

**TREATMENT PROGRAM FOR SEXUAL OFFENDERS AND THOSE AT RISK OF
OFFENDING SEXUALLY: A PROGRAM PROPOSAL**

Sponsored by the Cornwall Public Inquiry

From the Cornwall Community Hospital Assault and Sexual Abuse Program

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Dear Commissioner Glaude,

On October 1st, we began to look at current services offered for sex offenders and individuals with deviant sexual behaviours in order to make a recommendation of a local service for this clientele.

Our mandate was to review existing services being offered, up-to-date research on treatment options, treatment programs available and consultations with local professionals in the field. Barriers to individuals wanting treatment but scared of the criminal repercussions if they disclosed their criminal behaviours were also considered.

The Cornwall Community Hospital Assault and Sexual Abuse Program is pleased to submit its report *Services for Sexual Offenders and Individuals at Risk of Offending Sexually in Cornwall and the United Counties of Stormont, Dundas and Glengarry*. This report will offer recommendations to prevent and address sexual offenses.

Consultations with various community partners have repeatedly expressed a need for a local service. We have also heard of barriers and challenges faced when accessing services in Ottawa, mainly due to transportation issues.

We believe that by servicing at-risk individuals as well as clients with sexually abusive histories with education, treatment and community support, we can reduce recidivism and in consequence, reduce the number of victims. This would mean being proactive instead of reactive to these types of situations; ultimately it could mean saving victims and lives.

We wish to recognize the outstanding contributions made by all of the participants in the consultation process. We greatly appreciated the candid conversations and feedback from all participants. We would like to thank the Cornwall Public Inquiry for sponsoring and supporting this project.

We are confident that these recommendations will contribute towards ensuring a positive and safe community by preventing further victimization.

Respectfully,

Angèle Lynch
Project Lead

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GLOSSARY

Sex offender

A person who has been convicted of a sexual offence or who has been found not criminally responsible of a sexual offence on account of a mental disorder

Sex offence

Sexual interference; invitation to sexual touching; sexual exploitation; incest; bestiality; child pornography; parent or guardian procuring sexual activity; exposure; sexual assault; sexual assault with a weapon; threats to a third party or causing bodily harm; and aggravated sexual assault.

Paraphilia

Recurrent, intense sexually arousing fantasies, sexual urges, or behaviours generally involving 1) nonhuman objects, 2) the suffering or humiliation of oneself or one's partner, or 3) children or other nonconsenting persons that occur over a period of at least 6 months. For some, these fantasies or behaviours are necessary to be aroused, whereas others can become aroused without paraphilic fantasies or behaviours (American Psychiatry Association, 2000:566).

Pedophile

Pedophilia is a form of paraphilia. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving sexual activity with a prepubescent child or children (generally age 13 years or younger). The person has acted on these sexual urges, or the sexual urges or fantasies cause marked distress or interpersonal difficulty. The person is at least age 16 years and at least 5 years older than the child or children.

EXECUTIVE SUMMARY

Sexual assault is a world-wide health problem because of its massive number of victims and the extent of the ongoing damage to the victims' health. In order to fight this epidemic we need to focus on the cause; perpetrators. It is well researched and documented that diagnosis followed by effective therapy can help prevent further victims.

In contemporary society the sex offender is the most vilified offender. We are repulsed by their actions and consequently we fear them. As a result, we dehumanize them and attempt to banish them from our society. Once charged for their horrendous crimes, we seek maximum incarceration in the hopes of eliminating the problem. Then once released, we chase them out of our communities and ostracize them. This may seem like a reasonable solution, by removing the problem, but in fact we are in turn creating more victims. The sex offender is isolated and socially withdrawn, unemployed because no one wants to hire a sex offender and untreated for fear of being known. Consequently, "if the offender feels his case is hopeless and he will always be seen in a negative light, he may come to believe that reoffending would make little difference to him" (Wakefield, 2006:143). More education and acceptance of sex offenders along with access to treatment is the beginning of a long term solution.

There is an increasing amount of research that supports the idea that sex offenders can be treated successfully to allow them to lead crime free lives upon release (John Howard Society, 2002:2). Sex offenders with paraphilic behaviours, cannot be 'cured' but can learn through effective therapy to stop victimizing others. Treatment is possible. This report rests on the presumption that treatment of sex offenders is effective in reducing further crimes. Research also clearly indicates that the vast majority of individuals with paraphilic sexual disorders are males. Throughout this report, we refer to sex offenders as males.

Currently, sex offenders on probation in Cornwall are not always mandated to receive treatment but those who are mandated to receive treatment, travel to the Ottawa at the Royal Ottawa Mental Health Care Sexual Behaviours Clinic (SBC). A leader in Sexual Behaviours research, there, offenders

receive extensive assessment and treatment. Through consultations, it became evident that the distance is a major barrier to probationers. Many are without vehicles and rely on volunteer services to travel to Ottawa on a weekly basis. This method is unreliable and causes missed appointments.

In Cornwall, adolescent sex offenders can receive treatment at the Children's Treatment Centre (CTC). They are offered individual counselling and group therapy. If the adolescent denies having offended, he is referred to the Sexual Behaviours Clinic (SBC). Professionals in Cornwall are pleased with the current services offered at CTC but director Robert Smith advises that their staff is overworked and have high caseloads. Fortunately, they are able to maintain exceptional service but they are in need of more financial support. Since the centre relies solely on donations this is our responsibility as Cornwallites.

Our consultations clearly outlined the need for a treatment program operated in Cornwall for sex offenders and individuals at risk of offending. It is necessary to include those who have not committed a crime since, as Dr. Federoff explains, "Not all paraphilic interests are criminal, and even among people with criminal sexual interests, not all act on their criminal interests" (Levine, 2003:354). All interviewees agreed that such a program should be operated through the Cornwall Community Hospital. We are recommending a service for sex offenders and individuals at risk of offending sexually in Cornwall operated through the Cornwall Community Hospital. This hospital-based service will include social workers with specialized training that will provide clinical therapy, group therapy and community assistance. An important aspect of our program will also include education and awareness to professionals and the general public. We need to take a more proactive role to stop further victimization. It is our society; it is our responsibility to ensure that our most vulnerable members are protected. In order to reflect this, offenders need to have treatment readily accessible. "If the sex offender is ostracized, stigmatized, and isolated, rather than reintegrated into the community, it becomes more difficult for him to resist reoffending (Wakefield, 2006:145). We need to talk openly and honestly

about sexual abuse in the same manner that we can discuss drinking problems in order to remove the fear and hatred. Abusers need to be part of this process and hence part of the solution.

Sex offenders are the most vilified group in society. People hate and despise them and think they should be locked up for life. Other criminals consider them too abominable to associate with. They are seen as dangerous sexual predators for whom treatment won't work and who are at a high risk to reoffend. These beliefs are widespread, unsupported by facts, and have resulted in harsh laws specifically targeting sex offenders (Quinn, Forsyth, & Mullen-Quinn, 2004).

1.1. Purpose, Scope and Objectives

The purpose of this project was to examine whether individuals with maladaptive sexual behaviours are receiving adequate treatment in Cornwall and the United Counties of Stormont, Dundas and Glengarry and if there is community support for a local service. Specifically, we examined:

1. Provincial, national and international sex offender treatment services;
2. Current local services offered in Cornwall and the United Counties of Stormont, Dundas and Glengarry for adults and adolescents who have offended sexually, for adults and adolescents with deviant sexual behaviours, and for children with inappropriate sexual behaviours;
3. Consultations with local service providers; and

Finally, a recommended service model will be devised.

1.2 Methodological Design

The following processes were used in the development of this report.

1. Conducted a literature review, focusing on research for adult male sex offenders.
2. Researched existing community-based treatment programs for sex offenders by using the National Inventory of Treatment Programs for Child Sexual Abuse Offenders 2002 and searching the web.
3. Our research involved semi-structured qualitative interviews face-to-face with key stakeholders in Cornwall.
4. Visited centers in Ottawa and the Toronto area. Which included:
 - a. Peel Children's Centre - Sexual Abuse Treatment Program,
 - b. Community Child Abuse Council of Canada – Child and Youth Trauma Services, and
 - c. Royal Ottawa Mental Health Centre – Sexual Behaviours Clinic.

1.3 Background

The Cornwall Public Inquiry was established by the Government of Ontario on April 14th, 2005. The mandate of the Commission is to “inquire into and report on the events surrounding allegations of abuse of young people in Cornwall by examining the response of the justice system and other public institutions to the allegations” (www.cornwallinquiry.ca, 2008). The Commissioner will then make recommendations to the Ministry to strengthen old services or start new services that will encourage reconciliation and healing and prevent similar events in the future.

The number of victims in our society is overwhelming. 51% of women in Canada have experienced at least one incidence of physical/sexual violence since the age of 16 which represents 5 million women (Statistics Canada, 1994). In our work, we are constantly trying innovative ideas to educate the community about these issues, more specifically, on where to go if you have been victimized, how to recognize abuse and how to prevent being assaulted.

When we step back and look at an eighth grade class of 30 students “there are four girls who have been sexually abused, two boys who have been sexually abused, and one boy who is already sexually abusing much younger children. That means that nearly one-fourth of all children, by the time they reach the eighth grade, are sexual abuse victims or are already victimizing much younger children (Abel & Harlow, 2001). Sexual abuse is an epidemic problem.

In the past, society’s response has been primarily reactive and victim-based, triggering a system response only after the fact that a child has been sexually assaulted or been exposed to sexually abusive behaviours. We not only want to educate children and adults on how to recognize signs of abuse but to help the abusers recognize and seek help for their behaviours. Let’s work on preventing more victims. Let’s stop the abusers.

The Cornwall Community Hospital Assault and Sexual Abuse Program (ASAP) is part of the Ontario Network of Sexual Assault and Domestic Violence Treatment Centres. We provide emergency, follow-up and counselling services to victims/survivors of intimate partner violence and/or sexual

assault/abuse. Since our development in 1992, we have helped numerous individuals in our community. In truth, our numbers have doubled since last year.

We started to look at services in our community for sex offenders or individuals who are at risk of offending. Through our consultations, we were surprised to find out that very little is being offered for these individuals in our community.

1.4. Demographic and Economic Profile

Cornwall is a small city located between the Quebec border, Ottawa, Kingston and sits on the United States border. According to the 2006 Statistic Canada Census, Cornwall's population is maintaining at 45,965 in 2006 for a population growth of 0.7% from 2001-2006. Cornwall is situated in the United Counties of Stormont, Dundas and Glengarry. Consequently, most Cornwall service providers serve not only Cornwall but all three counties creating a combined population of 110,399.

Cornwall is a bilingual community of 23,100 Anglophones, 935 Francophone only, 20,720 Bilinguals and 160 for neither English nor French. It prides itself on offering bilingual services in all government buildings and most commercial businesses.

According to the Cornwall Community Police Services, there are currently 70-75 sex offenders on the registry in Cornwall. The Probation Office has approximately 40-50 sex offenders on their caseload at any given time with supervision periods of 2-3 years, along with the federal parole officer's 15-20. Many of these individuals have substantial supervision periods.

2. Review of Theoretical and Research Literature

2.1. SEX OFFENDERS

The term ‘sex offender’ encompasses a wide range of offenders. The two main types of sex offenders are **child molesters** (who victimize children) and **rapists** (who victimize adult men and women). Some like to further divide the group child molesters to separate incest and non-incest. Yet, in a study “that attempted to find a difference in the erotic preferences of incest and non-incest child molesters, a majority of offenders were indistinguishable as either type of offender according to their erotic preference.” (John Howard Society, 2002)

Rapists on the other hand, are quite different than child molesters. Sexually assaulting someone is an act of violence where rapists use sex as their weapon of choice in a sexual assault. They are more likely than child molesters to commit other crimes that are not sex-related. Rapists share more characteristics with the general criminal population. In terms of treatment, education on general crime issues as well as sex crimes need to be addressed. These individuals present more challenges in treatment.

2.1.1. PEDOPHILIA

Individuals with pedophilia generally report a sexual attraction to children. According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR, 2000:571), some pedophiles are only attracted to children (exclusive type) while others are also attracted to adults (inclusive type).

Starting with a study sample of over 16,000 adults who were treated in 41 states in reaction to possible sexual boundary violations, the authors analyzed the reports of 4,007 adults, ages 18 to 95, who admitted that they had sexually molested one or several children (Abel & Harlow, 2001). *The Abel and Harlow Child Molestation Prevention Study*’s goal was to gather information that could be used to prevent further child victims of sexual assault.

Below you will find a chart comparing U.S. males from the general population to admitted child molesters. They are mirror images of one-another disproving the general belief that child molesters are uneducated, socially inept and homosexuals.

**COMPARISON OF MEN FROM THE GENERAL POPULATION
AND THOSE WHO WERE ADMITTED MALE [CHILD] MOLESTERS (IN PERCENT)**

	U.S. males	Admitted male molesters
Married or formerly married	73%	77%
Some college or higher education	49%	46%
High school graduate	32%	30%
Working	64%	65%
Religious	93%	93%
Ethnicity		
Caucasian	72%	79%
Hispanic/Latin American	11%	9%
African-American	12%	6%
Asian	4%	1%
American Indian	1%	3%

Adult sexual orientation

Although many believe that the vast majority of men who sexually abuse boys are homosexuals, research indicates that assumption to be false. According to the *Abel and Harlow Child Molestation Prevention study*, more than 70% of men who sexually molest boys rate themselves as heterosexual in their adult sexual preference. 9% report that they are equally heterosexual and homosexual. Only 8% report that they are exclusively homosexual. It is also important to note that only 7% of child molesters show no sexual interest in adults (Abel & Harlow, 2001:11).

The media often misrepresents homosexuals as sexual abusers by replacing sexual abuse with ‘homosexual behaviours’. This is clearly evident in a January 15th, 2009 article by Rachel Zoll, entitled: “Vatican: Gay ‘behavior’ in seminaries declines.” The article states:

A Vatican evaluation of U.S. Roman Catholic seminaries in response to the clergy sex abuse scandal concluded that administrators have largely been effective in rooting out “homosexual behaviour” in the schools, although the agency said it persists... Past

studies commissioned by the U.S. Conference of Catholic Bishops have found that the majority of known victims of abuse by priests in the last 50 years were adolescent boys. In response, some Catholics blamed gay clergy for the scandal; experts on sex offenders argued that gays are no more likely than heterosexuals to molest children.

After stating that they were ‘victims’, that the victims were adolescents, and that the experts on sex offenders argued that homosexuals were no more likely than heterosexuals to molest children, the article still finishes stating that perpetration is a homosexual act. After the American diocese having spent more than \$2 billion since 1950 on settlements with victims, legal fees and other abuse-related costs, they are still incapable of putting the correct term of pedophilia instead of homosexuality. Instead, in the second last paragraph, the article questions that the priesthood was becoming a predominantly gay vocation. *Full story see Appendix 1.*

Prevalence of molested boys and becoming sexual abusers

While most molesters were abused as children not all children who are abused become molesters. In the study “Beyond Sexual Abuse: The Impact of Other Maltreatment Experiences On Sexualized Behaviors” which sought to broaden research findings linking maltreatment to sexualized behaviours by investigating whether maltreatment experiences other than sexual abuse predict such behaviours, the results suggested that “early and late reports of physical abuse and late reports of emotional abuse consistently increased the odds of engaging in sexualized behaviours” (Merrick et al., 2008:129).

In the study, the molesters who had been sexual abused (47%), started molesting children at an early age and molested more children than those who were not abused as a child (53%). “The most striking difference occurred with the adult molesters who, as children, had been severely sexually abused (molested more than 50 times).

	Age of first sexual offense		Average child victims	Average acts
	< 10 yrs old	> 10 yrs old		
Never been abused	9%	28%	7	37
Severely sexually abused	25%	40%	25	142

Some clinicians caution not to get distracted by spending too much time concentrating on people with paraphilias' personal victimization. "As a rule, time spent reviewing childhood events in search of an explanation for current paraphilic activities is time taken from ending the misery caused by the paraphilia in the present." (Levine, 2003:351).

2.1.2. PARAPHILIAS

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), the essential features of paraphilia are "recurrent, intense sexually arousing fantasies, sexual urges, or behaviours generally involving 1) nonhuman objects, 2) the suffering or humiliation of oneself or one's partner, or 3) children or other nonconsenting persons that occur over a period of at least 6 months." For some, these fantasies or behaviours are necessary to be aroused, whereas others can become aroused without paraphilic fantasies or behaviours (American Psychiatry Association, 2000:566). Full DSM-IV-TR criteria of different paraphilias, see Appendix 2.

Individuals with a paraphilia may work around their preferred sexual stimulus. Often, we are shocked to find out those who 'dedicated' their life to help children, the mentally delayed, or other vulnerable groups, would take advantage of these individuals. When in fact, they purposely put themselves exactly in those situations in order to meet their sexual fantasies. On December 11th, 2008, newspaper headlines read "Ambulance attendants accused of molesting patients". Greg Kafoury, the victims' lawyer, explains to the press that it's the ideal job for a sexual predator. "Everything is there: Women who are incapacitated, so they're hugely distracted. Medical cover to put your hands in places where, in any other context, a predator would be immediately recognized as such." For full story, see Appendix 3.

The etiology of paraphilic sexual disorders (what causes sexual offending) is unknown but is likely influenced by both biological and environmental factors. Many theories exist regarding the

etiology of paraphilias, including psychoanalytical, biological, and sociobiological theories; however, none are conclusive. Nonetheless, it is clearly evident that the vast majority of individuals with paraphilic sexual disorders are males except for sexual masochism, where the sex ratio is estimated to be 20 males for each female (American Psychiatry Association, 2000:568). A review of Correctional Service of Canada's offender management system revealed that the majority of sex offenders listed to date are men (99.6%) (Correctional Service Canada 2004).

Individuals with a paraphilia disorder might start by having a single paraphilia but increase to a second paraphilia. For example, of the pedophiles who molested girls or boys, 33-36 percent were also voyeurs. (pp13). This finding clearly indicates the importance for more extensive evaluation of exhibitionists and voyeurs in order to prevent these individuals from starting pedophilic tendencies.

Fantasies

Paraphilia fantasies and behaviours begin in childhood but become more evident in adolescence and early adulthood. The disorders are chronic and lifelong but diminish in intensity and frequency throughout the years. Individuals with this disorder claim that these fantasies are always present but can vary in frequency and severity during their life.

Treatment

Most individuals with paraphilias present themselves for treatment once arrested, incarcerated or when their behaviour has brought them into conflict with sexual partners or society. Families will not come forward for treatment if prison is the preferred remedy.

3. THERAPY MODELS AND TREATMENT TECHNIQUES

3.1. Therapy Models

Sexual offending has become the focus of intensive treatment and research. There is an increased amount of research that supports the idea that sex offenders can be treated. Although clinicians support this claim, they state that there is no ‘cure’. Those who have sexually offended can benefit from treatment to lead offense-free lives.

During our consultations, the therapeutic modalities most utilized but not limited to are: Cognitive-Behavioural Therapy and The Good Lives Model. Below is a brief overview of these methods used with sex offenders.

Cognitive-Behavioural Therapy (CBT)

It is becoming clear that the implementation of cognitive-behavioural treatment interventions (CBT) in receptive environments can reduce reoffending rates considerably. A recent large outcome study of sexual offenders found that CBT reduced sexual recidivism rates from 17.4% to 9.9%, as well as reducing general recidivism rates from 51% to 32% (Hanson et al., 2002). CBT’s main approach is focused on relapse prevention. The goal is to help offenders understand their offence process and cope with situational and psychological factors that place them at risk for reoffending (Ward & Hudson, 2000). The basic idea behind cognitive-behavioural therapy with sex offenders is to **identify** and **reduce or eliminate** the array of dynamic risk factors.

The Good Lives Model (GLM) or The Good Lives Model – Original (GLM-O)

GLM has a broader focus than CBT programs. It encompasses the positive human goods or goals all humans seek in order to live satisfying and good lives by focusing on providing offenders with the necessary conditions (e.g. , skills, values, opportunities, and social supports) for meeting their human

needs in more adaptive ways, the assumption is that they will be less likely to harm others or themselves (Ward & Stewart, 2003). The primary goal of this approach is to help offenders live a better life and in turn, reduces the chances that they commit other crimes.

“Primary human goods are states of affairs, states of mind, personal characteristics, activities, or experiences that are sought for their own sake and are likely to increase psychological well-being if achieved.”(Ward & Gannon, 2005) In no particular order, the primary goods are:

- Life (including healthy living and functioning),
- Knowledge,
- Excellence in work and play,
- Excellence in agency (i.e. autonomy and self-directedness),
- Inner peace,
- Friendship,
- Community,
- Spirituality,
- Happiness, and
- Creativity.

“The possibility of constructing and translating conceptions of Good Lives into actions and concrete ways of living depends crucially on the possession of *internal* capabilities (i.e., skills, attitudes, beliefs) and *external* conditions (i.e., opportunities and supports) (Ward & Gannon, 1996:7).

3.2. TREATMENT COMPONENTS

Fantasies

Fantasies play a crucial role in sex offenders’ atypical sexualized behaviours. The fantasy is just as important as the act itself. Research indicates that molesters’ fantasies relate to the number of children they molest and doubled the number of assaults. “Having child-centered sexual fantasies nearly quadrupled the number of children the molester victimized. Men who did not fantasize about children averaged 4 victims. Men with child-centered sex fantasies averaged 15 victims” (Abel & Harlow, 2001:11).

Without treatment, the fantasies intensify with every passing year. Like a heroin addict, sex offenders need to increase the fantasy in order to get aroused. Dr. Salter, author of *Predators: Pedophiles, Rapists and Other Sex Offenders: Who They Are, How They Operate and How We Can Protect Ourselves*, interviewed a 30-year-old rapist who had been incarcerated for the past eleven years. Since being incarcerated, Mr. Morgan's (fictional name) fantasies had not dimmed but they had transformed. Mr. Morgan later states that putting someone in the penal system for a dozen years doesn't help the behaviour, it adds to the deviancy. He is fed three meals a day and has all the time in the world to fantasize about what he wants to do when he gets out.

"When I was on the street, the age ranges that I masturbated to were around thirteen to seventeen. But as I came in prison, the ages started dropping off from sixteen down to twelve down to eleven, and then the fantasies increased to where they didn't have any pubic hair and things of that nature. So I could see the degree that it's changed in eleven years. They have also switched from young females to young males. Wanting to rape young males, ages seven to nine." (Predators p.91)

Sex offenders in Anna C. Salter's book *Predators, Pedophiles, Rapists, & Other Sex Offenders: Who They Are, How They Operate, and How We Can Protect Ourselves and Our Children*, found that prison did not interfere with their ability to develop newer and better fantasies. "In fact, he used prison to reflect on the mistakes he made in the first crime that caused him to get caught" (Salter, 2003:93).

When assessing sex offenders' risk, it is very difficult to know how maladaptive their sexual behaviours are by their record alone. Their fantasies relate the true story more than their actions. The worst is happening in the offenders' heads. Some therapists require clients to maintain a 'fantasy log'. The offenders record the fantasies and their arousal level and brings this information to the therapy sessions. The therapist is then able determine the offender's level of improvement.

Empathy

Different sex offenders have different levels of empathy. Sadists have a kind of reverse empathy. They are well in tune with how others feel or react and they feed off of their pain. Instead of feeling empathy and sadness for another person's pain, a sadist will feel high and happy. They

deliberately inflict pain and fear while torturing the victim (Salter, 2003:108). At the same time, they will also increase the victim's terror by telling the individual in advance what they will do to them. Some sadists begin by convincing themselves that the victim enjoys the act, that the child wanted more and telling themselves that the child was not being harmed. While other sadists do not bother with excuses and believe that the child is evil, sick and deserves the abuse. In the words of one offender, "I viewed children as a piece of meat. To me children were a toy. Do what I wanted with and then throw it away" (Salter, 2003:111).

While sadists feed off of their victim's pain, violent rapists, child molesters and all psychopaths ignore the pain for their own enjoyment. Many child molesters fail to recognize that children cannot consent to sexual acts. When admitted child molesters were asked about the amount of aggression they used during the act, "15 percent reported that the child initiated the act, and a surprising 50 percent reported that the act was by mutual consent" (Abel and Harlow, 2001:12).

Relapse Prevention

Pedophilia is generally chronic, especially in those attracted to males. The DSM-IV-TR (American Psychiatry Association, 2000:571) indicates that "the recidivism rate for individuals with pedophilia involving a preference for males is roughly twice that for those who prefer females." However, treatment is effective. Federoff (Levine, 2003:351) states that "The average published rate of relapse for sex offenders is below 14%, making the success rate for the treatment of paraphilias in general better than almost any other psychiatric condition."

Treatment is most effective when interventions attempt to address the life long potential for reoffences (John Howard Society, 2002:8). Sex offenders cannot be 'cured' following a single set of sessions. However, clinical evidence suggests that maintenance in the community is the most difficult part of reducing reoffense risk. Most sex offenders are returned to the community with very few supports in place. When servicing sex offenders, it is crucial to remember the importance of long-term support.

4. SEX OFFENDER SERVICES AND SITE VISITS

4.1. Prison Settings

Prison-based sex offender treatment programs are often criticized as being ineffective and useless. Claims are often made that treatment does not work, and that most if not all sexual offenders will reoffend after their release from prison (Gordon and Hover 1998:3). This clouded judgement encourages the idea of harsher punishment for sex offenders. In reality, most sex offenders will be released and could benefit from treatment. The success of sex offender treatment is evident where comparing recidivism rates of sex offenders who received treatment and those who did not.

Correctional Service of Canada has “continually been implementing more sex offender treatment programs since it began offering sex offender treatment in 1973 (John Howard Society, 2002:4). The Phoenix Program in Edmonton, Alberta has been recognized as one of the most effective sex offender treatment programs and has gained international recognition. Offenders are there on a voluntary basis but are required to stay for a minimum of six months. They attend 32-35 hours of therapy per week. “The therapy is delivered in many forms, including: psychotherapy, victim empathy, cognitive restructuring, anger management, human sexuality, recreation, substance abuse, relapse prevention, life planning, goal attainment and more” (John Howard Society, 2002:9). They rarely use psychotropic medication to decrease the sex drive.

Encouraging sex offenders to receive treatment while incarcerated is challenging. Often, they do not seek treatment for fear of the repercussions of being known as a sex offender by other inmates. Sex offenders are the most vilified offenders not only in the general public but even in prison. Many sex offenders are released into the community without treatment.

4.2. Community Settings

Peel Children's Centre – Sexual Abuse Treatment Program

Peel Children's Centre is an extensive centre with 26 different programs and services. Their vision is a caring community working together for children and their mission is to provide a high quality mental health service for children, youth and their families who are experiencing, or may experience, serious emotional difficulties. While visiting their site, focus was placed on their Sexual Abuse Treatment Program and the ECHO Residential Treatment Program.

The ECHO Residential Program is for adolescents (ages 13-16) who have offended or are at risk of offending sexually and cannot be treated safely in the community. The team helps the individuals work on their strengths and helps with sexual behaviours and feelings. The adolescent begins at a special school in the residence but can attend a school in the community further in his treatment.

The Sexual Abuse Treatment Program helps children and their families deal with sexual abuse or sexual behaviours. The clinical services detailed below are available at the Sexual Abuse Treatment Program:

- Trauma-Focused Assessment and Treatment – using interviews and tests to determine the effects of verified sexual maltreatment and working in partnership with parents/caregivers to provide the most effective treatment approach;
- Sexualized Behaviour Assessment and Treatment – working collaboratively with parents/caregivers to intervene using a cognitive-behavioural approach with children under 12 who have exhibited sexualized behaviour;
- Assessment and Treatment – working in partnership with parents/caregivers to provide services to youth ages 12-17 who have sexually assaulted
- Family Assessments and Treatment – working with families where sibling incest has occurred.

Community Child Abuse Council of Canada – Child and Youth Trauma Services

The mission of the Community Child Abuse Council is to reduce the incidence and impact of child abuse and to promote the safe and healthy development of children. The council was formed in 1982 to provide services and programs to greater Hamilton area for children and families who experienced sexual abuse. Some of their programs include; children and youth who have been sexually abused, children under 12 with sexual behaviour problems, and children under 12 in a family who have engaged in sibling sexual abuse.

The Child and Youth Trauma Services offers assessment, recommendation for treatment and interventions and finally treatment and intervention. The primary type of counselling provided is individual sessions and is trauma specific treatment. Counsellors offer treatment to both children who have been victimized and children who victimize others sexually. When asked of the difficulty of counselling both perpetrator and victim, the clinician answered: “How can you not?” As long as safety was addressed (i.e. the waiting area) servicing both clienteles is not an issue.

The Community Child Abuse Council contracts with several therapists. Many of their therapists have second jobs in the community. This helps facilitate communication among organizations and increases the clinical team’s resources.

There are no fees for those in the Hamilton area. The program receives funding from a number of sources, including the Ministry of Children and Youth Services, the Ministry of Health, the City of Hamilton and fundraising efforts.

Circles of Support and Accountability (COSA)

In 1994, a man named Charlie was being released from an Ontario prison for having been convicted of multiple sexual offences involving young boys. Dr. Bill Palmer, Charlie’s therapist, was very worried that once Charlie would be released that there was a high risk that he would re-offend. Dr. Bill Palmer contacted some people who had known Charlie since the last time he was released as well as

Rev. Harry Night and his congregants at the Mennonite church. They met Charlie at the penitentiary to plan for his release. This is where the idea of “circle of on-going support” was brought up. (Wilson, 2008:1) Currently there are sixteen programs running in Canada. They range in size from 0-57 circles currently operating at any given time and with as many as 150 volunteers actively participating in circles within one program. They use The Good Lives Model as their best practice guidelines and are guided by two beliefs; no more victims and no one is disposable.

Circles of Support and Accountability aim to have safer communities and fewer victims by assisting and holding accountable individuals who have committed sexual offences and are re-entering society so that they would lead responsible and productive lives. The Circle meets together regularly and is guided by a written and signed agreement called a covenant. Individual volunteers also meet on a daily basis with the core member. CoSA’s volunteers are professionally supported by local psychiatrists, therapists, parole and probation officers, the police, the courts, and other service providers and are asked to make a one-year commitment.

When starting a CoSA, professionals should be consulted as soon as the CoSA is formed. Many professionals should be recruited for advisory boards or steering committees to provide oversight and accountability for CoSA. Professionals voluntarily provide specialized training, advice, and support to CoSA.

Stop It Now!

Stop It Now! was founded in 1992 by Fran Henry, a sexual abuse survivor, who recognized that standard ideas on how to prevent child sexual abuse were not working. Stop It Now! is an international organization who believes that child sexual abuse is not inevitable – it is preventable. They provide resources to individuals who are worried about children being at risk of sexual abuse and help them recognize and challenge these behaviours. Stop It Now! also supports families and individuals at risk to

abuse. “We offer adults tools they can use to prevent sexual abuse before there’s a victim to heal or an offender to punish” (www.stopitnow.com).

Stop It Now! operates the only confidential, national, toll-free helpline which offers support, information, and resources to adults who are concerned about sexualized behaviours in themselves or in others. “Nearly 60% of calls are from people in situations where they could intervene to prevent abuse” (2005-2006 Annual Report). *Full report available in Appendix 4.* Canadians are encouraged to call the helpline for support or information but unfortunately, they are not resourced to refer to Canadian services.

Stop It Now! is known for their bold advertisement campaigns featuring direct messages like “Having sexual thoughts about children?” and “It doesn’t feel right when I see them together” to those who are at risk of abusing children sexually to stop their actions and get treatment. These include posters, bill boards, and radio announcements headlining “I wanted to stop thinking about sex with children, but I didn’t know how. Thankfully I found understanding people who are helping me. I’m getting control so I don’t hurt children” (Stop It Now! Minnesota). *See Appendix 5 for poster samples.*

These campaigns are effective in reaching this clientele. The eight months following these bold campaigns, Minnesota state helpline calls increased by 43% to the same eight-month period the previous year (2005-2006 Annual Report). The full Annual Report is included in the appendices.

5. CURRENT LOCAL SERVICES

Children's Treatment Centre

Eligibility criteria:

- Adolescent males
- Aged 12-18
- Have a level of acceptance for their offence
- Teen has sexually offended,
- Teen had sexual acts with an adult, or
- Teen has chronic inappropriate sexual behaviours.

Duration:

- A few sessions up to three years

Services offered:

- Assessment.
- Family counselling
- Group therapy

Assessment Tools:

- Estimate of Risk of Adolescent Sexual Offense Recidivism (The “ERASOR”)
Version 2.0

Correction Service Canada - Probation Office

Clientele:	- Probationers who committed a sexual offence
Eligibility Criteria:	- Individuals who are waiting for an assessment at the ROMHC, - Individuals who have been assessed and are receiving treatment, or - Individuals who have already completed treatment.
Behaviours:	- Sexual assault
Duration:	- Ten weeks, one to one-and-a-half hour weekly session - Runs twice per year
Services offered:	- Group Therapy: Sex Offender Relapse Prevention (SORP)
Referrals:	- Corrections Services - Legal referrals (judges, courts, crown attorneys, lawyers)
Strategies:	- Cognitive-behavioural and relapse prevention strategies
Staff:	- Probation Officer

The probation office aims to see the sex offender on their release date. After they are assessed at the Royal Ottawa Mental Health Center – Sexual Behaviours Clinic (ROMHC), they can take part in their group sessions. Should there be a waiting list with the ROMHC, the probation office will complete and assessment and the individual can then participate in group. It is a ten week, one to one-and-a-half weekly session, averaging ten participants, that runs twice per year.

CURRENT LOCAL SERVICES 'cont



Royal Ottawa Health – Care Group Sexual Behaviours Clinic

- Type of Program:**
- Psychiatric Hospital Setting
 - ROMHC is a teaching hospital
 - Community mental health recovery framework
- Clientele:**
- Men, women and adolescents (18+). On rare occasions, may service under 18.
 - Actual or potential sex-related offences
 - Almost all are voluntary
- Behaviours:**
- Sexual assault, Sexual dysfunction, Paraphilias and Gender identity disorder
- Duration:**
- Access to psychiatric beds
 - Medium security facility
 - Manage long-term in a community setting
- Services offered:**
- Interdisciplinary assessment
 - Treatment (Group therapy, Individual therapy, Pharmacotherapy)
 - Rehabilitation
 - Community reintegration
 - Education (Two Universities, Professional colleagues, community)
 - Research
- Referrals:**
- Corrections Services
 - Legal referrals (judges, courts, crown attorneys, lawyers)
 - Mental Health Professionals (1/3 referrals are by physicians)
 - Various agencies
 - Self referrals
- Strategies:**
- Cognitive-behavioural and relapse prevention strategies
 - Biological, psychological and sociological perspectives
- Staff:**
- Four Psychiatrists
 - One Psychological Associate
 - One Social Worker
 - One Lab Technician
 - Registered Nurses

General Inquiry: 613-772-6521 *6375

Clinical Manager: Heather Tarnai-Feely *6478

Director of Integrated Forensic Program:

Dr. Paul Federoff and Dr. Bradford

Director of Operations: Joan Dervin *6362

Address:

Royal Ottawa Health Care Group
1145 Carling Avenue,
Ottawa, Ontario
K1Z 7K4

6. CONSULTATIONS AND RECOMMENDATIONS

We conducted semi-structured qualitative interviews with service providers for sexual abuse perpetrators and sexual abuse victims to get their opinion as to what needs to be offered for Cornwall and the United Counties, if any service is needed at all.

Please note that the views and comments of the individuals interviewed reflect their own opinion and not necessarily those of their organizations.

Organization	Interviewee	Title
Children's Aid Society	Rachel Daigneault	Executive Director
Children's Treatment Centre	Robert Smith	Executive Director
Circles of Support and Accountability	Susan Love	Program Coordinator
Circles of Support and Accountability	Susan Haines	Volunteer
Cornwall Community Police Services	Jeff Carroll	Manages the Sex Offender Registry
Crown Office	Murray Macdonald	Crown Attorney
Laurencrest	Wayne Kyte	Executive Director
Private Counselling	Protius Grant	Counsellor
Probation Office	Claude Legault	Regional Director
Ottawa District Parole Office	Gérald J. Daigle	Parole Officer
ROHCG Integrated Forensic Program	Heather Tarnai-Feely	Social Worker
ROHCG Integrated Forensic Program	Joan Dervin	Director of Operations
The Men's Project	Rick Goodwin	Executive Director

Key Findings:

Here are some key issues and solutions brought forward through the above consultations that can be addressed.

Issue #1

Travelling distance to the ROMHC for treatment is a barrier to sex offenders. Most sex offenders do not own a vehicle and cannot afford transportation to Ottawa. They rely on volunteer services like the Red Cross or the Salvation Army. These methods are not always reliable and cause missed appointments. In some instances, sex offenders who are mandated to receive treatment are sometimes even excused from treatment due to transportation barriers.

Solution

Development of a local treatment program through the Cornwall Community Hospital will be offered in Cornwall. Once assessed at the ROMHC, clients will be offered individual and group therapy in Cornwall.

Issue #2

Lack of services for sex offenders who want to deal with their own historical victimization.

Solution

The new program will provide therapy using a holistic approach. Most sex offenders are also victims or survivors of some form of abuse which plays a significant role in their well-being. Clinicians will use The Good Lives Model in therapy which focuses on reaching the offender's personal goals and needs in order to achieve a fulfilling social life. In consequence, the offender will have a change to deal with their own victimization.

Issue #3

Due to criteria restraints, some individuals concerned with their maladaptive sexual thoughts, fantasies or behaviours but have not yet offended are denied therapy.

Solution

The new program will be mandated for individuals who have offended sexually or are at risk of offending. The new program will also accept self-referrals. This means that individuals can receive therapy and prevent perpetration.

Issue #4

Probationers need more in-depth therapy in order to get to the core of the problematic behaviour. Presently in Cornwall, probationers are offered locally a Sex Offender Relapse Prevention (SORP) program. It's a ten week weekly session to prevent future offences but doesn't deal with the core issues.

Solution

Probationers will be offered one-on-one clinical therapy and group therapy in Cornwall.

Issue #5

A sex offender treatment programs needs credibility.

Solution

The program will be operated through the Cornwall Community Hospital.

Issue #6

Need to find innovative ideas to get sexual abusers to come forward for treatment.

Solution

Through different marketing tools and strategic planning, the new program will address these issues. A marketing consultant will be hired to develop a complete communication package. A Community Development Worker will work on targeting individuals who have not come forward for their maladaptive sexual behaviours and interests to come for treatment before they further victimize.

Issue #7

There needs to be more awareness and acceptance to the general public and professionals about individuals with sexual abusive behaviours and sex offenders. Individuals need to feel safer seeking treatment.

Solution

As per the communications strategy, the Community Development Worker will provide education and awareness through marketing tools, presentations and resources.

Other comments from interviewees:

- Minimal francophone services creating longer wait time or the client receiving treatment in their second language of choice
- A waiting list for assessment for the ROMHC. At sentencing the sex offender may not have been assessed.
- The probation office needs a co-facilitator for the Sex Offender Relapse Prevention (SORP). Currently, they only have one staff member trained to deliver the group.
- Referrals to the ROMHC need to be by physicians only. Most probationers do not have a family doctor and need to go to a walk-in clinic to request a referral. Some doctors even refuse to refer.
- Not all sex offenders are mandated to receive treatment.

Feasibility of Initiating a Circle of Support and Accountability program in Cornwall

Some professionals felt that CoSA would not be able to function in such a small community.

Concerns included; lack of professionals and para-professionals to volunteer for such a program, problems with confidentiality, and safety concerns about the location.

CoSA members believe that all communities, big or small, would benefit from such a program.

Unfortunately, we felt that this initiative should be pursued by interested volunteers. We did not proceed further in the feasibility of such a program in Cornwall for this project but would fully support such an initiative.

Sex Offender Program operated by the Cornwall Community Hospital

Throughout the consultations all professionals agreed that the Cornwall Community Hospital would operate the program. While most found it fitting to be managed by the same manager of the Assault and Sexual Abuse Program, a service program for sexual assault/domestic violence victims,

some had reservations on the stigma it may inflict, while others were concerned for safety. Once it was explained that both programs could be supervised by the same manager but would be their own entity and separate location, interviewees agreed it seemed logical to utilize the resources already in place. It has also been established that program has to have a community focus. Involvement with community agencies and agreements need to be in place. This is already well established with the Cornwall Community Hospital Assault and Sexual Abuse Program (ASAP). ASAP maintains a long standing Community Advisory Committee and is represented on many municipal, regional and provincial committees.

One interviewee expressed concern that since Cornwall is a small town, clients may not seek treatment in their city for fear of being recognized. One interviewee expressed concern that a hospital-setting might frighten clients. Another concern expressed by one agency is that many men coming forward for treatment are adamant that they do not want to receive treatment at any hospital-based program. The stigma attached and the fear of “institutions’ are the main reason. The Assault and Sexual Abuse Program clinician stated that all the inhibitions can be quickly dispelled depending on the approach the therapist uses. These issues can be addressed with the therapist.

Some benefits of having the program run through the CCH were easy access to numerous hospital services while benefiting from being part of a multi-disciplinary team.

In conclusion and based on the literature review, the site visits and most importantly, the community consultations, there is strong support for a high quality local service for sex offenders operating through the Cornwall Community Hospital Assault and Sexual Abuse Program.

PROPOSED SERVICE MODEL

7. PROPOSED SERVICE MODEL

A strategic planning process involving ASAP staff would be the first step in developing this new program. The following are recommendations but may change according to funding received and feedback during the strategic planning process.

7.1. Proposed Names

- Center for Offender Rehabilitation and Education (CORE)
- Commitment to Change
- Sexual Abuse Intervention Services (SAIS)
- Sexual Treatment Outreach Program (STOP)
- New Hope Treatment Center
- Sexual Abuser Recovery Services (SARS)
- Sexual Health And Relapse Prevention (SHARP)
- Treatment for Sex Offenders (TSO)

7.2. Location:

Our goal is to have this new program located at the Cornwall Community Hospital. This may not be possible because of limited office space. If the program becomes off-site, extra expenses need to be considered.

Rooms:

- 1) Waiting room (sits 5-6)
- 2) Large room that will be used for group therapy and as a conference room.
- 3) Social Worker office #1
- 4) Social Worker office #2

Please note that the program clerk typist and the Community Development Worker will be working in conjunction with ASAP. Therefore, these individual will utilize ASAP office space.

7.3. Staffing (*see Appendix 6 for all job descriptions*):

- **(2) Social Workers (Part-Time)**
- **(1) Community Development Worker** (Will expand ASAP Community Development Worker to full-time)
- **(1) Clerk Typist** (Will expand ASAP Clerk Typist to full-time)

7.4. Accountability

The Program will be part of the Cornwall Community Hospital and managed by the Assault and Sexual Abuse Program Manager. Clinical supervision will be arranged by experts in the field. This may be available through the Royal Ottawa Health Care Group Sexual Behaviours Clinic.

7.4. Description of Service

Client Profile: Description of Target Population

- Eligible adults on probation
- Eligible adults

Determination of Eligibility

- Referrals shall be made directly to the Social Worker. Referral package will include, if applicable; a referral form, a copy of court order, police report and case assessment.
- The client will be over the age of 18 who meets one or more of the following criteria:
 - Have been adjudicated for criminal sexual offence(s),
 - Have expressed responsibility for sexual offence and are determined in need of out-patient sex offender specific treatment,
 - Returning from out-of-home specific sex offender treatment,
 - Have been determined in need of supportive counselling services associated with sexually acting out behaviour(s),
 - Individuals seeking therapy for their sexual thoughts or feelings towards children. These thoughts or feelings may or may not have resulted in sexual acts towards children or youth.

Description of type of services to be offered

- Initial assessment and treatment plan. If the client has been assessed at the Royal Ottawa Mental Health Centre, review of assessment. If the client has not been assessed, the Social Worker will refer for assessment if applicable.
- Individual therapy
- Family therapy
- Group therapy
 - Relapse Prevention
 - On-going Support
- Profession training
- Public education and awareness
- Social work services
- Representation on relevant committees

Description of outcome expected

- Prevention and reduction of additional criminal sexual offenses committed by clients.
- Avoiding of out-of-home treatment placement.
- Reduction of the days of care in out-of-home residential placement. (early release)
- Opportunity for victim restoration and healing relationship.

Best Practice Guidelines

Using a Cognitive-Behavioural Therapy (CBT) approach we will integrate The Good Lives

Model in our best practice. It is simply not enough to teach sex offenders how to identify and manage

their risk factors. It is important to take a holistic approach of the individual's lifestyle leading up to his offending and without merely focusing on offending behaviours. Ward & Gannon suggests that "we give people the necessary capabilities to live more fulfilling lives rather than simply seek to reduce risk factors or focus on the amelioration of psychological deficits."

The Royal Ottawa Mental Health Care Group Sexual Behaviour Clinic (SBC) will continue to offer services to individuals from Cornwall and the United Counties of Stormont, Dundas and Glengarry. Their assessment services are extensive and effective and should not be duplicated. Instead, we would like to offer clinic therapy locally for individuals from the Cornwall area. On-going collaboration, service agreements and professional consultation will be put in place to ensure a stable high quality program.

7.6 SERVICE MODEL BUDGET

Start-up Budget	
Program Development Worker 0.6	\$44,000.00
Communications Strategy (<i>see Appendix 7</i>)	20,000.00
Office Equipment	15,000.00
Training for four staff (<i>see Appendix 8</i>)	20,580.00
TOTAL	\$99,580.00

Annualized Budget	
*Social Worker 0.6	\$64,000.00
*Social Worker 0.6	64,000.00
Community Development Worker 0.4	37,000.00
Program Clerk Typist 0.4	21,000.00
Staff Training	5,000.00
Office Expenses/Supplies	6,000.00
Staff Travel	5,000.00
Advertising/Marketing	4,000.00
TOTAL	\$206,000.00

**Off-Site Location: Annualized Additional Costs	
Rent	\$24,000.00
Insurance	5,000.00
Security	1,500.00
Property Management/Maintenance	1,000.00
Information Technology	4,000.00
TOTAL	\$35,500.00

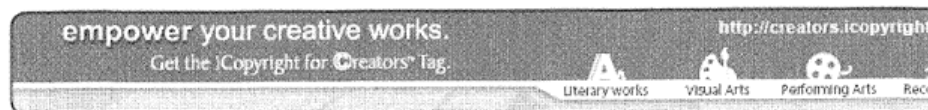
*Staff job descriptions, qualification and rate of pay are in the appendices.

**The aim is to have the new program located at the Cornwall Community Hospital. With the hospital's restructuring, we are unable to be certain that this will be attainable.

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APPENDICES



January 15, 2009

Vatican: Gay 'behavior' in seminaries declines

By RACHEL ZOLL
AP Religion Writer

A Vatican evaluation of U.S. Roman Catholic seminaries in response to the clergy sex abuse scandal concluded that administrators have largely been effective in rooting out "homosexual behavior" in the schools, although the agency said it persists.

The Congregation for Catholic Education sought a broad review of how the schools screen and educate prospective priests, but gave special attention to teachings on chastity and celibacy. The Vatican also directed evaluators to look for "evidence of homosexuality" in the schools.

In a report U.S. bishops released this week, the Vatican agency noted past "difficulties in the area of morality" within seminaries that "usually but not exclusively" involved "homosexual behavior." The evaluators said the appointment of better administrators in diocesan seminaries "has ensured that such difficulties have been overcome."

"Of course, here and there some case or other of immorality — again, usually homosexual behavior — continues to show up," according to the report. "However, in the main, the superiors now deal with these issues promptly and appropriately."

The evaluators had no such praise for schools run by religious orders, which critics consistently condemn as too liberal on celibacy, homosexuality and church teaching in general. The report said "ambiguity vis-a-vis homosexuality persists" within institutes run by religious orders. The report also cites those schools for failing to fully adhere to Catholic theology.

Nearly one-third of the 40,580 U.S. priests belong to religious orders.

Past studies commissioned by the U.S. Conference of Catholic Bishops have found that the majority of known victims of abuse by priests in the last 50 years were adolescent boys. In response, some Catholics blamed gay clergy for the scandal; experts on sex offenders argued that gays are no more likely than heterosexuals to molest children.

The Vatican ordered the review at the height of the abuse scandal, which erupted in 2002 with the case of one predator priest in the Archdiocese of Boston, then spread throughout the U.S. and beyond. American dioceses have spent more than \$2 billion since 1950 on settlements with victims, legal fees and other abuse-related costs. Bishops and seminary staff conducted the onsite evaluations between 2005 and 2006.

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19/01/2009

DSM-IV Paraphilia Criteria**Exhibitionism (exposure of genitals)**Diagnostic criteria for Exhibitionism

-
- A. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving the exposure of one's genitals to an unsuspecting stranger.
 - B. The person has acted on these sexual urges, or the sexual urges or fantasies cause marked distress or interpersonal difficulty.
-

Of the pedophiles who molested girls or boys 17-20 percent were also exhibitionists. (pp13)

Fetishism (use of nonliving objects)Diagnostic criteria for Fetishism

-
- A. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving the use of nonliving objects (e.g., female undergarments).
 - B. The fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
 - C. The fetish objects are not limited to articles of female clothing used in cross-dressing (as in Transvestic Fetishism) or devices designed for the purpose of tactile genital stimulation (e.g., a vibrator).
-

Frotteurism (touching and rubbing against a nonconsenting person)Diagnostic criteria for Frotteurism

-
- A. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving touching and rubbing against a nonconsenting person.
 - B. The person has acted on these sexual urges, or the sexual urges or fantasies cause marked distress or interpersonal difficulty.
-

Pedophilia (focus on prepubescent children)Diagnostic criteria for Pedophilia

-
- A. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving sexual activity with a prepubescent child or children (generally age 13 years or younger).
 - B. The person has acted on these sexual urges, or the sexual urges or fantasies cause marked distress or interpersonal difficulty.
 - C. The person is at least age 16 years and at least 5 years older than the child or children in Criteria A.
-

In this criterion, it is important to specify if:

- Sexually attracted to males

- Sexually attracted to females
- Sexually attracted to both
- Limited to incest
- Exclusive type (attracted only to children)
- Nonexclusive type

Sexual Masochism (receiving humiliation or suffering)

Diagnostic criteria for Sexual Masochism

- A. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving the act (real, not simulated) of being humiliated, beaten, bound, or otherwise made to suffer.
 - B. The fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
-

Sexual Sadism (inflicting humiliation or suffering)

Diagnostic criteria for Sexual Sadism

- A. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving acts in which the psychological or physical suffering (including humiliation) of the victim is sexually exciting to the person.
 - B. The person has acted on these sexual urges with a nonconsenting person, or the sexual urges or fantasies cause marked distress or interpersonal difficulty.
-

Transvestic Fetishism (cross-dressing)

Diagnostic criteria for Transvestic Fetishism

- A. Over a period of at least 6 months, in a heterosexual male, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving cross-dressing.
 - B. The fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
-

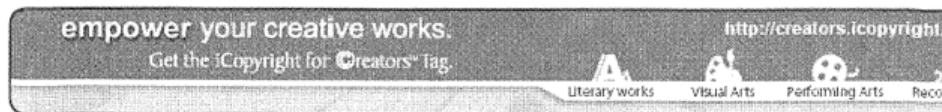
Voyeurism (observing sexual activity)

Diagnostic criteria for Voyeurism

- A. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving the act of observing an unsuspecting person who is naked, in the process of disrobing, or engaging in sexual activity.
 - B. The person has acted on these sexual urges, or the sexual urges or fantasies cause marked distress or interpersonal difficulty.
-

Paraphilia Not Otherwise Specified

This category includes, but are not limited to; telephone scatologia (obscene phone calls), necrophilia (corpses), partialism (exclusive focus on part of the body), zoophilia (animals), coprophilia (feces), klismaphilia (enemas), and urophilia (urine).



December 11, 2008

Ambulance attendants accused of molesting patients

By DANNY ROBBINS
Associated Press Writer

They answer the call 24-7, often risking their own safety to rescue the sick and injured and rush them to the hospital. But some paramedics have been more predator than hero.

Over the past 18 months, at least 129 ambulance attendants across the U.S. have been accused of sex-related crimes on duty or off, an investigation by The Associated Press found. Some of them molested patients in the back of an ambulance.

"It's a dream job for a sexual predator," said Greg Kafoury, a Portland, Ore., lawyer who represents three women who were groped by a paramedic. "Everything is there: Women who are incapacitated, so they're hugely distracted. Medical cover to put your hands in places where, in any other context, a predator would be immediately recognized as such."

Across the U.S., emergency medical technicians have been accused in recent months of such crimes as rape, soliciting minors over the Internet and possession of child porn, according to an AP survey of the state agencies that oversee those professions.

Exactly how many of these EMTs were alleged to have committed their crimes on the job is unclear. But some of more shocking cases include:

_ A Standish, Mich., paramedic sent to prison in March for molesting a girl who was on her way to the hospital after she was injured at her 15th birthday party.

_ A Pinellas County, Fla., paramedic arrested in July after he allegedly sexually assaulted a woman in an ambulance en route to a hospital.

_ A Chester County, Pa., paramedic sentenced in July to up to 20 years in prison for engaging in sex and providing alcohol to teenagers he befriended through their interest in emergency medical service.

_ A Copperas Cove, Texas, paramedic awaiting trial in January on charges he exposed and touched an 18-year-old accident victim's breasts while pretending to tend to her injuries.

_ A Chattanooga, Tenn., EMT accused in a lawsuit of giving a 30-year-old woman an extra dose of

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12/12/2008

morphine and then completely undressing her in the back of an ambulance even though her injuries were minor.

State health officials in 23 states reported receiving sex-related complaints involving EMS workers. New York reported the most complaints — 17. Thirteen of the complaints were substantiated and resulted in workers losing their certification. Texas reported 13 complaints, Massachusetts 11 and Virginia 10. No breakdown was immediately available showing how many of those allegations involved sexual misconduct on the job.

Several EMS officials said the number of complaints is troubling but does not necessarily point to an industrywide problem. They noted that the profession employs nearly 900,000 people in the U.S.

"That number in and of itself doesn't shock me, knowing the number of providers we have in the country," said Steve Blessing, state EMS director in Delaware and president of the National Association of State EMS Officials. "Is even one case tolerable? I think most state directors would say no. But we're bound by reality here."

In Portland, paramedic Lannie Haszard was sentenced to five years in prison in August after pleading guilty to five counts of attempted sexual abuse. Haszard, 62, was charged with inappropriately touching four female patients while they were being taken by ambulance to hospitals.

Three of the women have sued Haszard and American Medical Response, his employer at the time. The lawsuits contend that the company, which operates ambulances in 40 states, failed to react to previous complaints about the paramedic's conduct.

Haszard's behavior came to light last December when a 28-year-old single mother of three, Royshekka Herring, told police that he touched her genitals while she was en route to the hospital for emergency treatment of a gastrointestinal condition.

In a recent taped deposition, Herring's voice shook with emotion as she described how a nurse tried to convince her that Haszard was probably performing an abdominal exam.

"I started yelling at her, because I didn't feel safe," Herring testified. "Somebody I never expected to touch me touched me."

A spokesman for American Medical Response had no comment on the case.

Former Dallas Fire Chief Steve Abairra suggested ambulances carry three workers. Ambulances usually have two — one in the front, one in the back.

"If there's a person predisposed to do something wrong, there's nobody there to witness or discourage that individual from doing something," said Abairra, now the fire chief in Palm Bay, Fla.

Twenty-eight states do not automatically bar known sex offenders from working as EMTs, the AP found.

Although most insist they would rarely, if ever, allow sex offenders to work those jobs, the AP found that Texas has knowingly allowed eight, Louisiana two and Maine, Virginia and North Carolina one each. There is no indication any of those people were accused of sexual misconduct after being allowed to work EMS jobs.

Twenty-two states strictly prohibit such offenders from working as EMTs.

"This is the type of person we don't want in the back of an ambulance with your mother or daughter," said

March Tucker, an EMS regulator in West Virginia.

All but one of the eight registered sex offenders certified to work in Texas victimized children ranging in age from 6 to 16.

"Oh, my goodness, that's really scary," said Winfred Dean, who supervises the sex offender monitoring unit for the Harris County probation department in Houston. "I thought people like that would more than likely be eliminated."

Texas officials said state regulations call for EMS licensing decisions to be made on a case-by-case basis.

"The only thing we can do is follow the law, and the law allows this," said Maxie Bishop, state EMS director. "We have to take a look at the crime, how long it's been, the nature of it and what that person has done since."

Associated Press writers Brian Farkas in Charleston W.Va., and Richard Richtmyer in Albany, N.Y., contributed to this report.



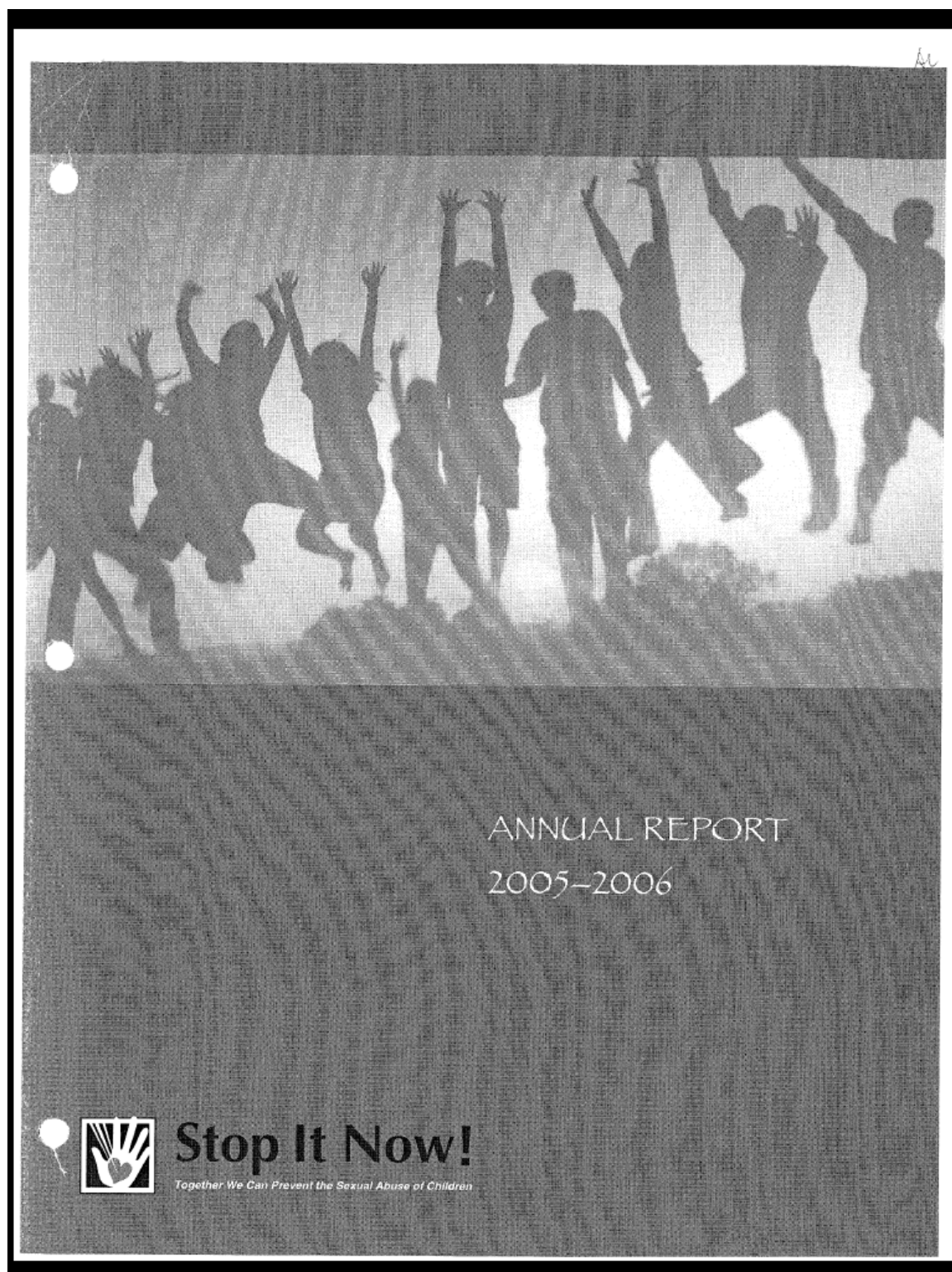
This 2008 booking photo released by the Multnomah county Sheriff's

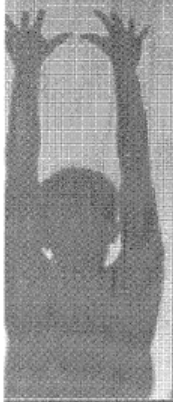
office shows paramedic Lannie Haszard who was sentenced to five years in prison in August 2008 after pleading guilty to five counts of attempted sexual abuse. Haszard, 62, was charged with inappropriately touching four female patients while they were being taken by ambulance to hospitals. (AP Photo/Multnomah county Sheriff's Office)



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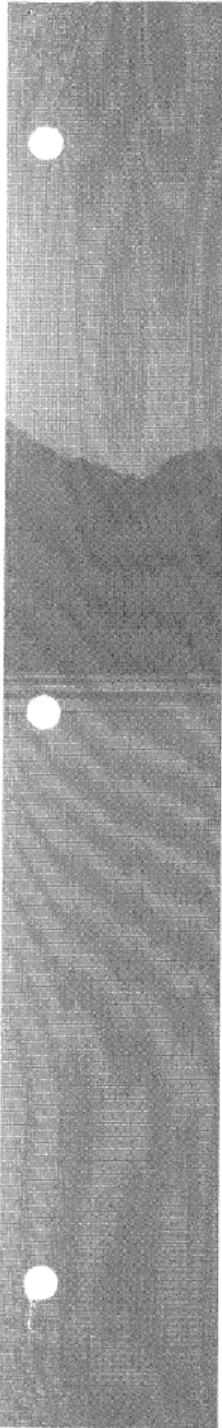




"Stop It Now! gives me hope for a world where families like mine can deal with our problems effectively and compassionately. I was a victim of child sexual abuse, and the real tragedy for me was that the abuser was my father who was loved dearly by the whole family, including me. The only choices I felt I had were to keep the silence or cause disaster for us all.

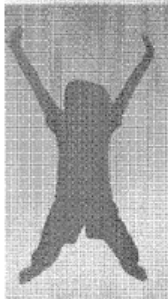
Stop It Now! offers more options for dealing with the heartbreaking fact that most people who abuse children are not monsters, but people in our own families and communities who we love. Stop It Now! offers us all the freedom to break through the secrecy and shame that surrounds this issue."

—CICI PORTER
ADULT SURVIVOR OF CHILD SEXUAL ABUSE,
ACCOMPLISHED MUSICIAN, ACTIVIST



In the vast majority of child abuse cases, the child knows the adult, teen, or child who abuses them. Because sexual abuse occurs mostly in homes, neighborhoods, and other familiar settings, children are unlikely to reveal their abuse. Estimates are that 1 in 3 girls and 1 in 7 boys will be sexually abused by age 18. Most of these crimes will never be reported. Teaching children to disclose abuse, helping survivors recover, and punishing abusers who have been caught and convicted doesn't prevent the initial harm to a child. Stop It Now!'s groundbreaking work has shown that adults can and will step forward to prevent child sexual abuse before a child is harmed. Together we can prevent the sexual abuse of children.

Stop It Now! 1



Dear Friends and Supporters,

At Stop It Now!, our vision is fundamentally hopeful. We believe that child sexual abuse is not inevitable – it is preventable. We know that adults can and will take action to prevent sexual abuse before a child is ever harmed. But only with the proper resources and support.

Stop It Now! teaches strategies to individuals and groups that turn worry and fear into action. We provide resources for all adults to recognize and challenge behaviors they see in others that put children at risk to be sexually victimized. We provide information and support to community and family members, as well as to people at risk to abuse.

The early work of Stop It Now! was groundbreaking and reflected the vision and tenacity of its founder, Fran Henry, an adult survivor of child sexual abuse. Our standing now as an international organization and a leader in the field is testimony to the foresight of our early donors and foundation supporters.

But barriers to prevention still exist.

Through our Helpline and local programs, we hear from adults of all backgrounds, ages and social groups — parents of children with sexual behavior problems, grandmothers concerned for their children and grandchildren, teachers, and childcare providers. Despite heightened awareness about child sexual abuse, people across the country need more help and information.

In response, Stop It Now! has dedicated itself to reaching larger and more diverse groups of people with hopeful messages and practical tools. We are committed to guiding more people to critical resources and support by expanding our Helpline and creatively harnessing the capacity of the Internet and our local programs.

Stop It Now! is unique in its willingness to help individuals, families and communities confront people at risk to abuse. Our priority, first, is to protect children, and second, to prevent future harm by directing the people who need it to treatment, support, and accountability. Up to 50% of sexual harm toward children is perpetrated by other minors, and half of that is by children under age 13. By failing to offer understanding and treatment to youth with sexual behavior problems, our society compounds the harm done to children – and multiplies it into the future.

In this report, you will find evidence that our strategies to attack the root causes of child sexual abuse are effective – and are catching on. International interest in Stop It Now! has never been greater. And, increasingly harsh yet unproven policy measures for managing child sex offenders are seeing a backlash from the criminal justice sector and the editorial pages. We field regular inquiries from state agencies, task forces, and journalists about how our approach can fill a gap in the face of increasingly stringent registration and sentencing.

Please be an active stakeholder in our vision of families and communities that foster safety for children and compassion for all.

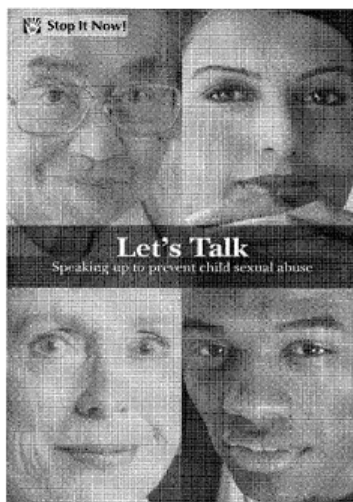
Together we can prevent the sexual abuse of children.

Maxine J. Stein
PRESIDENT AND CEO

Steven Brown, PsyD.
CHAIRPERSON, BOARD OF DIRECTORS

Program Highlights

- Stop It Now! operates the only confidential, national, toll-free **Helpline (1-888-PREVENT)** which offers support, information, and resources to adults who are concerned about sexualized behaviors in themselves or people they know. Nearly 60% of calls are from people in situations where they could intervene to prevent abuse. In the first half of 2006, call volume increased 18% over the number of calls during the same period in 2005.



Stop It Now! helps empower adults to take responsibility for protecting children from harm. Talking to other adults about the issue is the first step.

- Over half of Helpline callers find Stop It Now! through the Internet. During the second half of 2005, our website (www.stopitnow.org) had 50,000 unique visitors and over 1.1 million hits.
- The Dialogue Project features facilitated panel discussions between survivors of child sexual abuse, recovering sex offenders, family members of both, and often, therapists. Our Dialogues are a rare public opportunity for those most directly affected by sexual abuse to expose the complexity of the issue for all involved.
- Our newest publication, *Let's Talk*, outlines a straightforward process for discussing concerns about sexualized behavior without making accusations.
- Our booklet, *Do Children Abuse Other Children*, is available in both Spanish and English. It reminds readers that there is help available for both the child who abuses and the one who is victimized. Intervention when both parties are young increases the likelihood that each will have a chance to heal.
- For additional program highlights and a full publications list, visit our website (www.stopitnow.org).

"I've been a cop for almost thirty years. I've seen more than a fair share of man's inhumanity to man (and) plenty of social service programs... I am not one to jump on a bandwagon. [These are] the first positive programs to ever stop or discourage the abuse of children before it occurs. Every other program steps in after the initial abuse to prevent a recurrence."

—A POLICE OFFICER IN AN URBAN LOCATION

Stop It Now! 3

Community-Based Programs

Stop It Now! continues to deepen, adapt and extend its program model by growing and coordinating a network of Stop It Now! programs that are hosted and sponsored by local organizations.

AUSTRALIA

Hosted by Phoenix House

- **Formalized collaboration with Phoenix House**, the host agency that provides a range of community education programs and services for survivors of sexual abuse and people at risk to abuse.
- **Stop It Now! Australia officially launched** in November 2006, with Stop It Now! (international) attending and providing technical assistance.

GEORGIA

Hosted by Prevent Child Abuse Georgia

- **Developed a training-of-trainers program** to build statewide leadership and skills among community groups for preventing child sexual abuse. Over 400 community members attended 16 community orientations and nine two-day trainings. Seventy-five trained community partners throughout the state have started incorporating Stop It Now! messages into their own trainings. An additional 4,000 individuals were reached through conferences, community meetings, and special events throughout the state.

- **Collaborated on the world premiere musical play, *Love Jerry***, a story about two brothers who grapple with the complexity of sexual abuse in their family. Now! Georgia developed a discussion guide and trained production staff to lead discussions after every performance of the play's seven-week run.

- **Launched a public service announcement (PSA) campaign statewide** on all Clear Channel radio stations, resulting in a 400% spike in website hits, a tripling of email inquiries, and a steady increase in Now! Georgia Helpline calls.

MASSACHUSETTS

Hosted by Stop It Now! (national)

- **Galvanized support for the Stop It Now! Helpline** in Massachusetts, including support from the Massachusetts Association for the Treatment of Sexual Abusers (MATSA) and the Massachusetts Coalition for Sex Offender Management (MCSOM). With donor and corporate support, Stop It Now! will expand community education events and professional training of family and child welfare professionals.
- **Selected for the special, tenth anniversary edition of the Massachusetts Catalogue for Philanthropy.** The Catalogue is an annual publication that features the best of the state's non-profits in order to encourage giving among the state's top philanthropists.

**Having sexual thoughts
about children?**

1-888-PREVENT
Safe and Confidential Helpline

YOU CAN STOP IT NOW.ORG



The latest Stop It Now! Minnesota advertising campaign calls on individuals at risk to offend or reoffend to stop their behavior – and to seek help.

MINNESOTA

Hosted by Project Pathfinder

- **Conducted extensive market research** to determine what factors will encourage people at risk to sexually abuse children to come forward for help. A majority of the study participants wanted to stop their abusive behaviors toward children, but didn't know how. Based on this, a targeted communications and advertising strategy was developed and tested.
- **Launched a bold advertising campaign** featuring direct messages that challenge people who are at risk to act sexually toward children to stop the harm they are causing – and to seek help. Helpline calls from the state increased by 43% compared to the same eight-month period in the previous year. The campaign website received over 23,000 unique visitors during the eight months following the launch.
- In collaboration with Minnesota's child care licensing agency, **trained twenty professionals to conduct workshops for child care providers** on "How Understanding and Responding to Children's Sexual Behaviors Can Prevent Child Sexual Abuse." Ninety child care licensing professionals received training to help child care providers identify sexual behaviors that are common and uncommon in healthy children.

PHILADELPHIA

Hosted by the Joseph J. Peters Institute

- **Mobilized community members to guide the development of training modules** that respond to the core interests of families and community groups. Non-clinical training on healthy sexual development, effective parental communication, and adolescent behavior problems attracted and engaged a wide range of audiences.
- **Trained nearly 1,000 adults** on child sexual abuse prevention and adult intervention strategies totaling over 4,500 training hours. This included 300 foster parents and child care providers, and over 600 frontline professionals (all mandated reporters of child sexual abuse) in 50 agencies.
- **Conducted an updated child sexual abuse survey** to measure changes in knowledge, attitudes and behaviors in Philadelphia county. The study will establish benchmarks for evaluation and guide program design. Release of the results brought significant media and public attention to the issue.

COMMUNITY-BASED PROGRAM CONTACTS

Stop It Now! Georgia
Tel: 404-870-7363
Email: info@stopitnowga.org

Stop It Now! Massachusetts Helpline
Tel: 413-687-3500
Email: info@stopitnow.org

Stop It Now! Minnesota
Tel: 651-644-8515
Email: stopitnowmn@projectpathfinder.org

Stop It Now! Philadelphia
Tel: 215-701-1570
Email: stopitnow@jip.org

Stop It Now! Virginia Helpline
Tel: 804-864-7740
Email: Becky.Odor@vdh.virginia.gov

Stop It Now! Wisconsin
Tel: 414-453-1400
Email: stopitnowwi@cssw.org

Stop It Now! UK & Ireland
Tel: 44-52-759-8184
Email: office@stopitnow.org.uk

Stop It Now! Australia/Queensland
Tel: 07-41-53-4299
Email: stopitnowmedia@queenslander.net.au



The Stop It Now! Smart Car is a unique feature of the campaign in Surrey, United Kingdom.

UNITED KINGDOM & IRELAND

Hosted by The Lucy Faithfull Foundation

- **Released the Stop It Now! UK/Ireland Helpline Report** analyzing three years of activity (2002-2005). A key finding is that 45% of callers were individuals seeking help out of concern for their own sexual thoughts, feelings, and behaviors toward children.
- **Expanded program reach through new projects** in the Irish Republic, Wales, greater London, and Scotland and welcomed a new agency to host the Derby/Derbyshire program.
- **Developed a new leaflet on Internet safety** that provides factual information about the risks to children presented by new technologies and offers useful tips for keeping children safe online.

VIRGINIA

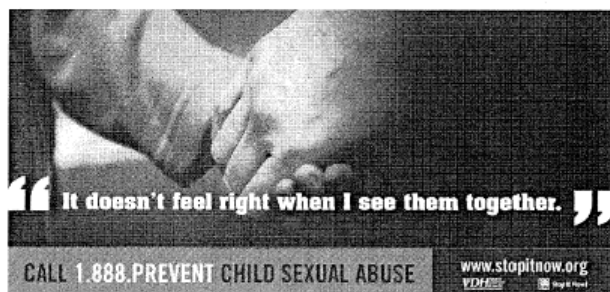
Hosted by the Virginia Department of Health

- **Collaborated with the Virginia Department of Health** to design and plan a new social marketing campaign advertising the Stop It Now! Helpline through radio PSAs, bus ads, billboards and posters.
- **Launched a Stop It Now! Helpline advertising campaign** in the Richmond area. Market research showed that people who heard the radio ads were three times more likely to believe that child sexual abuse is preventable and those who saw the print materials were ten times more likely to believe that they can prevent child sexual abuse.

WISCONSIN

Hosted by the Child Abuse Prevention Fund and the Wisconsin Children's Trust Fund

- **Joint program leadership established**, with guidance provided by a broad-based, 22-member statewide steering committee.
- **Conducted a market research survey** in Marathon and Milwaukee counties to gather baseline evaluation data and to guide program design. Market research findings will be released in conjunction with the program launch in early 2007.
- **Participated in the PREVENT Institute**, an intensive, eight-month leadership development and strategic planning program at University of North Carolina. The Wisconsin team, which includes Now! national staff, will plan and implement a marketing and campaign launch strategy with support from a PREVENT advisor and Wisconsin communication professionals.



As part of its violence prevention social marketing program, the Virginia Department of Health collaborates with Stop It Now!.

Financial Statement

Stop It Now! depends on and appreciates the generosity and courage of our supporters. We take the stewardship of these investments very seriously. We work hard to maximize their impact and cost-effectiveness, while building a financially stable organization that can be sustained far into the future.

In fiscal year 2006, 79% of all financial contributions directly supported programs and services to prevent the sexual abuse of children.

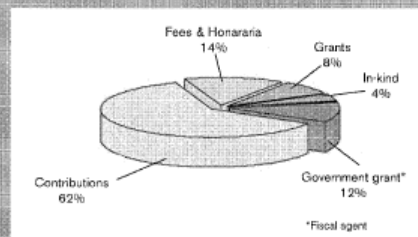
STATEMENT OF ACTIVITIES*

For the fiscal year ending on June 30, 2006

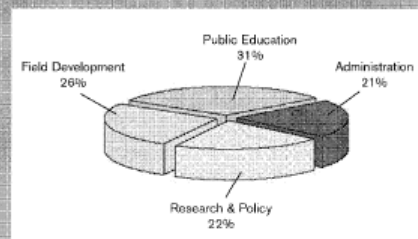
<u>Category</u>	<u>Total</u>
Revenue and Support	
Contributions	\$ 347,447
Contributions In-Kind	25,310
Grants	45,000
Government Grant	66,498
Fees and Other Income	81,389
Interest Income	142
Total Revenue and Support	\$ 565,786
Expenses	
Program Services	
Public Education	190,308
Field Development	157,489
Policy	124,288
Research	7,643
Total Program Services	\$ 479,728
Support Services	
Development	65,536
Management & General	65,814
Total Support Services	\$ 131,350
Total Expenses	\$ 611,078
Changes in Net Assets	(45,292)
Net Assets at Beginning of Year	74,195
Net Assets at End of Year	28,903

* This statement is based on the 2006 Audited Statement of Stop It Now! Inc. Copies of the most recent audited statements and tax filings are available upon request. Stop It Now!'s tax identification number is 04-3150129.

INCOME



EXPENSES





Thankyou . . .

for your contributions to Stop It Now!. Your financial support is helping adults, families and communities to protect children from sexual abuse before they are harmed. These investments in preventing child sexual abuse will have a lasting, positive impact on the health of families and the safety of communities everywhere.

A special thanks goes to federal employees and military personnel who helped make our **first year of participation in the Combined Federal Campaign (CFC)** a success. In 2005, CFC donors pledged their support through over 50 Area Campaigns at home and abroad.



Participating charity #1990

Stop It Now! was accepted as a new **member of the Women, Children and Family Service Charities of America (WCFS)** – a coalition of some of the country's most reputable national charitable organizations. In the future, Stop It Now! will participate in the CFC and access dozens of other workplace giving programs as a WCFS member.



Stop It Now! is also a qualified **member of Independent Charities of America (ICA)**. The ICA Seal of Excellence indicates that Stop It Now! has undergone a rigorous independent review to certify, document, and demonstrate that it meets the highest standards of public accountability, and program and cost effectiveness. Of the one million charitable organizations operating in the U.S., Stop It Now! is one of fewer than 2,000 that have been awarded the ICA Seal.



To make a donation or explore giving options, contact Stop It Now! at 413-587-3500, ext. 18. To make a donation online, visit www.stopitnow.org.

After seeing a presentation from Stop It Now!, we made a radical shift in the way we operate. I have always considered prevention the most important part of my job, but working with your organization has made me truly believe that we can stop child sexual abuse and has given me renewed enthusiasm for the work I do.

—GIANNA GARIGLIETTI, LPC
EXECUTIVE DIRECTOR, CITIZENS AGAINST SEXUAL ASSAULT

Stop It Now! wishes to thank its many donors. In addition to our most recent individual donors, there is a long list of individuals and organizations that have supported and nurtured this work. The early and steadfast support of major donors, key foundations and other organizations deserves special recognition. Thank you – one and all.

Together we are preventing sexual abuse before a child is harmed.

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Fiscal year 2005-06

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Charles Schwab Inc.
Cici Porter Wholeness Project

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eclecTechs
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JKG Group
Mervin Manufacturing
Mass Mutual Financial Group
Northfield Savings Bank
Pounce! PR
Sunfeather Natural Soap Company
Traumatic Stress Institute
Whitfield Martial Arts

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Anonymous foundations
The Annie E. Casey Foundation
Ben & Jerry's Foundation
Berkshire-Taconic Community Foundation
Brook J. Lenfest Foundation
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Community Foundation of Western Massachusetts
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Stop It Now!



Stop It Now!

Together We Can Prevent the Sexual Abuse of Children

351 Pleasant Street
Suite B-319
Northampton, MA 01060
Tel: 413.587.3500
Fax: 413.587.3505
Helpline: (1.888.PREVENT) Monday-Friday, 9 AM-6 PM EST
Email: info@stopitnow.org
Website: www.stopitnow.org



IT'S NOT WHAT I SAW, BUT WHAT I FELT.



If you are uncomfortable about behaviors between a child and an adult or older child,
trust your gut.

It's not easy to talk about.

Should you be concerned or not? Learn more. It's your call.

1-800-CHILDREN (244-5373) - A Confidential HELPLINE
or visit www.stopitnowga.org



Stop It Now! Georgia

*Together we can prevent the sexual abuse of children
a program of Prevent Child Abuse Georgia*

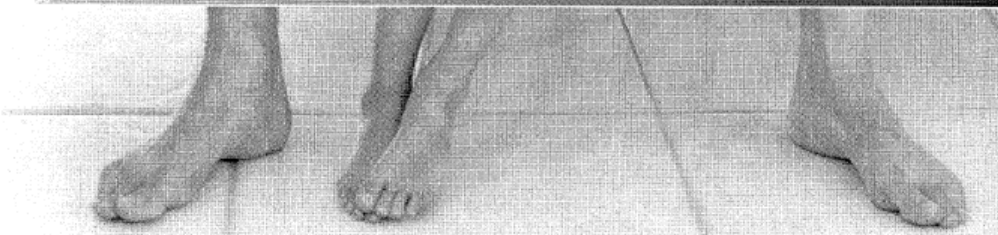


Prevent Child Abuse
Georgia

This publication was supported by Grant/Cooperative Agreement Number 1R01CE000588-01 from the Centers for Disease Control and Prevention (CDC).



IT'S NOT WHAT I SAW, BUT WHAT I FELT.



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1-800-CHILDREN (244-5373) - A Confidential HELPLINE
or visit **www.stopitnowga.org**



Stop It Now! Georgia

*Together we can prevent the sexual abuse of children
a program of Prevent Child Abuse Georgia*



Prevent Child Abuse
Georgia

This publication was supported by Grant/Cooperative Agreement Number 1U59CE000801 from the Centers for Disease Control and Prevention (CDC).

**I didn't think I was hurting anyone by looking
at child pornography...I was wrong.**



YOU CAN STOP IT NOW

Looking at pictures made me crave sexual contact with children. I'm glad I found understanding people who are helping me. I'm getting control so I don't hurt children. Some people who touched children sexually said they started by looking at porn. Are you someone who wants to stop but doesn't know how? Are you depressed, alone, miserable, or out of control? At *Stop It Now!* we understand the struggle. We are ready to help with confidential information and referrals. People who get specialized help can and do learn to control their behavior. No more secrets. No more lies. **If you wonder about your own behavior, visit our web site and read the "Twelve Questions Only You Can Answer."**

Call for **safe and confidential** information from people who can help.

1-888-PREVENT • www.youcanstopitnow.org



Stop It Now!® Minnesota

Stop It Now! Minnesota calls on adults who are being sexual with a child, or who are having sexual thoughts about a child, to stop and seek help. Call our toll-free confidential helpline (1-888-773-8368) or visit our web site for information and referrals. Research shows child sexual abuse is *not* inevitable. It's preventable. **A non-profit program, not a law enforcement agency.**

Stop It Now! Minnesota is supported by Grant/Cooperative Agreement Number 522495-03 from the Centers for Disease Control and Prevention (CDC). The contents of these advertisements are solely the responsibility of the authors and do not necessarily represent the official views of the CDC. The persons pictured are models and the photo is used for illustrative purposes only.

**I'm not like those people on the news who get caught
being sexual with children. Or am I?**



YOU CAN STOP IT NOW

Admitting I want to be sexual with children is hard. Getting caught would be harder. I need help so I won't hurt children. Some people struggle with sexual thoughts and behaviors toward children. Are you someone who wants to stop but doesn't know how? Are you depressed, alone, miserable, or out of control? At *Stop It Now!* we understand the struggle. We are ready to help with confidential information and referrals. People who get specialized help can and do learn to control their behavior. No more secrets. No more lies. **If you wonder about your own behavior, visit our web site and read the "Twelve Questions Only You Can Answer."**

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**I wanted to stop thinking about sex with children,
but I didn't know how.**



YOU CAN STOP IT NOW

**Thankfully I found understanding people who are helping me.
I'm getting control so I don't hurt children.**

Some people struggle with sexual thoughts and behaviors toward children. Are you someone who wants to stop but doesn't know how? Are you depressed, alone, miserable, or out of control? Do you use alcohol, drugs, or pornography to forget the pain? At *Stop It Now!* we understand the struggle. We are ready to help with confidential information and referrals. People who get specialized help can and do learn to control their behavior. No more secrets. No more lies. **If you wonder about your own behavior, visit our web site and read the "Twelve Questions Only You Can Answer."**

Call for **safe and confidential** information from people who can help.

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**Cornwall Community Hospital
Hôpital communautaire de Cornwall**

Job Posting
(CUPE 7811)

JOB TITLE: Program Development Worker (**Temporary Part-Time**)

DUTIES: The Program Development Worker will collaborate with the Cornwall Community Hospital Assault and Sexual Abuse Program to develop a sex offender program consistent with community needs. They will ensure appropriate location, furniture and equipment for the needs of the program.

QUALIFICATIONS:

Required:

- Related clinical Bachelors Degree (e.g. Psychology or Social Work)
- Experience in management
- Good knowledge of existing social and community agencies related to this field
- Ability to establish and maintain effective working relationships with the general public
- Experience in initiating, planning, implementing and evaluation programs and services
- Excellent interpersonal/communication skills
- Knowledge of issues of sexual assault and paraphilia
- Motivated and able to practice independently
- Valid driver's license and access to own vehicle
- Advanced level in English (oral and written)
- Advanced level in French (oral)

SALARY: \$24.93 - \$28.71 per hour.

HOURS: Scheduled and called in as required.

In the event the Hospital is not successful in finding a candidate who meets all requirements, other candidates may be considered.

We thank all candidates for applying; however only those candidates selected for an interview will be contacted.

**Cornwall Community Hospital
Hôpital communautaire de Cornwall**

Job Posting
(CUPE 7811)

JOB TITLE: Social Worker (**Part-Time**)

DUTIES: As a specialist in social work the incumbent will provide comprehensive care to individuals who have sexually offended or are at risk of sexually offending. This may include but is not limited to therapy and psychoeducational aspects such as housing, employment and social assistance.

QUALIFICATIONS:

Requirements:

- Master's Degree in Social Work or equivalent.
- Registered with, or eligible for registration with the Ontario College of Social Workers and Social Service Workers
- Minimum of 3 years experience and demonstrated expertise in trauma, dissociation, symptomatology related to sexual assault and expertise in paraphilic disorders.
- Knowledge and application of Cognitive Behavioural Therapy and The Good Lives Model
- Valid driver's license and access to own transportation
- Proven ability to manage crisis situations
- Good interpersonal skills and the ability to develop a community network
- Ability to work independently
- Strong written and communication skills
- Good computer skills
- Good work and attendance record
- Advanced level in both official languages (oral and written in English and in French)

SALARY: \$32.81 - \$41.80 per hour.

HOURS: Scheduled.

In the event the Hospital is not successful in finding a candidate who meets all requirements, other candidates may be considered.

We thank all candidates for applying; however only those candidates selected for an interview will be contacted.

Strategic Communications Strategy

A well-planned communications strategy will achieve several things:

- help set priorities;
- help focus on specific objectives;
- set out a game plan for achieving these objectives;
- gain a better understanding of the target audiences; and
- help solidify the support of stakeholders

Budget considerations:

Integrated Brand (<i>Adams Jette Marketing and Communications</i>)	
Name	\$1,700
Program identity (Logo) Create visual look of the organization.	\$6,000
Generic corporate brochure (five-panel French/English tumble [4"x9"]) No translation or printing included.	\$3,200
Client brochure (five-panel French/English tumble [4"x9"]) No translation or printing included.	\$3,200
Develop and create a poster aimed at potential clients (24"x 36")	\$1,500
Printing (<i>Astro Printing</i>)	
Brochures (5,000 Five-panel, satin finish)	\$1,800
Posters (500)	\$1,400
Web presence (<i>WebProf.ca</i>)	
Custom programming	\$320-\$1200
Total	
One-time Cost	\$20,000.00

*These prices are estimates gathered by previous quotes.



Royal Ottawa Health-Care Group
Integrated Forensics Program

Evaluation & Treatment of Sexual Offenders

PROPOSED SCHEDULE & LEARNING OBJECTIVES

B. Booth, MD, FRCPC

Education Director

March 9, 2009

Disclaimer

This is a draft document. The presenters are open to alter content based on the learning needs of the group. The general schedule will act as a guide to sessions.

Outline

The program offered at Royal Ottawa Mental Health Centre (ROMHC) will consist of three days of intensive training in the evaluation and treatment of sexual offenders.

Presenters

John Bradford

Paul Fedoroff

Brad Booth

Bill Marshall

Target Audience

This training will be geared towards clinicians and treatment providers in the Cornwall area to facilitate a greater understanding of sexual offending, treatment of paraphilias and management of offenders in the community.

Learning Objectives

1. To gain a firm basis in theory of sex offender evaluation
2. To learn the limitations of risk assessment
3. To learn the treatment options for sex offenders
4. To gain experience in the evaluation and treatment of sex offenders
5. To gain experience and understanding of the role of sexual preference testing in the assessment and management of sex offenders.
6. To understand the empirical basis to predict sexual offence recidivism

	Day 1	Day 2	Day 3
0900 to 1020	Session 1 - Overview - Ethical Issues - Legal issues - Overview of Program - Interviewing of SOs	Session 4 - Observation & Administration of Phallometrics - Theory & Practice of evaluating Sexual Interest - Abel Screening	Session 6 -Pharmacotherapy - Treatment algorithms
1020 to 1040	Nutrition Break	Nutrition Break	Nutrition Break
1040 to 1200	Session 2 - Introduction to Paraphilias	Session 4 - PPT interpretation - Abel Screening	Session 7 - Psychological treatments
1200 to 1300	LUNCH	LUNCH	LUNCH
1300 to 1500	Session 3 - Special populations	Session 5 - Risk assessment - Recidivism issues	Session 8 Working Group #1 – pharmacotherapy Working Group #2 -psychological treatments
1500 to 1530	Break	Break **1445 to 1500**	Break
1530 to 1700	Session 3 (cont) - Special populations	Social Skills Group for Sex Offenders	Case Discussions & Wrap-up
1730 to 1930		Sex Offender Relapse Prevention Group	

SESSION #1

1. Training week overview
2. Legal Background
 - a. Dangerous Offenders
 - b. Sentencing issues
3. Ethical Issues
 - a. Understand limits, risks and potential misuses of phallometric testing
 - b. Review ethical considerations in the assessment of offenders
 - c. Discuss the potential coercive nature of offender evaluation and treatment
 - d. Treating physician vs risk evaluator
 - e. Duty to protect issues
 - f. Reduction of child victimization
 - g. Legal classifications vs actual risk

4. Overview of a Comprehensive Sex Offender Treatment Program

- a. Secure Treatment Unit
 - i. Provincial vs Federal System
 - ii. Programs
 - iii. Evaluation protocols
 - iv. Team roles
- b. Sexual Behaviours Clinic
 - i. Personnel
 - ii. Referral sources
 - iii. Structure

5. The Initial Interview

- a. Sources of information
- b. Clinical Interview
- c. Questionnaire format

SESSION #2

6. Diagnostic Issues

7. Introduction to Paraphilias & Sexual Offenders

- a. Theoretical & practical knowledge in diagnosis of paraphilias
- b. Learn the diagnostic criteria, epidemiology, and etiology of common paraphilias: pedophilia, voyeurism, exhibitionism, sexual sadism, fetishism, frotteurism and paraphilia NOS
- c. Understand base rates of deviant arousal in the population
- d. Learn about differences between rapists and pedophiles
- e. Paraphiliacs vs Sexual Offenders: Learn about the overlap of Sexual Offenders and Paraphilias and about non-paraphiliac sexual offender populations

SESSION #3

8. Diagnostic Issues in Special Populations

- a. Asperger's
- b. Mental Retardation
- c. Mentally Disordered Sexual Offenders

SESSION #4

9. Practical Session – Administration/ Observation of PPG/ Abel Screening (30 minutes)

10. Theory & Practice of Sexual Interest Testing

- a. General Overview
 - i. Initial vs repeat testing
 - ii. Use in monitoring treatment outcome
 - iii. Indications & contraindications
 - iv. Use in Mentally retarded populations
 - v. Use in Psychotic Populations
- b. Phallometrics/ Penile Plesmythography (PPG)
 - i. Theory of PPG
 - ii. Audio vs Visual stimuli sets
 - 1. Review of content of each
 - iii. Approach to interpreting PPG results

1. False positive rates
 2. Percent of controls responding to each stimuli
 3. Anomalous/ spurious results including response to neutral slides
 4. Z-scores, base-peak readings
 5. Suppressed results interpretation
 6. Assault/ Pedo indexes
- iv. Alcohol loaded testing
- c. Abel Screening
 - i. Theory of Abel screening
 - ii. Stimuli set of Abel Screening
 - iii. Interpretation of bar graph results
 - iv. Interpretation of questionnaires
 - d. Utility & interpretation of Self Report Measures
 - i. Derogatis Sexual Functioning Inventory
 - ii. PDS
 - iii. Bumby scales
 - iv. Others (rest of green book)

SESSION #4

11. Practical Session – Interpretation of Sexual Interest Testing

Social Skills Group for Sexual Offenders

Participants may attend optional group, depending on availability.

Relapse Prevention Group for Sexual Offenders

Participants may attend optional group, depending on availability.

SESSION #5

12. Treatment – Overview –
 - a. Overview of various strategies to manage the risk of sexual offenders
 - b. Incarceration
 - c. Civil commitment
 - d. Zoning bylaws
 - e. GPS
 - f. Castration
13. Risk Assessment
 - a. Introduction - Clinical vs Actuarial Risk assessment
 - b. Major studies on sexual offender recidivism

SESSION #6

14. Treatment – Pharmacological Approaches
 - a. Introduction & Background History –
 - b. For each drug, the speaker will discuss the background, mechanism of action, dosing, side effects, recommended monitoring, contraindications, relevant studies for each drug on outcomes
 - i. SSRI's –

- ii. Cyproterone acetate (in Canada) -
- iii. Medroxyprogesterone acetate (depo-provera) –
- iv. Leuprolide (Lupron) & Goserelin (Zoladex) –
- c. Treatment cases – –prepare three to five cases focussing on medication treatment, including response/ side effects/ negative outcomes

15. Risk Assessment

- a. SVR-20
- b. VRAG/SORAG -
- c. Static-99/03 –
- d. Others
- e. Risk Assessment of Special Populations
 - i. Elderly – **(20 mins)**
 - ii. Mental Retardation – **(20 mins)**
 - iii. Psychotic patients – **(20 mins)**
 - iv. Internet Pornography – **(20 mins)**

16. Treatment Algorithms –

- a. Deciding what medication for who
- b. Oral vs IM
- c. Initiation of Treatment
- d. Monitoring of Treatment Efficacy
- e. In-patient vs Out-patient Treatment

17. Pharmacological Treatment issues in Special Populations

- a. Mentally Retarded
- b. Elderly Populations
- c. Others

SESSION #8

18. Treatment – Psychotherapeutic Approaches

- a. Cognitive Behavioural Interventions
 - i. Covert sensitization
 - ii. Odour aversion
 - iii. Satiation
 - iv. Cognitive restructuring – Bumby's scales
- b. Relapse Prevention
- c. Self Regulation Group Therapy
- d. Other Psychotherapeutic Interventions
- e. Practical application