Fairfield County Sexually Aggressive Youth Program
Annual Report 2015
Mid-Ohio Psychological Services

12/28/2015

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Program Background

According the Center for Sex Offender Management (CSOM), an estimated one in every five girls and one in every seven boys are sexually abused by the age of eighteen. It is also noted that about one in six adult women and one in 33 adult men will experience an attempted or completed sexual assault (CSOM, 2008). The center reports that of those arrested for sex offenses just under 20% are juveniles under the age of 18. According to statistics in 2008, 2,200 juveniles were arrested for forcible rape and 9,200 juveniles for other sexual offenses. Of the juveniles arrested for a sexual offense 90% are male. CSOM also noted that juvenile offenders appear to respond better to treatment and are less likely to reoffend than adult offenders. According to CSOM's data an estimated 10% of juvenile offenders will reoffend with a sexual offense; however, it is noted that juveniles who sexually offend are more likely than the average population to be arrested for a non-sexual offense (CSOM, 2008). Researchers and clinicians have struggled to develop risk assessment tools that may provide insight into which offenders are more likely to recidivate. Researches have also attempted to apply assessment tools utilized for adult offenders to predict future recidivates (Viljoen, Mordell, & Beneteau, 2012; Stockdale, Olver, & Wong, 2010 Ralston & Epperson, 2013). The need to develop comprehensive, dynamic risk assessment tools continues to be important as current legislation influencing juvenile courts may create obstacles for juvenile offenders to lead normal, age appropriate lives (Letourneau & Caldwell, 2013).

Juvenile sex offenders are a heterogeneous group, while many studies have attempted to develop set criteria for risk factors; both static and dynamic, researchers have struggled to identify criteria to categorize juvenile sex offenders (Tidefors, Goulding, & Arviddson, 2011). The difficulty in using actuarial risk assessment tools may, in fact, be due to the heterogeneous nature of juvenile sex offenders and an environment that is constantly in flux. This has not stopped researches from attempting to establish distinctions within the groups. Lawing, Frick & Cruise (2010) investigated whether or not offenders who scored high in callous-unemotional traits would differ from other offenders with low scores on unemotional traits. Their study concluded that those with higher scores on callousness and unemotional traits had a greater number of victims, used more violence in their offenses, and engaged in more offense planning than those with low scores (Lawing, Frick & Cruise, 2010). Conversely, James Worling of the SAFE T Program in Toronto, Canada argues that researchers and clinicians have operated on false assumptions about treating adolescent sex offenders, that they are sexually deviant, delinquent, disordered, deficit-ridden, and/or deceitful. Worling (2013) points out the harmfulness of treating adolescents with a "one size fits all" approach, and the need to assess and develop treatment that is unique to the individual client, while avoiding assumptions made by previous researchers and clinicians. Researchers and developers of Multi-Systemic Therapy (MST) believe that adolescent sex offenders can be treated effectively in the community and have shown that programs that incorporate families and communities can have a better treatment effect than residential treatment programs (Letourneau, Borduin, Henggeler et. al, 2013; Borduin, Heiblum, & Shaeffer, 2009).

Mid-Ohio Psychological Services began treating adolescent sex offenders in 1992. Treatment at that time focused primarily on group counseling services. In order to better meet the individual needs of the sex offender population, Mid-Ohio began utilizing individual services in conjunction with group treatment in 2001. Mid-Ohio became a certified adolescent sex offender provider in 2010 and has maintained the certification through the current fiscal year. As will be explained further in the report, the SAY program at Mid-Ohio focuses on partnering with community referral sources, schools, and families to provide holistic treatment for participants in the program. Mid-Ohio is currently the only outpatient treatment facility in Fairfield County with a certified adolescent sex offender program.

The Sexually Aggressive Youth (SAY) program is an intensive form of counseling that is provided in the Fairfield County office for those who have engaged in sexually abusive behavior with the goal of rehabilitation and possibly reunification. This program is available for all children and adolescents and offers a sliding fee scale for those who are residents of Fairfield County.

The goal of this program is to reduce the risk of sexually abusive behavior occurring again. Due to offenses often occurring within the family system, a secondary focus of the program is working towards possible reunification and family management. This program does work through individual, group, joint and family sessions. Through individual and possible group work, clients develop an understanding of the abuse event through exploration of the event itself and potential history behind the event. The client then works to develop a plan to reduce the risk of reoccurrence through establishment of healthy relationships, environments and safety/protection plans. Work is also done with the family system, which may or may not include the victim, to discuss safety planning as well as possible reunification.

Treatment services for youth who have engaged in sexually aggressive behavior need to be tailored to the specific needs of the youth, being sensitive to the age, developmental status, intelligence, and unique environment that the youth experiences. Although most youth participate in formal groups, some participants receive treatment only through individual/family counseling, depending on these particular dynamics. To aid in identifying what kinds of specific services a particular youth might need, the Sexually Aggressive Youth Service Matrix should is reviewed for each youth. No group has more than 12 participants, with at least one facilitator for every 6 youth.

Virtually all participants it the Sexually Aggressive Youth Program are required to complete the following core assignments: Adolescent Autobiography, Why Did I Do It, Victim Impact, Victim Apology Letter, and the Relapse Prevention Workbook.

These assignments may be modified based on the developmental/intellectual functioning of the youth and the youth's prior exposure to treatment services. For example, young sexually aggressive youth may not fully understand the material in the "Why Did I Do It? Worksheet" and

therefore this assignment might be done verbally as opposed to doing it in written format. Further, youth who are coming to our program as an "aftercare" service may have already been exposed to the conceptual material that is addressed by the Autobiography, Victim Impact Worksheet, and Why Did I Do It? Worksheet, and therefore the youth may only be required to complete the Relapse Prevention Workbook.

For treatment to be effective, it must be coordinated with other agencies that are likely to be involved with the sexual aggressor, including Children Services and the Court. Contact with these other agencies should occur and be documented at least once a month, as needed. Many referral sources require monthly reports of progress that can be completed by completing treatment summaries through CIS or the Sex Offender Treatment Progress Report

When initiating services for sexually aggressive youth, it is important to attempt to engage the family system in the therapeutic process. To this end, the biological family/foster parents/other caretakers are provided the Parent Handout, and this document should be reviewed with the appropriate parental figures. Caretakers are strongly encouraged to meet with the primary therapist at least once a month to ensure coordination of care. More frequent contact is encouraged.

Prior to initiating the sexually aggressive youth program, the youth and their caretaker must sign the Sexually Aggressive Youth Contract, which attempts to delineate the nature of the program and each person's responsibility while the youth participates in the program.

The primary goal to all intervention with sexually aggressive youth is to create safety within the community to help reduce the risk of future sexually abuse. Upon the initiation of treatment, the concept of safety planning is introduced and reinforced throughout the course of treatment. To help facilitate the skill of safety planning and to help develop appropriate safety planning skills, the Understanding Safety Planning handout is provided to the youth and their caretakers, with the first portions being completed as early in the treatment process as feasible. This handout is completed again any time that a major change in life circumstances occurs for the youth (moving to a different community/home, etc.). The last portion of this handout, "My Specific Safety Plan" is completed any time the youth encounters a new situation that could reasonably be expected to increase the youth's risk within the community.

When a sexually aggressive youth transitions from one home to another, or one treatment program to another, it is essential that an additional assessment of his risks be conducted and specific safety planning occur. The Understanding Safety Planning handout is completed any time a youth moves from one home to another or otherwise experiences a significant change in their life circumstances.

In virtually all cases, some level of reunification occurs-whether it is simply visiting with non-victimized siblings to fully moving back into the home with the victim. To facilitate the reunification process, the Family Reunification Phases handout is provided to the family and reviewed in detail and the involved clients and family members complete the Family Reunification Contract.

Successful discharge occurs when clients have attained all treatment goals listed on their treatment plans. This typically includes completion of the core assignments and demonstrating application of the skills learned in counseling. Most participants will be in the program for two years or more. Successfully completing the program does not guarantee that a future offense will not occur. Discharge from the program will occur when the participant has met maximum benefit from the program. Participants who successfully complete the program will have evidenced knowledge of personal risky behaviors and will have discussed reasons that they would know that they should return to counseling.

Program Participants (Demographics)

During the 2015 fiscal year, the Sexually Aggressive Youth program had 27 participants. Participants included all those enrolled in the program at any time during 07/01/2014 to 06/30/2015. Out of the 27 participants only one was female and the rest male. As seen in Figure 1, participants ranged in age from 13 to 20 with an average age of 16.33. Those clients whose ages are above 18 were adjudicated for their offense prior to turning 18. The age reflects their age at the end of the 2015 fiscal year.

Age	# People
13	1
14	5
15	5
16	4
17	4
18	3
19	3
20	2

Figure 1- Age Distribution

The participants were primarily Caucasian (89%), two participants were African American (7%) and one participant identified multiple races (4%).

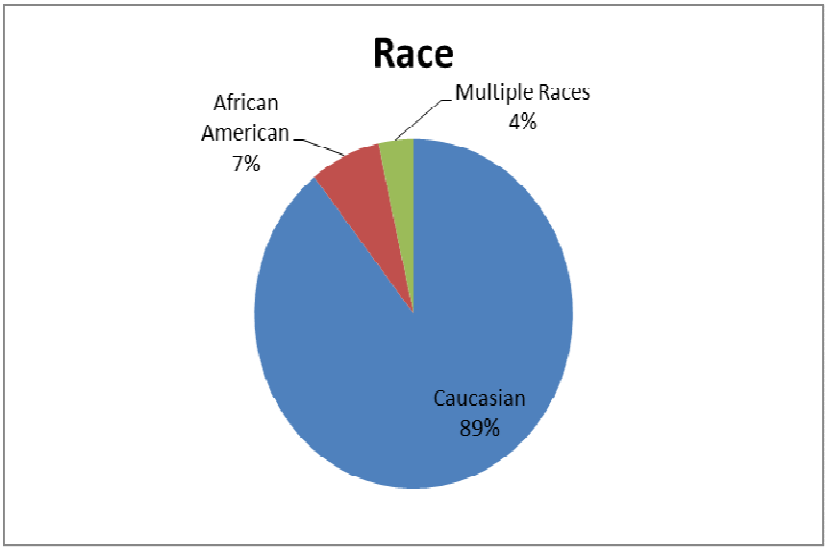


Figure 2- Race Distribution

Clients were referred to the program from several agencies in both Fairfield and Hocking County, with one referral source coming from Wayne County. Referral source was identified at the time of the intake and noted in the assessment or on the original treatment plan. One referral came from Hocking County Juvenile Court and one from Wayne County Juvenile Court. All other referrals were identified as being from Fairfield County. Two clients were referred for counseling services by Fairfield Academy, a local group home for boys who have been removed from their previous placement. Nine clients were referred by the Fairfield County Juvenile Court; two clients were referred by Fairfield County Child Protective Services; three clients were referred by Fairfield County Child Advocacy Center; seven clients were referred by family members; and two clients were referred by an attorney. In Figure 3, Fairfield, Hocking, & Wayne County have been combined, due to only two referrals coming from Wayne and Hocking County. Child Protective Services and Child Advocacy Center have also been combined as Children Services. Clients who identified a family referral had also noted that they were seeking services prior to court involvement with the understanding that the court system would be referring them to counseling.

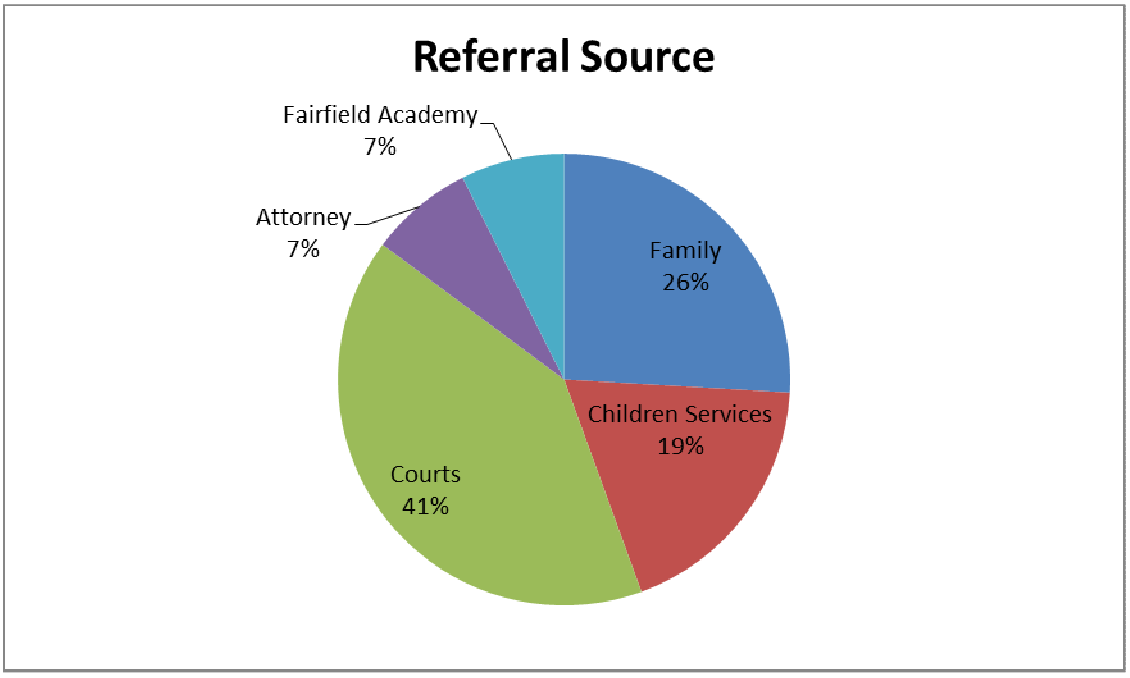


Figure 3- Referral Source Distribution

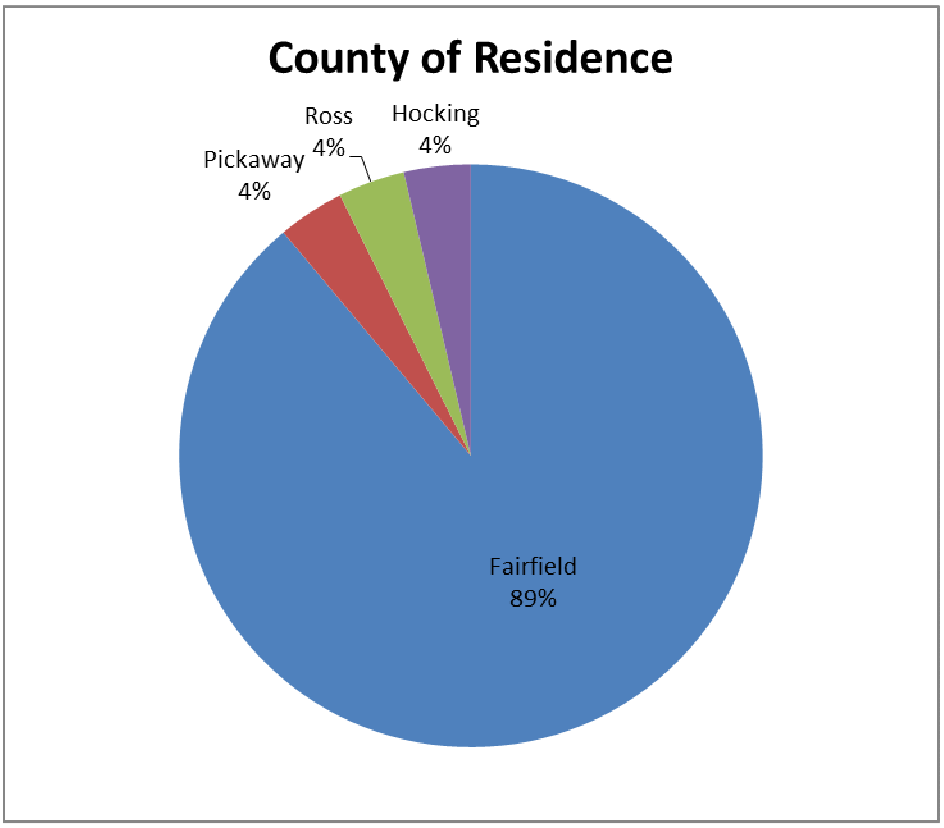


Figure 4- County of Residence Distribution

As seen in Figure 4, 89% of the SAY population were residents of Fairfield County, while one client resided in Hocking County (4%), one in Pickaway County (4%), and one in Ross County (4%).

Of the 27, 19 (70%) were estimated to be of average intelligence, with six participants (22%) estimated as below average. Two participants were given Axis II diagnosis for Borderline Intelligence (3.5%) and Mild Mental Retardation (3.5%). See Figure 5.

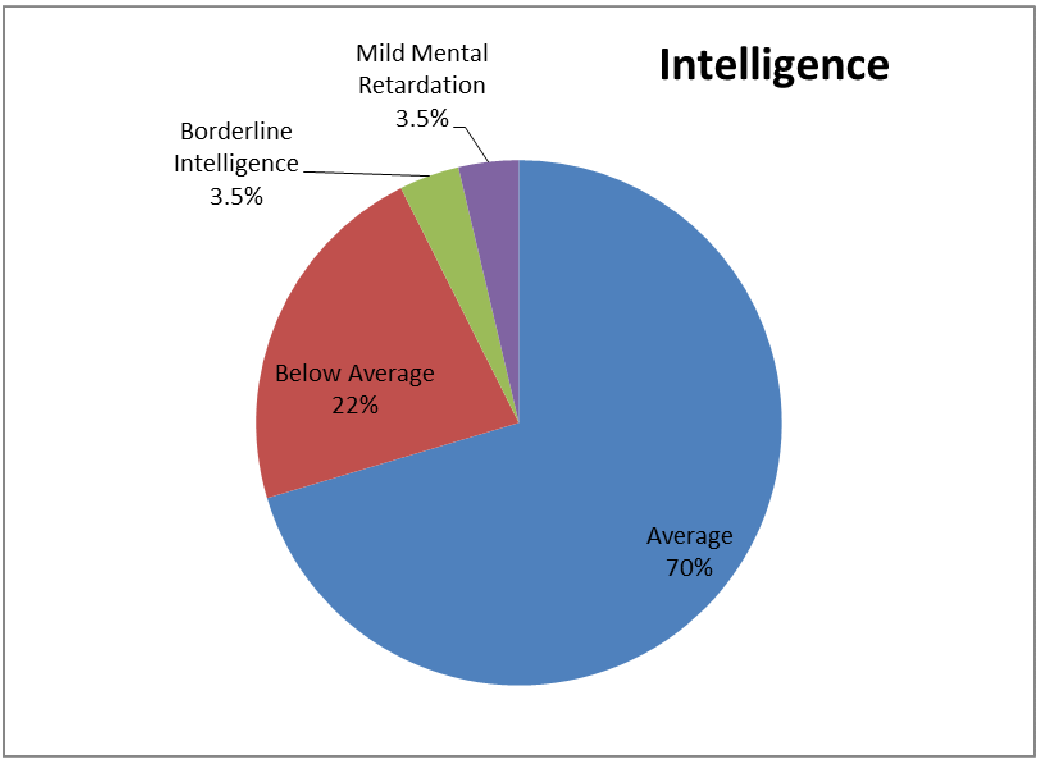


Figure 5- Intelligence Distribution

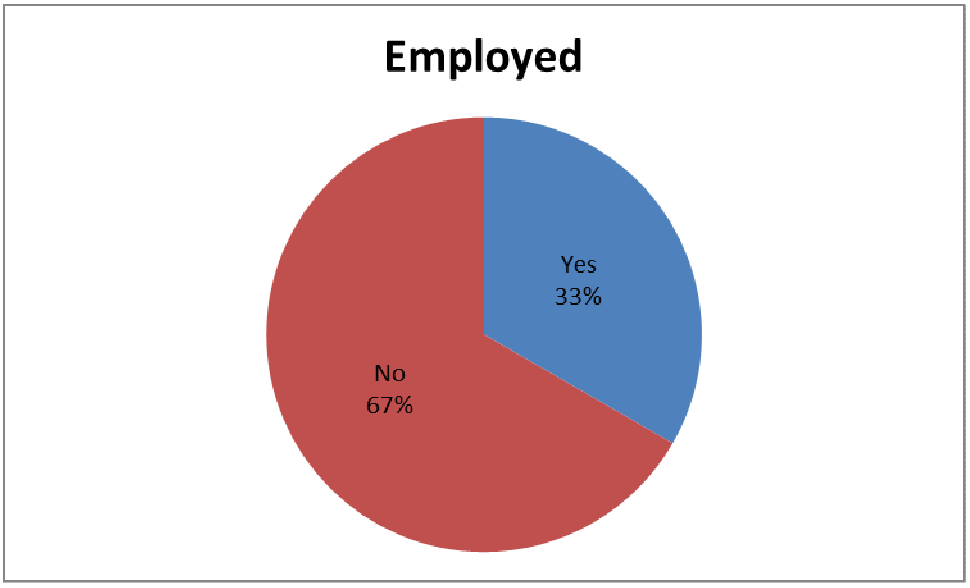


Figure 6- SAY Employment Distribution

As seen in Figure 6, a third of the 27 participants in the SAY program were unemployed (67%), while 33% of the participants reported employment at the time of this report.

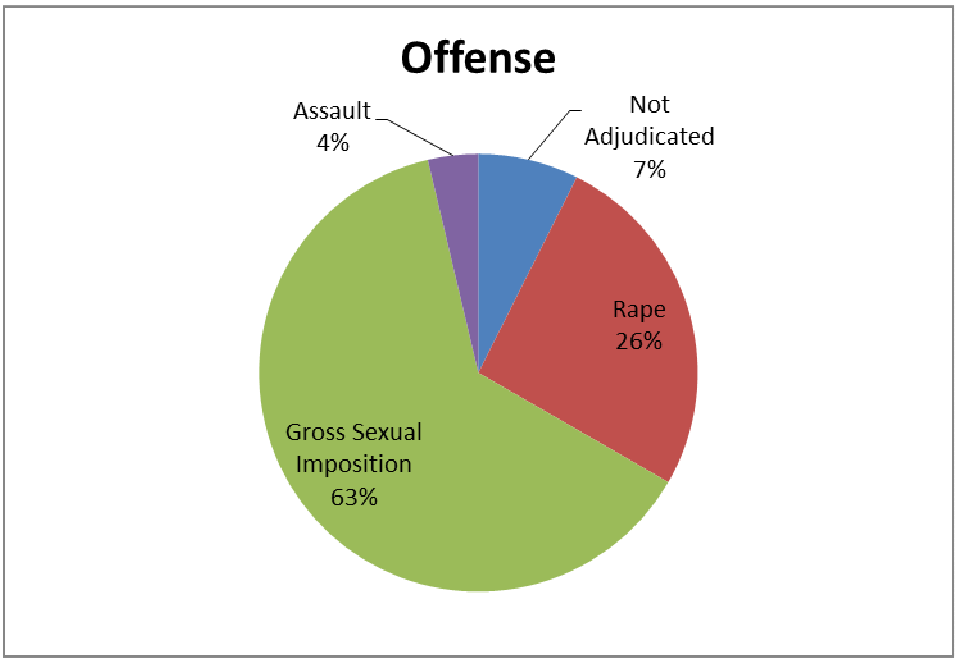


Figure 8- Offense Distribution

As seen in Figure 8, of the 27 participants, 7% were non-adjudicated agressors. Sixty-three percent were adjudicated for Gross Sexual Imposition and 26% were adjudicated for Rape, while one participant (4%) was adjudicated for an assault charge, which had been plead down from an original sexual charge. The information gathered on offense history was found in initial treatment plans, diagnostic assessments, and documents from the court system, Child Protective Services, and county prosecutor's office. However, not all participant's offense history was documented with collateral information in their charts. The offense listed in their treatment records is then based on self-report from the client or the client's family. This is a limitation to the offense distribution information and reccomendations for correcting this limitation will be offered at the end of this report.

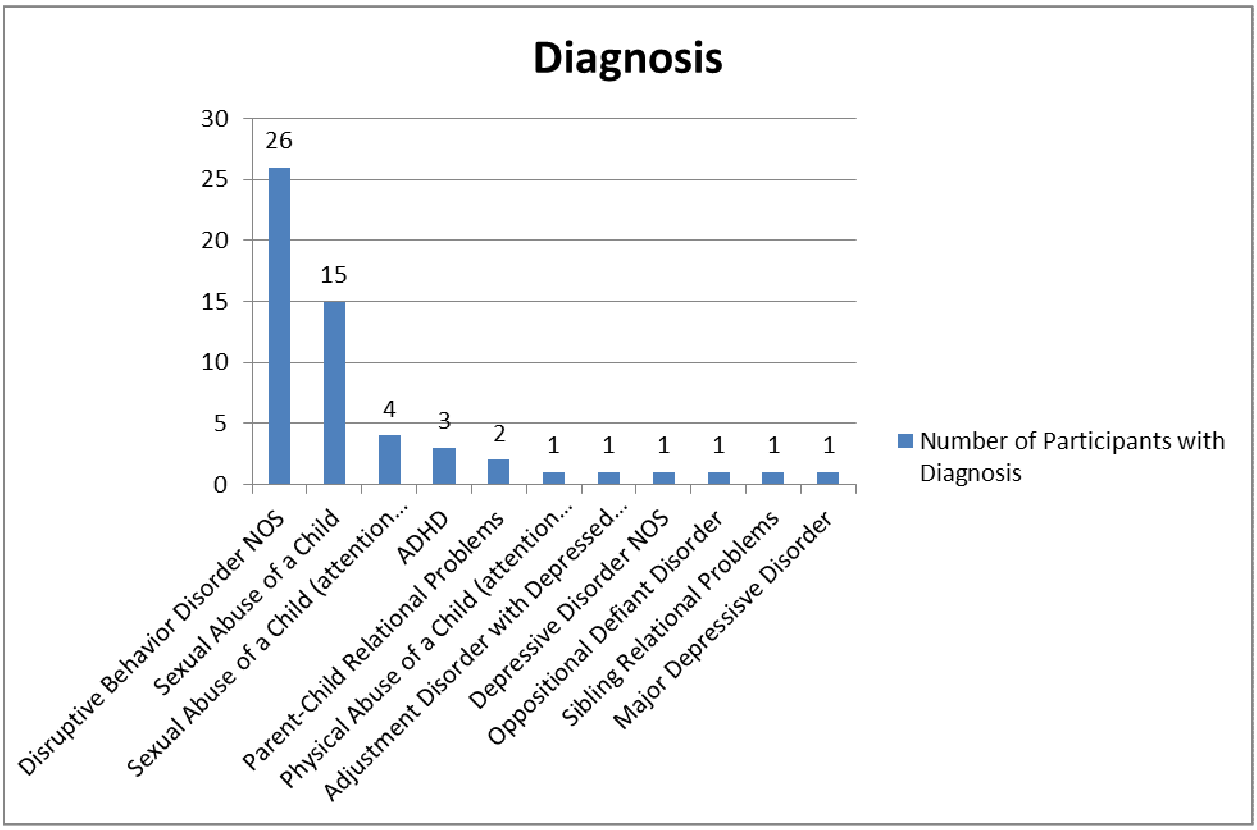
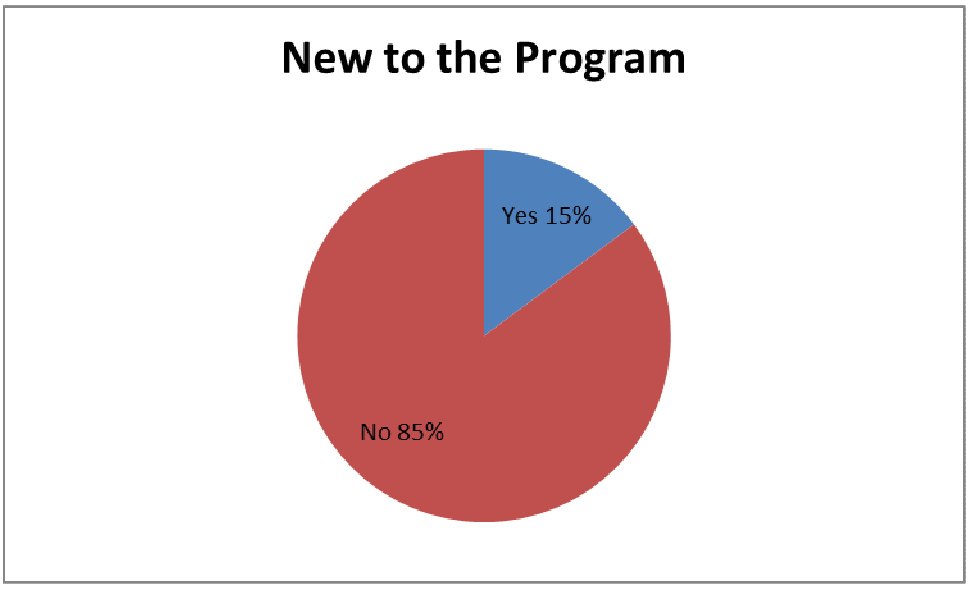


Figure 8- Diagnosis Distribution

As can be seen in Figure 9, of the 27 participants in the SAY Program, 26 of them were diagnosed with Disruptive Behavior Disorder NOS, 15 were also diagnosed with Sexual Abuse of a Child, 4 with Sexual Abuse of a Child (attention focus on the victim), and 3 with ADHD. Two participants were diagnosed with Parent-Child Relational Problems. Other diagnosis included Physical Abuse of a Child (attention focus on the victim), Adjustment Disorder with Depressed Mood, Depressive Disorder NOS, Oppositional Defiant Disorder, Sibling Relational Problems, and Major Depressive Disorder. The information regarding diagnosis was taken from the most recent ISP update prior to the end of the 2015 fiscal year. Upon review of participant's charts, it appeared that a majority of the treatment plans did not have an identified "primary" diagnosis. A review of the most recent diagnosis indicated 4 participants (14%) were victims of sexual abuse. There also appears to be a discrepancy between the number of participants adjudicated for a sexual offense of Rape or Gross Sexual Imposition (89% of participants), and those given a diagnosis of Sexual Abuse of a Child (53% of participants). A more detailed review of the participants' charts, including information about the participants' victims would need to be conducted in order to determine if the discrepancy is based on victim information or clinical error in diagnosis. It should also be noted that at the beginning of the 2016 fiscal year, all client's diagnosis were updated to reflect the change to the DSM-5. The 2016 report will reflect major changes in diagnosis for those participating in the SAY program as Disruptive Behavior Disorder NOS is no longer an accepted diagnosis.



Firgure 10-New Referrals

As seen in Figure 10, 4(15%) of program participants began the program during the fiscal year, with 23 (85%) having been enrolled in the program prior to the start of the fiscal year. New enrollment in the program was low for 2015, as the 2014 report reflected that 12 participants were added in 2014. It is unclear as to the nature of the drop in new referrals at this time; however, it should be noted that during the 2015 fiscal year, Fairfield County Juvenile court did elect a new judge to office. The court system has also undergone changes to the juvenile prosecuting attorney, and the court system has changed many of its policies and procedures. It is possible with the new changes, that less juveniles are being adjudicated for offenses and are not enrolled in the program. Anecdotally, the agency appears to have continued to receive referrals for juveniles who have engaged in inappropriate sexual behaviors who have not been adjudicated by the court system due to varying factors. Further discussion on this trend will continue in the recommendation section. Of the 27 participants, only 12 (44%) were succesfully discharged from the program. Implications based on these statistics will be discussed in the Recommendations section.

Service Utilization

The following chart details the service utilization of participants in the SAY program for the 2015 Fiscal Year. Total income for the program was $68,522.10. The largest section of income came through individual counseling services $42,371.10, while case management services had $7,523.52. It should be noted that adult clients in the SAY program only received 3.05 units of case management services, and 0 units of group treatment. Recommendations for increasing this area are listed in the recommendations section.

FY15 Service Income

Services	Youth Units	Adult Units	Rate	Income
Group	352.25	0	40.00	$14,090.00
Case Management	80.51	7.67	85.32	$7,523.52
Diagnostic Assessment	8.25	3	135.00	$1,518.75
Individual Counseling	451.87	18.92	90.00	$42,371.10
Psychological Testing	4.7	0	129.99	$610.93
Forensic Evaluation	2	0	600.00	$1,200.00
Formal Assessment	4.08		135.00	$550.80
Report Writing	7.3		90.00	$657.00
Total Income				$68,522.10

Below is a projected Program Budget for the 2016 fiscal year, based on last year's utilizations and the recommendations for change to the program.

Projected Program Budget

Income			
	Diagnostic Assessment	$1,350.00	1.4%
	Individual Psychotherapy	$48,600.00	51.8%
	Group Therapy	$21,600.00	23.0%
	CSP Services (Coordination)	$6,375.00	6.8%
	Case Manager/Mentor	$14,875.00	15.8%
	Formal Assessment	$1,110.00	1.2%
Total Income		$93,910.00	
Expenses			
	Payroll	$77,287.93	82.3%
	Occupancy	$9,203.18	9.8%

Travel	$1,033.01	1.1%
Professional Development	$563.46	0.6%
Office Supplies	$2,066.02	2.2%
Communication	$657.37	0.7%
Insurance	$657.37	0.7%
Advertising	$375.64	0.4%
Misc. Expenses	$469.55	0.5%
Bad Debt	$187.82	0.2%
Information Systems	$1,314.74	1.4%
Depreciation	$93.91	0.1%
Total Expenses	$93,910.00	
Net Income	$0.00	

As seen above the projected program budget includes a net income of $0.00, with $93,910.00 in Total Income and Total Expenses. This is an increase of $25,387.90 in both Total Income and Total Expenses. The differences in the budget are directly linked to a projected increase in group treatment and case management/therapeutic mentorship services. Income from group therapy is projected to increase by $7,510. Income from case management/therapeutic mentorship services are projected to increase by $7,351.48. While these are substantial increases in both group treatment and case management services, it is believed that by following the recommendations outlined in this report that the SAY program is likely to reach those numbers.

Program Outcomes

Participants in the SAY program are required to participate in quarterly treatment updates, which may include changes in treatment goals, collecting updated information, and completing an Outcomes questionnaire. The Outcomes form is utilized to gain an understanding of how the client has been doing in several key areas of their life.

The Outcomes for the youth participants of the SAY program are based on 14 participants who had completed outcomes forms during the 2015 fiscal year. While it is still a relatively small sample size, the data can be important in understanding trends in the population and areas that can be improved through treatment. These outcomes show four negative difference, in the areas of School/Work, Parents, Other Family, and Overall. School/Work moved from 9.17 to 8.99 for a -.19 difference, Parents went from 8.68 to .8.21 for a -.47 difference, Other Family went from 8.63 to 8.33 for a -.30 difference. Overall scores moved from a 9.11 to a 8.91 for a -.20 difference. While it is uncertain the reasons for the negative results from these outcomes reports, it may be reasonable to consider some of the possible causes. In regards to work/school, some participant began working during the course of the fiscal year, others may have started counseling during the summer while they were not in school and may have answered differently as the school year began. The differences in Parents and Other Family may be the result of parental/family problems that typically occur during the course of treatment. The negative difference in Overall may be the result of participants being more open with how they are doing in their lives. The outcomes showed positive changes of .11 in Criminal Justice, AOD use (1.23), Significant Relationships (.08), Friends (1.16), Emotions (.36), Thoughts (9.6), and Health (.05). The 9.6 increase in Thoughts, appears to be the result of clients denying "bizarre thoughts" during the pre-score, however, one participant reporting a 9.6 during the post score. It should also be noted that higher average pre scores make it difficult to see significant positive results. The lowest pre score was a 7.68 out of a "perfect" 10. Participants often see fluctuations in scores between the first administration and second and third administrations after participants began to recognize different areas of their life that need improvement. The low number of participants completing Outcomes forms to provide quality data is also an area of concern that will be addressed in the recommendations section.

While these numbers on the surface may appear to reflect negative outcomes, it is important to understand the types of transitions occurring in participant's lives while moving from adolescence into adulthood. Participants may have to transition from graduating high school to finding employment, which may lead to feeling that school/work has been more difficult. Some participants chose to seek employment opportunities, move out of the house, and have children, all while completing the program and following probation requirements. While these are positive changes in the participant's lives it may also increase the amount of stress and responsibility of the participant, which could lead to some of the more negative scores. Recommendations for improving the transitional period of adolescent to adulthood through the SAY program will be offered in the Recommendations section.

Recommendations

In order to facilitate a more cohesive treatment process, provide more accurate and clear outcomes, and continue to grow the Sexually Aggressive Youth Program it is recommended that the Fairfield County SAY program consider implementing the following changes/additions.

During the course of the review, it was determined that several clients had not been captured during the outcomes reports due to not having the appropriate SOC on their treatment plan. While the new SOC of SAY (Fairfield County) was added during this fiscal year, it appears that several clinicians failed to update the SOC leading to an inaccurate count on the outcomes form. It is recommended that the SAY program coordinator, the Lancaster site supervisor, and other clinical supervisors monitor the SOCs of clients to ensure they are enrolled in the appropriate program. Questions regarding the appropriateness of enrollment in the program should be directed to the program coordinator. This recommendation has been carried over from the last fiscal year report. It appears that while enrollment in the appropriate SOC has been handled more effectively, clients and their providers are not completing Outcomes reports at the standard rate. Supervisors and clinicians should continue to monitor their outcomes reporting to capture the data effectively. It is believed that the implementation of CIS 2.0 and its reminders will help reduce outcomes data not being tracked.

Clinicians should request collateral reports from the prosecutor's office, county court systems, the local police department, and the child advocacy center. Clinicians should ensure that they have gathered documentation on the participants' original charge and finally the charge they plead or are adjudicated for. These procedures should be fleshed out on the current Standard of Care to ensure that all clinicians understand the procedure.

It will take most participants more than 2 years to complete the program. During this time participants may go through major life changes, such as graduating high school, finding their own home, and starting a career. Current data seems to indicate that participants may be struggling with these phase of life changes and may need additional support. Currently, only 2 out of 28 or 7% of the total number of participants are utilizing the Therapeutic Mentorship Program. Clinicians should be encouraged to speak with their supervisors about the appropriateness of their client for the TM program. The TM may help clients with the transition from adolescence to adulthood in the form of job and college applications, interviewing skills, budgeting, time management, and looking for housing. This recommendation has also been carried over from the previous report. While efforts were made to begin implementing TM, due to heavy turnover at the position, this was not implemented as effectively as hoped. It is recommended that providers spend more time working with the TM program coordinator to find effective ways of providing TM to clients. This could take the form of the TM clinicians joining the SAY group at the end of group sessions to discuss goals for the week, and to check in with their clients. The SAY program may also work with the TM program to develop other ways that TM might be implemented with the specific SAY population, such as reviewing safety plans in the community and/or at home, working on homework assignments, developing appropriate social skills, and looking for employment.

During the 2015 fiscal year, Fairfield County Juvenile Court made substantial changes to their structure, including the election of a new juvenile court judge. While the courts continued to maintain a positive relationship with MOPS, it appeared that referrals decreased. Through conversations with probation officers and the judge it appeared that fewer juveniles were being adjudicated for sexual offenses than in past years. Maintaining an active relationship with the courts will be necessary to continue to receive referrals for the cases that are adjudicated.

The Fairfield County Juvenile Court probation officers continually reported concerns about the length of the SAY program, noting that in some cases 2 years seemed too long. Research into effective SAY treatment shows that low intensity/long duration treatment is most effective in maintaining positive cognitive and behavioral changes. For this reason, the SAY program has continued to provide education to the court system to provide quality care. During the 2015 fiscal year, several participants completed the program in under 18 months. These participants completed homework assignments in a timely fashion and had positive participation by their families and caregivers. SAY clinicians should continue to highlight the importance of completion of homework assignments and participation in sessions to complete the program in a timely manner.

The SAY program may also wish to explore developing a short term psychoeducation group on sexually inappropriate behaviors. This group may capture juveniles who have plead down from a sexual offense to another charge, but who could benefit from healthy sexual education and treatment. The court system may be more willing to refer juveniles to this program.

In the 2014 Fiscal report, it was recommended that the SAY program begin tracking overall outcomes more, and implement more testing throughout treatment both at the beginning and the end of treatment to determine the effectiveness of the program. During the 2015 fiscal year, an SAY Independent Review was developed and established. The review is set to be administered annually to participants in the program, which is in accordance with new standards established by certification boards. These reviews should continue to be explored and developed to help gather helpful information about the program's effectiveness in getting participants to reach appropriate milestones in treatment.

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