Mid-Ohio Psychological Services
Sex Offender Program

Program Evaluation

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Introduction

Mid-Ohio Psychological Services has been treating sex offender clients since 1992. At that time, the Sex Offender program served an adolescent male population, and adult male services were added two years later. Sex Offender programs for the MR/DD population were initiated in 1996. The sex offender services were initially conducted in the form of group counseling sessions. In 2001, however, individual counseling sessions were added to address the unique needs of the populations being served. The agency is open to other populations of sexual offenders if the needs are identified.

Periodic reviews of specific programs at Mid-Ohio Psychological Services are completed as part of the monthly Quality Assurance reports generated by this agency. The Quality Assurance Committee decided in October 2004 that a detailed review of this agency's Sex Offender Program would be appropriate at this time, in part as a response to increased demand for services at the Franklin County office. In addition, the Sex Offender Program Director, Dr. Bradley Hedges, indicated that no formal review of this program had been done before.

Is the Sex Offender program at Mid-Ohio Psychological Services effective? This question, while simple in nature, becomes more complex when the term "effective" is defined by various systems. The program staff believes that the "community's" definition of effective management of sexual abusive behavior would be that the community is safe from sexually abusive people reoffending due to their participation in the program and the education they receive. The "community" would define effective intervention/management of this population as no new sexual behavior problems and further to see no new criminal or behavioral problems. However, in addressing the effectiveness of any sex offender program, there are other factors that need to be utilized when measuring effectiveness. This report serves as an internal program review. Because of this, the term "effectiveness" will be defined as follows:

1) Is the Sex Offender program being implemented according to the "best practice" of the profession? This includes issues such as quality and thoroughness of data gathered during the initial assessment and screening of each client, identification and adjusting to special needs a client may present with, and whether the program is operating under the ethical constructs of non-malfeasance, beneficence and autonomy/least restrictive environment.
2) Is the Sex Offender program being implemented in a way that demonstrates "fidelity"? This includes a peer review of whether staff members are being faithful to the accepted protocols and recommended interventions of the program.
3) Is the Sex Offender program generating outcomes that will satisfy both internal and external evaluators of the program? This includes cost effectiveness, comments by evaluators at exit interviews, and tracking of recidivism rates by participants of the program once they have completed the program requirements.

Program Review Methodology

Assessment Tools

In order to answer the questions of whether the Sex Offender program at Mid-Ohio Psychological Services is effective, the members of the Quality Assurance committee conducted a comprehensive peer review of the clients involved in the program. The reviewer form (See Appendix A) used in this peer review focused on various aspects of the program's implementation. Information gathered on this form includes completeness of intake information, selected issues during treatment, and completion of the core components on the program. In addition, this form provided client information such as adjudicated charges, location of court, dates of evaluations, whether the program was completed by the client, number of hours of service, identification of special needs, and the initial and discharge diagnoses. The chart review forms were created specifically for this review. The peer review issues will help answer the question of whether the program staff operates in a faithful manner in carrying out the Sex Offender Program.

Another instrument to be used in this program review was the Correctional Program Assessment Inventory (CPAI) (See Appendix B). The CPAI is a tool created by Gendreau and Andrews (1994) from the University of Cincinnati to assess correctional intervention programs in six primary areas: 1) program implementation and leadership; 2) offender assessment and classification; 3) characteristics of the program; 4) characteristics and practices of the staff; 5) evaluation and quality control; and 6) miscellaneous items such as ethical guidelines and levels of support. The CPAI items will be analyzed on a point-by-point basis to help answer the question of the program's commitment to "best practice".

Limitations of Review

There were sixty-seven charts reviewed for this program evaluation. The majority of these clients were currently active in one of the agency's sex offender groups. There were 25 historic clients compiled by the program staff to be reviewed. This list was limited to the memory of staff.

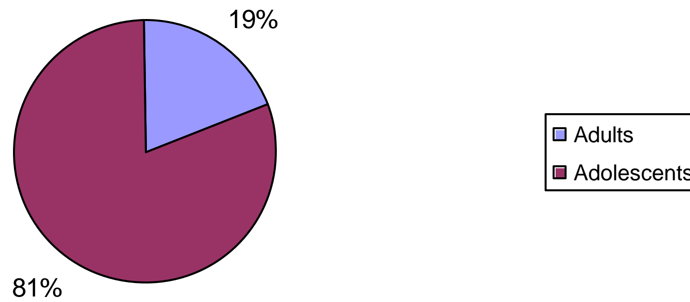
Demographics

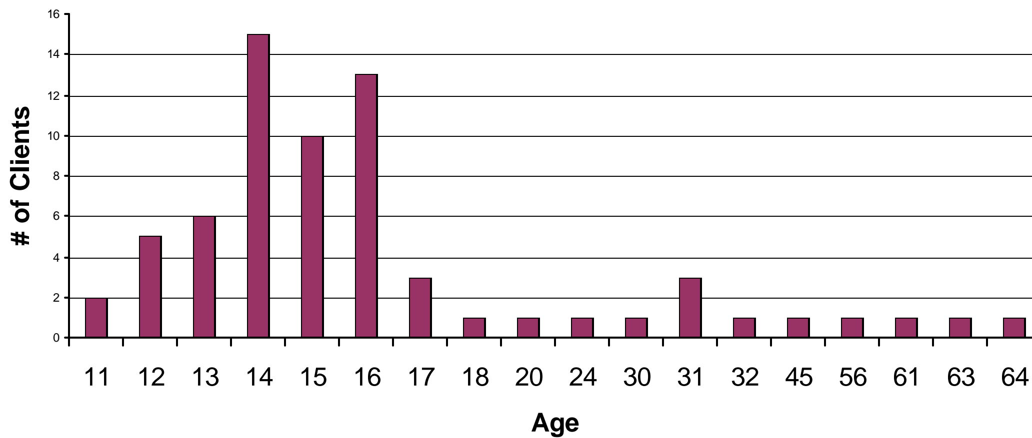
Gender

Only males were included in this program review. No females were reviewed due to there being no female clients in the program.

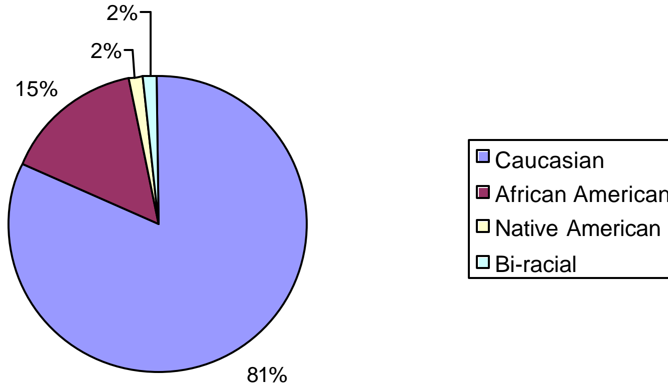
Age

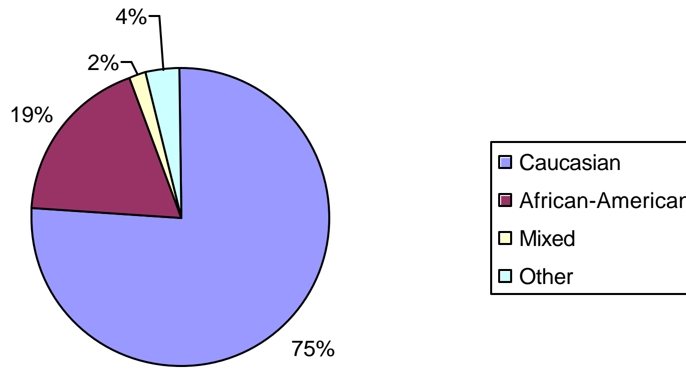
Eighty-one percent of the participants reviewed were under the age of 18. Nineteen percent were 18 or older.

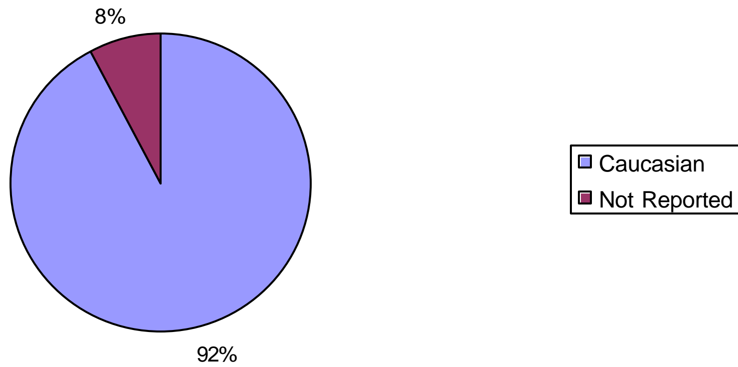




Race

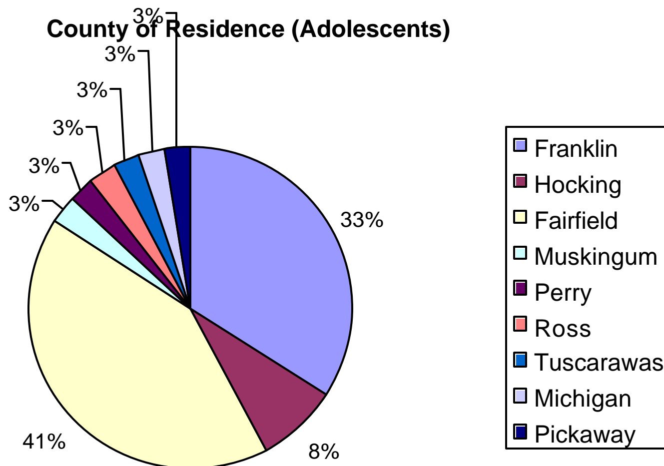


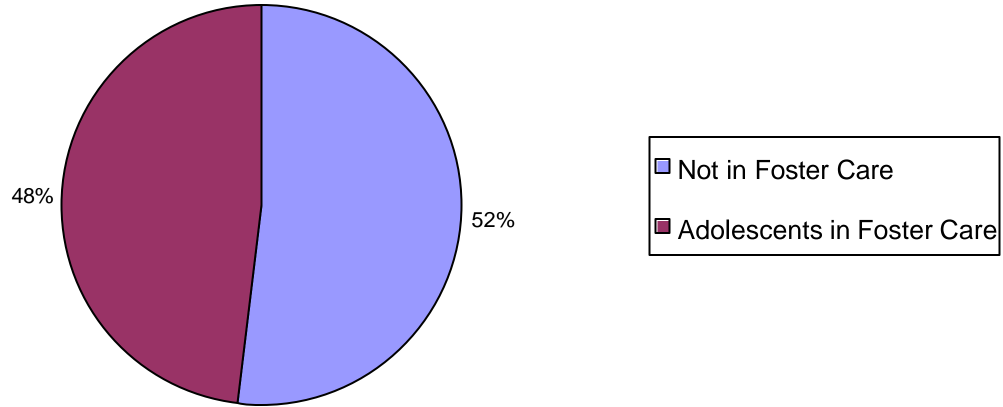


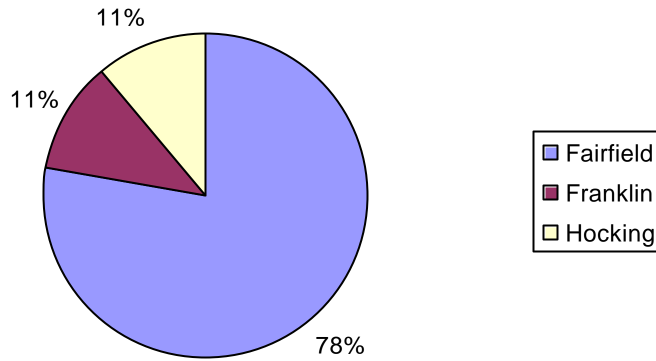


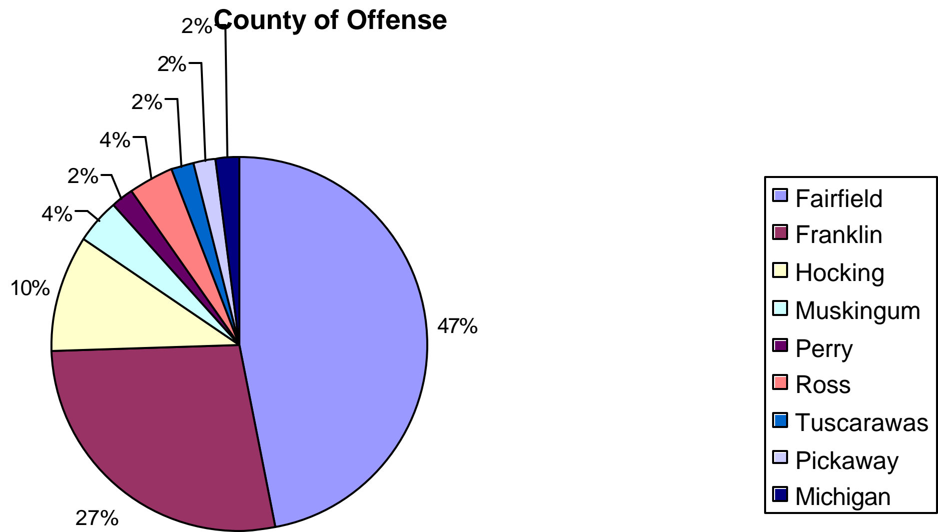
County

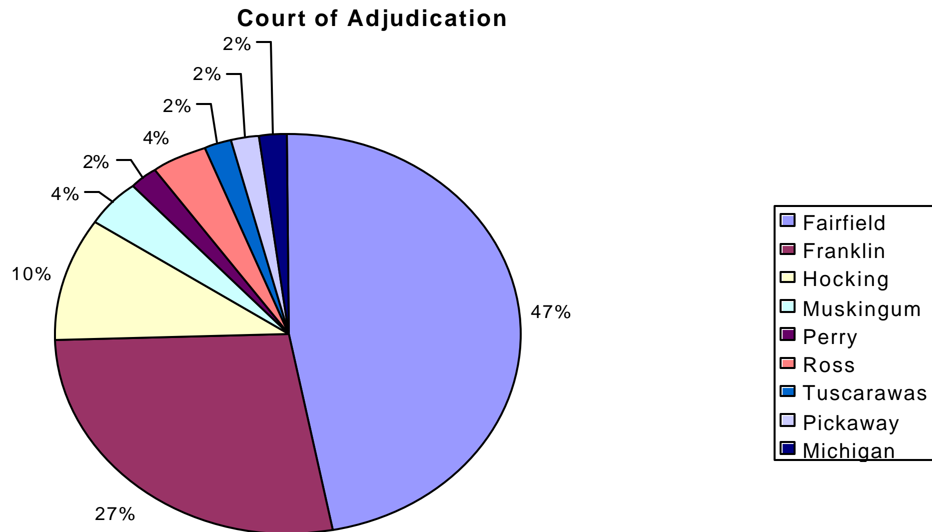
The agency's service area includes Fairfield County and the surrounding counties. The participants reviewed were first separated into adolescents and adults and then by county of residence and county of offense. Also shown is the county for the court that adjudicated clients in cases where charges were filed.




Adolescents in Foster Care
48%
52%
Not in Foster Care
Adolescents in Foster Care


County of Residence (Adults)
11%
11%
78%
Fairfield
Franklin
Hocking





Program Completion

The mean time in the program from referral to completion for adults was 31/2 years and for adolescents it was 21/2 years. The mean hours of treatment services for successful completion were 213 hours for adolescents, and for adults the hours for successful completion were 179.6 hours.

CPAI Data Results

Program Characteristics

1) The name of the program is The Mid-Ohio Psychological Services Sex Offender program.

2) The name of the contact person is Bradley A. Hedges, Ph.D.

3) The program is implemented at the following agency locations:

   624 East Main Street
   Lancaster, Ohio 43130
   (740) 687-0042
   Fax: (740) 687-6677

   Eastland Executive Square
   2246 South Hamilton Road
   Suite 202
   Columbus, Ohio 43232
   (614) 751-0042
   Fax: (614) 751-0047

4) Mid-Ohio Psychological Services has been treating sex offender clients since 1992.

5) Mid-Ohio Psychological Services provides a broad range of community mental health issues, including alcohol and drug addictions treatment, in addition to the Sex Offender Program.

6) Currently, the program is serving 34 clients, 29 of which are adolescents. All current clients in the program are male. The capacity for the current adolescent groups is 40 clients, while the adult group's capacity is 10 members. The overall program's capacity is undetermined, as the agency will create or dissolve groups based upon the community needs and the flexibility of the group facilitators.

7) The number of staff involved is as follows:

	Clinical	Support
# Full-time:	5	Unknown
# Part-time:	1	Unknown
# Hours Spent/week	9.5	Unknown
# Male/Female	3/3	Unknown

   It should be noted that the number of hours spent per week is difficult to measure due to clients being seen individually in addition to group counseling. However, the agency is currently utilizing nine and one half hours per week for sex offender groups. Clinical staff does not work full-time in the Sex Offender Program; the therapists involved in the implementation of the program generally average three to four hours a week of direct service time.

8) What is the program budget? How much does the program cost to provide?

The program's budget varies according to the number of participants utilizing its services. However, it can be estimated that the program is costing $150,744 yearly for services.

9) Does this program receive all its resources from the government or is it funded by grants or contracts from other sources?

Currently, the program receives its resources from Medicaid, private insurance, or client self-pay for services. There are no grants or contracts from other sources being utilized.

10) What is the documented program philosophy?

1) Treatment cannot begin until a clear clinical picture is established. Utilizing a "psychology model", clinicians utilize a range of clinical tools to clarify this clinical picture. A clear clinical picture can best be established through client self-disclosure, the acquisition of collateral information, and the utilization of formalized assessment techniques.
2) Clinical formulation is a dynamic process and must adjust to the acquisition of new information.
3) Recovery is a process--not an event. Clients determine the pace of recovery, recognizing that many forms of recovery require accountability both to oneself, as well as to an external entity.
4) Clients often lack the ability to recognize resources within themselves and within their community to address their needs on a day-to-day basis and thus, are seeking assistance in this process. An important component to most intervention strategies is the identification of both assets and liabilities within an individual and within an individual's environment that contributes to both recovery and pathology.
5) Therapeutic intervention is a proactive response to the change process. Intervention may include utilizing community resources to leverage recovery. Intervention may include traditional counseling, but may also include modifying the client's environment or other life circumstances.
6) Intervention should be based on a sound theoretical basis and/or on empirical evidence.
7) Treatment services do not fix people's problems, but rather expedite the recovery process for individuals who are willing to engage in the recovery process.
8) All clinical practices must utilize sound ethical principles. All clinical decisions should be filtered through these three ethical constructs: 1) non-malfeasance, 2) beneficence, and 3) autonomy/least restrictive environment.

Program Implementation

11) Was the program manager instrumental in designing the program before it was implemented?

Yes, Dr. Hedges created the program originally as well as the homework assignments.

12) Describe your program manager's educational background, degrees received, specialized training with client population.

Dr. Hedges earned a doctorate degree in Counselor Education from Ohio University, and holds an Ohio Psychology license as well as Professional Counselor with Clinical Endorsement, and a Board Certified Forensic Examiner. As an undergraduate at Ohio University, Dr. Hedges completed a field experience at the Chillicothe (Ohio) Correctional Institution. While earning his Masters degree in Community Guidance and Counseling at Ohio University, Dr. Hedges completed a six-month internship at Buckeye Youth Center in Columbus, Ohio.

13) Did your program manager have any previous experience in any type of offender treatment program?

Prior to developing the Mid-Ohio Psychological Services Sex Offender program, Dr. Hedges spent one year at the Orient (Ohio) Correctional Institution as a psychology assistant, five years at Southeastern Correctional Institution developing and coordinating a sex offender treatment program, and established a private practice in Lancaster, Ohio providing individual treatment of sexual offenders.

14) Is the program manager directly involved in hiring and providing training to the staff?

Yes, as the Director of Mid-Ohio Psychological Services, Dr. Hedges oversees the staff of the agency Sex Offender program, and is the person responsible for hiring clinical staff.

15) Is the program manager involved in providing direct service delivery to clients? Is the program manager involved in directly supervising the staff in the program?

Currently, Dr. Hedges provides direct client contact in the form of sex offender evaluations that can lead to placement in the agency program, as well as exit interviews to determine if clients have met the criteria to be terminated from the program. As the Director of Mid-Ohio Psychological Services, Dr. Hedges oversees the clinical staff, although most of the program staff is independently licensed.

16) Was there a literature search to identify relevant program materials needed to design the program? What was the scope or extent of the search?

    Dr. Hedges based this program on research done to create his book "An Introduction to Sexual Deviance." The research consisted of information gathered through literature searches, as well as conclusions drawn from the outcomes of Dr. Hedges' program implemented at Southeastern Correctional Institution.

17) Prior to the implementation of the formal program, was there a pilot program to try to work out the practical aspects of the program and any problems?

    There was no formal pilot program. However, the program has evolved to meet the needs of clients and community referral sources.

18) Was there an assessment of the need for the program in the community? How was this assessment done?

    This program was created following consultation between Dr. Hedges, the Fairfield County Juvenile Court, Fairfield Family Counseling, and the Fairfield County Alcohol, Drug Abuse and Mental Heath (ADAMH) Board. The ADAMH Board approached Dr. Hedges about creating a community-based outpatient sex offender treatment program.

19) Were the values and goals of this program consistent with existing values in the community?

    The Ohio Department of Youth Services created a program called Reclaim Ohio, and the goal of this program was to encourage community-based services rather than incarceration for convicted or adjudicated sex offenders. The prevailing values at the time were to treat rather than incarcerate this population. In addition, the program received the "Venture Award" in 2001 for the most innovative program in Fairfield County by the Fairfield County ADAMH Board.

20) Is the program generally perceived by the administration and the line staff to be cost-effective? What are some of the reasons why?

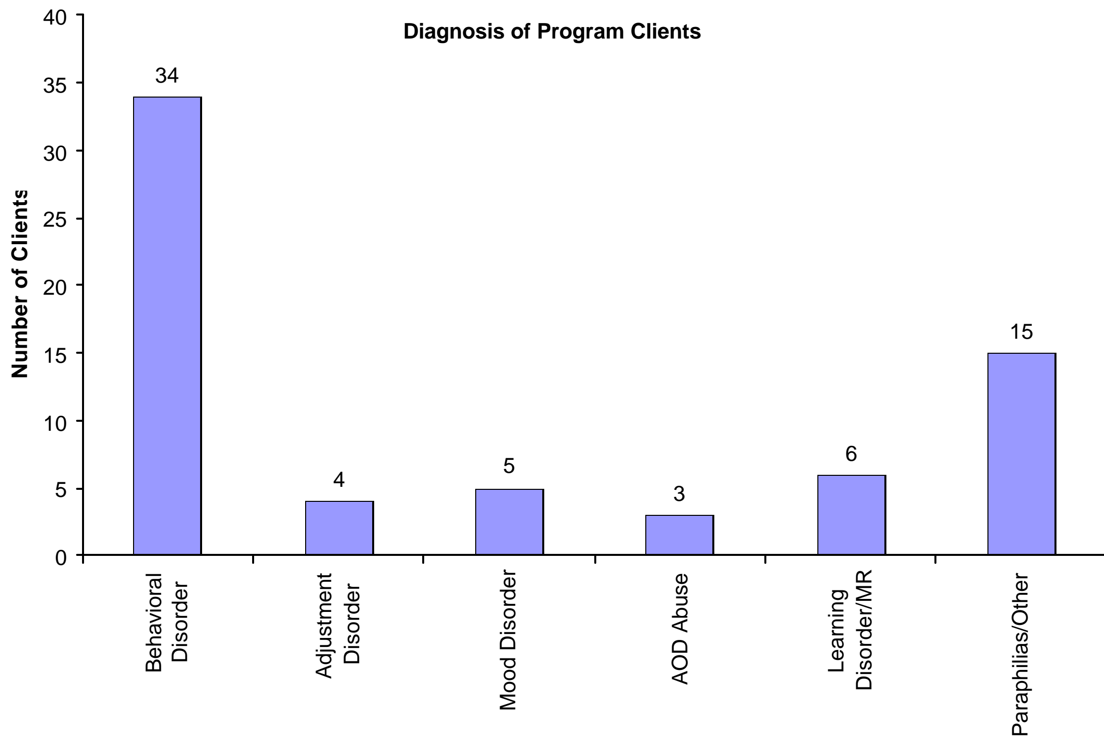
    The cost effectiveness of the program is difficult to measure; services are paid for by Medicaid, private insurance, and client self-pay, since the program is long term, in many cases the total costs are high. In many cases, private insurance benefits are exhausted and clients make payments on balances for years after completing the program. Program staff make every effort to facilitate the completion of the program in an appropriate amount of time, however completion times are effected by many factors including the client's cooperation during services, as well as other factors that affect a clients ability to complete assignments. No formal evaluation of the cost effectiveness of the program has been utilized with administration and line staff.

21) How was the program initially funded? Was the initial funding considered to be adequate to sustain the program? If not, what are the concerns about funding?

Initially, the program was funded by clients who self-paid for their services. As this was not generating enough income to sustain the program, the program director attempted to transition into more stable funding by obtaining the ability to bill Ohio Medicaid for program services. The current funding concerns are the lack of available county funds, which ultimately led to the dissolving of some sex offender groups in 2004.

Client Pre-Service Assessment

22) When clients first come to the program, what kinds of problems do you most often see? (e.g., drug abuse, emotional problems, antisocial values or attitudes, sexual offending.)



23) Are the types of clients that are being received appropriate for the treatment that is provided?

Clients in the Sex Offender program must present with documentation of conviction or adjudication for criminal sexual behavior. During the treatment process, each client's Individual Service Plan is adjusted according to the needs the client presents

with. In addition, the clients in the Sexually Aggressive Youth program must present with a documented history of aggressive acts of sexuality.

24) Are there any exclusionary criteria that would prohibit a client from entering the program? If yes, what is the basis for excluding clients?

Clients may be excluded from the program for six reasons:

- Complete denial of the offense
- Continued efforts to offend
- No Medicaid and the inability to self-pay
- Thought disorders, delusions/hallucinations
- Free unsupervised access to the victim of the offense
- Complete refusal to engage in treatment

25) When a client enters the program, are the risk factors that would predict recidivism assessed? How? What is the basis/rationale for this technique?

Risk and responsivity are addressed in the clinical recommendations made during the assessment/evaluation. These recommendations are based on the client's past history and a modified decision making model. These factors are also addressed during treatment by addressing high risk situations for clients and creating appropriate safety plans with clients.

26) Are a client's needs (dynamic characteristics- situational variables) assessed that are associated with possible recidivism? How? What is the basis/rationale for this technique?

Each clients criminogenic needs (environmental variables, antisocial attitudes, alcohol and/or drug abuse, etc) are addressed during the assessment or evaluation sessions. This is done during the gathering of psychosocial history information from the client, as well as collateral information from caregivers. The rationale is an etiology of behavior model designed by Dr. Hedges for use in the prison system.

27) Are a client's personal characteristics, attributes and styles of interaction assessed? (e.g., intelligence, verbal ability, level of anxiety, psychopathology). How? What is the basis/rationale for this technique?

The client assessment/evaluation includes a thorough psychosocial history, education/occupational history, history of victimization, history of potentially abusive behavior, mental health and substance abuse history, medical status, mental status examination, projective testing, history of aggression, history of sexual behavior, clients version of alleged offense, documented version of alleged offense, risk factors of recidivism, clinical formulation, diagnosis, and recommendations. This information is utilized during treatment in order to make adjustments for special needs and to provide appropriate treatment.

28) If a standardized risk assessment is used, is a summary score used? Describe tool.

No standardized risk assessment tool is utilized in the evaluation process.

29) If a standardized needs assessment is used, is a summary score used? Describe tool.

No standardized needs assessment tool is utilized in the evaluation process.

30) If a standardized responsivity assessment is used, is a summary score used? Describe tool.

No standardized responsivity assessment tool is utilized in the evaluation process.

Program Characteristics

31) What changes in the person and life circumstances does the program target?

The sex offender programs offered by this agency are behavioral in nature and utilize low intensity, long-term strategies. The program advocates for less antisocial behavior by treating the clients as individuals rather than "sex offenders." The program puts emphasis on healthy social behaviors and tailors the individual's treatment plans to create goals that work on these behaviors.

Once the client is deemed appropriate for group, the clinician in charge of the group sets up the client's goals; they typically include 6 key goals that are related to successful completion of the program. The first goal is to complete the client's autobiography assignment, the second goal is to complete the Why Did I Do It program assignment, the third goal is to complete the Victim Impact program assignment, and the fourth goal is to complete the Relapse Prevention program assignment. The remaining goals are related to behavioral issues, and they include maintaining the current home environment (foster home etc.), no new criminal offenses and compliance with probation requirements.

The program's assignments and goals are tailored to each client based on their needs such as mental functioning level, reading and learning disorders, and other issues that may affect a client's ability to complete the required tasks of the program. Assignments are primarily completed in a group setting, however clients may also receive individual counseling services if needed to work on assignments and issues surrounding the program.

The program targets criminogenic needs (antisocial attitudes, value and beliefs supportive of criminal behavior, negative peer associations, substance abuse, etc.). These needs are addressed through treatment goals, pre-group focus forms that are

discussed at the beginning of each session and the Relapse Prevention portion of the sex offender program.

The behavior issues in addition to sex offending, often seen in clients include conduct disorder in the form of antisocial behavior, family issues and discord, social skills deficiencies, and drug abuse.

The program tries to disrupt criminal networks through calls to probation officers, which can result in criminal charges in some cases. The program discourages socializations with antisocial peers, and requires participants to be accountable for their behaviors. Services are coordinated with protective services such as Children Services and judicial systems to ensure client and public safety through telephone calls and the sharing of treatment summaries on a regular basis.

The client's progress is monitored on the clients Individualized Service Plan through progress towards goals and completion of homework assignments required to complete the program.

32) Specifically, what types of treatment are provided to clients?

Mental Health Assessment services are designed, through face-to-face contact, to determine the functional level, psychological state, and contributing medical conditions, and to formulate a diagnostic impression through the use of psychological testing and clinical interviewing for the purpose of establishing the nature and extent of treatment, which is indicated for a particular individual.

Forensic mental health services are face-to-face evaluations conducted by order of the local court to address issues involving persons interacting with the legal system. This can include services for sexual predators, or other specific issues directly related to the application of the law with regard to a mental health condition.

Behavioral Health Counseling Therapy Services are face-to-face verbal interactions that are designed to help reduce the impact of the individual's mental illness or emotional disturbance on their day-to-day life. Through counseling, individuals are aided in maximizing the quality of their life through utilization of traditional therapeutic techniques, which aid the individual in interfacing with their environments.

Group Therapy treatment approaches to these groups follow a primarily cognitive-behavioral model, with some insight-oriented focus as well. This approach is based on the belief that members can develop some understanding and basis for new skills through insight, but successful treatment depends on the development and implementation of new skills to facilitate a long-term plan of recovery. The group approach offers members a safe place to learn and practice

new skills with peers. For adolescents, the group approach also capitalizes on a developmental stage in which peer influences are very important.

Pharmacological Management Service (psychiatric) services are designed as medical interventions, including physical examination, prescription or supervision of medication, and medical interventions to address the physical health needs of the person served. These services are provided in a face-to-face fashion by a physician.

33) Are clients whereabouts and peer associations closely monitored? How? By whom?

Activities outside of treatment are monitored on a limited basis. These primarily depend on the caretakers, the client's self-report and probation officers. In addition, behavioral strategies for program participants are communicated by the qualified staff to parents, foster parents, and other care givers. These strategies are reinforced through contacts with probation officers, parents, and foster parents both verbally and in writing. Some of the barriers to managing sexual offenders are that these individual clients can be very time and labor intensive given the level of systematic involvement.

34) Is there a manual that details the types of treatment to be provided and treatment activities?

There is no formal manual for the Mid-Ohio Psychological Services Sex Offender program. However, the worksheets that are utilized as part of treatment are available on the agency website, and clients or guardians are given information prior to the assessment sessions detailing agency policies and procedures.

35) What is the schedule that clients follow during a typical day? How does this differ from day-to-day and throughout the program?

Since services are not intensive, clients are often seen on a weekly basis only for treatment.

36) How does this program vary (e.g., intensity, duration) according to level of risk of the client? Provide some examples of how this is done.

For lower-risk clients or clients who have completed similar programs successfully in the past, more low-intensity assignments or different worksheet requirements are used. Some clients may represent a lower risk, so they would only be seen individually or have a requirement of completing the relapse prevention assignment. Higher-risk clients would be expected to progress through the program more slowly, with more individual attention paid to the assignments in the form of individual sessions in addition to group sessions. The program is flexible to accommodate differing risk levels in clients.

37) Does the program match the type of treatment with the characteristics of individual clients? How? Provide examples of when this was done.

By creating a clear clinical picture during the evaluation process, the client's therapist can more effectively prescribe treatment. For example, some the cognitive level of some clients may not allow them to be involved in groups, so they may be seen individually rather than in a group in order to more effectively facilitate treatment.

38) Does the program match the personal and professional skills of the staff with the type of treatment they provide? How? Provide examples of when this was done.

Staff members who facilitate treatment have acquired a competent skills set through education and observation of more experienced staff, so staff members are able to provide the type of treatment that is necessary to help clients complete the program. However, the main facilitators of the groups are usually clinicians who have extensive experience with these populations.

39) Does the program match the personal and professional skills of the treatment providers with the type of client and nature of his problem? How? Provide examples of when this was done.

The program director is responsible for assigning clients to clinicians, and matches the personal and professional skills of clinicians to the specific referral problem of each client. As before, all of the clinicians in the program have acquired competent skills in working with this population, so the expectation is that any of the clinicians would be providing similar services to each client. This would be an example of the program facilitators' fidelity to the program.

40) Do clients have a mechanism whereby they may provide input into the structure and rules of the program? How? Provide examples of when this was done.

Clients can provide feedback to the program director or group therapists by scheduling individual sessions with the group therapist. They can email Dr. Hedges or they can speak with the agency's Client Rights Officer. Surveys for program participants are also offered. In addition, clients also participate in the formulation of the group rules.

41) What incentives and rewards are used to encourage program participation and compliance? What is the ratio of rewards to punishers?

The incentives for completing assignments include positive feedback to the client, family members and probation officers. Clinicians will often advocate for increased freedom and privileges for clients who comply with program

requirements. In addition, clients are made aware that compliance with treatment will often result in completing the program in a more timely manner.

42) Describe the theory that underlies the use of punishments.

The principal theory behind punishments is that natural and logical consequences of behavior serve as a way to hold clients accountable for their own misbehaviors. In addition, this method of punishment allows clients to decide what behaviors are most appropriate, and allows clients to learn from the natural order of events. This theory also focuses on present and future behavior.

43) What disincentives and punishments are used to encourage program participation and compliance?

The natural and logical consequences for choosing to not complete the requirements of the program include negative feedback and prolonging the length of treatment.

Within the program, some providers use a three-strike system, in which the client is removed from the group session after three disruptive incidents. The client is then sent to the lobby to complete the assignment alone.

Negative behavior in groups and not completing assignments would result in calls and/or letters being made to probation officers and caretakers. Consequences may be imposed by the probation officers, or family members in the forms of denial of requests for social events or privileges.

44) How are punishments and disincentives administered?

The consequence process is utilized immediately after every incident. Prosocial behaviors are discussed after each consequence.

45) Is there an assessment of whether the punishment produced unintended negative effects?

Unintended negative effects of consequences are monitored by the therapist visually and are processed after the session if needed.

46) How is it determined when a client has completed the program? Are there any instances when a client would leave the program before he has completed the treatment? Are there any instances when a client would remain in the program even after completing the treatment?

Successful program completion is determined when treatment goals are met or the client has received the maximum benefits of treatment. A client should have completed all program requirements, after which an exit interview is conducted

with the Program Director or other qualified evaluator to identify any remaining needs.

Extended social support systems and skills for adapting to the community are developed as part of the Relapse Prevention Plan of the program. Some clients have a harder time with this area given limited natural support networks. Clients may be referred for after care in the form of joining Sexaholics Anonymous groups, Alcoholics Anonymous groups, or the option to return to counseling as needed. Staff talk with families and significant others to help reinforce these skills and support systems.

There are occasions where clients voluntarily terminate services from this program. Examples of this include termination from probation, or relocation to another service area.

47) Does this program train the clients to monitor and anticipate problem situations? How? Provide an example of when this was done.

The final part of the program consists of Relapse Prevention. In this assignment, clients are encouraged to identify high-risk situations, and create direct and remote linkages to these high-risk situations. In addition, clients create plans on how to avoid and/or cope more effectively with risk, utilize these coping skills in the community, and evaluate the effectiveness of their decisions.

48) Does the program teach clients to plan or rehearse alternatives to problem situations? How? Provide an example of when this was done.

These issues are also addressed in the relapse prevention assignments in the program. Therapists work with clients to identify more appropriate responses to high-risk situation. One of the components for completion of the program is the ability to articulate alternative responses to problem situations in the exit interview.

49) Does the program train the clients to practice new behaviors in increasingly difficult situations? How? Provide an example of when this was done.

As part of the individualized treatment, clients are encouraged to gain insight into which situations represent higher levels of risk, and create and implement safety plans during the course of treatment. For clients who are at a higher risk of re-offending, more individual attention outside of group sessions can be utilized to create more effective coping and problem solving skills.

50) Upon leaving the program, are clients routinely referred to other services that offer services relevant to the offender's needs? Provide an example of when this was done.

Clients are given the option of returning to therapy if desired at the exit interview. There is no formalized aftercare program, and no formal community-based services exist at this time to provide linkages from the program. However, clients may be referred for aftercare in the form of twelve-step groups such as Sexaholics Anonymous or Alcoholics Anonymous.

51) Are close relations/friends of the clients trained to provide help to the client during problem situations? What type of training do they receive?

Parents, caregivers and spouses of clients are encouraged to come to selected sessions as part of the Relapse Prevention portion of the programs, and these support networks are encouraged to review the rules, policies, and procedures of the agency as well.

52) After the client is released, is the client brought back into the program for "booster" sessions (aftercare component)? Describe:

There is no formalized aftercare integrated into the program. However, clients are encouraged to re-engage in therapy at any time if needed, and guardians are also informed of this policy.

Staff Characteristics

53) Education of staff:

The program staff consists of three members with doctoral degrees, and four members with Masters degrees.

54) Areas of study for staff:

The program staff has areas of study such as clinical psychology, counselor education, clinical social work, and theology.

55) Relevant experience of staff with sex offender populations:

Dr. Bradley Hedges, Ph.D. is identified as the Program Director. Bradley A. Hedges, Ph.D., Psychologist, has extensive experience in providing sex offender assessment and treatment in both the corrections setting and community setting with both adults and adolescents. He provides consulting services in the development of sex offender programs and education workshops on conducting evaluations for sex offenders. He developed the collection of homework assignments that are used in this agency's program.

Dean Bachelor, M.Div, received his Masters of Divinity from the Asbury Theological Seminary. He has worked with the sex offender population for approximately seventeen years in both the adult corrections environment and the community. He has conducted individual and group therapy with adult sex offenders.

Scott Craft, Ph.D., received his Masters in Clinical Psychology and Doctoral Degree in Clinical Psychology from Bowling Green State University. He has provided services to the sex offender population for approximately four years.

Misty Coleman, MSW, LISW, received her Masters in Clinical Social Work from Ohio State University and is a Licensed Independent Social Worker in the state of Ohio. She has provided services for the adolescent sex offender population for approximately four years.

Joni Krzycki, Ph.D., received her Masters in Counselor Education and Doctoral Degree in Counselor Education from Ohio University. She has provided services for the adolescent sex offender population for approximately eight years.

Karis Mason received her Bachelors in Psychology from the Ohio State University and a Masters in Clinical Counseling from Ashland Theological Seminary. She has provided services for the adolescent sex offender population for approximately one year.

56) Besides training and years of experience, are there any other personal characteristics that are considered important in hiring staff? List the characteristics:

Other staff characteristics include being comfortable discussing issues regarding sexuality, flexibility in thinking style, and the ability to build rapport with adolescents and adults.

57) How long has staff been with the program?

Dr. Hedges and Dean Bachelor have implemented the program since its inception in 1992. The other staff members have implemented the program for the number of years indicated in the answer to Question #55.

58) Are staff assessed yearly on clinical skills that are related to service delivery? If yes, are the evaluations kept in the employees file?

Clinical staff members are evaluated yearly on many issues, which include clinical delivery of services. Staff members are given a copy of this evaluation, and another copy is placed in their files.

59) Does staff receive regular clinical supervision? Describe:

Clinical staff who are not independently licensed are supervised one hour per every 20 hours of service by an independently licensed clinician with supervision privileges. Clinical staff with independent licenses attends weekly group supervision and/or supervisory meetings to discuss clinical issues.

60) Describe how staff is trained to work in the program.

New staff observes group sessions with current staff members as a way of orientation into the program. They are encouraged to discuss the interventions observed in supervision meetings, and also consult with existing staff regarding implementation of the program. In addition, new staff is encouraged to learn basic concepts of human sexuality as well as the theoretical basis for sex offender treatment. Dr. Hedges encourages the staff to attend his seminars on sex offender treatment.

61) How long is staff trained in the program before functioning with full staff responsibility?

There is no set time when a new staff member begins functioning as an existing staff member. Once a new staff member demonstrates a comfort level and a competence in skills related to implementation of the program, they function as a member of the program staff with full responsibilities.

62) Do all program staff participate in ongoing training programs, workshops or conferences? How often? Describe the training experiences:

Program staff is encouraged to attend any continuing education opportunities regarding sex offender treatment. Dr. Hedges conducts regular seminars on this topic. There is no mandated number of training programs staff must attend on sex offender treatment.

63) Has staff been able to modify the program structure? Describe program modifications made by staff.

Program staff has made periodic changes to the program structure. For example, the autobiography assignment was changed dramatically following feedback from program staff. By starting periodic internal reviews, staff can better gauge the effectiveness of this program.

Ongoing Program Evaluation

64) Do supervisors provide quality assurance assessments such as a file review, clinical supervision (live or taped sessions), client feedback or other with program checks that monitor the treatment process? Describe:

Supervisors monitor client treatment progress by reviewing case notes and treatment plans when the therapists update them. In keeping with agency policy, supervisors do not attend sessions, nor are sessions taped for review. However, groups are typically co-facilitated to ensure compliance and to monitor effectiveness of treatment. Client feedback is requested throughout the treatment process through comments on treatment plans, as well as the opportunity to consult with the program staff regarding concerns with treatment.

65) Are clients surveyed each year as to their satisfaction with the services being provided?

A yearly survey is not part of the current program. However, feedback from clients is encouraged at any time during the treatment process.

66) Are there objective, periodic, standardized assessments of clients on target behaviors? Describe. Is the assessment in the file?

Target behaviors are included in the goals and objectives in each client Individual Service Plan, and this plan is updated at a minimum of every 90 days to include progress on these goals. The Individual Service Plan is kept in each client file.

67) Is reconviction data gathered on clients six months or more after leaving the program?

The program staff has been unable to gather this data, primarily because of the difficulty in monitoring clients after completing the program.

68) Have any formal evaluations of the program been carried out? Describe. Outcome or process evaluation? Was a comparison group used?

This is the initial formal evaluation of this program. The evaluation serves to examine outcomes and processes, although outcome information has not been able to be gathered. No comparison group is used in this current evaluation procedure.

69) Is there a document containing the details of the effectiveness of the program on file?

There is no such document on file, as this is the initial program evaluation.

70) Has an evaluation of the program been published in an edited journal?

No, as this is the initial program evaluation.

Other

71) Are client records kept in a confidential file? Who has access to the file?

Client records are kept in a file that resides in a file room at the agency. This is in accordance with the agency records policy. Only a client's therapist or clinical supervisor, file room staff, or quality assurance personnel have access to a client file.

72) Is there documentation of the ethics of intervention for the program (e.g., least intrusive intervention)?

This information is presented to the client as part of the "Policies and Procedures" packet, which is mailed to each client prior to the assessment procedure. The client or guardian must sign to indicate that they have received this information, and understand it.

73) Have there been any changes in the program itself in the last two years? Explain. In what way have these changes jeopardized the smooth functioning of the program?

The program has evolved over time and has experienced changes based on client needs and clinical experience. These changes have been discussed with the Program Director. Examples of changes include changes to homework assignments given to clients. The staff has made changes to clarify what is required for each assignment. A parent support group was also attempted within the program but there was not enough participation to sustain the group.

In the past two years, there have been additional groups added to the program due to demand and the expansion of services to an additional site. There have been changes in the clinical staff facilitating the groups. The changes in clinical staff may result in an interruption in the smooth functioning of the group due to the natural adjustment period of new facilitators.

74) Have there been any changes in the area of program funding? Explain. In what way have these changes jeopardized the smooth functioning of the program?

There have been changes in program funding due to decreased available county financial support. The program saw a funding decrease for an income based sliding scale for group participants, which resulted in a greater cost for the clients to participate in services. In some cases the cost was prohibitive for clients to continue

to receive services. Because of this event, one adult sex offender group had to be disbanded due to lack of clients.

75) Have there been any changes in community support for the program in the past years? Explain. In what way have these changes jeopardized the smooth functioning of the program?

No changes in community support have been noted in the past two years other than funding.

Past concerns that have been voiced about the program from others who are not really familiar with the agency is that we don't "teach" things such as the cycle of offending. We often have to educate these individuals that the agency is less concerned about a participant being able to talk about their treatment and more concerned about their overt behavior.

76) Does the program have an advisory board (Board of Directors) or a consultant, officially designated to oversee or advise the program in some fashion or another? What level of authority do these persons carry?

Mid-Ohio Psychological Services has a Board of Directors who oversees the agency as a whole. There is no specific advisory board or outside consultant for the agency Sex Offender Program.

File Completeness

Charts were reviewed for the following components; sexual history, offense history, treatment history, appropriate testing, appropriate collateral materials, risk factors identified, supervision concerns, treatment recommendations, contact with probation, interface with family, accommodations for learning, safety management, risk factors, and supervision concerns.

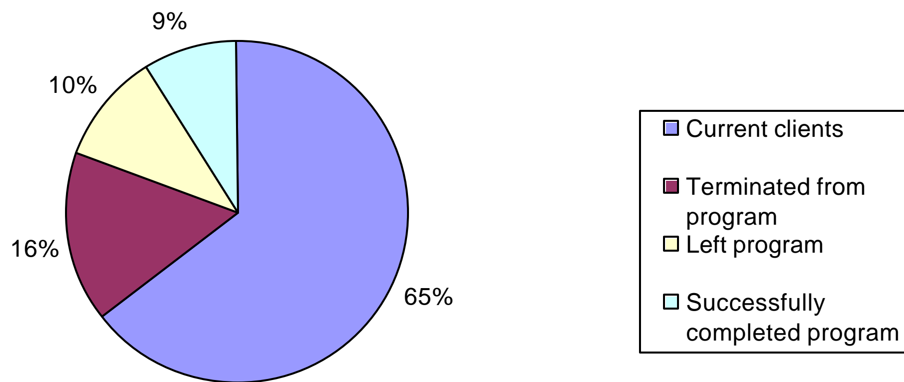
- Seventy-seven percent of the charts contained a complete sexual history.
- Ninety-four percent of the charts contained a complete offense history.
- Ninety-eight percent of the charts contained a complete treatment history.
- Ninety-five percent of the charts contained appropriate testing.
- Ninety-five percent of the charts contained appropriate collateral materials.
- Ninety-five percent of the charts addressed appropriate risk factors.
- Ninety-five percent of the charts addressed supervision concerns.
- Ninety-five percent of the charts contained treatment recommendations.
- Seventy-five percent of the charts contained documentation of contact with probation officers.
- Seventy-five percent of the charts contained documentation of contact with the client's family.
- Ninety-eight percent of the charts documented accommodations made for identified learning issues.
- Ninety-eight percent of the charts documented safety management plans.
- Eighty-six percent of the charts documented data supported the risk factors identified.
- Ninety-two percent of the charts documented data supported the supervision concerns identified.

This data set indicates that program staff is having difficulties in regards to "fidelity" to the Sex Offender program in four specific areas. Less than ninety percent of the charts reviewed were compliant in the areas of gathering complete sexual histories, documenting contact with probation officers, documenting contact with the client's family, and the collection of data to support the risk factors identified for each client. The components of data gathering relate to the assessment or evaluation process, while the documentation of contact with people in the client's environment relate to the implementation of the Sex Offender Program.

Treatment Outcomes

Status of Clients in Treatment

Thirty-four of the 67 clients reviewed are currently in treatment.



It should be noted that no data is available at this time regarding client behaviors following termination or completion of program.

Costs

The average number of contacts per client is 124 units of service. The average cost of the treatment episode for services is approximately $10,197. An “average” breakdown of units and costs would include the following for each client:

	Units	Cost
Evaluation/Assessment	2.94	$ 396.69
Group Sessions	97.66	$ 7813.03
Individual Sessions	16.75	$ 1507.57
CSP Services	6.32	$ 410.63
Medication Mgmt Services	.34	$ 69.49
Totals	124.01	$10,197.42

Other Outcome Considerations

The other outcome considerations mentioned at the beginning of this program review are difficult to measure. Clients are given the opportunity to evaluate the program upon completion, but most choose to not take advantage of this opportunity. There is no formal instrument to gauge client satisfaction at this time. In addition, this agency does not gather information on recidivism rates for clients upon completion of the program. Often, clients move away or change placements, and it is not possible to track the whereabouts of clients. Also, this is not an intensive inpatient program, so most reports on behavior emanate from client self-report, probation officers or caregivers. These parties do not keep in contact with the agency after the program. The releases of information are not valid following six months. These outcome issues will be addressed in future evaluations of this program.

Synthesis of Data

Strengths and Weaknesses

The agency's strength is its commitment to working with individuals that engage in sexually abusive behavior and the qualified staff network it has to work with this population.

A weakness of the program is a lack of financial support to subsidize individuals that are self-pay or insurance. This cannot be controlled by the agency as it is due to a lack of funds in the mental health system of the area.

A second weakness of the program is that the agency needs to better meet the needs of this population by having more opportunities to do individual and family work with offenders. However, there has not been enough interest by community stakeholders to sustain activities in these areas in the past. The agency would be willing to consider these activities again in the future if interest increased.

The program staff on an as needed basis has revised the exercises used in the program since they were created. These revisions have included changing wording on assignments to help clients understand what is being asked of them.

Recommendations

The CPAI-generated data indicates that a standardized risk, needs and responsivity assessment tool is not currently being utilized in this program. The agency director has been working to create such an instrument, and there has been discussion of utilizing this instrument in the near future. In addition, the data indicates that recidivism information has not historically been gathered as part of the program. In order to generate more effective outcome information, such information could be helpful for future program reviews.

The peer review data indicates non-compliant levels by clinicians in gathering sexual histories from clients during the intake process. While it is possible that the clinicians are obtaining this information, the sexual history forms create a structured manner for this client-generated data to be gathered and analyzed. Also, clinicians are not documenting contacts with probation officers and caregivers for clients in a compliant manner. It may be helpful to set up a more structured schedule of contact with these individuals (such as whenever treatment plans are to be updated) in order to ensure that this part of the process of the program is being carried out.

For the purpose of future program reviews, information such as re-arrest rates and incarceration rates would be helpful to effectively measure outcomes of treatment. This data will be necessary to fully address the third research question regarding effectiveness of this program.

References

Gendreau, P. and D. Andrews (1994) The Correctional Program Assessment Inventory (5th edition) Saint John: University of New Brunswick.

Appendix A- CPAI

PROGRAM CHARACTERISTICS

1. Name of the Program:

2. Name of Contact Person:

3. Address, phone # and fax # of program setting:

4. Years in Operation: ____

5. Program Setting (e.g., community residential center, institution, probation office):

6. Number of residents/participants:

	Current	Capacity
# juvenile:	_________	_________
% male/female:	_________	_________

7. Number of staff:

	Support	Clinical
# Full-time:	_________	_______
# Part-time:	_________	_______
# Hours Spent/week	_________	_______
% male/female:	_________	_______

8. What is the program budget? How much does the program cost to provide?

9. Does this program receive all its resources from the government or is it funded by grants or contracts from other sources?

10. Is there a documented program philosophy? (Attach documentation)

PROGRAM IMPLEMENTATION

11. Were you (program manager) instrumental in designing the program before it was implemented?

    Describe involvement:

12. Describe your (program manager) educational background, degrees received, specialized training with client population:

13. Did you have any previous experience in any type of offender treatment program?

    If yes, what previous experience with any type of offender treatment program have you had?

    How long did you work with the previous program?

    How long have you worked with this program?

14. Are you directly involved in hiring and providing training to the staff?

15. Are you involved in providing direct service delivery to clients?

    Are you involved in directly supervising the staff in the program?

16. Was there a literature search to identify relevant program materials needed to design the program?

    What was the scope or extent of the search?

17. Prior to the implementation of the formal program, was there a pilot program to try to work out the practical aspects of the program and any problems?

    How long did the pilot program last?

    What, if any, changes were made in the program as a result of the pilot experience?

18. Was there an assessment of the need for the program in the community?

    How was this assessment done?

19. Were the values and goals of this program consistent with existing values in the community?

    Describe how the values and goals were either consistent or inconsistent with those of the community.

20. Is the program generally perceived by the administration and the line staff to be cost-effective?

    Do you perceive the program to be cost effective?

    What are some of the reasons why?

21. How was the program initially funded?

Was the initial funding considered to be adequate to sustain the program?

If not, what are the concerns about funding?

CLIENT PRE-SERVICE ASSESSMENT

22. When clients first come to the program, what kinds of problems do you most often see? (e.g., drug abuse, emotional problems, anti-social values or attitudes, sexual offending.)

23. Do you feel that the type of clients that you receive are appropriate for the treatment that you provide?

24. Are there any exclusionary criteria that would prohibit a client from entering the program?

If yes, what is the basis for excluding clients?

25. When a client enters the program, do you assess his or her risk factors that would predict recidivism?

How?

What is the basis/rational for this technique?

26. Do you assess a client's needs (dynamic characteristics--situational variables) that are associated with possible recidivism?

    How?

    What is the basis/rational for this technique?

27. Do you assess a client's personal characteristics, attributes, and styles of interaction? (e.g., intelligence, verbal ability, level of anxiety, psychopathology)

    How?

    What is the basis/rational for this technique?

28. If a standardized risk assessment is used, is a summary score used? Describe tool.

29. If a standardized needs assessment is used, is a summary score used? Describe tool.

30. If a standardized responsivity assessment is used, is a summary score used? Describe tool.

PROGRAM CHARACTERISTICS

31. What changes in the person and life circumstances does the program target?

(You may want to prompt for the following targets listed below)

a) change attitudes, orientations, and values favorable to law violations and anti-criminal role models.
b) change antisocial feelings
c) reduce antisocial peer associations
d) reduce problems associated with alcohol/drug abuse
e) reduce anger/hostility level
f) replacing the skills of lying, stealing, and aggression with prosocial alternatives
g) increase self-control, self-management, and problems solving skills
h) encourage constructive use of leisure time
I) improve skills in interpersonal conflict resolution
j) promote more positive attitudes/increase performance regarding school work
k) resolve emotional problems associated with intra or extra-familial child abuse
l) promote family affection/communication
m) promote family monitoring/supervision
n) improve family problem solving
o) resolve deviant sexual arousal/attitudes/behavior
p) provide low-pressure, sheltered environment for mentally disordered offenders
q) focus on harm done to victim
r) relapse prevention
s) alleviate their personal and circumstantial barriers to service (client motivation, background stressors)

32. Specifically, what types of treatment are provided to clients?

33. Are client's whereabouts and peer associations closely monitored?

How?

By whom?

34. Do you have a manual that details the types of treatment to be provided and treatment activities? (Obtain a copy)

35. What is the schedule that clients follow during a typical day?

How does this differ from day-to-day and throughout the program?

36. How does your program vary (e.g., intensity, duration) according to level of risk of the client? Provide some examples of how this is done.

37. Does the program match the type of treatment with the characteristics of individual clients?

How?

Provide examples of when this was done:

38. Does the program match the personal and professional skills of the staff with the type of treatment they provide?

How?

Provide examples of when this was done:

39. Does the program match the personal and professional skills of the treatment providers with the type of client and nature of his or her problem?

How?

Provide examples of when this was done:

40. Do clients have a mechanism whereby they may provide input into the structure and rules of the program?

    How?

    Provide examples of when this was done:

41. What incentives and rewards are used to encourage program participation and compliance?

    What is the ratio of rewards to punishers?

42. Describe the theory that underlies the use of punishments.

43. What disincentives and punishments are used to encourage program participation and compliance?

44. How are punishments and disincentives administered? (After every occurrence, immediate, alternative prosocial behavior provided after punishment, punishers vary, etc.)

45. Do you assess whether the punishment produced unintended negative effects?
    (Do you look for: emotional reactions, avoidance/aggression toward punishers, increase in future use of punishment by offender, signals of reinforcement, contrast effects, response substitution, generalization)

    How?

    Describe how this has been used:

46. How do you determine when a client has completed the program?

    Are there any instances when a client would leave the program before he/she has completed the treatment?

    Are there any instances when a client would remain in the program even after completing the treatment?

47. Does this program train the clients to monitor and anticipate problem situations?

    How?

    Provide an example of when this was done:

48. Does the program teach the clients to plan or rehearse alternatives to problem situations?

    How?

    Provide an example of when this was done:

49. Does the program train the clients to practice new behaviors in increasingly difficult situations?

    How?

    Provide an example of when this was done:

50. Upon leaving the program, are clients routinely referred to other services that offer services relevant to the offender's needs?

    Provide an example of when this was done:

51. Are close relations/friends of the clients trained to provide help to the client during problem situations?

    What type of training do they receive?

52. After the client is released, is the client brought back into the program for "booster" sessions (aftercare component)? Describe:

STAFF CHARACTERISTICS

53. Education of staff:

54. Areas of study of staff:

55. Relevant experience of staff:

56. Besides training and years of experience, are there any other personal characteristics that are considered important in hiring staff?

    List the characteristics:

57. How long have staff been with the program?

58. Are staff assessed yearly on clinical skills that are related to service delivery?

If yes, are the evaluations kept in the employees file?

59. Does staff receive regular clinical supervision?

Describe:

60. Describe how new staff are trained to work in the program.

61. How long are staff trained in the program before functioning with full staff responsibility?

62. Do all program staff participate in ongoing training programs, workshops, or conferences?

How often?

Describe the training experiences:

63. Have staff been able to modify the program structure?

Describe program modifications made by staff:

ONGOING PROGRAM EVALUATION

64. Do supervisors provide quality assurance assessments such as a file review, clinical supervision (live or taped sessions), client feedback or other within program checks that monitor the treatment process?

    Describe:

65. Are clients surveyed each year as to their satisfaction with the services being provided?

66. Are there objective, periodic, standardized assessments of clients on target behaviors?

    Describe:

    Is the assessment in the file?

67. Is reconviction data gathered on clients 6 months or more after leaving the program?

68. Have any formal evaluations of the program been carried out?

    Describe:

    Outcome or process evaluation?

    When conducted?

    Was a comparison group used?

69. Is there a document containing the details of the effectiveness of the program on file? (Obtain copy)

70. Has an evaluation of the program been published in an edited journal? (Obtain copy)

OTHER

71. Are client records kept in a confidential file? Who has access to the file?

72. Is there documentation of the ethics of intervention for the program (e.g. least intrusive intervention)? (Obtain copy of documentation)

73. Have there been any changes in the program itself in the last two years?

    Describe:

    In what way have these changes jeopardized the smooth functioning of the program?

74. Have there been any changes in the area of program funding?

    Describe:

    In what way have these changes jeopardized the smooth functioning of the program?

75. Have there been any changes in community support for the program in the past two years?

Describe:

In what way have these changes jeopardized the smooth functioning of the program?

76. Do you have an advisory board (Board of Directors) or a consultant, officially designated to oversee or advise the program in some fashion or another?

What level of authority do these persons carry?

Appendix B- Chart Review Form

Sex Offender Chart Review Form

Client Name: ______________________________ Chart # ______________________

Gender: _____ Date of Birth: ______________________ Race: ____________

Adjudicated Charge(s) : ____

What Court?: (ie Juvenile) ____

What County: ____

Date of Referral for MH Services: ____

Date seen for evaluation: ______________ Date evaluation completed: __________

Date seen for treatment: __________________

- ❑ Terminated Date of termination: __________________________
- ❑ "Successful Termination" (met maximum medical benefit of service)

Length of Service (hours)

Diagnostic ___________
Group _____________ Which group? :_______________________________
Individual ___________
CSP _______________
Medication __________

Special needs (ie. Low IQ, Learning Problems, etc.):
____
____

Intake Diagnosis Discharge Diagnosis

Yes	No	N/A	
❒	❒	❒	Complete Sexual History Given
❒	❒	❒	Complete Offense History Given
❒	❒	❒	Complete Treatment History Given
❒	❒	❒	Appropriate Testing Conducted
❒	❒	❒	Appropriate Collateral Materials Utilized
❒	❒	❒	Risk Factors Identified
❒	❒	❒	Specific Supervision Concerns Raised in evaluation with context defined
❒	❒	❒	Specific Treatment Recommendations Given in evaluation
❒	❒	❒	Appropriate contact with probation department during treatment
❒	❒	❒	Appropriate interface with family system during treatment
❒	❒	❒	Appropriate accommodations made for learning problems if present
❒	❒	❒	Appropriate safety management techniques applied during treatment

Does data support:

Yes	No	N/A	
❒	❒	❒	Risk Factors
❒	❒	❒	Supervision Concerns
❒	❒	❒	Treatment Recommendations

Yes	No	N/A	
❒	❒	❒	Completed Autobiography
❒	❒	❒	Completed Victim Empathy assignments
❒	❒	❒	Completed “Why Did I Do It” assignments
❒	❒	❒	Completed a Relapse Prevention Program
❒	❒	❒	Does chart generally comply with agency expectations for records?
❒	❒	❒	Level of Care Identified (How?)
❒	❒	❒	Level of Care appropriate given offense/risk factors (Evidence):
❒	❒	❒	If terminated, were appropriate recommendations made in writing?