NO. 93195-0

SUPREME COURT OF THE STATE OF WASHINGTON

In Re the Detention of:

CURTIS BROGI,

Petitioner.

ANSWER TO PETITION FOR REVIEW

ROBERT W. FERGUSON
Attorney General

SARAH SAPPINGTON
Senior Counsel
WSBA #14514
BROOKE BURBANK
Assistant Attorney General
WSBA #26680
800 Fifth Avenue, Suite 2000
Seattle, WA 98104
(206) 389-3916

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Statutes

Other Authorities

Rules

I. INTRODUCTION

Curtis Brogi, a sadistic rapist, sexually assaulted numerous women during the late 1980s to mid-1990s. These assaults involved anal and oral rape, use of weapons such as knives or guns, and threats to kill or seriously injure. He has denied committing any sexual offenses, including those for which he has been convicted, claiming that his victims lied.

Rather than participating in the sex offender treatment program offered by the Special Commitment Center, Brogi participates in the Native American Healing Program, a spiritual and cultural program. The program is run by a volunteer with no training in psychology, social work, or sex offender treatment. The program does not keep any records, and does not share any information about participants with professional staff at the Special Commitment Center.

At an annual review hearing, Brogi argued that his mental condition had changed due to participation in these Native American activities, as well as a substance abuse self-help group, such that a new unconditional release trial was warranted. The trial court rejected this argument, and the Court of Appeals, after accepting discretionary review, affirmed. *In re Brogi,* 193 Wn. App. 1003, 2016 WL 1090645. The Court of Appeals properly found that Brogi's involvement in the Native American Healing Program does not constitute "treatment" under the statute such that a new trial is warranted, and this Court should deny review.

II. ISSUE PRESENTED FOR REVIEW

The State does not believe that Brogi has raised any issues that are appropriate for review pursuant to RAP 13.4(b). However, if this Court were to accept review, the issue presented would be:

> **Where the statute requires that, in order to obtain a new trial, Brogi show "a substantial change in his mental condition as the result of a positive response to continuing participation in treatment," and where Brogi refused to participate in sex offender treatment at the Special Commitment Center, did the trial court and the Court of Appeals properly reject his request for a new trial?**

III. STATEMENT OF THE CASE

Brogi's first conviction for a sexual offense was in 1990, when he was convicted of Assault in the Fourth Degree for an assault on his fiancée. CP at 245. He threatened to break her jaw and, after anally raping her, forced her to fellate him, causing her to vomit. After the assault, he fell asleep holding a knife in his hand. *Id.*

Brogi's next conviction was in 1995, having pled guilty to Assault in the Second Degree with a Deadly Weapon. CP at 245. After persuading a 25-year-old woman he had just met to come with him to measure timber for harvest, Brogi took her down a logging road, where he forced her to undress and pose for photographs. *Id.* at 246. He then pushed her to the ground, hit her in the head, and forced her to lie on the ground while he ran his knife down her face and across her throat. *Id.* After toying with her with the knife, he raped her, hitting her when she cried, and threatened to anally rape her after first cutting her anus

open with the knife he was holding. *Id.* After he had raped her, he demanded she fellate him and swallow his semen, threatening that his "biker friends" would take care of her if she told anyone what had happened, and warning that he could use the photographs he had taken of her as blackmail. *Id.* When questioned by the police, Brogi said that he had had consensual sex with the victim and produced the photographs as evidence. *Id.* The medical examination, however, was consistent with rape, and revealed swelling to the face, a bruised lip, and a perforated eardrum. *Id.*

Fewer than six months after he was released from prison following the 1995 offense, Brogi offended again. He met his victim, a 35-year-old woman, at a restaurant, and told her that he had arranged work for her. CP at 247. He brought her to his house, where he pointed a gun at her and told her to undress. *Id.* He then strapped her to his bed in only her bra and panties. *Id.* As she lay there, he produced a knife, cutting his own arm and, while fondling her vaginal area and breasts, told her that others wanted to kill her and that he might have to kill her himself. *Id.* The victim managed to escape when Brogi fell asleep. *Id.* Brogi denied having assaulted the woman but entered an Alford plea to Assault in the Second Degree.[1]

---

[1] In addition to these convictions, Brogi has been identified as the perpetrator of several other sexual assaults. A report submitted by Dr. Robert Saari as part of the annual review process includes detailed descriptions of sexual offenses Brogi was alleged to have committed between 1986 and 1996. Three of those, while reported to authorities, were not charged. CP at 244-45. Two additional allegations were not reported to authorities. CP at 245. A report submitted by Dr. Saari in 2011 also contains a reference to Brogi's rape of his pregnant wife in

Prior to his scheduled release in August of 1997, the State filed a petition pursuant to RCW 71.09 to have Brogi committed as a Sexually Violent Predator (SVP).[2] *In re Detention of Brogi,* 127 Wn. App. 1033, 2005 WL 1300751 at *1. Following a unanimous jury verdict in 2000, the trial court entered an order committing Brogi to the custody of the Department of Social and Health Services ("DSHS") for care, control, and treatment until he no longer meets the definition of a sexually violent predator or can be conditionally released to a less restrictive alternative in the community. RCW 71.09.060. Brogi has been confined at the Special Commitment Center ("SCC") on McNeil Island since that time.

Pursuant to RCW 71.09.070, DSHS has submitted an annual review to the trial court each year since Brogi's commitment. In 2014, Dr. Rob Saari, a forensic psychologist employed by DSHS, submitted that annual review. CP at 242.

As part of his assessment, Dr. Saari considered Brogi's treatment history at the SCC, noting that Brogi's records for the period reviewed did not reflect any participating in sex offender treatment, and that his case management sessions "did not involve any specific work on sex offender treatment issues." CP at 251. A report from 2011, also authored by Dr. Saari, indicates that Brogi had not participated in any treatment in the 2010-2011 review period, nor did he

---

the hospital "when this could have killed her and his unborn child." CP at 49. No further details were included in that report.

[2] "Sexually violent predator" means any person who has been convicted of or charged with a crime of sexual violence and who suffers from a mental abnormality or personality disorder which makes the person likely to engage in predatory acts of sexual violence if not confined in a secure facility. RCW 71.09.020(18).

participate "in any individual therapy sessions or other treatment groups that may have benefitted him." CP at 50. Although Brogi had completed what is known as a "sexual autobiography" the previous year, that document was based "on his quite hard to believe stance that he committed only one sexual offense, which was slapping his 1995 victim during the course of consensual sex.' CP at 50. In a 2010 clinical interview with Dr. Saari, Brogi said that his diagnosis of Sexual Sadism "was based on 'hearsay and false reports,' and did not think he was at any risk at all to sexually re-offend." CP at 50. As of that time, Brogi had "not yet taken [the] first step in the change process," that is, "acknowledging that there is a problem to address[.]" CP at 51.

His most recent treatment plan, authored in December of 2013, indicated that Brogi had made "'minimal effort' to understand his dynamic risk factors since his admission to the SCC." *Id.* His treatment team noted "that he has started and quit treatment at least twice, and believes his participation in the Native American Circle 'takes precedence over the core treatment provided by the Special Commitment Center.'" *Id.* The team also noted that his last attempt at treatment "was adversely affected by his temperamental and unpredictable nature." *Id.* Brogi told Dr. Saari that he "felt degraded" the last time he was in treatment "and did not like the confrontational therapeutic approach." *Id.* at 254. Moreover, he did not think the SCC treatment program was "'deep enough' and considers the 'blue book,' which includes SCC treatment assignment, 'ridiculous.'" *Id.*

As part of his comprehensive evaluation, Dr. Saari assigned Brogi diagnoses of Sexual Sadism; Pedophilia, Sexually Attracted to Females, Nonexclusive Type, Rule Out; Alcohol Use Disorder, In a Controlled Environment; Stimulant Use Disorder (Amphetamine-type Substance), In a Controlled Environment; Rule Out Cannabis Use Disorder; Major Depressive Disorder, Recurrent; and Antisocial Personality Disorder. CP at 246-249. In explaining his diagnosis of sexual sadism, Dr. Saari pointed to the fact that Brogi "committed sexually sadistic acts against women for about a 10-year period," and noted that, after Brogi's last release from incarceration, he acted on his sexually sadistic urges within just a few months. *Id.* at 246. Sadistic fantasies were evident, he wrote, by the fact that Brogi, in preparation for his last offense, had prepared the bed with straps that he used to tie his victim. *Id.* at 247. He also noted that most of Brogi's victims "reported that he behaved toward them in a manner consistent with him enjoying and experiencing arousal to their psychological and physical suffering." *Id.* During several of his offenses, for example, he "made up stories and made statements that were likely to stimulate fear in his victims," telling one teenage girl that her boyfriend was going to be killed and his last victim, an adult woman, that there was a contract out on her life. *Id.* Many of his offenses "involved gratuitous violence that involved torturing his victims with a knife and slapping them." *Id.*

> He bound at least two of his victims. During the 1995 assault, he ran his knife across the woman's face and throat, and at one point, he threatened to cut her anus open to make penetration easier for him. During the 1988 assault, he forced the girl to bark like a dog while he anally raped her and told her to call him

> "master." Similarly, in the 1995 assault, he made numerous degrading comments to his victim, such as "you're a dumb bitch like all the rest" and "you're a good bitch, you do as I told you to do." Degradation was also apparent in the 1990 assault when he forced his ex-wife to fellate him after he anally raped her, which made her vomit. She reported that after this assault, Mr. Brogi began a pattern of forced anal sex and requests for fellatio immediately afterward (without washing).

Id. Anal rape, Dr. Saari noted, "is often the preferred method of the sexual sadist since this type of assault is quite painful and humiliating." *Id.* Brogi's anal assaults "include both penile rape and object insertion," and his ex-wife "reported that he inserted multiple, large objects into her anus (e.g. vacuum cleaner parts and vegetables)...." *Id.*

Brogi has shown little remorse for his sexually assaultive behavior (CP at 248) and, in a number of interviews with Dr. Saari, "he denied almost his entire history of sexual assault." *Id.* at 253. Asked about his crimes, Brogi told Dr. Saari "that his victims, for the most part, lied and distorted the truth" and acknowledged only that he had slapped one victim, the woman at the campsite.[3] *Id.*

Dr. Saari also conducted a detailed risk assessment that included consideration of both static and dynamic factors. CP at 249-52. Noting that Brogi's dynamic risk factors "are somewhat difficult to identify because he has not, to my knowledge, ever been open and forthright about his sexual offenses

[3] Brogi's position on this has been consistent since his commitment trial, at which the State's expert, Dr. Richard Packard, testified that "Mr. Brogi, in both the depositions in which he was sworn to tell the truth under oath as well as in his interviews with me, has steadfastly denied ever committing any kind of sexual assaults against anyone. Has stated straightforwardly I never did any of those things." 2005 WL 1300751 at *5.

or the mental states that preceded his offenses," he tentatively identified several factors based on Brogi's past behaviors: Deviant Sexual Interest (in sexually sadistic rape); "Sexual Preoccupation; Sexual Entitlement; Lack of Concern for Others; Hostility toward Women; Impulsivity; Poor Problem-solving Skills; Poor Cooperation with Supervision; and Poor Self-assessment of Risk." *Id.* at 252. In closing, Dr. Saari opined that Brogi continued to suffer from mental abnormalities and a personality disorder that make him more likely than not to reoffend if not confined in a secure facility. *Id.* at 255.

In response to the filing of Dr. Saari's report, Brogi filed a petition for unconditional release, supported by an evaluation conducted by Dr. Robert Halon, and several other documents. CP at 114-230. Brogi argued, *inter alia*, that residency at the SCC, participation in the SCC's "Native American Healing Program," ("NAHP") and involvement in substance abuse self-help groups constituted "treatment" as intended by the legislature (CP at 119) and that he had provided sufficient proof to warrant the granting of a trial on the issue of whether he continues to meet the definition of a sexually violent predator. *Id.* at 125. At a subsequent hearing, the trial court rejected Brogi's petition for an unconditional release trial, concluding that he had failed to show substantial change in his mental condition "through a positive response to continuing participation in sex offender treatment..." *Id.* at 7. The court also

found Brogi had "not recently participated in sex offender treatment at the Special Commitment Center." *Id.* at 6.[4]

Brogi sought discretionary review, which was granted. In its unpublished opinion, the Court of Appeals rejected Brogi's argument that his participation in Native American activities constituted "treatment" for purposes of the granting of a new trial. 2016 WL 1090645 at *2. The court determined that the NAHP, as described in the record in this case, "is not consistent with the legislature's community safety goals," and as such "is not 'treatment' that may trigger an unconditional release trial." *Id.* Brogi timely sought review.

IV. REASONS WHY REVIEW SHOULD BE DENIED

Brogi argues that his rights under both the statute and the Due Process Clause were violated by the trial court's denial of his request for a new trial, and urges that there is a substantial public interest in the "critical question" of the type of treatment in which a committed sexually violent predator must participate in order to obtain a new trial pursuant to RCW 71.09.090(4).

Brogi's arguments fail. The NAHP, while a useful adjunct to the SCC's core sex offender treatment program, does not constitute "treatment" under the statute. The court correctly determined that the NAHP is run by a volunteer with no special training in sex offender treatment or psychology, who is not

[4] The State agreed to set a trial on the issue of Brogi's conditional release to a less restrictive alternative because RCW 71.09.090(2)(d) allows such a hearing without requiring the SVP to show change in his condition. CP at 7. That trial concluded on June 22, 2016, with the jury rejecting Brogi's request for conditional release to the community.

supervised by any SCC staff, does not report disclosures by participants to SCC staff, and keeps no official records of NAHP activities. 2016 WL 1090645 at *4. The Court of Appeals properly found that the program "lacks a level of public accountability consistent with the legislature's community safety goals" and does not constitute "treatment" under the statute. *Id.*

A. Purpose and Procedure of the RCW 71.09.090 Show Cause Hearing

A person committed as an SVP to the custody of DSHS is entitled to an annual review of his mental condition by DSHS. RCW 71.09.070. DSHS's annual review evaluation must address whether the committed person continues to meet the definition of an SVP.[5] The SVP may also submit his own expert evaluation to the court. *Id.* At the show cause hearing that follows these submissions, the State must "present prima facie evidence that the committed person continues to meet the definition of a sexually violent predator...." RCW 71.09.090(2)(c). If the State fails to meet its burden, the court must order a new trial. RCW 71.09.090(2)(c).

Once the State has made its prima facie case, a new trial will be granted only upon a showing that there is probable cause to believe that evidence exists, since the person's last commitment trial, that: 1) there has been a "substantial" change in the respondent's condition; 2) the change results from either a permanent physiological event such as a stroke or dementia rendering the committed person

[5] The statute also mandates consideration of the propriety of placement in a Less Restrictive Alternative (LRA). Because this appeal does not involve consideration of LRAs and in the interests of brevity, statutory reference to LRAs will be omitted from this brief.

unable to reoffend, or from a "positive response to continuing participation in treatment." RCW 71.09.090(4)(c). These requirements have withstood repeated challenge in the appellate courts of this State, most recently in *State v. McCuistion*, 174 Wn.2d 369, 275 P.3d 1092 (2012).

In upholding release procedures outlined in RCW 71.09.090, the *McCuistion* Court determined that requiring change as a prerequisite for an evidentiary hearing "does not offend substantive due process principles." 174 Wn.2d at 384. Substantive due process, the Court noted, "requires only that the State conduct periodic review of the patient's suitability for release." *Id.* at 385. The State, the Court noted, "has a substantial interest in encouraging treatment" and "by making treatment the only viable avenue to a release trial (absent a stroke, paralysis, or other physiological change)," the State creates an incentive for participation in treatment. *Id.*

B. Brogi Was Not Entitled To A New Trial Under RCW 71.09.090 Because He Did Not Present Evidence Of Substantial Change Through Treatment

1. "Treatment" means sex-offender specific treatment

It is undisputed that, at the time of the show cause hearing, Brogi had not recently participated in the SCC's sex-offender specific treatment program. CP at 6. Brogi, however, argues that the Court of Appeals' decision that participation in the NAHP does not constitute "treatment" under the statute was "unreasonable." Pet. at 11. This view finds no support in the legislative history of the 2005 amendments to RCW 71.09.090 or in case law, which make clear that, by requiring participation in

"treatment" as a precondition of release, the legislature intended to require participation in sex offender specific treatment, and not simply ancillary programs which, while beneficial, do not address the mental conditions that drive the sex predator's sexually violent behaviors.

RCW 71.09 is intended to address the very long-term treatment needs of violent sexual predators and to incentivize participation in treatment by limiting new trials to those who have participated in treatment. RCW 71.09.010; *McCuistion*, 174 Wn.2d at 394. In 2005, the Legislature amended the portion of the statute governing post-commitment release procedures, clarifying that the only way for an SVP to demonstrate sufficient change such that a new trial is warranted is to show a "substantial" change based on either permanent physical incapacitation or a "positive response to continuing participation in treatment."[6] RCW 71.09.090(4). The *McCuistion* Court noted that, in requiring participation in treatment as a prerequisite to a new trial, the legislature intended to "address the 'very long-term' needs of the sexually violent predator population for treatment and the equally long-term needs of the community for protection from these offenders." 174 Wn.2d at 389. The legislature, the Court continued, "wanted to ensure that the statutory focus remains on treatment and did not want to remove the incentive for successful treatment participation." *Id.* at 390. The

[6] This limitation relates only to the burden on the SVP of demonstrating change sufficient to warrant a new trial. An SVP may still obtain a new trial if the SCC authorizes him to petition for release pursuant to RCW 71.09.090(1); or if the State fails to present prima evidence that the person remains an SVP pursuant to RCW 71.09.090(2).

Court further acknowledged the State's "substantial interest" in incentivizing treatment for sexually violent predators, noting "the link between *sex offender treatment* and decreased recidivism," and the State's interest "in protecting public safety by restricting evidentiary hearings to those who have participated in treatment." *Id.* at 394-95 (emphasis added). This Court considered a similar issue in *In re Meirhofer,* 182 Wn.2d 632, 639, 343 P.3d 731 (2015). There, the Court used the terms "sex offender treatment" and "treatment" interchangeably, noting, for example, that Meirhofer had "declined treatment" in the same paragraph as recognizing the legislature intended to incentivize "sex offender treatment." *Id.* at 639.[7]

In considering what "treatment" qualifies under the statute, the court should consider other statutes or parts of the statute on the same subject matter. *US West Communications, Inc. v. Wash. Util. & Transp. Comm'n*, 134 Wn.2d 74, 118, 949 P.2d 1337 (1997). In reference to "treatment" in the context of RCW 71.09.090, the legislature was clear as to its intent. In fact, the 2005 amendments to the act included a stated purpose:

> [T]he legislature finds that a new trial ordered under the circumstances set forth in *Young* at *Ward* subverts the statutory focus on treatment and reduces community safety by removing all incentive for successful treatment participation in favor of passive aging and distractive committed persons from *fully engaging in sex offender treatment.*

CP at 108 (emphasis added).

---

[7] *See also In re Det. of McGary* ("McGary has refused to participate in *sex offender* treatment since at least 2007." 155 Wn. App. 771, 784, 231 P.3d 205 (2010) (emphasis added)).

Other portions of the statute make clear that "treatment" means "sex offender treatment." For example, RCW 71.09.020(19) defines a "total confinement facility" like the SCC is "a secure facility that provides supervision and *sex offender treatment services* in a total confinement setting." (Emphasis added). Further, when an SVP has successfully progressed to the point that they are eligible for release to a less restrictive alternative facility, the SVP is required to receive additional treatment only from "certified sex offender treatment providers or certified affiliate sex offender treatment providers under chapter 18.155 RCW" with exceptions not relevant here. RCW 71.09.350(1). If the conditional release is to a DSHS-run "secure community transition facility," that facility will "either provid[e] or ensur[e] the provision of sex offender treatment services." RCW 71.09.020(16). It would be nonsensical to conclude that the legislature intended to require sex offender treatment upon conditional release, but not while in total confinement at the SCC. That sex offender specific treatment is a prerequisite to a release trial was made even more clear by the legislature's passage, in 2015, of H.B. 1059, defining "treatment" as "the sex offender specific treatment program at the special commitment center or a specific course of sex offender treatment pursuant to RCW 71.09.092(1) and (2)." RCW 71.09.020(20).

2. The NAHP does not constitute "treatment" under the Statute

Brogi asserts that the Court of Appeals rejected his argument that the NAHP constitutes "treatment" under the Statute "because there were not enough

official documents to allow for public accountability." Pet. at 1. This argument mischaracterizes the court's decision. The court noted that Brad Mix, a graphic designer who volunteers as the NAHP's "spiritual advisor," has no experience treating sexually violent predators nor any training specific to SVPs, has "limited knowledge of 'sex offender treatment modalities'" (2016 WL 1090645 at *1,3), is not supervised by any SCC treatment team members, keeps no official records of NAHP activities (*Id.* at *1), "never discloses 'details about what goes on in ceremony' to SCC staff," and does not report disclosures made by participants. *Id.* at *1,3. While the court acknowledged that Brogi's long-term participation in the NAHP may have been beneficial, it concluded that:

> the NAHP's activities are largely confidential and are not supervised or conducted by members of a SCC treatment team. No official records are generated from each treatment session. Such a cultural and spiritual program run by a volunteer without oversight by a SCC treatment provider and documentation of participation and progress lacks a level of public accountability consistent with the legislature's community safety goals.

Id. at *4.

This conclusion is well-supported by the record, and does not, as alleged, violate Brogi's statutory or constitutional rights. Mainstream treatment of sex offenders is best when the treatment program incorporates cognitive-behavioral elements. App. A at 14.[8] "Treatment should be cognitive-behavioural in orientation, should include relapse preventions, should focus on skills

[8] This article was referenced at CP 16 and attached to Brogi's Motion for Discretionary Review ("MDR") in the Court of Appeals as Appendix D.

acquisition, and should explicitly target those criminogenic need factors identified during initial assessment." *Id.*

Cognitive-behavioral treatment methods attempt to treat the offender by having him identify his risk factors and learn ways to deal with them. CP at 150. It operates under the scientifically validated premise that negative and inappropriate behavior is often linked to learned negative thoughts. App. A at 8. The purpose of the treatment model is to confront and unlearn the negative thoughts thus eliminating the inappropriate behaviors associated with the negative thoughts. *Id.* Relapse prevention strategies are often incorporated into cognitive-behavioral treatments. *Id.* at 10. Theoretically, relapse prevention teaches the sex offender how to avoid or deal with risky situations and promote "effective self-management." *Id.* "According to [relapse prevention], the best way to reduce recidivism rates is to identify and reduce or eliminate an individual's array of dynamic risk factors." CP at 151.

Brogi's evidence at the trial court was clear that, while incorporating Native American healing often adds to the effectiveness of cognitive-behavioral treatment, it does not replace it. *See generally* App. B.[9] Nearly all of the examples of Native American programs Brogi presented to the trial court include cognitive-behavioral treatment within their program descriptions. The La Macaza Clinic in Quebec, for example, notes that "conventional treatment" is "very useful," and adds that "cultural components" "can enhance participation

[9] This article was attached to Brogi's MDR as App. F.

by aboriginal offenders." *Id.* at 3. The Native Clan Organization at Stony Mountain in Rockwood, Manitoba, provides "a meld of cognitive-behavioural interventions with spiritual healing." *Id.* at 4. The Aboriginal Sex Offender Healing Program at the Bowden Institution in Alberta is described as "a blend of core programme teaching with service being provided by an Elder to cover spirituality and culture." *Id.*at 8. Another source cited by Brogi concludes that Aboriginal sex offenders are "most likely to benefit from treatment programs" in which the treatment program "focuses specifically on sexual offending," and "is based on a cognitive-behavioural model" that "incorporates content specific to relapse prevention..."App. A at 27-28.

The Native American activities available at the SCC do not incorporate any cognitive-behavioral methodology, a focus on relapse prevention, or any other recognized therapeutic method for treatment of sex offenders. As Mr. Mix explained, "Native American practices are not – it is not psychotherapy." CP at 70. Rather, the activities in which Brogi actually participated involve spiritual practices, such as the Medicine Wheel and Sweat Lodge, which were organized by a spiritual leader. *Id.* at 181.

Nor do the Native American activities at the SCC involve clinical or counseling staff. The activities are supervised by a tribal elder—Brad Mix—and the SCC chaplain; not members of a treatment team. CP at 67-68. Mr. Mix has no formal training in social work, mental health counseling, or psychology. He

is not a licensed mental health provider,[10] sex offender treatment provider, or social worker. He carries no advanced degrees related to the mental health profession. His training has been "traditional" and has involved talking to individuals who do sex offender treatment. *Id.* at 92. His entire understanding of how to treat sex offenders comes from reading on his own and talking to others who do the work. As he stated in his deposition: "So, yeah, I've gotten training through, you know, the people that I've been around and asked questions of, but for the most part it's traditional." *Id.* at 92-93.

Nor does NAHP keep any records of their activities, as is required of DSHS. Pursuant to RCW 71.09.080, DSHS must keep records regarding any treatment in which an SVP participates, and those records must be made available upon request. Those records are only to be made available to "[t]he committed person, his or her attorney, the prosecuting agency, the court, the protection and advocacy agency, or another expert or professional person who, upon proper showing, demonstrates a need for access to such records." *Id.* (*See also* WAC 388-880-042 (1)(a)). In part, those records are used to monitor progress, assess treatment outcomes, develop future treatment plans, and produce the statutorily required annual reviews. RCW 71.09.070.

[10] Note that while Mr. Mix is not a licensed professional, he appears to be exempt from such a requirement under RCW 18.225.030(4). "Nothing in this chapter shall be construed to prohibit or restrict: ... (4) the practice of marriage and family therapy, mental health counseling, or social work under the auspices of a religious denomination, church, or religious organization."

In contrast, the activities organized by Mr. Mix are confidential. CP at 71. According to Mr. Mix, "[t]he details of what's happened within the ceremony [are] meant to be private." *Id.* Mr. Mix does not produce any treatment records and does not discuss treatment needs with other counseling staff at the SCC. The fact that the practices – and records thereof – are not able to be reviewed by persons performing the annual reviews means that the reviewer can never have a complete picture of the individual he or she is attempting to assess. Without record keeping, the only person assessing progress is Mr. Mix, who, as noted above, has no experience or training in conducting an assessment.

Nor is it clear how "progress" in such a program would be measured, a consideration that goes directly to the issue of whether the materials presented by Brogi demonstrate a substantial change in his mental condition. Brogi argues, based largely on Mr. Mix's Declaration, that his work in the NAHP has allowed him to "'achiev[e] insight into his unconscious trauma' that led to his crimes and his poor decisions" (Pet. at 3; CP at 180) and has "enabled him to understand and accept his violent offense history." Pet. at 3. Brogi, however, continues to deny—as he always has—that he committed any sexually violent offenses at all. CP at 244-246; 248; 253. *See also* FN 3, *infra.* Likewise, Mr. Mix applauds Brogi for his "near completion" of his studies to become an addictions counselor with a specialty in, *inter alia,* Domestic Violence. CP at 181. He does so, however, without noting that Brogi continues to deny the brutal rape and assault of his fiancée, for which he was convicted. A thrice-convicted sex offender who

continues to deny that he has ever committed any sex offenses cannot plausibly be said to have changed in any meaningful way, much less in any way relevant to his risk of re-offense.

V. CONCLUSION

The Court of Appeals correctly affirmed the trial court's decision denying his request for a new trial. This Court should deny review.

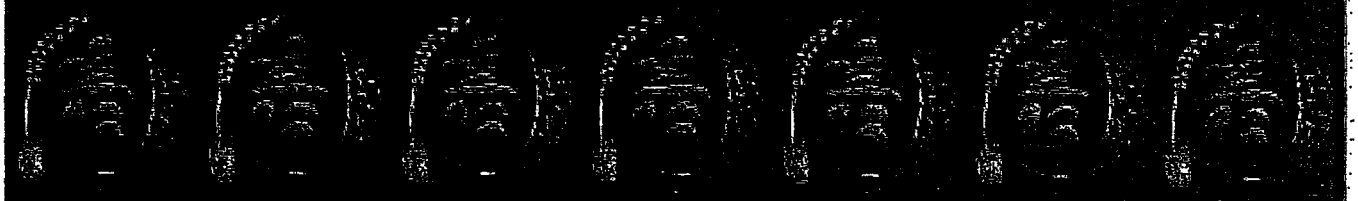
RESPECTFULLY SUBMITTED this 27th day of July, 2016.

ROBERT W. FERGUSON
Attorney General

SARAH B. SAPPINGTON, WSBA #14514
Senior Counsel

APPENDIX A

Aboriginal Sexual Offending in Canada



The Aboriginal Healing Foundation Research Series

First Edition 2002
Second Edition 2006

Published by:
Aboriginal Healing Foundation
75 Albert Street, Suite 801, Ottawa, Ontario K1P 5E7
Phone: (613) 237-4441
Toll-free: (888) 725-8886
Fax: (613) 237-4442
E-mail: communications@ahf.ca
Website: www.ahf.ca

Design & Production:
Aboriginal Healing Foundation

1st and 2nd printing by:
Anishinabe Printing (Kitigan-Zibi)

ISBN 1-897285-33-7

This project was funded by the Aboriginal Healing Foundation,
but the views expressed in this report are the personal views of the author(s).

Ce document est aussi disponible en français.

Aboriginal Sexual Offending in Canada

Prepared for

The Aboriginal Healing Foundation

by

Dr. John H. Hylton

With the Assistance of:

Murray Bird
Nicole Eddy
Heather Sinclair
Heather Stenerson

2002

Table of Contents

Chapter 5

The Treatment of Sex Offenders

In previous chapters, a number of problems associated with relying on the criminal justice system to address crime and offending in Aboriginal communities were discussed. The importance of understanding current problems in Aboriginal communities in the context of the undermining of Aboriginal cultures and nations that has taken place in Canada for well over one hundred years was also emphasized. The suggestion that the most meaningful and long-lasting solutions to Aboriginal sexual offending, Aboriginal crime generally, and other social issues in Aboriginal communities, mostly lie outside the criminal justice system. These solutions have to do with the building and strengthening of Aboriginal families, communities and nations through the recognition and support of the Aboriginal right to self-determination and self-government.

The broader strategies that have been discussed cannot be implemented quickly. Rather, as the Royal Commission on Aboriginal Peoples (1996) has pointed out, the healing and empowerment will take a number of decades, and perhaps even generations, to fully achieve. Thus, while these long-term strategies are being pursued, there is also a need to deal with the immediate threats to the well-being of Aboriginal women and children — threats that also undermine the prospects for positive social development in Aboriginal communities. In particular, all concerned stakeholders must recognize that sexual offending among Aboriginal people is widespread in Canada. Steps must be taken to provide effective rehabilitation and support services to offenders and victims so that wounds can be healed, and the risk to Aboriginal families and communities can be minimized.

In this chapter, treatment and support services for sex offenders are considered. Trends in the provision of treatment services for sex offenders and some of the current services that are available in Canada are reviewed. Leading approaches currently advocated by experts in the field and what is known about the effectiveness of these interventions.

Although there is little experience with programs specifically for Aboriginal sex offenders, this chapter reviews a number of promising approaches. In addition, the results of several evaluations that have been completed are discussed, and some of the emerging "best practices" in this highly specialized field are outlined.

Trends in Sex Offender Treatment

Over the past two decades, greater public awareness about sexual abuse, as well as legislative changes designed to detect and punish offenders, have resulted in more disclosures, charges being laid, and sexual offenders being processed through the criminal justice system. While the concerns of interest groups initially centered on the needs of victims and families, the identification of an increasing number of sexual offenders has led to a heightened interest in the development and delivery of effective sex offender treatment programs.

The current literature on programs for sex offenders makes use of three related terms. At the outset, it is helpful to distinguish among them, since each term usually reflects somewhat different views about what leads to sexual offending and what programs for sex offenders should seek to accomplish:

1. Treatment. If the person who offends is regarded as a person who has psychological or psychiatric problems, a treatment program for "the patient" is often called for, whether in a hospital, correctional institution or community clinic. Treatment is a therapeutic process that places the emphasis on the psychological needs of the individual offender. While healing is hoped for, the focus is on personal healing. It is reasoned that this must occur before reintegration into society is possible. Through treatment, it is intended that the sex offender will learn about his distorted thinking and feelings, and what has led to their development. It is hoped that this awareness will help the offender to change or control his thinking patterns and behaviour.

2. Rehabilitation. If the person who offends is regarded as a "sex offender," a rehabilitation program that will reduce the risk of reoffending is called for, whether within an institutional or a community program setting. In the rehabilitation paradigm, the sex offender is not viewed as a "bad" person, but as someone whose destructive surroundings and upbringing have led to the development of inappropriate and unacceptable behaviours. Through the rehabilitation program, the person who sexually offends is encouraged to acknowledge wrongdoing and change behaviour (Yantzi, 1998).

3. Healing. This term is increasingly in use, particularly with regard to what might otherwise be termed rehabilitation programs for Aboriginal offenders. Healing refers to an all-encompassing recovery process that involves not only the sex offender, but often the victim, the family and the community as well. While it involves psychological and emotional components, whole health is also seen as having an important spiritual dimension. In this paradigm, the unhealthy or "out-of-balance" individual is seen as a complex, multifaceted individual who is an integral member of a family and community network. The focus is on restoring balance. The perspective brought to the healing process is one of hope for positive outcomes (Solicitor General Canada, 2001).

Although the terms are often used interchangeably, in point of fact, "treatment" and "rehabilitation" are predominantly used to describe programs based on Western healing paradigms, while "healing" is predominantly used to describe programs based on traditional Aboriginal beliefs and practices. This usage will be followed.

1. Types of Sex Offender Treatment Programs

The specific design of sex offender treatment programs is based on the underlying theory of causation that has been used in the program design. Because there has been a good deal of uncertainty and disagreement about these causes, different approaches to treatment have flourished (Coleman, Dwyer and Pallone, 1992). In part, this is due to the fact that sexual offending is a relatively new area of concern for mental health professionals and the criminal justice system. This has meant a good deal of speculation about causes, a good deal of experimentation with different types of treatment and not a lot of systematic research. However, this is changing and there are a number of common themes that now run through much of the literature on the treatment of sex offenders. These will be discussed at the end of this section.

The majority of current treatment programs are based on a cognitive-behavioural approach. However, before describing this approach, some of the other treatment options that have been tried are discussed. Some of these other approaches are controversial and may even be seen by some as inhumane or unethical.

Nonetheless, they are mentioned here so as to provide a more or less complete overview of the types of programs that have been in vogue or are currently in use.

Some theorists believe that persons who offend sexually have a biological or organic disorder. For example, there has been particular interest in understanding the role of elevated levels of testosterone. In some hospitals and correctional institutions, including those in Canada, sex offenders are given anti-androgen treatments such as Depo-Provera to reduce their testosterone levels and sexual drive. Concerns related to what some refer to as "chemical castration" treatments include the ethics of administering such drugs, the side effects that may develop as a result of the treatment, and the fact that it is extremely difficult to ensure compliance with the treatment (Hollin and Howells, 1991). A further concern is that the empirical evidence does not clearly support the proposition that elevated testosterone levels are the underlying cause of most sexual offences. Nonetheless, this treatment is often provided particularly in those cases where the offender has extreme difficulty in suppressing deviant sexual arousal (e.g., sexual attraction to children). In most cases, it is used where the suppression of sexual drives is seen as a prerequisite to effective participation in other types of treatment programs.

Another controversial technique that also involves attempts to reduce the production of testosterone involves surgical castration. This technique was widespread in Europe for many years and, after a moratorium, it has been reintroduced in some countries (e.g., Denmark). Thorne-Finch (1992) explores this issue at some length. The conclusion he reaches is that the effectiveness of the treatment is somewhat dependent on the sex offender himself. If the sex offender chooses this treatment, it appears to increase its effectiveness. However, castration does not guarantee the cessation of a man's sexual activities or desires. The sex offender may, therefore, be able to continue with the behaviours that the treatment was designed to eliminate. The ethics of this technique are especially controversial in jurisdictions where offenders may be enticed into choosing castration as a stated or unstated condition of winning release from a custodial institution.

There has also been experimentation with psychosurgery. This technique involves destroying the parts of the brain that are believed to control sexual behaviour. This approach was never widely used and is not practiced in Canada today.

Proponents of psychotherapeutic approaches to treatment believe that intrapsychic dynamics are at the root of sexual offending. Treatment programs based on this approach involve exploring intraspychic and developmental conflicts through individual and group psychological counselling or therapy. Usually, the goal is to identify and resolve the early life conflicts and trauma that are believed to have led to sexual offending (Becker, 1994). This form of treatment is lengthy, since it involves attempts to restructure the individual's personality, and it usually does not involve a specific focus on sexual offending (Hollin and Howells, 1991). Unfortunately, there are no common standards for measuring the outcomes of this treatment approach (Becker, 1994). Moreover, because of its impracticality, as well as concerns about effectiveness, this form of treatment is seldom provided today. It has been suggested that psychotherapeutic approaches are limited because they fail to take into account society's role in the creation of violence against women and children.

Many sex offenders have been found to be socially anxious or lacking in the skills needed to function satisfactorily with other adults. They may also have attitudes and thought patterns about relationships that

increase the likelihood they will offend sexually. Treatment programs have, therefore, often incorporated group and individual skills training components to address these issues. Some therapists also incorporate the use of surrogates and role playing, so that the sex offender can learn and practice sexually appropriate behaviour (Hollin and Howells, 1991).

Another type of therapeutic intervention can best be described as a behavioural, classical conditioning or stimulus-response type approach. In these programs, the sex offender undergoes aversion therapy, covert sensitization, imagery, systematic desensitization, satiation or a variety of other behaviour shaping techniques (Hollin and Howells, 1991). These approaches involve the pairing of an image or thought about particular behaviours or sexual partners with unpleasant or pleasant consequences in an attempt to shape appropriate behaviour patterns. With covert sensitization, the patient may also create imagined alternatives to the offending behaviour and the positive consequences that would follow. The main goal is to reorient sexual preferences so that they are more appropriate. In this approach, it is theorized that appropriate attitudes and values will follow. Some research indicates these techniques can reduce recidivism, at least for some offenders.

A variation on these approaches involves orgasmic reconditioning (or masturbatory conditioning). In this approach, the sex offender replaces deviant fantasies with non-deviant fantasies during masturbation (Hollin and Howells, 1991). These techniques are self-conducted. Therefore, misinterpretation by the patient and failure to follow through with "assignments" are difficult to monitor. These techniques require highly specialized personnel and, sometimes, specialized facilities. If not done properly, they may be ineffective or worse (Ryan and Lane, 1991).

2. Cognitive-Behavioural Therapy

Cognitive-behavioural therapies are the most commonly used and widely evaluated of all of the treatment approaches used with offenders generally, and with sex offenders in particular (Becker, 1994). This approach originates in social learning theory (Bandura, 1986), and in the work of Dr. David Burns, the author of *Feeling Good: The New Mood Therapy* and *The Feeling Good Handbook*. In this approach, negative thinking patterns and inappropriate behaviour are thought to be linked. Furthermore, these negative thought patterns may become distorted and unrealistic, and are often the product of one's previous experiences or those of other close individuals. In other words, these negative thoughts have been learned. However, this theory is based on a belief that thoughts and behaviours can also be "unlearned." Assignments related to unlearning negative thoughts are common in this treatment approach. Confronting negative thinking is the foundation of cognitive-behavioural therapies.

The application of the cognitive-behavioural approach to the treatment of sex offenders focuses on three goals: changing the person's maladaptive pattern of deviant arousal, correcting the distorted thought patterns that support these maladaptive behaviours, and increasing the person's social competence (Morrison, Eroga and Beckett, 1994). In addition, these programs often incorporate an educational component that increases the sex offender's knowledge about human sexuality, the impact sexual assault has on victims and the sexual assault cycle.

An important component of cognitive-behavioural approaches involves addressing cognitive distortions. These are false or distorted beliefs that offenders rely on to justify or minimize their behaviours. For

example, they may blame the victim, minimize the harm that their offending causes or rationalize their sexual aggression. During treatment, these beliefs are challenged and altered so that the offender is able to make a more accurate assessment of his behaviour and its consequences.

Cognitive-behavioural treatment programs are used for offenders of all ages. However, it has been suggested that younger sex offenders may be particularly responsive to this approach because they have fewer distorted beliefs and less well-established deviant sexual arousal patterns (Morrison, Eroga and Beckett, 1994).

Cognitive-behavioural treatment programs typically begin with teaching the sex offender about the sexual offense cycle. Learning about this cycle, it is believed, allows the offender to develop an understanding of how fantasies about power, control and sexually deviant behaviour lead them into offending. This, in turn, is said to allow offenders to see that sexual offending has precursors and antecedents and does not occur randomly or without warning (Ryan and Lane, 1991).

It is within the context of learning what triggers the sexual offending behaviour that many cognitive-behavioural treatment programs incorporate conditioning assignments such as covert sensitization. The underlying purpose of these assignments is to interrupt the pleasurable associations and anticipation that the deviant sexual fantasy creates in the mind of the sexual offender. Offenders may work on a variety of scenarios, for example, about a deviant situation, an aversive one, and an escape or reward scenario. These assignments are intended to improve impulse control and decision making, as well as decrease deviant arousal patterns and the cognitive distortions that support them (Ryan and Lane, 1991).

Most cognitive-behavioural treatment programs entail group counselling in addition to individual cognitive counselling and assignments. The group provides a place where the sex offender is encouraged to openly discuss his offending behaviours. Offenders also have the opportunity to take responsibility for their actions and discuss their present experiences. Such groups may be used, for example, to develop an understanding of consent, equality and coercion, as well as to reinforce information about the sexual offense cycle. The treatment group also provides a combination of confrontation and support that bears some similarities to the pressures that peer groups may exert "on the outside" (Ryan and Lane, 1991).

Cognitive-behavioural treatment programs also focus on teaching the sex offender new ways to think about particular situations and the cognitive and behavioural responses to them. This process often involves exploring the societal messages and myths that support sexually abusive behaviours. Sex offenders are taught why the myths are false. New messages about appropriate relationships can then be learned.

Cognitive-behavioural treatment programs may also incorporate educational and skill-building sessions that address the sex offender's deficits in these areas. Sessions usually include information about healthy human sexuality, dating and relationship skills, social skills, the definition and acceptance of one's own sexuality, and the development of values that support consensual sexual interactions (Ryan and Lane, 1991).

Because many sexual offenses occur within families, cognitive-behavioural treatment programs sometimes incorporate family systems therapy into the treatment. This is considered to be essential in the treatment of incest offenders (Morrison, Eroga and Beckett, 1994). It is also used quite extensively in the treatment of juvenile offenders (Ryan and Lane, 1991).

3. Relapse Prevention

Relapse prevention programs are an extension of cognitive-behavioural treatment. A focus on relapse prevention has developed from a realization that, like other compulsive behaviours, impulses to offend sexually require lifelong management. Relapse prevention for sex offenders has been adapted from addictions research and practice. It is a post-treatment intervention that is intended to maintain the benefits of treatment and assist the offender to avoid relapsing. The primary goal of relapse prevention is to assist offenders to acquire the skills they need for effective self-management.

Relapse prevention programs focus on encouraging the sex offender to recognize that offending behaviour is a choice over which control can be exercised. It is a choice for which each offender must take responsibility. Through cognitive-behaviour therapy, the sex offender learns the patterns of thinking, feeling and behaving that have contributed to their offending in the past. The sex offender then makes a plan to avoid the triggers that increases his risk of reoffending. In developing the relapse prevention plan, strategies for controlling behaviour are learned and rehearsed.

The relapse prevention plan, usually a written plan, requires the sex offender to avoid activities and situations that have previously been identified as risky (Mathews, 1995). For example, a pedophile may need to avoid pornography that depicts children in a sexual manner or situations where he would be alone with a child. In addition to avoiding these activities and situations, the sex offender also develops a plan of action if and when he finds himself at risk.

Sex offenders who are enrolled in relapse prevention programs are also encouraged to develop new hobbies and pastimes, and to learn and develop the skills required to have positive, healthy relationships. Attention is paid to attending to the factors that contribute to physical and emotional health (Mathews, 1995). Offenders may also be encouraged to deal with family issues and any past experiences as victims of physical or sexual abuse.

Groups that provide continuing support for relapse prevention have also been developed. The purpose of such groups is to create a safe environment where recovering sex offenders can share their experiences and receive the support they require to maintain their personal relapse plans. Sex offenders are encouraged to rely on support groups to assist them in dealing with any real or perceived issues they are experiencing in maintaining their relapse prevention plan (Mathews, 1995).

4. Themes and Issues

A number of common themes and issues emerges from the literature on effective sex offender treatment programs. The state of the research in the field does not allow many definitive statements to be made about "best practices." Therefore, what follows might more appropriately be described as "emerging best practices."

- The Purpose of Treatment. The underlying purpose of sex offender treatment programs almost always refers to the cessation of the sexually inappropriate behaviours. This is the case whether the program is for offenders who have been accused of a crime, those who have been convicted or those who have been referred or self-referred to a treatment program. In virtually all of these cases, whether

the program is in the community or offered within a correctional institution or hospital, or whether the program is offered within the criminal justice system or elsewhere, the main goal of treatment is to prevent future sexual offending behaviours.

- Multi-factoral Causation. A variety of types of treatment interventions have been implemented over the years. These include general psychotherapeutic, organic, behavioural, cognitive-behavioural and relapse prevention programs. Earlier approaches were often based on an assumption that a single factor, such as difficulty with emotional expression or intimacy, was behind sexual offending. However, the multidimensional nature of causation has been recognized and treatment programs have incorporated a variety of different approaches to address multiple factors (Yates, 1999).

- Treatment Methodology. Although different programs use different techniques, most contemporary sex offender treatment programs employ a cognitive-behavioural approach combined with relapse prevention. These programs focus on helping the sex offender decrease his deviant sexual arousal patterns, while increasing his non-deviant arousal responses. Usually, there is also a focus on developing functional social skills and learning how to manage stress and anger. Many of the cognitive-behavioural treatment programs also incorporate techniques aimed at helping the sex offender understand and change his cognitions regarding the impact that his actions have on the victim. Information about the sexual offense cycle and human sexuality, is also provided. Some programs also include techniques designed to bring about the restoration of the family; this is particularly true in cases involving incest (Becker, 1990).

- Sexual Preference. Contemporary thinking about sexual offending places the emphasis on the control of behaviour rather than on changing sexual preferences. No treatment method has been shown to be effective in changing sexual preferences.

- Cure vs. Control. It is now widely acknowledged that there is no "cure" for inappropriate sexual cognitions and behaviour. Therefore, contemporary treatment strategies focus on the control of behaviour. Similar to 12-step programs in the area of addictions, experts believe that successful rehabilitation and relapse prevention requires a recognition on the part of sex offenders and program providers that recovery is a lifelong process. Treatment in this way of thinking is seen as one step along the way, rather than as an end point.

- Eligibility for Treatment. With very few exceptions, participation in sex offender treatment is voluntary, even for offenders who have been convicted of sexual offences and are being incarcerated in correctional institutions. While there may be consequences for not participating that make offenders' decisions something far less than completely free choices, nonetheless, in the vast majority of programs, offenders must agree to cooperate in the treatment process. There is a firm belief among most therapists that compulsory treatment is not, and cannot be, effective. There are two other common preconditions that offenders must usually satisfy before being eligible for treatment: they must acknowledge their wrongdoing and be willing to accept responsibility for their actions; and they must see the offending as a problem and be willing to change their behaviours.

- Co-morbidity. Co-morbidity is a clinical term that refers to instances where a patient or offender exhibits two or more disorders that each require treatment. In the case of sex offenders, this is quite

common and, as a result, a good deal of the treatment literature discusses how to deal with these types of situations. In many cases, the problem behaviour will have taken place while the offender was under the influence of drugs or alcohol. Many sexual offenders have themselves been victims of physical or sexual abuse. Some sex offenders have been diagnosed with a mental disorder or have an intellectual deficit. Therefore, in addition to whatever programming is specifically directed at the inappropriate sexual behaviour, there is almost always a need to develop specific plans for addressing these other issues, either as part of the sex offender treatment itself, or through separate treatment modules or programs. Many sex offender programs have specific rules about eligibility for treatment that require the prior completion of treatment for concurrent disorders. There are differing views about how best to deal with these issues (e.g., McEvoy, 1990; Morrison, Eroga and Beckett, 1994).

- Individualization of Treatment. No treatment approach has been found to be effective for all sex offenders. Increasingly, experts believe the appropriate treatment approach in any particular case involves combining educational, cognitive-behavioural, family system, pharmacological, and other interventions to create a specialized and individualized program that addresses the specific needs of each sex offender (Morrison, Eroga and Beckett, 1994).

5. Treatment Effectiveness[1]

Because the field of sex offender treatment is relatively new, few evaluative studies have been carried out. Moreover, as Yates and others have pointed out, this limited treatment outcome literature is hampered by a "plethora of methodological limitations which affect the quality, validity and generalisability of findings" (1999:11). This is a new field and there is much to be learned.

There is considerable concern among experts about general psychotherapeutic approaches to the treatment of sex offenders. These approaches have not been shown to be effective. More worrisome yet, a number of studies have found that those who have received this type of treatment sometimes have higher recidivism rates than comparison groups who did not receive any treatment (e.g., Furby, Weinrott and Blackshaw, 1989; Thorne-Finch, 1992). This has led to a growing consensus among experts that treatment for sex offenders must specifically address the offending behaviour. Generic sex offender treatment programs appear to be less effective than programs that address specific types of sexual behaviour. For example, there are different treatment issues for rapists, pedophiles and incest offenders; experts believe programs that address the issues specific to each type of offending hold the most promise.

The leading treatment modality, cognitive-behavioural therapy combined with relapse prevention, has been shown to be superior to behavioural interventions alone. A number of studies have shown that this type of intervention is effective in reducing recidivism among exhibitionists, rapists, pedophiles, incest offenders and mixed offenders (e.g., Marshall et al., 1991; Nicholaichuk et al., 2000; Marques et al., 1994; 1989). Recent reviews of the literature have also led to positive conclusions about the effectiveness of this type of treatment (e.g., Hall, 1995). In one such review of 79 programs involving some 11,000 treated and untreated sex offenders, Alexander (1999) found that those who received cognitive-behavioural treatment combined with relapse prevention recidivated at a rate that was a third below that of untreated offenders (13% vs. 18%).

At the same time, the results of cognitive-behavioural treatment evaluations are by no means universally positive. Many studies of cognitive-behavioural therapy have shown no treatment effects, and a number of literature reviews bluntly conclude this approach is not effective (e.g., Furby, Weinrott and Blackshaw, 1989).

Polizzi and colleauges (1999) found 21 evaluations of sex offender treatment in their comprehensive review of the literature. Of these, 8 were too low in scientific merit to be included in an analysis of treatment effectiveness. Of the 13 remaining studies, about half showed a positive treatment effect. Four of these used a cognitive-behavioural approach. There was stronger evidence in support of the effectiveness of non-prison-based programs than prison-based programs. Taken together, the studies did not provide enough information to make any informed judgements about the effectiveness of treatment for specific types of sex offenders.

In recent years, researchers have begun to focus on several methodological problems that may be masking treatment effects. One of these is what researchers refer to as the "low base rate of recidivism." Contrary to popular belief, sex offenders are less likely to recidivate than many other types of offenders. The rate of recidivism for some types of sex offenders, for example, incest offenders, is very low. This means that treatment effects are difficult to detect because the rate of recidivism is already so low.

A second methodological problem concerns the fact that treatment appears to have differential effects depending on the offender's risk of reoffending and the specific type of offence he has committed. Treatment effects, for example, are more evident with high-risk offenders than with low-risk offenders.[2] If treatment is provided to all types of offenders, the positive effects for the high-risk offenders may be masked when their follow-up data is lumped in with others for whom the treatment has been less beneficial. This is particularly the case because a relatively low proportion of high-risk offenders (e.g., repeat offenders) are prone to recidivate at a high rate, while a relatively large proportion (e.g., first-time offenders) are prone to recidivate at a low rate. This is leading program designers and researchers to focus on assessing who will most benefit from treatment.

A further complication relates to the definition of recidivism and the determination of what constitutes "success." Some studies only examine sexual reoffending. Others examine further offences involving violence. Still others look at all types of reoffending. This has a confounding effect because some types of sex offenders (e.g., rapists) are much more likely to commit a further non-sexual offence, while other types (e.g., pedophiles) are more likely to commit a further sexual offence.

Researchers are increasingly interested in examining the types of interactions that have been described. Alexander's (1999) literature review, for example, showed that exhibitionists benefitted substantially from treatment relative to other groups, while child molesters fared considerable better when treatment was offered in outpatient rather than prison settings. Other studies (e.g., Worling and Curwen, 1999) have shown that juvenile sex offenders are particularly likely to benefit from treatment. These are the types of offender-offence-program-setting interactions that researchers are now investigating.

While there is no consensus on the issue, many experts believe that cognitive-behavioural therapy combined with relapse prevention can produce at least mild to moderate treatment effects, particularly with offenders who are at high risk of reoffending. For other offenders, the effect may be small or non-existent. Given

limited treatment resources, program personnel are increasingly likely to rely on screening and assessment tools to determine which offenders will be offered treatment.

There is a growing body of Canadian research on the effectiveness of sex offender treatment. This literature evaluates specific sex offender treatment programs, and contributes to the development of tools for assessing risk and predicting recidivism. Treatment evaluations have also been completed. To date, results have been mixed (e.g., Nickolaichuck, 1999; 1996; Barbaree and Seto, 1998). For example, one recent review concluded: "the results of studies done to evaluate the effectiveness of treatment programs in reducing sexual recidivism have been inconclusive" (Canadian Centre for Justice Statistics, 1999b:13). Nonetheless, there is growing optimism that further refinement of treatment selection criteria and research methodology will lead to stronger evidence of treatment effectiveness.[3]

In summing up this research literature, Yates has identified some further "emerging best practices:"

> Prior to receiving a disposition, a comprehensive assessment should be conducted to determine an offender's risk level, which should inform disposition decision-making and management. Applying the principles of effective correctional treatment, higher intensity interventions, including security, treatment, and supervision, should be reserved for higher risk offenders. It is suggested here that a substantial number of sex offenders can be safely managed within community settings, with appropriate treatment and supervision. Treatment should be cognitive-behavioural in orientation, should include relapse prevention, should focus on skills acquisition, and should explicitly target those criminogenic need factors identified during initial assessment. The relapse prevention plan should identify precursors to sexual offending behaviour, as well as observable cognitive, attitudinal, affective, and behavioural indicators of changes in risk, so that service providers conducting supervision of sex offenders in the community can assess and reassess risk as required. Adjunctive interventions, such as behavioural reconditioning or pharmacological interventions, should be applied as necessary in individual cases, again based upon the pretreatment assessment and later reassessments of risk ... Treatment of juvenile sex offenders should target clarification of sexual values and the promotion of healthy, age-appropriate sexuality, cognitive restructuring, development of empathy, human sexuality education, vocational, and living skills, and family therapy. Individual, group, and family therapies should each be used, again based upon individual needs and circumstances. Additionally, supervision of adolescent and adult sex offenders should also vary as a function of degree of internal versus external control of behaviour. Sex offenders with a greater degree of internal behavioural control should require less intensive supervision, while those with a lesser degree of internal control will require the external behavioural control that is provided by more intensive supervision. Similarly, offenders who tend to be impulsive may reoffend more quickly and, consequently, require treatment which focuses upon developing control of responding (1999:37-38).

As with other institution-based programs, a major challenge for sex offender treatment programs involves translating treatment gains into lasting benefits after release. Within the structure of the institution, most offenders do quite well. Once in the community, however, experience indicates that many offenders, particularly Aboriginal offenders, do not show any lasting benefits from the treatment that has been provided.

Chapter 5

6. The Current Status of Sex Offender Treatment in Canada

The completion of an inventory of sex offender programs currently operating in Canada was well beyond the scope of this review. Such an inventory would be of considerable value, since it would establish the number and types of programs, the capacities of these programs, the type of offenders served, and where the programs are currently available. In addition, such a resource would increase opportunities for networking and communication among those involved in this challenging and highly specialized field.

Fortunately, one aspect of this task has been completed. Health Canada (1999a) recently compiled a directory of services for adult survivors of child sexual abuse that listed over 400 programs, as well as a national inventory of treatment programs for child sexual abuse offenders (Health Canada, 1999b). This inventory was originally prepared in 1989, and updated in 1993 and 1996. The current edition, prepared in 1999, lists over 200 treatment programs in all parts of Canada.

The Health Canada inventory, although valuable, has several limitations for present purposes. Firstly, as the analysis earlier in this review has shown, many sexual offences do not involve children. Since there are a number of important differences in approaches to the treatment of rapists and pedophiles, and since many programs for pedophiles do not provide treatment services for rapists, further work is required to complete a comprehensive inventory of services for all types of sex offenders. The programs listed in the inventory provided a general assessment or counselling service, or an information and referral service, as opposed to any sort of specialized treatment program for sex offenders. Although the inventory was prepared in 1999, many of the programs had changed their focus or were no longer operating since being listed. This was particularly true of the programs provided by non-government agencies; even within the public sector, there were many changes. The most commonly cited problem was a lack of adequate financial resources. These issues suggest some of the problems that must be overcome is in compiling and maintaining an up-to-date program inventory of this type.

As has been discussed, the development of specialized treatment programs for sex offenders is a relatively recent phenomenon. Until recently, most programs have been provided within the criminal justice system, and primarily within correctional institutions. While some programs operate within provincial and territorial correctional systems, most are provided to federal inmates by the Correctional Service of Canada.

In recent years, increasing attention has been paid to the development and delivery of sex offender treatment programs outside of correctional institutions. Most of these programs are linked to the justice system in one way or another. That is, even if they are not formally provided by criminal justice personnel, protocols between the agency and the criminal justice system have been developed to allow services to be provided to offenders. Some of these programs offer treatment as an alternative to criminal justice system processing, while others provide services to probationers and parolees. These programs may also provide assessment services to the courts prior to conviction, they may assist in providing sentencing recommendations, and they provide court-mandated treatment.

A number of community-based sex offender treatment programs are now available across the country. They are usually offered through the psychiatric or forensic psychiatric programs of large hospitals or through mental health clinics. Most of these programs provide services to offenders who have been charged and

convicted with a sexual offence. The capacity for dealing with other perpetrators, for example those who might be referred by another agency or self-referred, appears to be quite limited.

Most of the available programs are for adults, and most are for men. There were only a few programs that had any capacity to provide specialized services to female sex offenders or young sex offenders.

In some instances, programs are specifically intended for sex offenders. In many other instances, however, the program has a broader mandate to deal, for example, with family violence or anger management.

As mentioned, Correctional Service of Canada (CSC) is the leading provider of sex offender treatment services in Canada. For the past ten years, CSC has amassed considerable experience in the development, delivery and evaluation of sex offender treatment programs. It is widely regarded in Canada and beyond as one of the leading authorities on sex offender treatment.

The programs provided by CSC are varied and extensive. Ongoing programs are provided in the regional psychiatric centres operated by CSC, and in a number of other federal penitentiaries. CSC employs many staff at the regional and national levels that specialize in sex offender treatment. These staff include program development staff, program delivery staff and staff who specialize in research and evaluation.

CSC has devoted considerable resources to the development of sex offender treatment programs and now has one of the most fully developed programs of its kind anywhere in the world (Correctional Service of Canada, 2000a; 2000b). Detailed program manuals have been developed that specify numerous program details. These manuals are based on the latest findings about what works in providing effective treatment for sex offenders. The CSC has also developed national standards for its sex offender treatment programs, as well as significant resources for service providers. These resources include guidelines for completing assessments, program standards, program content specifications, and the like.

Programs at three levels of intensity are provided to federal inmates. The high intensity program is intended for high-risk sex offenders. Program delivery consists of a minimum of 15 hours of group therapy and a minimum of 2 hours of individual therapy each week for a period of six to eight months. The moderate intensity program, intended for moderate-risk sex offenders, involves a minimum of 10 hours of group therapy and a minimum of one hour of individual therapy each week for a period of four to five months. The low intensity program involves a minimum of five hours of group therapy and a minimum of one hour of individual therapy bi-weekly over a two- to four-month period. This program has been deigned so that it can be delivered in the community directly by CSC or by other agencies (e.g., community clinics, hospitals, etc.).

CSC has also made a significant commitment to the evaluation of sex offender programs using a wide variety of process and outcome measures. In future years, it is expected that a good deal of information will become available about what types of assessment tools and interventions are most effective with specific types of offenders.

Chapter 5

Programs for Aboriginal Sex Offenders

As mentioned earlier, there is no inventory of sex offender treatment programs in Canada, nor is their any inventory of Aboriginal sex offender treatment programs. Nonetheless, some programs do exist. An attempt to compile a comprehensive a listing was done by: reviewing the sex offender treatment literature; contacting federal, provincial and territorial justice officials, and experts in the field of sex offender treatment; and requesting information from Aboriginal organizations, governments and communities. Through this communication and networking, an attempt to identify every Aboriginal-specific sex offender treatment program in Canada was made. While there is no way of knowing if all the programs are currently operating, most of the programs have been identified.

One of the challenges in collecting information from respondents was defining precisely what constituted an Aboriginal-specific sex offender program. Many different definitions were encountered. For example, Aboriginal-specific programs were regarded as including:

- some, many, most or all of the program participants were Aboriginal;
- some, most or all of the program content incorporated traditional Aboriginal beliefs and/or practices;
- the program was delivered in whole or in part by Aboriginal therapists; and
- program development had been completed by Aboriginal experts, including Elders.

For the purposes of this exercise, a program that had Aboriginal participants was not considered to be an Aboriginal-specific program unless it also had some of the other elements enumerated above. If these programs were included, viritually all the programs in some regions of the country as well as in some institutions could have been considered Aboriginal-specific. Instead, programs that combined the first criteria with one or more of the others were sought out.

The four criteria mentioned above can be combined to create a continuum of program models with various degrees of Aboriginal specificity. Very few programs contain all the elements that have been mentioned, however, most combine two or more elements. As will be discussed later, very little is known about which combination of these program features contributes most to an effective program for Aboriginal sex offenders.

Before discussing the currently available Aboriginal-specific sex offender programs, some of the trends with respect to the provision of Aboriginal-specific correctional programs generally are reviewed. A review of a number of Aboriginal-specific sex offender programs, a discussion on what is known about the effectiveness of these programs, and a review of a number of issues relating to the way these programs are organized and delivered will follow.

1. Programs for Aboriginal Offenders Generally

Provincial, territorial and federal justice programs and programs in other sectors have been adjusted over the years to taking into account the fact that, in some areas of the country, there are many Aboriginal

people who require services. Conventional service delivery models have not always proved to be that effective. Therefore, there have been many reforms within the justice system. These have been extensively documented elsewhere and, therefore, they will not be described here (e.g., Rudin, 1999; Royal Commission on Aboriginal Peoples, 1996a). Nonetheless, it is worth recalling the discussion in a previous chapter where it was pointed out that there have been several common types of reforms, including:

- affirmative action hiring policies;
- the creation of specialized Aboriginal units, staffed by at least some Aboriginal employees, within larger non-Aboriginal programs and agencies;
- cross-cultural awareness and training programs;
- programs or initiatives that have provided for Aboriginal input into the decision-making processes of non-Aboriginal programs and agencies; and
- initiatives that have provided for the use of traditional Aboriginal practices or ceremonies within non-Aboriginal programs.

These types of initiatives still represent the most common responses to dealing with Aboriginal overrepresentation and Aboriginal cross-cultural issues in the justice system. In fact, provincial, territorial and federal justice agencies, almost without exception, continue to adopt a wide variety of policies and programs to put these types of approaches into effect.

Recently, Epprecht (2000) conducted a survey of federal, provincial and territorial correctional programs across Canada. She examined any intervention that was systematically applied to offenders with the expectation that it would result in reduced recidivism. In all, 586 program descriptions were submitted from 10 jurisdictions. Thirteen Aboriginal-specific programs were identified. All were institutional programs, most targeted substance abuse, and 11 of the 13 were located on the Prairies. Although this survey is disappointing with respect to the number of Aboriginal-specific programs, the variety of these programs and their accessibility, there is some indication that the justice system is making an increased commitment to the improvement of services for Aboriginal offenders and communities. Developments within the Correctional Service of Canada serve as a case in point.

According to the Correctional Service of Canada (2001a), a wide variety of Aboriginal-specific programming and support services are now available or are being developed within the federal correctional system. These include, for example, Native liaison services (a type of advocacy and support service for Aboriginal offenders, family members and communities), culturally appropriate addictions and substance abuse treatment, and sex offender treatment. Solicitor General Canada (2001) has outlined a number of other programs and services for Aboriginal offenders. These include traditional cultural and spiritual programs, Elder services, mandatory cross-cultural training for staff, and specialized post-release services for Aboriginal offenders. In addition, the National Parole Board now offers Elder-assisted parole hearings.

The federal government has also made a commitment to restorative justice programs involving Aboriginal offenders and communities. Two examples include Hollow Water in Manitoba and Waseskun House in Quebec.

A further commitment of the federal government relates to Aboriginal healing lodges. These are residential programs of varying security that provide culturally appropriate services to Aboriginal offenders. A number of these programs are operational, while others are currently being developed. Specifically (Correctional Service of Canada, 2001b):

- in 1995, the Ochimaw Ohci Healing Lodge was opened on Nekaneet First Nation's land in Maple Creek, Saskatchewan. This 29-bed facility for Aboriginal women was developed partly in response to the need to phase out the federal prison for women in Kingston;
- the Pe Sakastew Centre opened in August 1997. It is a 60-bed facility on Samson Cree First Nation's land near Hobbema, Alberta, just south of Edmonton;
- in 1994, a 30-bed healing lodge was opened on the Wahpeton First Nation reserve near Prince Albert, Saskatchewan;
- renovations are underway at the Elbow Lake minimum security facility located on the Chehalis First Nation's reserve in British Columbia to convert the facility into a "healing village;"
- the Stan Daniels Healing Centre has been operated by the Native Counselling Services of Alberta for a number of years. This facility was transferred to Aboriginal control in 1999;
- the Waseskun House became a healing lodge in 1999. It is located just outside Montreal and provides programming in both French and English;
- the O-Chi-Chak-Ko-Sipi First Nation near Dauphin, Manitoba, operates a 24-bed facility; and
- a 40-bed healing lodge is operated by the Beardy's Okemasis First Nation, near Duck Lake, Saskatchewan.

In recent years, Correctional Service of Canada has formalized a National Aboriginal Strategy (Wilson, 2001). The four elements of the strategy consist of:

- strengthening Aboriginal partnerships and relations;
- strengthening Aboriginal programming;
- strengthening Aboriginal human resources; and
- enhancing the role of Aboriginal communities.

In addition to the initiatives already mentioned, Correctional Service of Canada is also planning to significantly expand Aboriginal programming, Aboriginal staffing, and research relating to the assessment and treatment of Aboriginal offenders. A further key strategy of Correctional Service of Canada is to expand partnerships with Aboriginal communities using the enabling provisions of Sections 81 and 84 of the *Corrections and Conditional Release Act*. In addition to the agreements already in place, negotiations are currently under way to establish 25 additional agreements (Wilson, 2001).

Although there have been many developments within the federal correctional system, as outlined in a previous chapter, changes in other parts of the justice system are also occurring. For example, the federal government and the RCMP have made an extensive commitment to Aboriginal policing, and the federal Aboriginal Justice Directorate has sponsored numerous initiatives in the areas of diversion, adjudication and sentencing. Parallel developments are also underway within a number of provincial and territorial jurisdictions, particularly in western and northern Canada.

This brief overview serves to underscore the fact that many conventional approaches to responding to Aboriginal crime and Aboriginal offending continue to be widely used by justice agencies today, even though these approaches have not proven to be that effective in the past. While it is important that these initiatives be continued, it is clear that new and different approaches are also required. In this regard, there are promising indications that justice agencies are increasingly prepared to work with and support Aboriginal governments and organizations to bring about the more fundamental changes needed to address crime in Aboriginal communities. As shown in the next section, some of these same patterns are also evident in the provision of programs and services for Aboriginal sex offenders.

2. Sex Offender Programs for Aboriginal Offenders

Attempts to identify Aboriginal-specific programs for sex offenders in Canada uncovered only a few programs. The programs identified were generally one of three types:

1. programs for Aboriginal sex offenders offered in correctional institutions, mostly federal institutions;

2. programs offered by the justice system for Aboriginal sex offenders in the community, either as an alternative to incarceration or as a post-release program; and

3. programs provided by Aboriginal organizations to Aboriginal sex offenders in the community, both in the justice system and others.

In the study referred to earlier, Epprecht (2000) identified 586 distinct correctional programs offered by provincial, territorial or federal authorities in Canada. Three Aboriginal-specific sex offender programs, all institutional, were also identified in this survey: one provincial program in Newfoundland, and two federal programs, one in Manitoba and one in Saskatchewan.

A current overview of federal correctional programs was provided to the review team by the corporate advisor for sex offender programs at Correctional Service of Canada. According to Williams (2001):[4]

- there are no Aboriginal-specific sex offender programs in Atlantic Canada or Quebec. In Quebec, Correctional Service of Canada did offer a program at La Macaza up until 1997, but this program no longer operates;

- there is currently one Aboriginal-specific sex offender program in Ontario: a program for Inuit sex offenders has just been initiated at Fenbrook Institution in Ontario. There used to be a program at Bath (Kingston), but this is no longer operating;

- there are three programs on the Prairies. In Winnipeg, the Native Clan runs institutional programs at the Rockwood and Stony Mountain Institutions, as well as a community-based program in Winnipeg. An institutional program for federal inmates, the Clearwater Sex Offender Program, operates at the Regional Psychiatric Centre in Saskatoon, while a community-based program is offered for Aboriginal sex offenders in Edmonton;

- there used to be an Aboriginal sex offender program at Bowden Institution, but it no longer operates. Inuit sex offenders have been transferred to the new program that has started at Fenbrook Institution; and

- in the Pacific region, an Aboriginal sex offender program is offered once a year at Mountain Institution, and a small community follow-up program is offered out of Abbotsford.

An Inuit-specific program was found operating at the Baffin Correctional Centre in Nunavut. At the time of writing, a survey of federal Aboriginal-specific sex offender programs was being conducted. The results of this survey should provide a status report on current program offerings.

In addition to the correctional programs, this review uncovered several community-based programs operated by Aboriginal organizations. These include the Hollow Water Community Holistic Healing Circle Program in Hollow Water, Manitoba, Waseskun House in Quebec, the Canim Lake Family Violence Program in Canim Lake, British Columbia, and a community-based healing process on the Mnjikaning First Nation in Ontario. A listing of programs, along with their status and capacities, is provided in Table 5.1.

Detailed program descriptions of all Aboriginal-specific sex offender programs will be found in Appendix A. Included is a sample of non-Aboriginal institutional and community-based sex offender treatment programs that are available, as well as descriptions of several innovative programs that had particular promise.

The institutional programs identified had mostly been developed by non-Aboriginal experts, usually forensic psychologists and other professional staff working within the justice system. Non-Aboriginal therapists were mainly responsible for program delivery. However, some of the programs contained an Aboriginal-specific element or program component. The Aboriginal-specific component was quite varied, and ranged from having a guest Aboriginal speaker attend a group meeting, to a significant commitment to incorporate Aboriginal knowledge, beliefs and practices. In some programs, Aboriginal therapists or Elders delivered a part of the program that dealt with cultural issues, Aboriginal spirituality or healing. Some programs also incorporated traditional ceremonies. In many of these programs, most or all of the program participants were Aboriginal.

Chapter 5

The few identified programs in Canada were mostly institutional programs that have small capacities. Some are experimental or in the planning stages, while a number of others have been discontinued. Only a few community-based programs were identified. These are mostly small programs that serve local communities. There are vast areas of the country where no specialized programs of any kind appear to be available. In addition, nearly all the programs identified did not have the capacity to serve women or young offenders.

Considering the extensive program and support service needs documented earlier in this review, the results of this survey were surprising and disappointing. A few isolated Aboriginal-specific sex offender treatment programs were found to have no systematic or coordinated effort to address the needs of Aboriginal sex offenders.

Table 5.1
Overview of Aboriginal-Specific Sex Offender Programs in Canada (2001)

	Program Type	Current Status	Clients*	Yearly Capacity*	
				Total	Aboriginal
British Columbia					
1. Mountain Institution	Institutional	Operational	m	10	10
2. Abbotsford	Community	Operational	m	?	?
3. Bowden Institution	Institutional	Discontinued	m	-	-
4. Canim Lake	Community	Operational	m/f/y	2	2
Prairies					
5. Clearwater	Institutional	Operational	m	40	20
6. Native Clan					
a. Rockwood	Institutional	Operational	m	38	14
b. Stony Mountain	Institutional	Operational	m	18	10
c. Community Program	Community	Operational	m	59	28
7. Hollow Water	Community	Operational	m/f/y	30	30
Ontario					
8. Bath	Institutional	Discontinued	m	-	-
9. Fenbrook	Institutional	Operational	m	9	9
10. Mnjikaning	Community	Operational	m/f/y	?	?
Quebec					
11. Waseskun House	Community	Operational	m	25	25
12. La Macaza	Institutional	Discontinued	m	-	-
Maritimes					
-	-	-	-	-	-
The North					
13. Baffin Correctional Centre	Institutional	Operational	Adult/m	50	50
Total Yearly Capacity				281	198

* Male = m, Female = f, Youth = y.
In some instances, capacities are estimates since no statistics were maintained.

Chapter 5

Information about a number of treatment programs for Aboriginal sexual abuse victims, Aboriginal victims of family violence and Aboriginal perpetrators of family violence was found (some information taken from the Aboriginal Healing Foundation project files). Although most of these programs do not deal with sexual offending in any detail, if at all, many of the concepts and strategies used in the development of these programs would nonetheless be of interest to those involved in the development of treatment programs for Aboriginal sex offenders. For this reason, these are referenced here. For example:

- Kahnawake Shakotiia'takehnhas Community Services and others (e.g., Mianiqsijit Project, Mid-Island Tribal Council, Beardy's and Okemasis Band # 96 and 97) have developed detailed program manuals and descriptions relating to their family violence and family healing programs;

- the Ma Mawi Wi Chi Itata Centre Inc. and Waseskun House have developed proposals and extensive resource materials relating to the Aboriginal offender who has been involved in family violence;

- a number of training programs and course curricula for training Aboriginal caregivers have been developed. Also found were recruitment strategies, instructors manuals, protocols and resource guides (e.g., Atenlos Native Family Violence Services, WUNSKA - The Aboriginal Social Workers and Social Services Educators Network, Helping Spirit Lodge Society). For example, the Nicola Valley Institute of Technology has amassed considerable experience since they began training Aboriginal sexual abuse counsellors in 1989;

- Native Child and Family Services of Toronto has compiled detailed information on their treatment program for Aboriginal adults and children who have been victims of sexual abuse; and

- the Aboriginal Corrections Policy Unit of Solicitor General Canada has prepared and distributed two technical manuals designed to assist Aboriginal communities to develop strategies to address sexual offending and victimization.

While these resources can assist Aboriginal communities in developing responses to community needs and issues, unfortunately, very little of this information pertains specifically to the issue of sexual offending. Therefore, while the general concepts, principles and strategies are useful, there is little guidance about how to deal with many of the sensitive and controversial issues that must be addressed in developing an effective community response to sexual offending.

Generally, programs and strategies related to family violence are much more fully developed than those dealing with sexual abuse. Among programs dealing with sexual abuse, programs and strategies for victims were much more fully developed than those for offenders.

3. The Effectiveness of Sex Offender Programs for Aboriginal Offenders

Over the years, there has been some interest in assessing the effectiveness of treatment and rehabilitation programs for Aboriginal offenders. Generally, recidivism rates have been used as an outcome measure, however, other measures have also been used. These have included the number of breaches or revocations for parolees or offenders participating in probation and other community corrections program. The results from these studies have been consistent: Aboriginal offenders do not do as well as non-Aboriginal

offenders on these outcome measures. In fact, Aboriginal offenders typically do far worse. A few examples from this research include:

- Bonta and colleagues (1997) followed up on 903 probationers in Manitoba. The Aboriginal offenders were younger, had less formal education, were more likely to be unemployed, and had longer criminal histories. During a three-year follow-up period, 65.9 per cent of the Aboriginal offenders and 47.8 per cent of the non-Aboriginal offenders recidivated. The Aboriginal recidivism rate was one-third higher than the non-Aboriginal rate. Higher recidivism rates have also been reported for Aboriginal offenders released from provincial correctional facilities;

- for federal offenders, the likelihood of an Aboriginal penitentiary releasee committing an indictable offence is 12 to 19 per cent higher than the corresponding rate for non-Aboriginal releasees (La Prairie, 1996). In another study of federal inmates, the Aboriginal recidivism rate (66%), was found to be 40 per cent higher than the non-Aboriginal rate (47%) (Hann and Harman, 1993); and

- in terms of parole, a male Aboriginal offender is almost twice as likely to have his parole revoked (51% vs. 28%) (La Prairie, 1996). Other studies have also shown that Aboriginal offenders are less likely to successfully complete their supervision period in the community, more likely to be revoked, and more likely to be returned to prison for a technical violation of release conditions (Aboriginal Issues Branch, 2001).

According to these conventional measures of effectiveness, Aboriginal offenders appear to benefit far less from treatment and rehabilitation programs than non-Aboriginal offenders.[5]

Some encouraging results are available with respect to Aboriginal-specific programs. Correctional Service of Canada (2001b) reports that healing lodges seem to be more effective in reducing recidivism among Aboriginal offenders relative to conventional correctional programs.

In one study, 16 of 286 Aboriginal offenders who completed a healing program were returned to federal custody. This recidivism rate of 6 per cent compared favourably with an 11 per cent rate for federal offenders. In terms of evaluations of sex offender treatment programs, very little is known about the benefits for Aboriginal offenders. In this review, only three studies assessed the effectiveness of sex offender treatment programs for Aboriginal offenders.

The Native Clan in Winnipeg has provided a sex offender treatment program for Aboriginal and non-Aboriginal sex offenders for over 10 years. This program has made a significant commitment to incorporating Aboriginal knowledge, beliefs and practices, and is certainly one of the leading programs in Canada (Ellerby, 1994; 2000; Ellerby and Stonechild, 1998). For example, the program makes extensive use of Elders and traditional ceremonies (see Appendix A).

In 1994, Ellerby (1994) examined the effectiveness of the program for a non-random sample of Aboriginal and non-Aboriginal clients who went through the program between 1987 and 1994. This is the most comprehensive Canadian research aimed at evaluating program effectiveness for Aboriginal sex offenders.

Chapter 5

The results of the Ellerby evaluation are at once instructive and disturbing. While he found that Aboriginal and non-Aboriginal sex offenders who completed the program had about the same recidivism rates, and while these recidivism rates were very low, the Aboriginal offenders were much more likely to drop out of the program. They were also much more likely to reoffend while they were enrolled in the program. Ellerby's results are summarized in Table 5.2.

During a follow-up period ranging from nine months to four years, none of the Aboriginal or non-Aboriginal participants who completed the Native Clan program were charged with another sexual offense. Only 2 per cent of the non-Aboriginal offenders and 4 per cent of the Aboriginal offenders were charged with a subsequent offence of any kind, and this difference was not statistically significant. This very low rate of recidivism for sex offenders has also been confirmed in other studies.

Program completion rates were dramatically different for the Aboriginal and non-Aboriginal participants. More than twice as many Aboriginal offenders dropped out, eight times as many were suspended, and six times as many recidivated while in treatment. Among Aboriginal participants, 15 per cent recidivated with a further sexual offence during treatment, while none of the non-Aboriginal offenders recidivated in this way. In all, 58 per cent of the Aboriginal offenders failed to complete the treatment program, compared to 16 per cent for the non-Aboriginal participants. These findings suggest that even though a program makes a specific and significant commitment to providing culturally relevant treatment, there is much to be learned about how to retain Aboriginal offenders in treatment and how to provide programming that is effective.

A further finding from Ellerby's evaluation is also important. In predicting who would recidivate and who would not, Ellerby found that there were some similar risk factors for both Aboriginal and non-Aboriginal sex offenders. These included such variables as associating with criminal peers, and having a history of substance abuse and a long criminal record. At the same time, not all the variables that were important in predicting recidivism by non-Aboriginal offenders applied to the Aboriginal offenders. In particular, a number of measures relating to family and marital status, mental health and capacity, and academic or vocational achievement were predictive for the non-Aboriginal participants but not for the Aboriginal participants. While the Métis were most like the non-Aboriginal participants in terms of risk factors, only 7 of the 15 significant risk factors for non-Aboriginal offenders proved to be valid for the on-reserve participants in the program, while only 4 of 15 predictors applied to the off-reserve participants. These findings suggest that risk factors may be quite different for Aboriginal than non-Aboriginal offenders.

Table 5.2
Indicators of Effectiveness for Aboriginal and Non-Aboriginal Offenders
in the Native Clan Sex Offender Treatment Program (1987 - 1994)

	Aboriginal	Non-Aboriginal
1. Entered Treatment	36%	64%
2. Did Not Complete Treatment	58%	16%
Terminated	4%	3%
Dropped Out	19%	8%
Suspended	16%	2%
Recidivated While in Treatment		
Sexual	15%	0%
Non-Sexual	4%	3%
3. Completed Treatment	42%	84%
4. Post-Treatment Recidivism*		
Sexual	0%	0%
Non-Sexual	4%	2%

Source: Ellerby (1994)

* Follow-up period ranged from 9 months to 4 years.

The Native Clan program continues to operate, and a further evaluation is currently being undertaken. The results of this research should provide important new insights into the effectiveness of Aboriginal-specific sex offender programming, as well as the risk factors associated with Aboriginal reoffending.

A second evaluation of sex offender treatment for Aboriginal offenders has been carried out by Nicholaichuk and Yates (2002). These authors conducted a long-term follow-up study of offenders who had participated in the Clearwater sex offender program at the Regional Psychiatric Centre in Saskatoon. This program operates on a cognitive-behavioural model and also incorporates relapse prevention. In addition, Elders have become part of the treatment staff and also conduct spiritual ceremonies and other cultural practices as part of the program (see Appendix A).

In a follow-up study of program participants, Nicholaichuk and Yates (2002) found that 14.5 per cent of the treatment group recidivated with a subsequent sexual offence during the five and a half year follow-up period, while 33.2 per cent of the non-treatment group recidivated sexually.

Since 28 per cent of the treatment group were Aboriginal sex offenders, Nicholaichuk and Yates (2002) were also able to examine whether there were any differences in the effectiveness of the program for Aboriginal and non-Aboriginal participants. The authors report there were no significant differences in outcome for treated Aboriginal participants and treated non-Aboriginal participants, and both groups reoffended at lower rates than their non-treatment counterparts.

This evaluation, like much of the research on the effectiveness of sex offender treatment, confronted a number of significant methodological problems. For example, while 28 per cent of the treatment group were Aboriginal, 44 per cent of the comparison subjects were Aboriginal. This has the effect of confounding dependent and independent variables. In addition, it was not possible to perfectly match the treatment and comparison groups for criminal history and offence type. And the follow-up period for the comparison sample was 1.4 years longer than for the treatment group (7.3 years vs. 5.9 years). While these differences are not insignificant and could have influenced the outcome of the evaluation, the study does suggest that cognitive-behavioural treatment may produce positive treatment effects for both Aboriginal and non-Aboriginal participants.

A third study involved an extensive qualitative assessment of the benefits of cognitive-behavioural therapy and traditional Aboriginal ceremonies for Aboriginal sex offenders in the Clearwater sex offender program at the Saskatoon Regional Psychiatric Centre (Mason, 2000). The study revealed that both forms of healing were beneficial for Aboriginal offenders and, in some ways, highly complimentary. The Aboriginal offenders who benefitted most from one approach also seemed to benefit the most from the other. However, there was considerable variability in preferences and responsivity owing to the fact that Aboriginal sex offenders exhibited a wide diversity of treatment needs. This study did not examine outcome measures.

Although few quantitative studies of program effectiveness have been completed, a number of reports provide the impressions of treatment staff, Aboriginal organizations and Elders. The issue of program effectiveness was discussed with many of the individuals and organizations contacted throughout the course of this review. Once again, these findings are presented as "emerging best practices," as the current state of research does not allow for more definitive statements. Generally, Aboriginal sex offenders are most likely to benefit from treatment programs with the following characteristics:

1. the treatment program focuses specifically on sexual offending;

2. program participants have all committed similar types of offences, in particular, rapists and pedophiles are not mixed;

3. program participants voluntarily agree to participate in the program;

4. in addition to participation in treatment groups, there is an individual treatment component;

5. provision of treatment, as well as treatment intensity, is matched with the degree of risk of reoffending and a continuum of services is available to meet needs;

6. there is ongoing assessment, before, during and after participation in treatment;

7. all or most of the program participants are Aboriginal;

8. low- and medium-risk offenders are provided with services in the community wherever possible;

9. the program is based on a cognitive-behavioural model and it also incorporates content specific to relapse prevention;

10. components of the treatment also address other key issues, such as substance abuse;

11. some or all of the service providers are Aboriginal, including Elders;

12. although there is a focus on sex offending, a holistic approach to healing that also incorporates traditional beliefs, values and ceremonies is included; and

13. there is a link between institutional treatment, community support and follow-up, and there is ongoing case management to insure appropriate services are provided when and where needed.

4. Issues to be Addressed

This review suggests that there are a number of key issues that must be addressed in order to insure that Aboriginal sex offenders receive effective treatment. These include:

1. Program Capacity. Given the numbers of Aboriginal sex offenders, it is evident that the currently available treatment programs are inadequate to meet the need. Within the federal system where it is easy to determine the gap, it can be estimated that about 200 treatment spaces are required for 800 Aboriginal sex offenders. Each require a year-long treatment program and are sentenced for an average period of four years. This would involve more than quadrupling current capacity. The few available programs are mostly institutional programs, even though the majority of Aboriginal sex offenders are in the community. Even in the institutions, most Aboriginal sex offenders do not receive treatment. The few existing programs are for adult men. No Aboriginal-specific programs for Aboriginal women or Aboriginal young offenders could be identified, even though research indicates there are significant service needs in these areas. There are vast regions of the country where it appears not a single Aboriginal-specific sex offender program is offered. Another concern is that available programs are mostly restricted to those who are incarcerated. The capacity to deal with sex offenders who have not been charged, convicted or sentenced to jail appears to be very limited.

2. Program Instability. Particularly in the community sector, but also within the justice system, program instability is evident. Over the past few years, a number of programs have been discontinued due to lack of administrative support or lack of funding (e.g., Bath, La Macaza and Bowden Institutions, etc.). In instances where funds have been devoted to Aboriginal sex offender treatment, it is not always clear that the programs have been developed. Within the federal correctional system, there are fewer programs now than in the past. When programs tend to come and go, it is usually a sign that an issue is not being given a high priority and there is a lack of commitment to a strategic development plan.

3. Program Development. Given the magnitude of the issue, remarkably few resources have been dedicated to developing institutional and community programs that specifically address Aboriginal sexual offending. The most common approach to service delivery involves a standardized cognitive-behavioural program delivered in an institutional setting. Although a few programs add an Aboriginal-specific component, this is quite varied from program to program and is often quite modest. The overall sense is one of lack of creativity, innovation and variety. This reflects the fact that there has been little support for the development of Aboriginal-specific sexual offending programs. Given the evidence concerning high drop-out rates from existing treatment programs and the high recidivism rates that occur during treatment, there is an urgent need to undertake the more systematic development of more meaningful program options for Aboriginal sex offenders.

4. Aboriginal Control of Culturally Appropriate Treatment Services. There are few programs for Aboriginal sex offenders and only a handful that operate under Aboriginal control. The limited strategies currently being adopted to improve the cultural relevance of Aboriginal sex offender programs are reminiscent of those that were common in other types of corrections and human services programs in years past. As previously discussed, these types of strategies, which appear to be primarily aimed at allowing Aboriginal offenders to "fit in" to programs based on the values, ideologies, beliefs and thought processes of the dominant society, have generally met with limited success. There is little experience in developing and delivering culturally specific programs that address the spiritual and cultural needs of Aboriginal sex offenders. And the few programs that have attempted to address these issues lack the resources and support to share their experiences with others.

   Why further progress has not been made in devolving appropriate resources and control to Aboriginal communities is not clear. It may be that many communities have not yet fully recognized the gravity of the issues or they may be reluctant to accept responsibility without the necessary resources. It is also possible that justice system authorities view the area of sexual offending as difficult and controversial; they may want to proceed cautiously. There is also the reality that there are few trained Aboriginal service providers in this highly specialized field. Nonetheless, it is evident that new models for cooperation involving the justice system and Aboriginal governments, communities and organizations are required.

5. Institutional-Community Links. Significant gaps in linking institutional treatment programs with community support and follow-up care are evident. Since sex offenders are engaged in ongoing self-management of behaviour, and since Aboriginal offenders have higher recidivism rates on account of their more disadvantaged circumstances, ongoing community support and follow-up would appear to be essential components of an overall support strategy. This is likely to be a particular problem when Aboriginal offenders from rural or remote areas are released in urban communities with few social supports. Yet, no evidence was found of a systematic approach to addressing these types of needs. Since most Aboriginal sex offenders are in the community, the provision of ongoing supportive care for lifelong self-management has major implications for programs at the community level. However, no evidence was found to show such needs were being recognized, much less addressed, except in a few communities.

6. Continuum of Care. There are few specialized sex offender treatment services available, which makes it difficult to match Aboriginal offenders with programs and services that are appropriate to their

specific needs. Ideally, a continuum of services would be available. Aboriginal offenders would receive appropriate services to begin with, but they would move along the continuum as needs changed. It has been suggested that services should include prevention and promotion programs, as well as treatment, rehabilitation and healing programs (Craig and Maracle, 1993). There are needs for crisis services, supportive resources and training. There is no evidence that this kind of coordinated continuum of care and support is available for Aboriginal sex offenders anywhere in Canada.

7. Effectiveness Research. It is apparent that few resources have been devoted to assessing what works best for sex offenders generally, and for Aboriginal sex offenders in particular. It is fair to say that little is known about the effectiveness of treatment approaches for Aboriginal sex offenders. This is true about treatment for Aboriginal men, and even more with Aboriginal women and youth who offend sexually. The following are some of the questions that need to be addressed:[6] 1) Are Aboriginal sex offenders who receive specialized sex offender treatment released at the same time as non-Aboriginals? 2) Do Aboriginal sex offenders access treatment at the same point in their sentence? 3) When they receive treatment, do Aboriginal-specific treatment programs improve outcomes relative to conventional sex offender treatment? 4) If there are improved outcomes, what specific components of Aboriginal-specific treatment account for the results — the spiritual or traditional teachings, the ceremonies, the holistic approach to healing, the Aboriginal service provider or Elder, etc.? 5) Does benefit of treatment for Aboriginal sex offenders vary with their risk of reoffending? and 6) Do institutional, community or other treatment settings work best for some Aboriginal sex offenders and, if so, for which ones?

8. Other Research. As previously discussed, basic information about available Aboriginal sex offender treatment programs is not routinely collected or maintained. There is no systematic information collected about how many Aboriginal sex offenders receive treatment and how many do not, how many go without treatment because programs are not available, and how many refuse treatment and why. In fact, there is no systematic information collected about the number of Aboriginal sex offenders who are incarcerated or on parole, where they are located, and what their needs are (Trevethan, 2001). A system needs to be put into place to routinely collect and maintain this type of information.

9. Risk Assessment. The type and intensity of treatment provided to an Aboriginal sex offender should be matched with the offender's risk of reoffending. Similarly, sentencing and release decisions require an assessment of risk. Decisions about program placement require an accurate assessment of needs. Yet, there are no specialized risk or assessment tools that have been developed for Aboriginal sex offenders. While some existing instruments do appear to have some applicability,[7] the few available studies also suggest that many of the factors that predict the behaviour of non-Aboriginal offenders do not apply to Aboriginal offenders. The systematic development of culturally appropriate needs and risk assessment tools for Aboriginal offenders should therefore be regarded as an important priority.

10. Human Resources. There are very few Aboriginal service providers, and it was reported that many non-Aboriginal providers lack the specialized knowledge and skills required to provide effective services to Aboriginal sex offenders. There does not appear to be many opportunities for training, continuing education, professional development or networking. A search was conducted for guides, course curricula, trainers' manuals, sample protocols and other resource materials, but with few exceptions, none were found. Caring for caregivers must also figure prominently in any human resources

strategy in the area of sexual offending. The recruitment, training and retention of Aboriginal service providers is a key to the provision of effective services, particularly in an area as specialized and vexing as Aboriginal sexual offending.

11. Knowledge Transfer. Existing Aboriginal sex offender treatment programs work in relative isolation from each other, and there appear to be few opportunities to share knowledge and experiences. This is less true within the federal correctional system, but certainly applies to programs at the regional and community levels. In some quarters, particularly among Elders, there is reluctance to commit program information to writing. Sometimes this reluctance is quite understandable and appropriate (e.g., sacred teachings provided by Elders), but often it reflects that there is insufficient support to undertake this important work. Some widely reputed programs, for example, had no written program information that could be shared. there were certain protectionism and defensiveness among some program personnel working in this field, perhaps because work with sex offenders remains controversial. Others, however, provided the utmost cooperation and support. Further efforts will be required to break down the barriers to knowledge transfer.

Action on all these fronts will be required to bring about a comprehensive, coordinated and effective system of care and support for Aboriginal sex offenders in Canada.

Conclusion

The focus of this chapter has been on the formal treatment services provided to sex offenders. The need to expand the current capacity for providing such services for Aboriginal sex offenders, both within the justice system and at the community level, have been identified. A number of strategies for moving towards a more effective system of Aboriginal-specific treatment programs has been outlined. This involves increasing commitments to research and program development, and investing in the development of Aboriginal human resources required to develop and deliver effective programs. Sexual abuse is a multifaceted problem that cannot be effectively addressed without the coordinated efforts of many organizations, communities and individuals (Williams, Vallee and Staubi, 1997).

In an earlier chapter, evidence was provided to show that programs designed and delivered by non-Aboriginal service providers for Aboriginal clients are often limited in their effectiveness. While more needs to be known about the effectiveness and potential of Aboriginal justice programs, all of the available evidence suggests they are more successful than non-Aboriginal programs in overcoming the main obstacles to program effectiveness. At the same time, a number of the funding, authority and recognition issues impeding the development of these programs were discussed. All these issues are constraining the development of an effective system of services and supports for Aboriginal sex offenders.

While the provision of specialized and effective treatment services for Aboriginal sex offenders is important, and while the justice system and Aboriginal communities must increase their commitments to insure these services are provided, such measures constitute only a small part of the overall, long-term plan that is required. As most Aboriginal sex offenders are in the community, having never been convicted or convicted and released, it is believed that sex offender initiatives at the community level are also required. These initiatives should assist communities in assessing their own needs and devising their own solutions.

Chapter 5

In the long-term, sexual offending, crime and other social problems in Aboriginal communities can only be addressed by dealing with the underlying causes of instability and distress in Aboriginal communities. These causes have to do with the marginalization and disenfranchisement that Aboriginal communities and nations have experienced within the Canadian state. Changes to address these issues must go hand in hand with improvements to the service system for Aboriginal sex offenders.

Notes

1. We are indebted to Yates (1999) for providing much of the information on which this section is based.

2. Within the federal correctional system, for example, only about 20% of sex offenders are considered high risk (Williams, personal communication).

3. For a small sampling of some of the Canadian literature on these issues, see: Gordon and Porporino (1990), Hanson, Scott and Steffy (1995), Hanson and Bussiere (1996), Hanson and Harris (1998), Hanson and Thornton (1999), Hanson and Scott (1996), Hanson (1997), Motiuk and Brown (1993; 1994; 1996), Motiuk and Porporino (1993), Barbaree, Seto and Maric (1996), National Clearinghouse on Family Violence (1997), Barbaree and Seto (1998) and Brown (2001).

4. Williams (2001). Personal correspondence.

5. As previously discussed, it is not known to what extent the differences in recidivism and revocation rates reflect differences in the intensity of supervision of Aboriginal offenders, or differences in enforcement and prosecution practices. There is certainly reason to believe that overt and systemic biases account for at least some of the observed differences. Additionally, it is possible that Aboriginal offenders would recidivate at even higher levels without the intervention provided by the justice system and that, relatively speaking, they benefit as much or more from these programs as do non-Aboriginal offenders. It is also possible that these justice system interventions are simply not as effective for Aboriginal offenders as they are for non-Aboriginal offenders.

6. We are grateful to Sharon Williams from Correctional Service of Canada for sharing her ideas with us.

7. For example, Nicholaichuk (2001), personal communication, has examined the value of a risk assessment instrument called "Static 99" in predicting recidivism among Aboriginal and non-Aboriginal sex offenders. While the instrument did differentiate between recidivists and non-recidivists for both groups, only about 5 per cent of the variation in sexual recidivism was predicted by the test scores for Aboriginal offenders. For non-sexual recidivism, test scores did not predict recidivism by Aboriginal offenders, although these scores were significantly correlated with outcomes for non-Aboriginal offenders.

APPENDIX B

Subjects
Aboriginal Corrections
Chaplaincy
Citizen Advisory Committees
Community Corrections
Ethnocultural
Families of Offenders
Health Services
Media
Research
Restorative Justice
Victims of Crime
Volunteers
Working at CSC
Careers in Corrections
Resources
Our Organization
Acts and Regulations
Facilities and Institutions
Forms
CSC in the World
Programs
Publications
Speakers Bureau
Educational Resources
Access to Information and Privacy
Reporting to Canadians
Completed Access to Information Requests
Proactive Disclosure

Aboriginal Sex Offenders: Melding Spiritual Healing with Cognitive-Behavioural Treatment

IV. PROGRAMS FOR ABORIGINAL SEX OFFENDERS

aboriginal-specific programs within correctional institutions should acknowledge the unique experiences and needs of aboriginal offenders. One of the most striking facts, is that aboriginal people are clearly over-represented in both provincial and federal correctional institutions and the numbers seem to be growing. aboriginal inmates do not constitute a homogenous group but generally speaking, aboriginal offenders do differ from non-aboriginal inmates "in terms of their attitudes, values, interests, identities and backgrounds" (Correctional Law Review, 1988).

With respect to programs within corrections, aboriginal inmates do not tend to participate in general rehabilitation programs although their participation is higher for aboriginal-specific programs (MacPhail, 1988). A paper by the Correctional Law Review states that "aboriginal offenders are an especially disadvantaged group, that aboriginal people should be more closely involved in the planning and delivery of correctional services, and that in some cases special services and programs should be established by and for aboriginal offenders" (MacPhail, 1988). These clear messages have been heard, and have been addressed in the **Standards and Guidelines for the Provision of Services to Sex Offenders** (1996), as well as in the programs outlined below. Although many are outlined in the 1995 **Sex Offender Programs in Correctional Services Canada** (CSC), each clinic has provided a description of their newly developed services for aboriginal sex offenders, and these are reproduced below verbatim.

1. La Macaza Clinic (LMC), Québec

The La Macaza Clinic (LMC) has given special attention since September 1995 to the treatment of aboriginal sex offenders, by giving them the opportunity to participate in cultural and spiritual ceremonies. This is a first phase, and other alternatives are also suggested to respond as effectively as possible to the desire of Canadian Correctional services to provide aboriginal offenders with treatment that is better adapted to their reality.

Despite similarities between the dominant culture and the aboriginal culture with respect to treatment needs, therapeutic methods and types of intervention may differ. Accordingly, suggestions have been developed both to improve the treatment currently available and to add a number of cultural components. This process is based more on intuition and understanding of the aboriginal and their therapeutic environment than on theoretical bases and empirically validated, scientifically verified factors.

Therapeutic development component

Throughout their treatment, participants follow a series of therapeutic methods. For each method, we have examined whether its application would help aboriginals or, on the contrary, constitute an irritant. Accordingly, we have made the following suggestions:

A) That therapists have awareness training on aboriginal culture, its differences and the reasons for its specific characteristics.

OBJECTIVES

- To increase understanding and awareness with respect to aboriginals.
- To identify more effectively the intrapersonal, interpersonal and environmental conditions that may perpetuate or aggravate problems.
- To foster understanding of social and community factors in the aboriginal community.
- To help therapists better understand the reasons for treatment modifications.
- To develop therapists' awareness of specific cognitive distortions of aboriginal sex offenders.
- To lead therapists to consider socio-cultural influences, the effects of racism and cultural identity confusion in an individual's background.

B) That all aboriginal offenders who agree to take part in treatment first have access to an elder.

OBJECTIVES

- To create favourable conditions so as to reduce existing psychosocial stress factors as much as possible (mistrust of the system, therapists, aboriginal fellow participants).
- To enable inmates to discuss their anguish and anxieties with a person of their own nation.
- To enable inmates to find meaning in the process they are about to undertake.
- To develop or strengthen their cultural identity with someone who will accept them unconditionally.
- To prepare them appropriately for treatment, thus fostering greater cooperation on their part.

C) That examples of role playing, knowledge of social abilities and skills be given during therapy that are better adapted to aboriginal reality.

OBJECTIVES

- To ensure greater cooperation by participants.
- To enable participants better to identify themselves as individuals and as sex offenders.
- To avoid the perception of complete mistrust of aboriginals by therapists.

D) That aboriginals be allowed to meet with significant family members during their therapy.

OBJECTIVES

- To make treatment more effective.

Cultural and spiritual development component

Therapeutic methods should be seen as only a part of the treatment process, rather than the whole. In that respect, the development of cultural and spiritual components is proving to be a positive complement to make therapy more effective.

Accordingly, we have made the following suggestions:

A) That an elder be hired to conduct ceremonies and provide individual counselling.

OBJECTIVES

- To give offenders access to someone with whom they can quickly forge a bond of trust.
- To respect aboriginals' often implicitly expressed desire to confide in one person.
- To allow for exchanges about their culture.
- To enable offenders to receive cultural and spiritual advice, thus further strengthening their cultural identity.
- B) That cultural and spiritual activities be maintained and developed (sweetgrass ceremonies and sweat lodge).

OBJECTIVES

- To allow inmates to undertake a quest for their identity, thus boosting their self-esteem and their feeling of belonging.
- To promote cultural exchanges.

- To provide an additional place for sharing and mutual assistance.
- To give treatment greater credibility to the program offfered by LMC.
- To enhance the effect of treatment provided by LMC.

C) That criteria be set for hiring an elder.

D) That a meeting be organized between the elder and the therapy team.

OBJECTIVES

- To prevent the cultural and spiritual messages from contradicting those conveyed by the treatment itself.
- To expand the elder's knowledge of the dynamics of sex offenders.
- To give the therapy team a better understanding of the import and objectives of the cultural activities.

In conclusion, while conventional treatment is still very useful, adding cultural components to it can enhance participation by aboriginal offenders. It is not a question of finding a magical treatment or of seeing cultural components as a substitute for any other treatment. It is a question of coordinating treatment and culture in pursuing a common objective: to prevent recidivism and to enhance sex offenders' quality of life.

2. Holistic Healing Circle, Hollow Water First Nation, Manitoba

The Hollow Water Community Holistic Healing Circle is a coordinated community response to sexual abuse (Hollow Water First Nation, 1991). This initiative is referred to as a process which started in 1985. During the initial phases, a Resource Group was formed, community awareness and education began, and a training program was organized. The community received inspiration from the success story of Alkali Lake where the community was able to move from virtually 100% alcoholism to 95% sobriety. Community members were sent to Alkali Lake for healing and training. This led to the development of a unique holistic approach that follows thirteen steps based on traditional values (Lajeunesse, 1993; Hollow Water First Nation, 1991).

"The Community Holistic Circle Healing (CHCH) aims to restore balance by empowering individuals, families and the community to deal productively, and in a healing way, with the problem of sexual abuse" (Lajeunesse, 1993). The approach is being implemented in four communities in Manitoba: Hollow Water First Nation; Seymourville, Manigotogan and Aghaming. The process is guided by an Assessment Team which works with the criminal justice system.

3. Native Clan Organization - Forensic Behavioural Management Clinic, Manitoba

The community-based treatment program offers three levels of sex offender groups, a moderate to moderately-high risk/need group, a group for high risk/need offenders and a maintenance group for offenders who have made the necessary and required treatment gains to advance from attending weekly group sessions to monthly group sessions. Most parolees participate in both individual and group sessions. If the offender is in a serious relationship, both partners participate in couple sessions, and if at the time of assessment the offender demonstrates a deviant sexual preference profile, he would participate in arousal modification sessions in the clinic's phallometric laboratory. Each of the groups is ongoing and has continuous intake. This reduces waiting lists and allows the Native Clan staff to provide a level of intervention that is designed to meet an individual offender's unique level of risk and need.

The treatment program encompasses a broad range of areas focussed on addressing offender specific issues as well as issues related to areas of more general personal functioning that contribute to an offending cycle.

aboriginal Elders are members of the clinical team. They are involved in healing rituals, and provide guidance on integrating traditional healing practices with conventional sex offender therapy. As mentioned earlier pipe ceremonies, sweat lodges, smudging, and holding the eagle feather during disclosures, are integrated with cognitive-behavioural approaches.

4. Native Clan Organization - Stony Mountain, Rockwood, Manitoba

This treatment model involves the integration of services between Stony Mountain and Rockwood and also attempts to integrate treatment services with parole services, to enhance the level of support for the offender's treatment and risk management in the community. Prior to an offender's release to the community, the parole office and the community correctional centre are provided with information about the offender's offence cycles and risk factors, to assist them in their ongoing supervision, monitoring and support of the offender. This allows the supervision component to be consistent with the treatment component and focuses parole officers on monitoring factors that are relevant to the parolees' risk. Once in the community, the Forensic Behavioural Management Clinic's community treatment program maintains ongoing contact with the offender's parole service officer and the community correctional centre, again in an effort to integrate systems and cooperate in managing risk.

The program provides the opportunity for both aboriginal and non-aboriginal offenders to participate in aboriginal Healing ceremonies and to have access to Elders.

Programs are structured so they are ongoing and have continuous intake. This allows them to decrease waiting lists for treatment and to provide a level of treatment (intensity and duration) appropriate for an individual offender's level of risk and need. Again, this approach is a meld of cognitive-behavioural intervention with spiritual healing.

5. Stony Mountain Institution, Manitoba

Stony Mountain Institution (SMI) currently provides two primary treatment alternatives for sex offenders. Inmates in the 'general population' can participate in individual counseling, and also work on the Relapse Prevention Sex Offender Workbooks with the support and assistance of a therapist. The typical high risk, high need, multi-problem inmates in the Administration Segregation Unit participate in an open, ongoing sex offender group. They are also eligible to receive individual counselling.

The treatment delivered by the Forensic Behavioural Management Clinic is cognitive, but the clinic has attempted to be eclectic in its approach to treating sex offenders and is open to models that may be most appropriate for particular clients.

This program contains elements of aboriginal culture and involves aboriginal Elders in the healing process.

The clinic believes that the most effective way to assist clients to internalize the insights they develop in treatment, is related to process-oriented learning rather than more didactic approaches.

The clinic does not perceive sexual offending as an addiction or as a disease. While the relapse prevention model, which is derived from the addiction literature, is a primary treatment model, it is assumed that offenders can learn to control their deviant thoughts, fantasies, arousal and behaviour. It is their responsibility to accept accountability for their actions and to develop the necessary insights and skills that will allow them to manage their deviant thoughts and behaviour. As well, the clinic does not suggest that treatment provides a cure. Offenders must manage their risk factors on an ongoing basis. Failure to do so will enhance the risk of lapsing or relapsing in the future.

Goals of treatment include:

- Accepting accountability for offending history (disclosure of offending history)
- Developing insight into the offending cycle (affect, deviant fantasy, distortions, planning, act)
- Challenging denial, minimization, cognitive distortions,
- Managing and modifying inappropriate sexual fantasies
- Modifying deviant sexual arousal patterns
- Developing awareness of consequences faced by survivors of sexual abuse
- Developing empathy
- Developing insight into factors contributing to offending (emotional, cognitive, behavioural and situational)

- Developing functional coping skills: problem solving; communication; social skills; awareness of emotions; anger management; assertiveness training; managing cognitions; relationship skills; enhancing self identity.
- Addressing personal victimization
- Discussing and addressing family of origin and socialization issues
- Discussing healthy sexuality
- Attitudes towards women
- Relapse Prevention
- Developing an offence cycle and control plan to assist the offender in understanding and managing risk and to aid in case management and later parole supervision.

6. Clearwater aboriginal Sex Offender Program , Saskatchewan

This treatment program has been provided to 40 offenders. There have been no dropouts, although the level of participation has varied. Services were integrated with a multidisciplinary treatment team, and were part of an integrated service.

As the Healer and his Helper functioned as part of the Treatment Team, we can not say there was a distinctly separate aboriginal Sex Offender program in place. Rather, the relationship between the healer and other Treatment Team members was very collaborative.

Feedback from Case Management suggested that aboriginal involvement is a valuable component in Correctional planning. Because of the Healer's participation as part of a Multidisciplinary team, feedback concerning offender progress is readily available. The result has enhanced Case Management decision making.

The aboriginal Sex Offender program has experienced some notable successes. For example, the Healer worked with an offender and his home community to facilitate the offender's return. The Healer escorted the offender on an ETA to attend a Sundance and the offender was eventually reintegrated into the community on a conditional release. It is unlikely that this release could have been effected without the participation of the Healer.

We are currently working with a contractor to develop an evaluation strategy which we hope to be able to employ at other sites. On the whole we have been encouraged by our experience working with the Healer and believe this is an initiative we should retain.

SWEATLODGE CEREMONY

GOAL

-To foster aboriginal Spirituality through holistic healing.

-To include a ceremony involving the disclosure or confession of offenders specific to sexual offending while in the sweatlodge.

OBJECTIVES

-To cleanse, heal, receive forgiveness from bad behaviour and offending.

-To allow for re-birth and renewal.

-To address shame and remorse in an environment where healing of spirit, mind, body and emotions are key elements of activity.

-To re-introduce and promote honour and respect.

DESCRIPTION

A Sacred Ceremony held within a lodge conducted by the Elder/Healer whereby participants cleanse and heal themselves. In particular this sweatlodge has been integrated to address aboriginal sexual behaviour by the offender/participant. Teaching is provided by the Elder/Healer regarding how offenders can Heal from this type of offending.

WHOOSPAGAN HEALING CEREMONY

GOAL

-To provide specific spiritual, ritual and cultural teaching to the participants.

-To foster greater understanding in regards to the aboriginal identity which many offenders are lacking.

OBJECTIVES

-To promote cultural, ceremonial and spiritual activity in which the offender will gain greater insight into their place of belonging in society (aboriginal/non-original).

-To encourage the participants to adopt the philosophy, values and beliefs which will promote change and behaviour, and attitudes.

-To promote participants to adopt these teachings in their lifestyle in general.

DESCRIPTION

A Sacred Circle Ceremony held within the Cultural Centre once a week for 2.5 hours.

ONE TO ONE COUNSELLING

GOAL

-To promote changes in attitudes and behaviour through fostering of cultural, spiritual values.

OBJECTIVE

-To identify specific "needs" of each offender.

-To reinforce the traditional/cultural and spiritual teaching.

-To assist the patients to adopt a healthier, holistic lifestyle with good values and beliefs.

-To develop a relationship with positive outcomes and to assist in making out a plan while he is in the RPC.

DESCRIPTION

Sessions and interviews are held on the Unit in the Cultural Centre and the Tipi outside. They consist of one or two long periods.

GRIEF SUPPORT SERVICES

GOAL

To co-ordinate and facilitate the holistic healing of aboriginal patients in RPC.

OBJECTIVES

Short Term

-To assist offenders experiencing emotional instability caused by grief and trauma.

-To develop a means of recognizing and coping with loss or changes.

-To neutralize internal personal conflict and establish individual, physical, psychological and emotional health.

Long Term

-To enable the patient upon release to continue the holistic healing process with Elders, and Spiritual ceremonies in the community. This coupled with family counselling will address and help neutralize the ongoing cycles of abuse and violence.

DESCRIPTION

To assist patients suffering from traumas caused by family conflict/violence, divorce, death, residential/foster home syndrome, substances, sexual injury, and general loss of cultural identity.

NATIVE BROTHERHOOD

GOAL

- To promote an understanding and awareness of cultural identity through traditional cultural/social activities which will better assist patients to integrate into the community.

OBJECTIVE

- To work co-operatively with the Elders/Healer, Administration and community agencies and volunteers.

DESCRIPTION

- The Native Brotherhood is a self help group for patients governed by an elected council (executive) which provides leadership, guidance to its members. The group as a whole identifies aboriginal program needs and participate in the planning of round dances, hobby Pow-wow's, crafts, and sporting events, etc. This group uses a traditional model of governing, developed and guided by the Elders/Healers.

DRUMMING, SINGING, DANCING

GOAL

- To provide for the teaching and therapeutic value of singing, drumming, and dancing.
- To provide further cultural/traditional teaching.
- To establish an avenue of positive cultural/social activities both inside and outside of institutional life for the participant.

OBJECTIVE

- To develop self-esteem and pride on an individual basis through participating in the Drumming.
- To further positive thinking, attitudes, behaviour.
- To ensure that a drum group is in place to represent the institution during our social/cultural events.

DESCRIPTION

A practice is held once a week in the Cultural Centre. A Drum Keeper is selected and taught the proper procedure in caring for our sacred drum.

PROBLEM AREAS

1) FASTING - (Issue)

There is difficulty experienced by the participant when he fasts in his cell.

- noise pollution
- swearing by passing patients
- temptation to break due to all the food on the unit
- poor concentration
- unexpected interference, intrusion by other patients<
- women on their cycle near the cell
- -complaints about the smudging

2) Ideally the fasting should be carried out on a UTA or while in the RPC off the Unit and into lodges built by the helper in the sweatlodge area. Alternatively a permanent structure could be built for these purposes. In this way many of these issues would be addressed.

FASTING - A SACRED CEREMONY

GOALS

-To participate in a ceremony which provides for the individual the Right of passage and prepares each person for enhanced spiritual holistic healing and lifestyle.

-To allow for meditation, sacrifice and action to address personal needs upon the healing path. To evaluate their lives to cleanse themselves of negative attributes.

OBJECTIVES

- To prevent and eliminate negative thought patterns and activities.
- To empower the participant to develop positive attitudes, responsibility, accountability, peace and more balanced lifestyles.

DESCRIPTION

Currently being carried out on the unit in their cell with sanction, guidance and moral support from the Elder/Healer. During summer months this activity will take place outside near the sweatlodge and Tipi.

In addition the Elder/Healer is involved in these areas on the unit on a daily basis.

1) Ward Rounds - upper and lower

2) CORE Programming - Sex Offender Treatment

3) Supplement Programming

- Anger Management
- Family Violence
- Values and Attitudes
- Cognitive Skills
- Empathy
- Relationships

4) Conflict resolution amongst inmates

5) Case Management consultation

6) Staff Training - cultural

7) ETA's, UTA's - Cultural

8) Supervision of patients

9) Direct involvement, intervention and strategy to ensure aboriginal patients complete the CORE programs.

10) Assist with NPB Hearing, providing moral support.

7. Aboriginal Sex Offender Healing Program, Bowden Institution, Alberta

Region: Prairies

Institution/District or Area Office/CCC: Bowden Institution

Programme Title: Aboriginal Healing Programme

Programme Description: Sex offender retraining which is delivered holistically, encompassing the four major life areas as per the Medicine Wheel i.e., physical, mental, emotional and spiritual. The programme is a blend of core programme teaching with service being provided by an Elder to cover spirituality and culture. It is recognized the latter will not be able to cover all cultures or spiritual practices of every participant.

Indicate whether this is a shared initiative with NPB: No, but would desire NPB be thoroughly informed. We would be pleased to provide workshops.

Method of Delivery: Group with occasional individual.

Service Deliverers: Elder, CSC.

Background of Service Providers: Elder who is recognized as such in the community. Able to provide cultural/spiritual teachings. Able to work under the umbrella of the partnership model.

Retrainer - specific training in working with sex offenders (Justice Institute of B.C.)

Occasional other co-facilitators with extensive experience working with sex offenders are used.

Number of sessions per week: Eight sessions over four days: 0800-1130 & 1300-1530 hours.

Capacity per session: < Maximum twelve.

Total Duration per Programme: Hours are 0815-1100 and 1300-1500 four days per week for 12 weeks. First two programmes were fourteen weeks.

Target Groups: Primarily, but not absolutely limited to, Indian, Metis and Inuit men who have committed a sexual offence.

Exclusions: Intellectual impairment or mental illness or an inability to work in group process. Those who flatly reject Native Spirituality.

Participant Assessment Approach: Motivation to make changes, action to demonstrate same, willingness to participate in group process.

Expected Results of Programme:

1) offenders will discuss the sexual offence behaviour

2) offenders will not blame others for their choice to offend

3) offenders will be able to identify their own feelings of victimization

4) offenders will be able to identify the likely feelings of their victim

5) offenders will be able to discuss some emotional and attitudinal precipitants of the sexual offence behaviour

6) offenders will discuss what situations and emotional states must be considered danger signals in the future and what action steps to take to change such situations

7) offenders will be encouraged to openly discuss their sexual fantasies and masturbation patterns

Follow-up After Programme: At approximately 6 months after completion of programme, individuals will be given the pre-post evaluation questionnaire again.

Two modules are currently being developed for formal follow-up:

1) Sex Offender Maintenance Model (programme)

2) Community Readiness Module

To date there has been an informal follow-up for those inmates who request an interview with either Elder, Facilitator or both.

Programme Evaluation Approach: Two knowledge questionnaires pre and post programme. Culture fair test - the Kelly Grid. Post programme interview wherein participants are seen individually and asked to answer such as the following: "describe your offence cycle; how might your victim feel or be affected?; describe your relapse prevention plan."

Commencement Date of Programme: September 3, 1996

Programme Completion in 1996-1997: Two

Target Completions for 1997-1998: Three

Assumptions: Outside resource people will be brought in (i.e., Healers).

8. Intensive Sex Offender Program For aboriginal Men, Mountain Institution, British Columbia

TREATMENT GOALS

This intensive program for aboriginal male sex-offenders is based on the holistic model, where participants will learn, experience and develop skills to maintain a healthy sexual and ***offense free lifestyle***, under the guidance of qualified correctional practitioners and an aboriginal Spiritual Advisor. aboriginal Culture/Spirituality will be the basis under which the program will function and Spiritual Healing will be the ultimate by product.

The responsibility for learning rests with the individual. Offenders must be motivated and have an idea of their own goals. They must accept responsibility for their offense(s)

Offenders will be required to participate in the cultural and spiritual components of the program

PROGRAM OBJECTIVES

- to provide a safe and healing environment that will assist the participant identify and correct his dysfunctional behaviors.
- to assist offenders develop skills to recognize the deviant patterns of thinking and behaving.
- to assist offenders to gain insight and understanding of deviant and dysfunctional behaviors.
- to assist offenders to be able to identify high risk situations and high risk factors
- to assist offenders to understand and establish their own Behavior Cycle
- to assist offenders to establish a Relapse Prevention Program (Personal Maintenance Program)
- to identify those offenders who require additional program involvement for enhancing successful community integration.

ADMISSION CRITERIA

The candidate will:

- have accepted responsibility for their sexual offending and be willing to discuss all parts of their abusive behavior cycle.
- request treatment and demonstrate the motivation to change.
- be able to understand the written work and complete it, bearing in mind the service of a tutor will be utilized as well as a 2 hour per week discussion on homework expectations for each forthcoming week. It must be recognized that English is often a second language and therefore, more assistance may be required than with the general population group.
- have a comprehensive psychological assessment on file.
- be totally committed to a full time program involvement, and not be involved in other assignments such as legal actions, temporary absences, other work assignments. Each participant will however, develop a WELLNESS PLAN, which they will be encouraged to follow.
- have preferably taken the Cognitive Living Skills Program and other programming identified in their Correctional Plan.

METHOD OF ACCOMPLISHING THE TREATMENT GOALS.

The Program will be provided by a male Spiritual Advisor, a qualified and experienced male sex-offender therapist and a female correctional practitioner who is specifically trained to deliver aboriginal sex-offender treatment. The three facilitators will be viewed as equal members of the treatment team.

Most importantly the aboriginal Sex-Offender Program will be based on a Cultural/Spiritual Concept and spiritual healing is viewed as the cornerstone of this program. The Program in it's entirety will, in essence, be considered a Puberty Ceremony, at which time those participants who complete the program will be honored as having passed into manhood. It should also be noted that the Educational modules are an integral component of the learning/healing process.

The facilitators will present each participant with:

- a special cup (preferably made of a metal from Mother Earth) that he will use each morning for the Water Ceremony.
- tobacco. In accepting tobacco he will be making a commitment to honesty and to completion of the program.
- a piece of print.
- a white candle to be used during prayer.

Each day will begin and end with a ceremony and/or prayer, lead by the Spiritual Advisor. A special prayer may be offered on occasion, for instance, to honor a death in the family, or celebrate a participants birthday. Participants will attend a Sweat Lodge Ceremony every second week which will be exclusively for group participants.

Visiting Elders will be invited to provide teachings at certain times throughout the program. For instance, during the Sexuality and Human Relationships module, a female Elder will be invited to provide teachings about these issues. An Elder whose expertise is Generational Grief and Shame will provide 2 days teachings on that issue. A visiting aboriginal resource person will provide a full day workshop on the Effects of Residential School. Yet another Elder who has been incarcerated in his past will spend an afternoon and share his life story. He will be viewed as a positive role model,

Halfway through the program a lunch will be served to honor the work and progress made thus far. The Graduation Ceremony at the end of the program will be a major celebration. Significant others (up to 2 each) will be invited to celebrate the event. Correctional Services of Canada people will be invited to join in the celebration. Each participant will be asked to give a talk about his experience and what he has learned. The Certificate of Achievement will be wrapped in leather and presented to each graduate. From an aboriginal point of view, we must celebrate the human being and our achievements, while recognizing that changing our deficiencies and dysfunctions will be our lifelong journey/ work plan.

The program will provide educational modules including; Thinking Error and Cognitive Restructuring, Rational Emotive Therapy, Sexuality and Human Relationships, Behavior Cycle and Relapse Prevention Planning.

The following is an outline of the aboriginal Sex-Offender Program offered at Mountain Institution.

HEALING/INSIGHT/FEELINGS GROUP

This is a free floating group where facilitators will steer the group process. It will not be labeled a psycho-therapy group or a Healing/ Talking / Sacred Circle. Unlike a true Healing, Talking or Sacred Circle, participants will be confronted and when necessary brought back on track. They will be encouraged to look at their attitudes, thoughts and behaviors. The facilitators will use a combination of techniques encouraging group cohesion and participation/ confronting problems, denial as they arise.

This group will begin with a WATER CEREMONY, in which the participants will drink pure spring water from a special cup, while the Elder/Spiritual Advisor teaches the SEVEN SACRED RULES OF LIFE. The significance of this ceremony is to water the essence of goodness within each person. The teachings may be alternated with PRAYER some days. This ceremony will take a few minutes. A special prayer may also be offered at this time for a specific reason, such as honoring a death in the family or celebrating a group members birthday, etc.

By fully participating in the group process, participants will have an opportunity to explore their own feelings, deviant thoughts and behaviors. They will identify with others thoughts/feelings and behaviors and provide feedback to assist themselves and others change. Throughout the group process, a supportive and safe environment will be maintained.

The group will maintain a strict time frame, commencing at 08.30, ending at 10.30 hours, Mondays through Thursdays.

Every three weeks the morning will be used for Review Group, where the facilitators and group members will provide feedback to each group member. Facilitators will encourage the members to provide positive feedback in terms of how they see their fellow members growing and progressing as well as positive criticism where they see their fellow members having to work harder.

AUTOBIOGRAPHY MODULE

Each participant will construct a genogram and an autobiography. Each person will present both verbally.

The genogram will include as many ancestors as can be remembered to a maximum of 5 generations. Participants, using different colored markers will mark each person in the genogram (as it applies) as having :

- been a victim of sexual abuse,
- suffered from alcoholism / cultural self hate, depression, poverty, family violence
- been a survivor of the residential school system,
- etc.

By using the genogram, participants can, at a glance, see what traumas/dysfunction have been generational, and in identifying them, they can then begin the process of understanding themselves and breaking the cycles.

The autobiography will include a summary of his childhood, school experiences, sexual development and experiences, adolescent and adulthood experiences and criminal behavior. The presenter will choose one or two other persons from the group to stand with him as he gives his presentation. The purpose of choosing another to stand with him is to begin to teach that aboriginal people need not stand alone. This exercise will begin the process that we can offer support to each other (and the presenter) can ask for support and help when we are in need.

The autobiography will serve two purposes. It will allow group members and facilitators the opportunity to get to know their fellow participant and allow the presenter an opportunity to take a risk, talking about himself in a safe environment , while facing the events and traumas of his life. Through this process they will begin to identify that aboriginal people have had similar experiences and are in a healing process.

THINKING ERROR and COGNITIVE RESTRUCTURING MODULE

This is an educational module in which the facilitators will teach the participants to identify and label their thinking errors. Based on the fact that every person, whether responsible of irresponsible has certain patterns of thinking, each person will be encouraged to look at their particular pattern of thinking.

To change their deviant way of thinking, the pattern must be disrupted and a new and more appropriate way of thinking learned.

They will maintain a log in which they will make 4 entries a day. Using the log they will identify their Thinking Errors, labeling and restructuring them.

Total hours = 18

RATIONAL EMOTIVE THERAPY MODULE

Will be included and incorporated into the Thinking Error Module, as well as six afternoons where the principles of RET will be taught and discussed. In this module, the basics of emotional disturbance and how to overcome one's own emotional disturbance will be taught. This module is of significant importance given that aboriginal people live with the effects of generational shame/trauma and grief and a very confused history.

Total hours = 12 hours

SEXUALITY AND HUMAN RELATIONSHIPS

This module is designed to assist the participant to identify unhealthy and disrespectful ways of thinking, behaving and relating to other human beings. A female Elder will be in group throughout the module to provide teachings about the sacredness of the human body and boundary issues. During this module the following areas will be covered:

- sex education, including factual information on basic anatomy and physiology, STDs, and contraceptives.
- responsible decision making skills in terms of sexual relationships, planned parenthood.
- understanding the development of the individual's sexuality, including deviant behaviors and their own sexual victimization.

- understanding past and present relationships, and learning about healthy vs unhealthy relationships.

Total hours = 18

BEHAVIOR CYCLE

1) In order for the offenders to identify a repetitive cycle of thinking, feeling and behavior that lead to offending or abusive behaviors the following will be covered:

- a detailed presentation by facilitators to teach the participants about the cycles they have developed.
- a detailed written and oral presentation on his individual Behavior Cycle, to the group identifying his own thoughts feelings and behaviors that were present prior to, during and after each offense.
- completing written assignments in the Freeman-Longo and Laren Bays workbooks, "Who Am I and Why Am I In Treatment?", Why Did I Do It Again?" and "How Can I Stop?"

2) As a second part of this exercise, the participant will present his appropriate interventions and deterrents that will effectively break the deviant cycle.

3) Their Behavior Cycle is to be shared with the individual's support people, as well as his Parole, Probation and Community Program people, i.e., Band Social Worker and/or Program Provider.

Total hours = 30

VICTIM EMPATHY

This module will focus on increasing the offender's awareness of the effects his offending behaviors have on his victim(s). To assist the offender to experience the feelings of his victim (both short and long term) and to develop empathy, the following exercises will be used:

a) Near the beginning of the program the offender will be asked to write a letter to his victim, which will be sealed and stored for later critiquing. During the Victim Empathy Module the offender will read his letter and will be asked to critique it himself and will be given feedback from the facilitators and the other participants.

b) A series of victim empathy videos will be shown and discussed.

c) One 3 hour session will consist of a panel of 2 or 3 victims (who have been in recovery and are comfortable and willing to face these offenders) will sit in the circle and tell their story.

d) Finally, each offender will participate in a Victim Empathy role play, where he will assume the role of his victim and another member will become the person he is confiding in. He will be coached by the facilitators and other group members.

e) The workbook, "Empathy and Compassion" by Freeman-Longo and Bays will be used to compliment this module.

Total hours = 48

SUCCESS / OUTCOME

Success is indeed impossible to determine. However, the offender's day to day behavior will be observed. His daily logs will be monitored. As an aboriginal cultural/spirituality based program, the focus is on healing and growing and becoming aware. As an alcoholic or drug addict, the sex offender will need to practice a relapse program for the rest of his life.

Furthermore, restitution will be discussed and the offender will be encouraged to make restitution to his victim(s) where doing so will not further traumatize the victim. This may be done by conducting a give-away, potlatch or shame feast or whatever tradition is specific to his people. However, this will not be "part" of the program, but will be something he may

consider for a later time. While for mainstream society this may not be an important consideration; however, in the aboriginal community, where families are closely related and offenders will likely be returning to their communities, a great deal of work needs to be done in this area.

EVALUATION

The offender agrees to participate in pre and post testing on a battery of psychometric battery of psychological tests. These tests have been adopted from the Personality Disorder Programs at RHC.

The offender's thoughts, feelings and behaviours will be monitored throughout the program. His general behaviour and his logs will be the sources of information in this regard.

Every 3 weeks review groups will be conducted where the facilitators and other group members will provide feedback and confrontation to all participants.

A final report will be written, and will speak to progress, changes in attitude, thoughts, feelings and behaviors, while in the program and areas that the offender needs further work, insight and change and will make recommendations for further programming.

PROGRAM SCHEDULE

Each morning will be dedicated to the Healing/Insight/Feelings Group. There are approximately six mornings when special resource people will attend and rather than proceed with group, a teaching will be offered.

Each afternoon will be dedicated to educational modules that will include Thinking Errors and Cognitive Restructuring, Behavior Cycle and Relapse Prevention Plan, Teaching from Elders, Victim Empathy, RET and Sexuality and Relationships.

Each Friday morning will be used to discuss and provide instruction for the following weeks homework. A tutor will be utilized to assist members with their homework.

Every second Thursday afternoon the members will participate in the Sweat Lodge Ceremony.

Throughout the program, tobacco, pure spring water, sage, sweetgrass, cedar and other sacred medicines will be used to aid the healing process.

9. Tsow Tun Le Lum Substance Abuse Treatment Centre

THUYTHUT, roughly translated as "Standing Tall", is an 18 week closed residential program for aboriginal sex offenders. This program commenced as a pilot project at Tsow Tun Le Lum Substance Abuse Treatment Centre (near Nanaimo B.C.) in 1992 and continues to offer 2 program cycles each fiscal year. The program is grounded in the culture of the aboriginal people of the region. The program schedule for the Sexual Abuse and the Alcohol and Drug Abuse programs are similar, although the group work for the Sex Offender program deals with subject matter specific to that group.

This community-based clinic offers comprehensive assessments and a multi-disciplinary treatment program for sex offenders. The clinic assesses incest offenders and rapists, and is open to both aboriginal and non-aboriginal offenders. Acceptance into the program is conditional upon the result of the assessment.

There are three phases. Phase 1 has a psycho-educational approach, and is didactic in nature. Phase 2 has a heavy emphasis on group therapy and reinforces the psycho-educational training of Phase 1.

In Phase 1, treatment includes psycho-educational lessons, both group and individual therapy, with the Thuythut panel of elders. Treatment concentrates on a psycho-educational curriculum covering sexual aggression, victim empathy, the offending cycle, human sexuality values and inappropriate myths about relationships, as well as relapse prevention planning. Participants attend educational group sessions and are required to do exercises on their own which are designed to help them understand each of the content areas. Group therapy initially focuses on denial. Offenders are required to share their deviant sexual

behaviour, sexual misdemeanors and crimes with each other in an open and honest way without minimizing, blaming, or rationalizing. Supportive confrontation is used to break through denial.

Each offender is required to develop a comprehensive sexual history and share this with the group. Peer feedback is developed and regularly used in group therapy. Stemming from their sexual histories, offenders begin to work on how they were abused during their own lives and how that abuse relates to their own sexually offensive behaviours. Care is taken not to allow blaming and rationalization to detract from full and honest accountability for their own actions.

Before the end of the first phase, offenders develop a plan to ensure against offending during the inter-session which occurs between the first and second phases of treatment. Work assignments are issued to offenders for completion during the inter-session period.

Elders lead sessions which teach cultural ethics, traditional values and principles and introduce spirituality. Traditionally, witnesses were paid to stand by the teacher and were responsible for remembering and validating the session. However, during treatment sessions, everything is recorded in writing, and at the beginning of each session, it is read aloud.

The second phase reinforces the psycho-educational training of the first phase and has the offender emotionally connect that content with his or her own experience and life. It helps offenders strengthen self-esteem, sobriety, and personal resources for reintegration into the community without re-offending. The offender is also required to define and create healthy relationships.

In general, the clients attend 5 hours per week of cognitive-didactic or psycho-educational sessions focusing either on sexual offending behaviour or on alcohol and drug issues. The program includes 5 hours per week of Traditional Values and Principles, 10 hours per week of more process-oriented group therapy and two hours per week of Elder sessions. Offenders are introduced to stress management techniques, complete homework assignments, attend AA, may participate in individual counseling sessions, and are involved in leisure pursuits and activities of daily living. The program is offered within a therapeutic environment. It would appear that the clients attend a total of 400 hours of group sessions over the course of the 18 week program, which is consistent with intensive programs (National Standards and Guidelines for the Provision of Services to Sex Offenders, 1996). This program integrates traditional healing with a cognitive-behavioural approach.

10. Canim Lake Family Violence Program

The Canim Lake Band developed a program for sex offenders. The initiative involves seven phases of intervention for perpetrators and survivors. The seven phases are: community orientation; deferred reporting; risk and trauma assessment; primary intervention; reunification; maintenance programs; and research and empirical growth. The treatment intervention takes a cognitive-behavioral approach, and the polygraph is used to provide additional monitoring.

11. Gwa'sala-'Nakwaxda'xw Family Intervention Program (FIP)

An evaluation of the Gwa'sala-'Nakwaxda'xw Family Intervention Program [known hereinafter as FIP], an aboriginal intervention program, produced by the B.C. Institute on Family Violence stated that the philosophy of the program was that:

(1) the program must be grounded in traditional values and customs of the people;

(2) it must employ both traditional aboriginal and mainstream psychological approaches to healing;

(3) it must base healing on support from families and the community;

(4) it should treat both abusers and survivors, and

(5) the ownership, responsibility and control of the program must reside with the community.

Although the philosophy was based on solid principles, the program was only in operation from April 1994 to February 1995. The evaluation took place a few months after it closed down. Except for some disagreements among the social workers themselves, the reasons for closing down the project are unclear in the report although the evaluation mentioned that the breakdown of the FIP was closely connected to problems related to band politics, money, shifting roles, and a weak administrative and management structure. By the same token, the evaluation was very thorough and the conclusions could be useful to other aboriginal intervention programs.

The evaluation states that the history and development of the FIP has strong roots in the community. The community has a history of relocation, residential schools, victimization and cultural devaluing. This history contributed to many problems including: a severe problem with alcohol abuse, child sexual abuse, child apprehensions, spousal abuse, elder abuse, child neglect, Fetal Alcohol Syndrome/Fetal Alcohol Abuse and dependence on social assistance. (Attempted or completed suicide was not identified by respondents as a serious problem in this community.)

FIP was initiated in 1991 when two mothers wrote to Chief and Council to express concern over sexual abuse. Between 1991 and 1992 the community used Federal "Family Violence" funds to develop a program. This Family Violence Initiative was jointly funded by the Department of Indian Affairs and Northern Development and the Medical Services Branch of Health Canada in an initiative lasting from 1991 to 1994-1995. By the end of 1992 the band administrator approached the consultant to work again for the community. Chief and Council played a key role in providing political leadership.

The components of the program for the abusers were the following:

- **Assessment:** This included a thorough psychological assessment and Risk Management Committee recommendations to Crown Counsel
- **Safe House:** This was a home originally designated for women and children at risk of violence or abuse. However, it was later decided that the abuser should leave the family home rather than the converse. This was generally supported by the community.
- **Individual therapy:** Occurred once a week with the consulting psychologist or the paratherapists, supervised by the psychologist.
- **Group therapy:** This occurred once a week and was co-lead by a consulting psychologist and paratherapists. Most reports indicate this was working well and the abusers were motivated and supportive of each other.
- **Sponsors:** Each abuser had a sponsor that he met with twice a week for 20 minutes.
- **Drug and alcohol counselling:** Was required for abusers when appropriate.
- **Case conferences:** Included relevant FIP staff and probation.
- **Community work:** Was supervised by the community patrol and seemed focused on providing services for the Elders. There were suggestions that this needed to be expanded.

Other FIP components included: (1) Individual therapy for children, adult clients, and staff, (2) Family therapy; (3) Group therapy (non-abuser men's group, an infrequent Elder's group, children's groups, women's groups); and (4) Support groups (A.A., Adult Grief). Note that for the children there were groups for 3-4 year olds, 7-10 year olds, 10-13 year old boys, and 10-13 year old girls.

There were also components in place for the community. These included Brief Emergency Intervention, as the FIP served as a Walk-In Clinic for individuals in acute distress. As well, there was an *On call* service provided by the paratherapists during evenings and week-ends.

The evaluation team noted some confusion regarding the definition of traditional healing and its role in the FIP. "It may be that people, including ourselves, are not always talking about the same thing when this topic is discussed" (B.C. Institute on Family Violence, 1995). The FIP evaluation stated that the problem of defining traditional healing needed to be clarified. It mentioned that if it is to be a model for treatment then it must be clearly defined for funders and evaluators. A distinction can be made between traditional healing and traditional mechanisms and the role each plays within a program. The traditional healing ways that exist in the community need to be a part of the program. The evaluation indicates that traditional healing may not be relevant to certain individuals, and would have to be an individual choice. On the other hand, traditional mechanisms of the community guide daily community life and are relevant to the operation of a program, as they can impact on the delivery of healing/clinical services (B.C. Institute on Family Violence, 1995).

Concerning the involvement of the Band Council, the evaluation mentioned that programs designed and controlled by the Band Council will not "get the job done" unless the community is involved. But by the same token, the evaluation indicated that the FIP should have been operated at arms-length from Chief and Council. There is always the risk that Chief and Council, a political body, will have a conflict-of-interest on matters related to the program and make decisions which are not in the best interest of the program (B.C. Institute on Family Violence, 1995). In the closing comments, the evaluation suggested that leadership must come from within the community but "expertise" is needed from without. It added that the role of the outside "expertise" is to support the community.

Date Modified: 2013-11-27

Top of Page

Important Notices

NO. 93195-0

WASHINGTON STATE SUPREME COURT

In re the Detention of: CURTIS GENE BROGI, Respondent.	DECLARATION OF SERVICE

I, Allison Martin, declare as follows:

On July 27, 2016, I sent via electronic mail, a true and correct copy of Answer to Petition for Review and Declaration of Service, to:

Nancy Collins
wapofficemail@washapp.org

I declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

DATED this 27 day of July, 2016, at Seattle, Washington.

ALLISON MARTIN

OFFICE RECEPTIONIST, CLERK

From: OFFICE RECEPTIONIST, CLERK
Sent: Wednesday, July 27, 2016 2:56 PM
To: 'Martin, Allison (ATG)'
Cc: nancy@washapp.org; wapofficemail@washapp.org; Sappington, Sarah (ATG); Burbank, Brooke (ATG)
Subject: RE: In re Brogi, WSSC #931950

Received 7/27/16.

Supreme Court Clerk's Office

Please note that any pleading filed as an attachment to e-mail will be treated as the original. Therefore, if a filing is by e-mail attachment, it is not necessary to mail to the court the original of the document.

Questions about the Supreme Court Clerk's Office? Check out our website:
http://www.courts.wa.gov/appellate_trial_courts/supreme/clerks/

Looking for the Rules of Appellate Procedure? Here's a link to them:
http://www.courts.wa.gov/court_rules/?fa=court_rules.list&group=app&set=RAP

Searching for information about a case? Case search options can be found here:
http://dw.courts.wa.gov/

From: Martin, Allison (ATG) [mailto:AllisonM1@ATG.WA.GOV]
Sent: Wednesday, July 27, 2016 2:52 PM
To: OFFICE RECEPTIONIST, CLERK <SUPREME@COURTS.WA.GOV>
Cc: nancy@washapp.org; wapofficemail@washapp.org; Sappington, Sarah (ATG) <SarahS@ATG.WA.GOV>; Burbank, Brooke (ATG) <BrookeB@ATG.WA.GOV>
Subject: In re Brogi, WSSC #931950

Attached, please find Answer to Petition for Review and Declaration of Service, filed on behalf of:

Sarah Sappington
Senior Counsel
WSBA #14514
OID# 91094
(206)389-2019

Allison Martin | Legal Assistant to
Sarah Sappington | Katharine Hemann | Charlyn Rees
Washington State Attorney General's Office | Criminal Justice Division | Sexually Violent Predator Unit
800 5th Ave | Ste. 2000 | Seattle WA 98104
206.389.3916 | **allisonm1@atg.wa.gov**