a) A description of all of the services currently available (including an analysis of both dedicated services, and those where there is no direct funding for the offender services provided)
 - b) Regional gaps in service
 - c) Numbers of identified clients
2. To review and comment on the continuum of services across the province of Ontario. This would include:
 - a) Residential services for high-risk offenders
 - b) Regional gaps in services (i.e. access to appropriate assessment)
 - c) Services for developmentally disabled clients
 - d) Services for offenders who are aggressive and/or difficult to manage
3. To make recommendations on broad based issues of service delivery and public safety in relation to:
 - a) Inter-ministerial planning for transitional age clients and/or the dually diagnosed
 - b) How current practice and/or services could be brought in line with what is acknowledged as best practice. This would include standards for assessment and treatment, training programs, and standards for outside paid institutions who provide offender specific services
 - c) The role that research and ongoing evaluation have in the delivery of services

Appendix B – Summary of Cases

Adolescents Who Have Sexually Offended

Cases on Advocacy Office's Client data base 1997 – June 2004

Number of cases, per year, with at least one of the following attributes:

- Sexually Aggressive Behaviour
- Sexual Abuse – Offender
- Offender – Sexual Abuse of a Child
- Offender Sexual Abuse of a Peer

| Total | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 |
|------------|-----------|-----------|------------|-----------|-----------|-----------|-----------|------------|
| 524 | 40 | 57 | 100 | 90 | 93 | 68 | 54 | 22* |

(as of June 30, 2004)

Note: It has been suggested that the decline in numbers may be attributable to a growing sense of discouragement on the part of referring agencies in the absence of substantive resolution of identified problems.

Appendix C – Committee Members

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Appendix D – Fact Sheet

- In Ontario in 2002, there were 8,877 sexual assaults. This represents one reported sexual assault every hour of every day
- Individuals aged 13 through 17 are significantly more likely to be charged with a sexual offence compared to any other age group in Canada.³⁰
- Of the 524 cases involving sexual behaviour brought to the Advocacy Office from 1997 to June of 2004, 123 or 23.5% were developmentally disabled.

From the Youth Court Survey for 2003 (Canada).³¹

- 961 youth received a total of 2188 charges in Canada.
- Youth in Ontario accounted for almost half of this: 466 Ontario youth were charged with Sexual Assault with 1172 charges

As for other sexual offences:

- Ontario accounted for approximately half with 219 youths (48.3%) accumulating 650 other sexual offence charges (53.4%).
- In the general population, although only 3% of the population have an intellectual disability³², they represent as much as 15% of individuals who are convicted of sexual offences³³
- Up to 50% of incarcerated adults who commit sexual offences began committing sexual offences as adolescents.
- There are no province-wide standards for assessment. As a result, some high-risk adolescents receive little or no appropriate treatment, and some low-risk/low-need adolescents receive intensive and intrusive treatment.
- Some intervention techniques actually lead to increased risk of reoffense.³⁴
- The Joshua Coroner's Jury recommendation (2001) that "[t]he Ministry of Community and Social Services establish specialized residential services dedicated to addressing the complex needs of developmentally handicapped sex offending youth"³⁵.
- There is one agency in Toronto that provides specialized comprehensive services for intellectually disabled youth who have sexually offended, yet it receives no funding for this specialized service, and it is restricted to serving Toronto area youth only.
- There are several privately operated, non-specialized residential programs for this population, but what is missing is a funding mechanism to purchase the offence-specific services that some of these youth need.

- Current treatment approaches—including cognitive-behavioural, skills-based treatment and systemic approaches—lead to a significant reduction in re-offending for adults and adolescents who have offended sexually³⁶.
- The SAFE-T Program (Sexual Abuse: Family Education and Treatment), developed twenty years ago has research indicating a 72% reduction in re-offending over an average of 6 years.
- There are province-wide policies and funding in both Nova Scotia and British Columbia to address youth who offend sexually.
- Incarceration and punishment-based correctional approaches to offender treatment actually serve to increase recidivism rates.³⁷

Appendix E – Effectiveness of Treatment

There is not enough published research to conduct a meta-analysis for adolescents who have offended sexually.

There are about 22 published reports regarding treatment; however, only 4 use a comparison group.

As such, it is difficult to comment on the effectiveness of treatment that is specifically designed for adolescents who offend sexually.

Appendix F – Research

From the Addendum Report (Curwen 2005)

- 13 respondents (38%) reported collecting data for research purposes
 - of those 5 reported to The Network for Research on Crime and Justice (RCJ-Net) National Study
 - 8 collected internal data only for various purposes

The Network for Research on Crime and Justice (RCJ-Net) was at one time collecting data from a number of different programs but due to funding restrictions and changing priorities this research proposal stalled. Anecdotal data from the survey indicated that programs would participate in a research proposal if there were a provincial initiative to evaluate the effectiveness of the treatment of this population.

Research Studies

- 1) Published Recidivism Rates For Adolescents Who Have Offended Sexually
– Worling and Langstrom, in press
- 2) Treating Youth in Conflict with the Law: A New Meta-Analysis
- Department of Justice Canada, Youth Justice Research
- 3) First Report of the Collaborative Outcome Data Project on the Effectiveness of Psychological Treatment for Sex Offenders from Sexual Abuse: Journal of Research and Treatment, Vol.14, No.2, April 2002 –R. Karl Hanson, Arthur Gordon, Andrew J. R. Harris, Janice K. Marques, William Murphy, Vernon L. Quinsey, Michael C. Seto

Endnotes:

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- ¹ Worling, J. R., & Curwen, T. (2000). Adolescent sexual offender recidivism: Success of specialized treatment and implications for risk prediction. Child Abuse & Neglect, 24, 965-982.
 - ² WWW.ATSA.COM
 - ³ Sattler, J. M. (1988) Assessment of Children, 3rd ed. San Diego: Sattler Publishing. The authors note that 89 percent of those who are developmentally delayed fall within the mild range, with 6 percent in the moderate range, 3.5 percent in the severe range and 1.5 percent in the profound range. Biasini et al. report that while the rate is likely near 3%, some studies have suggested findings of percentages as low as 1.25%. There are an estimated 899,000 people in Canada with an identified intellectual disability [as cited in F. Owen and J. MacFarland (2002) "The Nature of Developmental Disabilities" in Griffiths, Stavrakaki and Summers (eds.) *Dual Diagnosis: An introduction to the mental health needs of people with developmental disabilities*. Sudbury: Habilitative Mental Health Resource Network.] or approximately 3% of the population of Canada. See also Biasini, F., Grupe, L, Huffman, L. and N. Bray, "Mental Retardation: A Symptom and a Syndrome," in S. Netherton, D. Holmes, & C. E. Walker, (Eds.). (1999) Comprehensive Textbook of Child and Adolescent Disorders. New York: Oxford University Press.
 - ⁴ O'Connor, W. (1997) "Towards an environmental perspective on intervention for problem sexual behaviour in people with an intellectual disability. *Journal of Applied Research in Intellectual Disabilities*, 10, 159-175.
 - ⁵ Day, 1993.
 - ⁶ Kendall-Tackett, K. A., Williams, L. M., & Finkelhor, D. (1993). Impact of sexual abuse on children: A review and synthesis of recent empirical studies. Psychological Bulletin, 113, 164-180.
 - ⁷ *ibid*.
 - ⁸ Statistics Canada. (2003). Sexual offences in Canada. Ottawa, Canada: Canadian Centre for Justice Statistics.
 - ⁹ Association for the Treatment of Sexual Abusers (ATSA), 2001. Practice standards and guidelines for members of the Association for the Treatment of Sexual Abusers. Beaverton, OR: Author.; Correctional Service of Canada (1996). Standards and guidelines for the provision of services to sex offenders. Ottawa, Canada: Author.;; National Offense-Specific Residential Standards Task Force (1999). Standards of care for youth in sex offense-specific residential programs. Holyoke, MA: NEARI Press.
 - ¹⁰ Worling, J. R., & Curwen, T., 2000.
 - ¹¹ Association for the Treatment of Sexual Abusers (ATSA), 2001.
 - ¹² Burton, D.L., & Smith-Darden, J. (2001). North American Survey of Sexual Abuser Treatment and Models: Summary Data 2000. Brandon, VT: Safer Society Press.
 - ¹³ The term "intellectual disability" is used herein rather than terms which have some currency, such as "developmental handicap" and "developmental delay." These terms are usually favoured over the formal diagnosis of "mental retardation" as set out in the DSM IV-TR. This diagnosis is given to individuals whose IQ is lower than 70 who experience significant impairment in adaptive functioning and whose conditions has onset before 18 years of age. This diagnostic category is further subdivided into mild, moderate and severe or profound mental retardation. More recently, the term Intellectual Disability has achieved currency as a more specific way of denoting that an individual has a disability that impacts their functional and learning capacities.
 - ¹⁴ Sibbald, B., Canadian Medical Association Journal, April 2, 2002; 166(7)
 - ¹⁵ Recommendation #10, Verdict of Coroner's Jury, 2001.
 - ¹⁶ Sattler, J. M. (1988) Assessment of Children, 3rd ed. San Diego: Sattler Publishing. The authors note that 89 percent of those who are developmentally delayed fall within the mild range, with 6 percent in the moderate range, 3.5 percent in the severe range and 1.5 percent in the profound range. Biasini et al. report that while the rate is likely near 3%, some studies have suggested findings of percentages as low as 1.25%. There are an estimated 899,000 people in Canada with an identified intellectual disability [as cited in F. Owen and J. MacFarland (2002) "The Nature of Developmental Disabilities" in Griffiths, Stavrakaki and Summers (eds.) *Dual Diagnosis: An introduction to the mental health needs of people with developmental disabilities*. Sudbury: Habilitative Mental Health Resource Network.] or approximately 3% of the population of Canada. See also Biasini, F., Grupe, L, Huffman, L. and N. Bray, "Mental Retardation: A Symptom and a Syndrome," in S. Netherton, D. Holmes, & C. E. Walker, (Eds.). (1999) Comprehensive Textbook of Child and Adolescent Disorders. New York: Oxford University Press.
 - ¹⁷ O'Connor, W. (1997) "Towards an environmental perspective on intervention for problem sexual behaviour in people with an intellectual disability. *Journal of Applied Research in Intellectual Disabilities*, 10, 159-175.
 - ¹⁸ Tudiver, J., Broekstra, S., Josselyn, S., Barbaree, H. (1997) Addressing the Needs of Developmentally Delayed Sex Offenders: A Guide. Health Canada. See also Perske, R. (1991) Unequal Justice?: What can happen when persons with retardation or other developmental disabilities encounter the criminal justice system. Nashville: Abingdon Press.
 - ¹⁹ "The Continuum" is a collaborative organization that was formed in the mid-1990's to coordinate, research and enhance the full range of services to youth in the Greater Toronto Area who have sexually offended.
 - ²⁰ Griffiths, D., Hingsburger, D., Christian, R. (1985) "Treating Developmentally Handicapped Sexual Offenders: The York Behaviour Management Services Treatment Program" in *Psychiatric Aspects of Mental Retardation Reviews*, 4, 49-53.
 - ²¹ Gilby, et al., 1989.
 - ²² Wilcox, D. T. "Treatment of intellectually disabled individuals who have committed sexual offences: a review of the literature." *Journal of Sexual Aggression*. (March 2004), Vol. 10, No. 1, p.89.
 - ²³ Hingsburger, D and Susan Tough, "Healthy Sexuality: Attitudes, Systems, and Policies. *Research and Practice for Persons with Severe Disabilities*, 2002, Vol. 27, No. 1, 8-17.
 - ²⁴ Sobsey, D. & Doe, T. (1991) "Patterns of Sexual Abuse and Assault" in Sexuality and Disability, 9 (3), 243-259.
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- ²⁵ Day, K. (1994) Male mentally handicapped sex offenders. *British Journal of Psychiatry*, 165, 630-639.
- ²⁶ McAfee, J.K. and Gural, M. (1988) "Individuals with mental retardation and the criminal justice system." as cited in Griffiths, Stavrakaki and Summers (eds.) *Dual Diagnosis: An introduction to the mental health needs of people with developmental disabilities*. Sudbury: Habilitative Mental Health Resource Network. See p. 393.
- ²⁷ Wilcox, Daniel T. "Treatment of intellectually disabled individuals who have committed sexual offences: a review of the literature. *Journal of Sexual Aggression*. (March 2004), Vol. 10, No. 1, p.89.
- ²⁸ Worling suggests that treatment with non-disabled youth typically takes 12 to 24 months [see: Worling, J. R. (1998) "Adolescent Sexual Offender Treatment at the SAFE-T Program" in Marshal et al. (eds.) Sourcebook of Treatment Programs for Sexual Offenders. New York: Plenum Press.] In our experience, work with intellectually disabled youth who have sexually offended generally takes twice as long.
- ²⁹ WWW.ATSA.COM
- ³⁰ *ibid*.
- ³¹ Statistics Canada. (2003). Sexual offences in Canada. Ottawa, Canada: Canadian Centre for Justice Statistics.
- ³² Sattler, J. M. (1988) Assessment of Children, 3rd ed. San Diego: Sattler Publishing. The authors note that 89 percent of those who are developmentally delayed fall within the mild range, with 6 percent in the moderate range, 3.5 percent in the severe range and 1.5 percent in the profound range. Biasini et al. report that while the rate is likely near 3%, some studies have suggested findings of percentages as low as 1.25%. There are an estimated 899,000 people in Canada with an identified intellectual disability [as cited in F. Owen and J. MacFarland (2002) "The Nature of Developmental Disabilities" in Griffiths, Stavrakaki and Summers (eds.) *Dual Diagnosis: An introduction to the mental health needs of people with developmental disabilities*. Sudbury: Habilitative Mental Health Resource Network.] or approximately 3% of the population of Canada. See also Biasini, F., Grupe, L, Huffman, L. and N. Bray, "Mental Retardation: A Symptom and a Syndrome," in S. Netherton, D. Holmes, & C. E. Walker, (Eds.). (1999) Comprehensive Textbook of Child and Adolescent Disorders. New York: Oxford University Press.
- ³³ O'Connor, W. (1997) "Towards an environmental perspective on intervention for problem sexual behaviour in people with an intellectual disability. *Journal of Applied Research in Intellectual Disabilities*, 10, 159-175.
- ³⁴ Association for the Treatment of Sexual Abusers (ATSA), 2001.
- ³⁵ Recommendation #10, Joshua Inquest Verdict of Coroner's Jury, 2001.
- ³⁶ Hanson, R. K., Gordon, A., Harris, A. J. R., Marques, J. K., Murphy, W., Quinsey, V. L., & Seto, M. C. (2002). First report of the Collaborative Outcome Data Project on the effectiveness of psychological treatment for sex offenders. Sexual Abuse: A Journal of Research & Treatment, 14, 169-194.
- ³⁷ Dowden & Andrews (2000). The effects of community sanctions and incarceration on recidivism. *Forum on Corrections Research*, 12 (2), 10-13.
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Background

In December 2004 the Inter-Ministerial Provincial Advisory Committee (IMPAC) submitted a briefing outlining the provincial needs and deficits related to the assessment and treatment of sexually offending adolescents in Ontario. Following the briefing submission, funding was attained from The Children's Hospital of Eastern Ontario to provide detailed information on the *current* functioning of treatment programs for sexually offending adolescents.

This addendum to the IMPAC briefing was designed to update the existing information and to provide an overview of the current state of adolescent sexual offender programs in Ontario.

Provincial Treatment Providers Survey

A brief telephone survey was conducted to investigate the functioning of existing programs. The survey questions were designed specifically for this project and two research assistants contacted provincial programs to obtain the desired information. [Thus, these results are based on self-reports from 1 staff member at each program.](#) A total of 60 programs were contacted and information was collected from 51 (85%). Of those providing information, 17 (33%) indicated that they do not currently work with sexually offending adolescents. Of the 17 not providing services, 5 (29%) indicated that they needed to discontinue these programs due to funding issues ($n=3$), a lack of referrals ($n=1$), and a lack of resources ($n=1$). It should be noted that a number of respondents ($n=3$) indicated that they are attempting to procure funding to provide services to sexually offending adolescents. In addition, 3 (2%) individuals noted that, although they do receive referrals, they do not provide the services themselves and, instead, contract the work out to others. Therefore, information from this survey was collected from 34 adolescent sexual offender treatment programs that provide assessment and/or treatment to sexually offending adolescents in Ontario.

The information obtained from the survey is presented in appendices A and B. For the purposes of this report, information was provided separately based on level of functioning: those providing services to "average" intelligence youth ($n=30$) and developmentally delayed (DD) youth ($n=9$). It should be noted that 5 (14.7%) respondents indicated that they provide services to both intellectual groups and, of those, 1 (20%) indicated that they do not provide separate sex offender treatment programs based on intellectual functioning.

Results

[Participating programs were located across the province \(see Appendix C for locations\).](#) [Respondents reported that their programs provided services to urban \(47.1%\), rural \(17.6%\), and both rural and urban clients \(35.3%\).](#) [Many \(68%\) respondents noted travel for clients and staff as a major issue in providing services.](#)

Funding

Respondents reported various funding sources. Overall, 91% reported that they do not receive dedicated funds to provide services to sexually offending adolescent. Of these, 14.7% ($n=5$) reported that they do not receive any funding to work with this population, 64.7% ($n=22$) reported receiving per-diem funds or general funds that they then direct towards services for sexually offending adolescents, and 11.7% ($n=4$) indicated borrowing funds from other programs to sustain their services for adolescent sexual offenders.

With respect to those providing services to average intelligence youth, 60% of respondents indicated that they do not use the Association for the Treatment of Sexual Abusers (ATSA) best practice guidelines in their work with sexually offending adolescents. However, 33% did indicate using “other” guidelines, which included social work and self-developed guidelines. Similarly, in the DD programs, 66% reported that they do not use ATSA best practice guidelines.

In both populations, respondents indicated that staff is trained to work with sexually offending adolescents and this training included workshops (67.6%), consultations (44%), and conferences (73.5%). Of those who indicated that staff attend conferences, 5 (20%) reported attending conferences provided through ATSA, 2 (8%) reported attending the RCJ-Net and Continuum for Adolescent Sexual Offenders conferences, 1 (4%) indicated attending the National Adolescent Sexual Offender conferences, and 1(4%) program’s staff reportedly attended a 3-day certification training provided by the provincial police. It is important to note that many respondents (64%) did not describe the type of conferences attended and, therefore, it is possible that these were not specific to sexually offending youth. Many respondents noted that there is a lack of funding for training and, thus, much of their training is received from peers and is conducted in-house. Of those who noted receiving consultations, these were reportedly provided by psychologists* ($n=7$) and unspecified clinical forensic psychologists ($n=2$); however, the remaining 40% did not specify who provided consultation. Sexual offender specific supervision occurs in most of the programs (97%) with many respondents indicating that supervision occurs on a weekly to monthly basis, either between peers or with a supervisor. Again, it is important to note that trained sexual offender service providers may provide the supervision being received.

Many respondents noted the lack of resources and training opportunities specific to adolescent sexual offenders. Many also reported a deficit of psychological and psychiatric expertise, experts and consultants as well as a lack of research and educational programs geared towards working with this population. Moreover, when training opportunities are available, respondents indicated that they do not have the funding or resources to attend.

Respondents were questioned as to whether they utilized Cognitive-Behavioural Treatment (CBT) with their clients. A total of 28 (93%) of those working with the average intelligence group and 7 (78%) of those working with the DD group reported using CBT. Other sex offense specific work reportedly included Relapse Prevention (79.4%), Offense Chain (73.5%), Empathy Training (70.6%), Aversion Therapy (11.8%), and Plethysomography (8.8%). It should be noted that other treatment methods such as Narrative, play, and art therapy are also reportedly utilized to provide sex offense specific treatment.

A total of 13 (38%) respondents indicated that they provide residential placement for sexually offending adolescents and all respondents indicated that these youth do not share a bedroom with other residents. Of those providing residential care, 3 (23%) reported that they provide residential services to both average and DD sexually offending adolescents and 8 (61.5%) reported that they also provide residential placement to adolescents who have not sexually offended.

A total of 13 (38%) respondents indicated collecting data for research purposes: 3 (15%) of these programs were dedicated to DD youth and 7 (54%) provided services to average intelligence adolescents only. Of these, 5 (38%) reported that they provide data to the RCJ-Net National Study and this was the extent of the data collection for 4 respondents. One respondent indicated that they collect data for the RCJ-Net National Study and also collect minimal internal data and another 8 (61%) programs reportedly collect internal data only. For those collecting data internally, various sources of data collection were reported including: psychometrics, demographics, interviews, and medication information; one respondent indicated that even though they collect the information, they do not have the resources to analyze the data. One respondent reported that recidivism data is collected; however, they do not separate results for adolescents and adults and they do not compare recidivism rates of youth who attended their programs to those who attended other programs.

There is only one known Canadian study investigating the success of an adolescent sex offender treatment program; this is the only known study to examine recidivism rates for treated and comparison groups in Ontario. Therefore, it is impossible to know whether the vast majority of treatment programs for sexually offending adolescents in Ontario have successfully aided in reducing sexual recidivism.

Aboriginal Services

Over half of those working with average intelligence ($n=19$, 63%) and less than half of those working with DD ($n=3$, 33%) youth indicated providing services to Aboriginal adolescents who have sexually offended. Four respondents indicated that 25% ($n=1$), 50% ($n=1$), 75% ($n=1$), and 100% ($n=1$) of their clients are Aboriginal. The remaining respondents ($n=13$) indicated that Aboriginal clients ranged from 1-10% ($M=3.7%$) of their total adolescent sexual offending population. For DD youth specifically, respondents indicated that an average of 1.5% of all youth were Aboriginal.

Those working with Aboriginal youth reported a number of difficulties that they have encountered. For example, they listed travel and distance issues, cultural and spirituality differences, difficulties coordinating services within and outside the Aboriginal community, difficulties integrating and using traditional practices, substance abuse issues, and difficulties accessing resources/programming or schooling to support sexual behaviour treatment efforts. One individual also reported concern with Aboriginal clients being either too connected or disconnected from their communities, which makes treatment difficult. Psychometric and Risk assessment tools are not culturally sensitive and need to be revised. Refer to appendix D for a full list of concerns and recommendations reported by treatment providers working with sexually offending Aboriginal youth.

A brief review of treatment programs and resources for Aboriginal youth resulted in little information on how to integrate Western and Aboriginal treatment resources. Moreover, no specific resources for integrating Aboriginal and Western treatments for sexually offending adolescents were uncovered. This is not to say that these documents do not exist, they simply were not discovered during the completion of this paper. Thus, a thorough review of the literature on Aboriginal treatment for sexual offending adolescents is warranted. On the other hand, a number of documents regarding the role of Aboriginal culture in adult sex offender treatment have been produced along with a number of institutional and community programs for Aboriginal sex offenders (see Appendix E for a reference list). Much of the work on Aboriginal offenders has been done in the Prairie Provinces and British Columbia. Programs working with Aboriginal sexually offending adolescents would benefit from having access to resources to assist with integrating Aboriginal culture, spirituality, and treatment with best practices guidelines for adolescent sexual offender treatment. This may be accomplished through communication with, and mentoring from, Aboriginal treatment programs.

Existing Dedicated Funding Models

The Ministry of Health in Nova Scotia and the Ministry of Children and Family Development in British Columbia have initiatives in place to provide dedicated funding for assessment and treatment of sexually offending adolescents in their provinces. In British Columbia, the province funds a forensic team that provides all assessments and treatment for youth who have been charged with a sexual offence. Furthermore, the BC Ministry funds 3 residential treatment centres in the province. In Nova Scotia, the Ministry funds a specialized team that provides assessments and treatment to youth who acknowledge their offense or who have been found guilty of a sexual offense. In addition, this specialized team provides training to those social workers that support the youth.

Appendix A: Services for average functioning sexually offending adolescents in Ontario

Table 1: Treatment services for average functioning adolescent sexual offender ($n=30$)

| Areas of Evaluation | <i>n</i> | <i>% of total sample</i> | <i>% of all providing</i> |
|----------------------------------------------------------|-----------------|---------------------------------|----------------------------------|
| Primary Funding | | | |
| Dedicated | 3 | 10.0 | |
| General | 18 | 60.0 | |
| Borrow from other program | 5 | 16.7 | |
| No funding | 4 | 13.3 | |
| Population served | | | |
| Males | 30 | 100 | |
| Females | 17 | 56.6 | |
| Work with Aboriginal youth | 20 | 66.6 | |
| Charges not necessary | 24 | 80.0 | |
| Charges are required | 6 | 20.0 | |
| Referral sources | | | |
| Probation | 25 | 83.3 | |
| Private Practitioners | 7 | 23.3 | |
| Child Welfare | 20 | 66.6 | |
| Mental Health agencies | 10 | 33.3 | |
| Self/family | 13 | 43.3 | |
| School | 3 | 10.0 | |
| Lawyers | 6 | 20.0 | |
| Courts | 7 | 23.3 | |
| Police | 3 | 10.0 | |
| Other ^a | 7 | 23.3 | |
| Staff | | | |
| Bachelor's degree | 15 | 50.0 | |
| Master's degree (M.A, MSW) | 20 | 66.6 | |
| Child Care worker | 7 | 23.3 | |
| Doctoral Degree | 10 | 33.3 | |
| Medical Degree | 2 | 6.7 | |
| Other ^b | 4 | 13.3 | |
| Sex offender specific training | 30 | 100 | |
| Sex offender specific supervision | 29 | 96.7 | |
| Guidelines | | | |
| No guidelines | 8 | 26.7 | |
| Association for the Treatment of Sexual Offenders (ATSA) | 12 | 40.0 | 54.5 |
| Other ^c | 10 | 33.3 | 45.5 |
| Residential Program | | | |

| | | | |
|----------------------------------------------------------|----|------|-------|
| Provide residential placement | 12 | 40.0 | |
| Sex offenders share a room | 0 | 0 | 0 |
| Treatment Modality | | | |
| Sex offense specific | 28 | 93.3 | |
| Individual | 26 | 86.7 | 92.8 |
| Group | 17 | 56.7 | 60.7 |
| Family | 21 | 70.0 | 75.0 |
| Other ^d | 4 | 13.3 | 14.2 |
| Sex Offense Specific Treatment Approach | | | |
| Cognitive-Behavioural | 28 | 93.3 | 100.0 |
| Offense Chain | 23 | 76.7 | 82.1 |
| Plethysmography | 3 | 10.0 | 10.7 |
| Relapse Prevention | 24 | 80.0 | 85.7 |
| Empathy training | 22 | 73.3 | 78.6 |
| Aversion therapy | 4 | 13.3 | 14.3 |
| Other ^d | 8 | 26.7 | 25.6 |
| Generic Treatment | 22 | 73.3 | |
| Assessment* | | | |
| Prior to treatment | 24 | 80.0 | |
| Individual interview | 24 | 80.0 | 100 |
| Family interview | 21 | 70.0 | 87.5 |
| Psychometric testing | 14 | 46.7 | 58.3 |
| File review | 20 | 66.7 | 83.3 |
| Community resources | 16 | 53.3 | 66.7 |
| Other ^e | 4 | 13.3 | 16.7 |
| Offense specific | 12 | 40.0 | 50.0 |
| Generic | 3 | 10.0 | 12.5 |
| Offense specific and generic | 9 | 30.0 | 37.5 |
| Prior to adjudication | 6 | 20.0 | 25.0 |
| Risk Assessment* | | | |
| Conduct risk | 19 | 63.3 | |
| Pre-treatment | 3 | 10.0 | 15.8 |
| Post-treatment | 13 | 43.3 | 68.4 |
| Preadjudication | 1 | 3.3 | 5.2 |
| Concurrent with treatment | 3 | 10.0 | 15.8 |
| As part of assessment | 4 | 13.3 | 21.0 |
| Other ^f | 3 | 10.0 | 15.8 |
| Risk assessment tool* | | | |
| Estimate of Risk of Adolescent Sexual Offense Recidivism | 17 | 56.7 | 89.5 |
| Youth Level of Service Inventory | 2 | 6.7 | 10.5 |
| Other ^g | 7 | 23.3 | 36.8 |
| Research | | | |
| Collect research data | 10 | 33.3 | |

* Indicates areas where multiple responses from one respondent were provided

^a other referral sources included: youth diversion programs, Aboriginal bands, Detention facilities, medical doctors, hospitals, child advocates

^b other staff members included education backgrounds or professional training in: developmental service worker, art therapist, play therapists, expressionist therapists, recreation, law and security (n=1)

^c other guidelines included: self-developed guidelines (n=3), social work guidelines, National Adolescent Perpetrator Network, unknown which guidelines consulting psychologist uses

^d other therapeutic approaches included: narrative (n=4), art (n=2), play therapy, Pathways program, traditional Aboriginal approaches, dyadic and triadic work, systems, family therapy (n=2), therapeutic camp, parent support group

^e other methods to assess youth or types of assessment information collected included: psycho-social information,

victim/family interviews, academic information, blood work

note: 1 program does not complete psychological testing on “higher risk” youth as they indicated that this these youth will not complete the questionnaires, one program receives the referral after a community agencies completes the assessment, one program does not conduct assessments but utilizes information provided by probation

^f other times that risk assessments are completed included: every 6-months, after 1-year, as needed

^g other risk assessment tools being utilized included: Adapted Ross and Loss, Clinical model/ clinical judgment based on experience, Youth Management Assessment, JSOAP

note: one respondents indicated that a consulting psychologists assess risk; however, they did not know whether this included a specific risk assessment tool

^h 5 reported that they contributed to the RCJ-Net National Study and 9 reported collecting data for internal purposes

Table 2: Program details for average functioning sexually offending adolescents (n=30)

| Descriptives | <i>n</i> | <i>M</i> | <i>Range</i> |
|-----------------------------------------------------------------|-----------------|-----------------|---------------------|
| Length of time the program has been operating (months) | 28 | 147.82 | 5-30 |
| Number of staff | 27 | 6.47 | 1-24 |
| Number off full time staff | 27 | 4.12 | 0-18 |
| Experience working with sexually offending adolescents (months) | 25 | 118.24 | 36-240 |
| Duration of Treatment program (months) | 27 | 16.68 | 2.50-24 |

Appendix B: Services for developmentally delayed sexually offending adolescents in Ontario

Table 3: Treatment services for developmentally delayed sexually offending adolescents (n=9)

| Areas of Evaluation | n | % of total sample | % of all providing |
|----------------------------------------------------------|---|-------------------|--------------------|
| Funding source | | | |
| Dedicated | 0 | 0 | |
| General Funding | 8 | 88.9 | |
| No funding | 1 | 11.1 | |
| Population served | | | |
| Males | 9 | 100 | |
| Females | 8 | 88.9 | |
| Provide residential | 5 | 55.6 | |
| Work with Aboriginal youth | 3 | 33.3 | |
| Charges not necessary | 8 | 88.9 | |
| Charges pending | 1 | 11.1 | |
| Referral sources | | | |
| Probation | 7 | 77.8 | |
| Private Practitioners | 1 | 11.1 | |
| Child Welfare | 5 | 55.6 | |
| Mental Health agencies | 5 | 55.6 | |
| Self/family | 6 | 66.7 | |
| School | 4 | 44.4 | |
| Lawyers | 2 | 18.0 | |
| Courts | 2 | 18.0 | |
| Police | 2 | 18.0 | |
| Other (hospitals, doctors) | 2 | 18.0 | |
| Staff | | | |
| Bachelor's degree | 4 | 44.4 | |
| Master's degree (M.A, MSW) | 9 | 100 | |
| Child Care worker | 2 | 22.2 | |
| Doctoral Degree | 4 | 44.4 | |
| Medical Degree | 0 | 0 | |
| Other (journalism & law) | 1 | 11.1 | |
| Sex offender specific training | 9 | 100 | |
| Sex offender specific supervision | 9 | 100 | |
| Guidelines | | | |
| No guidelines | 5 | 55.5 | |
| Association for the Treatment of Sexual Offenders (ATSA) | 2 | 22.2 | |
| Other ^a | 2 | 22.2 | |

| | | | |
|----------------------------------------------------------|---|------|------|
| Residential Program | | | |
| Provide residential placement | 4 | 44.4 | |
| Sex offenders share a room | 0 | 0 | 0 |
| Treatment Modality | | | |
| Sex offense specific | 7 | 66.7 | |
| Individual | 6 | 66.7 | 85.7 |
| Group | 7 | 77.8 | 100 |
| Family | 6 | 66.7 | 85.7 |
| Parent support group | 1 | 11.1 | 14.3 |
| Sex Offense Specific Treatment Approach | | | |
| Cognitive-Behavioural | 7 | 77.8 | 100 |
| Offense Chain | 5 | 55.6 | 71.4 |
| Plethysmography | 0 | 0 | 0 |
| Relapse Prevention | 6 | 66.7 | 85.7 |
| Empathy training | 5 | 55.6 | 71.4 |
| Aversion therapy | 0 | 0 | 0 |
| Other ^b | 2 | 22.2 | 28.6 |
| Generic Treatment | 5 | 55.6 | |
| Assessment* | | | |
| Prior to treatment | 9 | 100 | |
| Individual interview | 9 | 100 | 100 |
| Family interview | 8 | 88.9 | 88.9 |
| Psychometric testing | 6 | 66.7 | 66.7 |
| File review | 8 | 88.9 | 88.9 |
| Community resources | 7 | 77.8 | 77.8 |
| Offense specific only | 2 | 22.2 | 22.2 |
| Generic only | 2 | 22.2 | 22.2 |
| Offense specific and generic | 5 | 55.6 | 55.6 |
| Prior to adjudication | 6 | 66.7 | 66.7 |
| Risk Assessment* | | | |
| Conduct risk assessment | 6 | 66.7 | |
| Post-treatment | 3 | 33.3 | 50.0 |
| Preadjudication | 1 | 11.1 | 16.7 |
| Concurrent with treatment | 1 | 11.1 | 16.7 |
| As part of or completion of assessment | 4 | 44.4 | 66.7 |
| Risk assessment tool* | | | |
| Estimate of Risk of Adolescent Sexual Offense Recidivism | 5 | 55.5 | 83.3 |
| Youth Level of Service Inventory | 1 | 11.1 | 16.7 |
| Other ^c | 3 | 33.3 | 50.0 |
| Research | | | |
| Collect research data ^d | 5 | 55.6 | |

* Indicates areas where multiple responses from one respondent were provided

^a one program follows social work guidelines and the other program has developed their own guidelines

^b narrative

^c risk assessment is specific to child welfare, adapted tool which is a combination of multiple things, note: multiple individuals indicated using various psychological measures including the Youth Self-report, Adolescent Psychopathology Scale, etc

^d two respondents indicated that this research is for their own purposes and three reported that they contributed to the RCJ-Net National Study

Table 4: Special programming for developmentally delayed sexually offending adolescents ($n=7$)

| Areas of Evaluation | <i>n</i> | % of total sample | % of those providing |
|-----------------------------------------------------------------|----------|-------------------|----------------------|
| Assessments | | | |
| Screened for psychopathology | 5 | 71.4 | |
| Cognitive/psychiatric diagnosis established prior to assessment | 5 | 71.4 | |
| Supported by visual cues | 6* | 85.7 | 100 |
| Modified to learning capacities | 6* | 85.7 | 100 |
| Includes sexual abuse history | 6* | 85.7 | 100 |
| Treatment | | | |
| Supported by professionals experience with DD | 6 | 85.7 | |
| Level of functioning diagnosed prior to treatment | 6 | 85.7 | |
| Modified treatment | 7 | 100 | |
| DD and nonDD are treated separately | 6 | 85.7 | |
| Treatment is based on relapse prevention best practice | 4 | 57.1 | |
| Communication between treatment provider and supports | 7 | 100 | |
| Sexual abuse history is included in treatment | 6 | 85.7 | |
| Removed from contact with victim | 4 | 57.1 | |
| Follow reporting protocols | 7 | 100 | |

Table 5: Program details for developmentally delayed sexually offending adolescents ($n=9$)

| Descriptives | <i>n</i> | <i>M</i> | <i>Range</i> |
|-----------------------------------------------------------------|----------|----------|--------------|
| Length of time the program has been operating (months) | 8 | 206.25 | 60-360 |
| Number of staff | 8 | 6.72 | 3-24 |
| Number off full time staff | 8 | 3.77 | 0-9 |
| Experience working with sexually offending adolescents (months) | 5 | 103.20 | 60-204 |
| Duration of Treatment program (months) | 7 | 33.86 | 15-84 |

Appendix C: City of Service Provider and areas serviced

| Location of Program City | Location of Clients Serviced | | |
|-----------------------------------|------------------------------|-----------|---------------|
| | Rural | Urban | Rural & Urban |
| Bracebridge | X | | |
| Chatham | | X | |
| Consecon | | | X |
| Clinton | | | X |
| Durham | | X | |
| Etobicoke | | X | |
| Hamilton | | X | |
| Fort Francis | X | | |
| Kapuskasing | X | | |
| Kenora | X | | |
| Kenora | X | | |
| Kingston | | X | |
| Kingston | | | X |
| Kitchener | | | X |
| London | | X | |
| London | | X | |
| London | | X | |
| Midland | | | X |
| Mississagua | | | X |
| Napean | | | X |
| North York | | X | |
| Oakville | | | X |
| Oshawa | | X | |
| Ottawa | | X | |
| Parry Sound | X | | |
| Peterborough | | | X |
| Sault St. Marie | | | X |
| Toronto | | X | |
| Toronto | | X | |
| Toronto | | X | |
| Waterloo | | X | |
| Welland | | | X |
| Woodstock | | | X |
| York | | X | |
| Total Serviced by location | 6 | 16 | 12 |

Appendix D: Unique considerations and concerns when working with Aboriginal youth who have committed sexual offenses

Difficulties experienced to date

Resources

- Difficult to access resources/programming or schooling to support efforts
- Hard to find right services within native community to support program

Other Issues

- High substance abuse/Solvent/drug abuse
- Fetal Alcohol Syndrome children
- Sexual abuse is normalized behaviours

Transportation issues

- Some families live in fly-in communities and have been placed by Child Welfare
- Isolation of communities

Cultural Issues

- Cultural denial
- Native spiritual awareness
- Difficult to accommodate spiritual element of culture
- Difficulties integrating and using traditional practices – not using medication
- Want traditional evaluations and assessments
- Do not have native workers in every office
- Would go to their own friendship centres

Family

- Parents have own problems and can't support child
- Tough to keep parents involved
- Want crisis support and not long-term treatment
- Either native clients are too connected or disconnected – difficult to coordinate

Suggestions for working with Aboriginal youth

- Provide culturally sensitive services
- Attempt to coordinate with Aboriginal programs in the community

Appendix E: Resources for working with Aboriginal youth who have committed sexual offenses

Tips for working with Aboriginal peoples for nonAboriginal medical providers

<http://tribal-institute.org/download/Working%20in%20Aboriginal%20Communities%202003.pdf>

Forensic interviewing techniques

<http://www.tribal-institute.org/download/Guidelines%20for%20the%20Forensic%20Interview.pdf>

Alaska - Aboriginal sexual offender recidivism study

http://justice.uaa.alaska.edu/forum/13/2summer1996/d_sexoff.html
<http://justice.uaa.alaska.edu/research/1990/9419sotp/9602sotp.html>

Correctional Services of Canada - statistics

http://www.csc-scc.gc.ca/text/rsrch/briefs/b16/b16e02_e.shtml

The Cultural Practices Of Aboriginal American Sex Offenders In Sex Offender Treatment - A Pilot Study, Jan Dickson, College of St. Scholastica – master’s thesis

Aboriginal sex offender treatment program - adults

http://www.lumiereboreale.qc.ca/wmfichiers/some_programm_and_services.pdf

Canadian programs for aboriginal offenders

http://www.csc-scc.gc.ca/text/pblct/forum/e121/e121n_e.shtml

- most aboriginal treatment-specific programs are in the Prairies and are for adults
- Yukon has Youth Sex Offender treatment program with community and institutional treatment for Aboriginal and nonAboriginal youth
- BC has youth program serving Aboriginal and nonAboriginal youth – Boulder Bay Youth Program
- NFLD has an Aboriginal Specific Program (Labrador Correctional Centre)

Hylton, J. (2002). Aboriginal Sexual Offending in Canada – prepared for the Aboriginal Healing Foundation. Aboriginal healing Foundation, research series

http://www.ahf.ca/newsite/english/pdf/ab_sex_offend.pdf

- how to work with aboriginal sexual offenders – 234 pgs

Ellerby, L. A., & Ellerby, J. H. (1998). Understanding and evaluating the role of elders in traditional healing in sex offender treatment for aboriginal offenders. Correctional Services Canada

<http://web.uvic.ca/ablo/documents/ELDERSEXOFFENDERMARCH98.pdf>

- Interviews with CSC staff working in penitentiaries and parole across the Prairie Region (Manitoba, Saskatchewan, Alberta) and Aboriginal Elders, Qualitative study

Resource list for victims and offenders from Aboriginal communities/backgrounds
http://www.lumiereboreale.qc.ca/wmfichiers/A_FEW_INFORMATION_GUIDES_METHODS_AND_INTERVENTION_TOOLS-ok.pdf