AD HOC COMMITTEE ON SEXUAL ABUSE

SECOND REPORT ON EVALUATION AND TREATMENT CENTERS

PRESENTATION

In its report Restoring Trust (November 1994) the Ad Hoc Committee on Sexual Abuse reported on ten evaluation/treatment centers. The report consisted of self-descriptions of these centers, some key questions for the centers and for the bishops to consider asking on the occasion of a referral, suggested criteria for assessing centers, and some general comments. In 1995 ten other centers were invited to supply similar information to the ad hoc committee and eight have responded.

Part One of the report which follows is similar in form to the November 1994 report on centers. This means, therefore, that NCCB members now have a description of 18 centers, plus comments and suggestions their leadership wanted to share with the bishops.

Part Two of this report consists of the results of a survey of all the dioceses regarding the centers they are currently using for evaluation/assessment, treatment, and long term care of priests alleged or acknowledged to have been involved in sexual abuse. The ad hoc committee was gratified with the participation of so many dioceses (145) in this survey and is grateful for this collaboration in such an important area.

REPORT ON ASSESSMENT/TREATMENT/LONG TERM CARE CENTERS

PART ONE: EIGHT CENTERS

OUTLINE

INTRODUCTION

One of the objectives for the Bishops' Ad Hoc Committee on Sexual Abuse relative to the use of evaluation and treatment centers. The objective reads:

> To compile descriptions of sexual abuse evaluation and treatment centers, church-related and others - for priests and lay employees - including their specialties, style of contact with referring bishops, and type of client information shared; to collate a series of key questions their professional staff expect to be asked by bishops on the occasion of a referral, along with a list of questions the bishops themselves may be asked; and to provide bishops with suggested criteria for looking at evaluation and treatment centers.

In **Restoring Trust** ten centers were described as outlined in the above objective. AHCSA decided to do a follow up report on additional centers being used by dioceses across the country. As a result of a survey to determine what centers were actually being used by the bishops, ten other centers (which have served at least three dioceses) were invited to respond in a manner similar to those reported in **Restoring Trust**. Eight responses are covered in this report.

These centers were requested to supply information in four areas:

- a self-description of their center
- key questions they would propose
- suggested criteria for assessing centers
- general comments

The bishops on the ad hoc committee are grateful for the response by these centers and for the insights offered for consideration by the bishops.

Supplying this material for review by NCCB members does not imply endorsement by the ad hoc committee of any or all of the facilities described. Their self-descriptions really do speak for themselves. The criteria for assessing a possible center for use by a bishop are also in the words of the respondents themselves.

*****

SECTION ONE: DESCRIPTION OF EIGHT CENTERS

All respondents were requested to describe their facility under four headings: general description, specialties, style of contact with referring bishop, and the type of client information that is shared with the bishop.

*****

BEHAVIORAL MEDICINE INSTITUTE OF ATLANTA

Suite T-30, West Wing
3280 Howell Mill Road, N.W.
Atlanta, GA 30327-4101
Phone: 404 351 0116
Contact Person: Gene G. Abel, M.D.

1. DESCRIPTION

1.1 In General

This is a free standing private facility adjacent to a medical center. The programs in place have been developed over the last 27 years by the Medical Director, Gene G. Abel, M.D. Ninety percent of evaluation and treatment is in the sexual area dealing with inappropriate sexual behaviors (such as child molestation and other paraphilias), professional sexual misconduct (non-deviant sexual behaviors that do not involve sexual deviations, but inappropriate sexual contact or unethical sexual contact between professionals and others) and sexual harassment, as well as sexual dysfunctions. ... 99% of all clients are evaluated and/or treated on an outpatient basis. Clients come from throughout the United States for 1-3 day evaluations or 4 to 6 weeks of treatment (called fast track treatments). They are then referred to members of the National Network (individuals knowledgeable and trained in the application of cognitive-behavioral treatments used at the facility) or to other therapists in the client's hometown for continued treatment and relapse prevention.

1.2 Specialities

1.2a Evaluation for the usual member of the clergy includes:

- Review of records accompanying the client
- Psychiatric assessment
- Social history, medical history, physical examination with laboratory measures conducted by specialists
- Neuropsychological and psychological assessment
- Psychophysiologic assessment including the Abel Assessment, the Abel Screen II, penile plethysmography and polygraph assessment

1.2b Treatment: The Institute generally has 260 individuals in treatment at any one time. Nearly all clients receive cognitive-behavioral treatment with a strong relapse prevention arm. In brief, treatment focuses on:

- identifying the antecedents to inappropriate sexual behavior
- teaching the client methods to disrupt the sequence, behavioral therapies to dampen or eliminate deviant sexual interests, and empathy in order to develop greater appreciation of the negative repercussions of the behavior on the victim
- normalization of the client's social and assertive skills
- and, most important, developing a relapse prevention program with an extensive surveillance system that extends out into the client's hometown (see National Network reference above)

The intense phase of individual treatment is given at the Institute. Therapy is generally done in group format and is completed in four to six weeks of six days per week treatment. Long-term follow-up and relapse prevention are conducted by a National Network therapist near the client's hometown.

For more problematic behaviors in the sexual area, the psychiatrist on staff treats the client with appropriate antidepressants for the reduction of compulsive sexual

behaviors,... For drug and alcohol issues prominent in the client's case, treatment is conducted along the 12-step model... and the Options 12-Step treatment program in the adjoining facility.

1.2c Long-term care is conducted predominantly for individuals from the neighboring states.

1.3 Style of contact with referring bishop

The Institute prefers to have written information regarding the client prior to arrival. Generally, the director speaks by phone with the bishop (or his designee) to delineate exactly what the issues are that are problematic for the bishop. On completion of the assessment it is the practice of the Institute to contact the bishop that day and explain the findings and recommendations.

1.4 Type of client information shared with the bishop

Interaction with the referring bishop regarding treatment is generally not implemented until the last third of treatment. The Institute, in general, has a better understanding of local facilities and the treatment needs of the patient. Unless provided by the bishop, the client's aftercare is coordinated with the client's previous therapist and a cognitive behavioral therapist in the client's local community. A report is always advanced to the bishop regarding the treatment plan and who would be carrying it out locally.

Regarding long-term care, the Institute generally provides four to six weeks of treatment in a concentrated form for individuals referred from out of state. This is done so that the client's time in Atlanta is minimized, while the amount of treatment received is maximized. Treatment is conducted on an outpatient basis and clients live in hotels, seminaries, and church facilities while in Atlanta. It is exceedingly rare that a member of the clergy would need hospitalization during treatment (this last occurred approximately four years ago) and the Institute does not provide residential treatment because it is generally not needed. In the cases where halfway houses are needed for drug using-abusing clients, housing is handled through the Options 12-Step program referred to above.

*****

ISAAC RAY CENTER

1720 West Polk Street
Room 107
Chicago, IL 60612
Phone: 312-942-4462
Contact Person: Jonathan Kelly, M.D.

1. DESCRIPTION

1.1 In general

Outpatient evaluation and treatment center, affiliated with academic university/medical center with educational and research components, dealing with civil and criminal issues in psychiatry and the law. Sexual behaviors section (SBC) specialties in comprehensive evaluation, brief consultations, and treatment of sexual disorders (esp. pedophilia and other deviant sexual behaviors).

1.2 Specialities

Psychiatric interviews (with emphasis on sexual history)
Psychological testing
Sexual questionnaires
Penile plethysmography
Medical tests, if indicated (e.g., CT scan/MRI brain scan, blood/urine drug or alcohol screens, etc.)

Treatment includes group therapy, individual therapy, behavioral therapy, medications.

Short-term inpatient hospitalization is available, if needed for crisis intervention.

1.3 Style of contact with referring bishop

Referring bishop (or designee chancellor/vicar/ provincial) contacts evaluation center by phone (312-942-4462) and/or mail or fax (312-942-2224), and physician case manager discusses clinical needs, concerns and costs with referring person on phone. Issues to be addressed by evaluation and/or treatment are clarified.

1.4 Type of client information shared with bishop

With consent of person being evaluated, issues to be shared with bishop could include diagnosis, prognosis, recurrent potential, risk management, limits/boundaries of contacts with faithful in ministry activities, treatment needs, parameters of treatment, specific/unique concerns raised by bishop.

*****

OUR LADY OF GUADALUPE RETREAT CENTER

39100 Orchard Street
Cherry Valley, CA 92223-3797
Phone 909 845 7777
Contact Person: Salvatore L. Busca, s.P., Director

General Description:

Our Lady of Guadalupe Retreat Center is located in the Diocese of San Bernadino, CA. It is situated in a small town that is about midway between the cities of San Bernadino and Palm Springs.

The actual property consists of six houses for staff and residents plus a larger house where we have our chapel, dining area, large living room and kitchen. One of the houses is used for the Servants of the Paraclete (three members); the other five are for residents. Each house has three bedrooms, two bathrooms, living room, and three have kitchenettes. The grounds are well maintained and filled with flowers. The area off the large house has a walled-in swimming pool area.

Guadalupe Center is different from many other long term centers in that there is no on-going therapy. It is actually, if you will, a "retirement center". Priests and brothers living here normally remain for the rest of their lives. They are people who will no longer benefit from therapy. In fact, many are "therapied out". There is a psychiatrist who visits some residents once a month; and a religious (degreed) who visits some for counseling sessions weekly. A staff priest is a registered nurse in the State of California.

The purpose of Guadalupe Center is to provide a place where these priests and brothers can live out their priestly and religious lives in a religious atmosphere. The daily schedule consists of a holy hour each morning at 7:30, with Morning Office included at 8:15. This is followed by a concelebrated eucharist (each priest resident wishing to do so takes his turn as principal celebrant and delivers the homily). Evening Office is held in common at 5:00 p.m.

The main meal is at noon each day - the residents make their own breakfasts and have a pick-up supper each evening.

There is not much for the residents to do. Some of them volunteer with the outside work - tending flowers, lawns, etc. Depending on their reason for being here, certain residents are now allowed to have cars or to leave the property unaccompanied. In fact, some bishops/superiors demand that their men do not leave the property unless they are accompanied by a Servant of the Paraclete. The Center does its best to accommodate the men in this area. One of the Paracletes is almost available to take the men shopping, to the movies, to dinners, to ball games, concerts, etc.

Guadalupe Center does not do evaluations or assessments. The Center's contacts with bishops/superiors are minimal. They want to know that their men are here and are appropriately following the established routine.

When a bishop/superior calls with a potential referral, the Center wants a general idea of the problem area in the life of the client. The Center asks the bishop/superior what their wishes are in regard to leaving the property, etc. They are informed that there is no therapy at the Center, and they are asked whether they wish the services of the psychiatrist or the counselor.

If bishops/superiors are looking for a long term center that provides therapy, job training, etc. there are other places available, some operated by the Servants of the Paraclete.

*****

PROGRESSIVE CLINICAL SERVICES

(also known as: PSYCH SYSTEMS of Greater Cincinnati)

4243 Hunt Road
Cincinnati, Ohio 45242
Phone: 513-891-9114
Contact Person: Al Ebert, MA, EdS

1. DESCRIPTION

1.1 In general

The **Bridge Program** is an intensive individual therapy program aimed at breaking through the denial of clinical issues that frequently accompany addictive and emotional problems. Most graduates of the **Bridge Program** will go on further treatment once they are clinically appropriate, although this by no means is a requirement.

The **Bridge Program** consists of between 1-10 hours of structured individual therapy which may include:

- psychotherapy with psychiatrist, psychologist or addictions counselor
- education on addictive disorders
- sexual abuse and what constitutes abuse
- preliminary treatment of an addictive disorder
- life-style evaluation counseling
- crisis counseling
- spiritual counseling
- expressive therapy
- psychodrama
- any other clinically indicated therapies

This program is tailored to the individual clinical needs of each client. There is no minimum or maximum length of stay, and the level of intensity is solely dependent on the needs of the client at that time.

The Bridge Program is particularly effective with clients preparing for treatment or clients unsure as to whether they are in need of treatment. Some typical diagnoses for the **Bridge Program** are as follows:

- any sort of addictive disorder, particularly sexual abuse and sexual addiction
- uncontrollable anger
- pedophilia
- acute or chronic depression

This is by no means a comprehensive list, but is meant to serve merely as an outline for some of the clinical benefits and treatment goals of the **Bridge Program.**

1.2 Specialities

A full multi-disciplinary assessment always includes:

a. a psychiatric evaluation by a Board-Certified Psychiatrist;
b. comprehensive psychological evaluation which includes MMPI, Weschler, Rorschach, Thematic Apperception Test and extensive clinical interviews;
c. medical assessment
d. psychosocial interview and history;
e. comprehensive addictions assessment;
f. sexual abuse assessment

When clinically indicated, the assessment process may also include neuropsychological testing; laboratory screening, including blood work and urinalysis; emotional and physical stress test; depression screenings and other services. Through treatment team meetings, the assessment data is compiled into a user-friendly report complete with all recommendations for treatment or follow up.

Progressive Clinical Services is committed to absolute confidentiality in the handling of these sensitive assessments.

1.3 Style of contact with referring bishop

Normally, referrals to our facility come from the bishop through the Priest Personnel Director, both in writing and by telephone call.

1.4. Type of client information shared with bishop

We strongly suggest the bishop require each priest to release all information from our facility to the bishop and Priest Personnel Director. Information that should be shared with the bishop would include: psychiatric evaluation, psychological assessment, medical issues, substance abuse issues and other specialized tests.

*****

SHALOM CENTER, INC.

13516 Morgan Drive
Splendora, Texas 77372-3121
Phone: 713-399-0520
Contact Person: Sr. Gina Marie Iadanza, M.S.C.

1. DESCRIPTION

1.1. In general

Shalom Center, Inc. is a treatment and renewal Center founded in 1980 for clergy and men and women religious, who are in need of a holistic program integrating the emotional, psychosexual, physical and spiritual dimensions of a person's life.

Shalom Center consists of a residential program which is facilitated by an interdisciplinary team of licensed professionals. This includes clinical psychologists, forensic psychologist, chemical dependency specialists, spiritual directors, registered nurses eating disorder specialists and various speciality therapists.

The center is a 16-bed, non-hospital, facility. Typically, clergy and religious who come are experiencing a variety of issues.

- Sexual Addictions (Behaviors related to pornography, sexual exploitation, exhibitionism, voyeurism, prostitution)
- Psychosexual Development (Inappropriate relationships, heterosexual, homosexual affairs, intimacy issues)
- Accusations of present or past alleged inappropriate sexual behaviors
- Sexual Abuse/Assault
- Alcoholics in Recovery
- Depression
- Anxiety and Phobias
- Stress and Burnout in Ministry
- Difficult transitions due to changes in assignments, Life Stages, or Vocational Discernment
- Authority Problems (Conflict with hierarchy/leadership, persons in ministry)
- Codependency
- Grief and Loss
- Vocational Crisis (Discerning to leave or remain in ministry)
- Reentry for Returned Overseas Missioners
- Renewal and Sabbatical

** In the area of pedophilia and ephebophilia, the center is prepared to do initial assessments and make appropriate referrals, if necessary.

1.2. Specialities

The center offers a two-week evaluation program that consists of the following:

1. Complete psychological assessment (MMPI, MCMI 16 PF, Multiphasis Sex Inventory, Rorschach, Mooney Problem Checklist, FIRO-B, and various psychological tests specific to presenting issue.)

2. Clinical interviews by psychologist, psychiatrist (as needed), chemical dependency specialists and various clinicians.

3. Comprehensive physical examination including cardiovascular and neurological.

4. Spirituality Assessment/Spiritual Direction

5. Individual/Group Psychotherapy

6. Self Reports:
   Personal Autobiography
   Sexual Autobiography
   Personal History Survey
   Spirituality Journey

7. Education Groups: Includes areas of sexuality, celibacy, human relationships, sexual ethics, boundaries, family of origin issues, addictions.

8. A communal living situation that accentuates wellness, healing and the opportunity for sharing and debriefing.

Many dioceses and religious communities participate in this evaluative process especially when assessments are needed for their clergy and religious who are confronted with sexual allegations.

The center assesses and treats persons with compulsive sexual behavior and various sexual addictions and also utilizes 12-step groups (SA, SAA, SLAS) for residents.

In cases of pedophilia, generally clients are referred to other institutions.

1.3 Style of contact with referring bishop

The center requests all information regarding the evaluee to be accessible. This includes past episodes or accusations of sexual abuse as well as current documentation of the presenting issue.

The center encourages participation of the bishop (with the consent of the resident) in the evaluation as well as treatment.

A complete report of the assessment and progress reports are sent to the Local Ordinary with the consent of the resident.

1.4 Type of client information shared with bishop

The center shares the information gathered with the bishop as fully as possible. This depends strictly on the written consent of the resident.

Note: All services are available in English and in Spanish.

*****

SAINT LOUIS CONSULTATION CENTER

1100 Bellevue Avenue
St. Louis, MO 63117
Phone 314 647 0070
Contact Person: Paul M. Midden, Ph.D.

1. DESCRIPTION

1.1 In General

The Intensive Outpatient Program of the St. Louis Consultation Center was established to provide a cost-effective outpatient alternative to residential care for clergy and religious experiencing emotional, psychological, and/or behavior difficulties. Our goal is to provide intensive, professional, and wholistic care for clearly defined problems while respecting the personal integrity of clients. It is also our goal to maximize the responsibility of individual clients for their own well-being and to assist them in acquiring skills necessary to engage in productive and personally satisfying ministry. We accomplish this by providing a personal and challenging clinical environment on an outpatient basis within which clients can face the exact nature of their distress and explore alternative ways of dealing with the sources of their difficulties.

The population consists of clergy and male and female vowed religious.

As an outpatient program, the center's practice is subsumed under the appropriate licenses to practice psychology and other healthcare disciplines in the State of Missouri. It is also affiliated with the Program for Psychology and Religion of the Division of Behavioral Medicine of St. Louis University Health Sciences Center.

1.2 Specialities

The intensive Outpatient Program is a four to six month wholistic treatment program. It consists of a core program which includes intensive group work, individual psychotherapy, individual spiritual direction, and the participation in a series of intensive psychoeducational workshops. Specific programming is available as needed for particular concerns, including twelve step involvement for addictive behavior, behavioral programs for specific anxiety conditions; and medical referral for various needs, including psychotropic medication.

- Specialization: in affective disturbances, anxiety disorders, behavioral problems, personality conflicts, and interpersonal problems.

- Ancillary Services: available, particularly through the Division of Behavioral Medicine of St. Louis University Health Sciences Center.

- Success Rates: Since admission criteria are selective, success rates in all areas are high. Since the program has a strong interpersonal focus, the most dramatic progress is seen with those individuals who are isolative and socially deficient.

- Clients Returning to Active Ministry: Over ninety-five percent of clients return to active ministry.

- Length of Stay: Since the program is wholistic in approach, the average length of stay is five to six months.

- Use of Residential Care: Since the goal of the program is outpatient care, residential treatment is used sparingly. When needed, this includes a one to four week primary care program either at a local hospital or at a facility specializing in primary care for a specific disorder.

- Non-Program Time: Since it is policy to provide an outpatient treatment experience, clients have considerable free time during the week. They are encouraged to take responsibility for structuring this time.

1.3 Style of contact with referring bishop

Collaborative Mechanisms: Feedback mechanisms consist of an initial contact with the referring superior, an interim report describing the client's progress in the program, a discharge conference at the end of treatment, and a final report, which includes a discussion of the client's progress and a list of recommendations for ongoing care.

1.4 Type of client information shared with bishop

Collaboration: Each client in the program has a designated contact person from his/her community. Generally this is the referring superior. Any major or unusual decision about a client is made with the client, the treatment team, and the contact person. These people are also in attendance at the discharge conference. High value is placed on collaboration among the client, the treatment team, and the superior. All are involved in decisions regarding disposition.

Prognosis: A detailed prognosis is provided upon completion of the program and specific recommendations are made if necessary.

*****

THE MENNINGER CLINIC

P.O. Box 829
Topeka, Kansas 66601-8000
Phone: 800-351-9058
Contact Person: Richard Porter, MSW

1. DESCRIPTION

1.1 In general

The Menninger Clinic is a private, not-for-profit psychiatric hospital located in Topeka, Kansas, approximately one hour west of Kansas City. The Menninger Clinic has been providing clinical services for over 70 years and has treated over 170,000 patients. The clinic offers comprehensive inpatient, day hospital, partial hospitalization, outpatient and consultation services for individuals, communities, dioceses and organizations.

The Menninger Clinic has several especially strong features. These include a comprehensive diagnostic approach; the development of individualized treatment plans based on this comprehensive diagnostic assessment; the utilization of a multi-disciplinary team of highly skilled professionals; a high ratio of treaters to patients; concern and help for family members, community members, and significant others who need to be involved in the treatment process; consultation services provided by Menninger's multi-disciplinary staff; a strong atmosphere of competent, caring treatment and hope.

Although not affiliated with any particular religious denomination, since its inception the Menninger Clinic has had a strong interest in and respect for the spiritual dimension of the lives of those who come here for treatment. Since its beginning, the Clinic has been involved in the diagnostic assessment and treatment of clergy, religous professionals and ministers. Menninger remains committed to providing the highest in diagnostic and treatment services for this particular group and in providing consultation to Bishops and religious superiors. Our 70 years of experience is brought to bear on the special needs of this unique population.

The Menninger Clinic has for many years been concerned both educationally and clinically with the area of Religion and Psychiatry. The Division of Religion and Psychiatry at Menninger, an active part of both the clinical and educational services, provides consultation, clinical intervention and educational programs for religious communities, dioceses, individuals and those in treatment at the Clinic. The Director of the Division is a non-ordained Benedictine Monk who is a licensed Clinical Psychologist.

1.2 Specialities

Two areas of Menninger's comprehensive diagnostic and treatment programs are of special note for clergy and religious. These are the Outpatient Evaluation Program (OPE) and the Professionals in Crisis Program (PIC). This evaluation service has been in place at the Menninger Clinic for over 40 years. The evaluation program typically lasts for five days, Monday through Friday. Prior to the individual's coming for the evaluation process, information is gathered through questionnaires, letters and telephone contact from the patient, the patient's superior and all significant others who might have information related to the evaluation process. This material is then reviewed by a multi-disciplinary diagnostic team which will be responsible for the evaluation. This includes an interviewing clinician, a psychologist for psychological assessment, a social worker to provide an understanding of family and group

dynamics, as well as other additional consultants, including those from Menninger's Division of Religion and Psychiatry. Comprehensive physical examinations, if indicated, are also a part of the evaluation process. The diagnostic process yields a comprehensive understanding of the patient's situation and the dynamics that led him or her to the problem they face. From this evaluation comes suggested outlines for intervention and treatment. In probably over 90% of our clergy cases the treatment recommendation is for some combination of outpatient treatments. Every effort is made to provide this in a geographic area convenient for the patient.

The Menninger Clinic works to have clear understandings regarding confidentiality of the results of these evaluations. We believe that these issues are best addressed prior to the beginning of the evaluation process so that all parties concerned have a clear understanding of what information will be shared. We recognize the need to provide detailed clinical information to mental health professionals and more focused information regarding diagnosis, prognosis and limitations regarding work to religious superiors.

Professionals in Crisis Program:

For those patients requiring either inpatient evaluation or inpatient treatment the Menninger Clinic offers the Professionals in Crisis Program, geared specifically for those professionals including business executives, physicians, clergy, attorneys, religious professionals and other high functioning individuals. It is an intensive and comprehensive program that focuses on the strengths of the individual while simultaneously working on problem areas needing treatment. Comprehensive inpatient treatment includes frequent individual therapy sessions, frequent group psychotherapy sessions, psycho educational discussions, psychodrama, activity and leisure skills development. Availability of consultation with clinicians from the Division of Religion and Psychiatry and with the hospital based chaplain are always available.

1.3 Style of contact with referring bishop

The bishop would initially be in contact with the Director of Clinical Resources who would facilitate the choice of evaluation or treatment, whether that be inpatient or outpatient. Following the evaluation or treatment arrangements, a member of the multi-disciplinary clinical team would have primary responsibility for maintaining frequent and direct contact with the bishop regarding the patient's overall progress and treatment. Conference calls are frequently part of the treatment as are visits by the bishop or other religious superior. Every effort is made to include the superior in the overall treatment program in order to provide the best possible continuity of care and to communicate as necessary the appropriate treatment needs of the patient to the bishop.

1.4 Type of client information shared with bishop

We realize that the bishop has very specific information needs regarding those priests that he sends for evaluation. Typically, this is not detailed clinical information about the day-to-day treatment process but rather information regarding larger issues.

The following information would be typically shared with the patient's bishop:

1. Diagnosis
2. General Treatment Plan
3. Prognosis
4. Specific recommendations for follow-up treatment upon discharge from Menninger or upon completion of the evaluation.
5. Recommendations regarding possible work limitations.
6. Other information as agreed upon at the initiation of the evaluation or treatment process.

*****

WOUNDED BROTHERS PROJECT
(Recon, Inc.)

P.O. Box 220
Dittmer, Missouri 63023
Phone: 314-274-1736
Contact Person: Bertin Miller, OFM

1. DESCRIPTION

1.1 In General

The Wounded Brothers Project provides long-term residential opportunity for clergy and religious in recovery from ministry limiting circumstances.

1.2 Specialties

The project has contracted the professional services of St. Louis University Health Sciences Center to deliver the therapeutic dimension of our program. Each client accepted into the Project is required to undergo a brief evaluation at Wohl Institute to determine the stage of problem identification and protocols consistent with the recovery expectations of the client, the diocese and the therapy providers. Such an evaluation assists us in determining the type and frequency of ongoing therapies to assure all that the client is working his recovery program. The therapies have included individual and group work with the professional staff at Wohl.

In addition to the therapeutic dimension of the Project, the client is expected to submit to vocational evaluation and skills training where appropriate so as to become employable. He is then expected to get a job and begin to contribute some portion to his room and board if the salary will permit. The employment must be consistent with the recovery protocols and caveats so that no one is at risk.

1.3 Style of contact with referring bishop

The client comes to the Project with a recommendation from his Ordinary and a recommendation from the primary treatment provider. In addition, the client comes to the project willing to work the **Project Expectations** outlined in the client packet.

The Project staff makes a monthly report to the Ordinary describing the client's progress in the Project. The Professional Staff at Wohl also make reports on the therapeutic progress of the client.

A scheduled progress meeting with the Ordinary, the therapists, and the residential staff is required every six months to assess the client's current situation and to help him plan for his future.

1.4 Type of client information shared with bishop

The client is required to sign appropriate "release of information" forms before he enters the Project allowing reports to be made to all parties involved in his placement in the Project. Thus, information on his progress in the residential, therapeutic and occupational components of his placement can be candidly shared with the Ordinary or his alternate. This information is vital in determining whether he remains in the active priesthood or whether he is offered a separation package.

*****

SECTION TWO: KEY QUESTIONS

2.1 Questions That May Be Asked of the Facility by Bishops.

The following is a synthesis of the sort of questions institutions/ centers would expect to be asked when a bishop contacts them regarding a possible referral.

- What is our experience in working with Catholic clergy?
  in working with clergy who have sexual boundary violations? in providing diagnostic appraisal? in providing treatment?
- What sorts of consultation services might we have available to parishes and congregations?
- What are the reasonable treatment costs?
- To what degree are religious and spiritual issues addressed during the treatment process?
- To what degree can and should the priest continue to function as a priest during the evaluation and treatment process?
- What is the extent of evaluation process?
- Extent of clinical experience in evaluation and treatment of ministers/clergy?
- Record of recidivism for clergy in treatment at your center?
- Response time after evaluation process
- Institutions to which you have referred clergy at your center?
- Type of assessment and whether the information will be accessible to the bishop?
- Length of time out of ministry and recommendations for placement in ministry?
- Is a forensic psychologist available?
- Will the assessment be valid if litigation ensues?

- What is our policy on confidentiality?
- Have our files ever been subpoenaed?
- How long can the client remain in the center?
- What resources are in place to protect the client and his recovery?
- Examine if the facility has professional, licensed staff, who are experienced in working with clergy and religious as well as trained in dealing with sexual abuse.
- Assess if program is integrated in its treatment modalities addressing psycho-sexual, emotional and relational as well as spiritual dimensions of the person.
- Consider if the facility is inclusive in sharing pertinent information with bishop, respecting federal/state laws regarding confidentiality.
- One center suggested: Network with the local bishop in the area of the facility and inquire whether the bishop supports the facility and endorses its credibility and performance.

2.2 Questions That May Be Asked of the Bishop by the Facility

The institutions/centers consulted had suggestions on certain points bishops might be asked on the occasion of exploring a referral to a facility.

- Are there legal issues pending?
- What history does the Bishop have on this patient?
- Is there significant information that the bishop is aware of regarding the case that the priest is not aware of?
- To what degree does the bishop wish to be involved?
- Has the bishop already decided on administrative action prior to the evaluation process?
- To what degree will the results of the evaluation or treatment process influence the administrative actions?

- History of sexual misconduct, allegations?
- Other past allegations, lawsuits, questionable behavior?
- Treatment history, prior evaluations?
- Significant contacts of persons who can provide history
- Medical, psychiatric records available?
- Admission of or denial of allegations?
- Risk factors identified for this person
- Legal complications (criminal or civil)?
- What can the client expect after participating in the center?
- It is crucial that a facility receive in writing all documentation regarding the reason for a priest being referred so that all assessments can be absolutely accurate.

*****

SECTION THREE: CRITERIA FOR BISHOPS LOOKING FOR A FACILITY

The institutions/centers described above were invited to suggest criteria bishops should look for when seeking a facility for personnel of their dioceses. What follows is a summary - for the most part in their own words - of what they would suggest to the bishops. There is much complementarity in these replies, along with nuanced differences on certain points.

- The length of time the facility has been in existence.

- The length of time the facility has treated clergy and religious professionals.

- The commitment the facility has to ongoing education of staff members and clergy and religious regarding issues around clergy mental health.

- The facility's experience in providing consultation and liaison services in addition to providing direct clinical services.

- The ability to provide comprehensive, sound psychiatric assessment and treatment that also includes a respect for and understanding of the important religious and spiritual issues in the patient's life.

- Affiliation with credible institutions of learning; other bishops' experiences with facility; reputation in community and among peer professionals (e.g. other reputable treatment centers); compare costs/quality of assessments elsewhere and what issues are addressed in evaluation and in treatment.

- We feel the most important criteria to look for is past success in treating priests with the problems necessitating the referral. The population of the clergy we serve does not naturally lend itself to effective outcome studies. Instead, we would suggest consultation among bishops as to which facility they have found to be most effective for their needs.

- In the way of minimum criteria for any healthcare facility, we recommend Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and State licensing.

- The major problem in the evaluation in cases of accusations of sexual abuse is the potential denial on the part of clients. In the experience of the center the pivotal issue in determining the likely success of an evaluation/treatment facility should be the facility's ability promptly and cost-effectively to break through the potential denial regarding the allegations. Cases where clients are forthcoming are not an issue.

- This center recommends that referrals only be made to programs that deal with a large number of individuals accused of the variants of sexual abuse. The reason is that the evaluation of such individuals is somewhat of a sub-speciality that requires a more confrontive approach than the usual evaluation center is accustomed to. (Check listing of programs by the Association for the Treatment of Sexual Abusers (503 643 1023) in Beaverton, Oregon, or the Safer Society Program and Press Listings (802 247 3142) in Brandon, Vermont.)

- Regarding treatment, this center strongly endorses programs whose primary focus is cognitive-behavioral treatment with a strong relapse prevention arm. This form of treatment is considered the "industry standard" for treating the various categories of sexual abuse. This approach is outlined in the excellent book entitled Sexual Assault edited by W. L. Marshall et al (1990).

- Regarding long-term care, this can best be done close to the client's residence. Long-term residential treatment in a facility is rarely necessary. The important therapeutic ingredient for long-term care is the surveillance system ..., the presence of a local therapist familiar with the treatment, and the religious support for the client.

*****

SECTION FOUR: OTHER COMMENTS

The institutions/centers contacted were invited to offer other comments they might want to share with the bishops. Here is a sample of what was received:

- It is extremely important that the primary treatment evaluation address the possibility of multiple addictions or personality disorder issues contributing to the behaviors. Too often the client is evaluated only on the issue of sexual transgressions and boundary violations. Many times chemical addictions are associates with the behaviors and must also be treated.

- A factor that is becoming increasingly more obvious in boundary transgressions is the issue of POWER and ROLE. We find that these factors if not appropriately addressed become a very strong conflictive problem in the recovery process.

- Many programs provide treatment for sexual disorders and boundary violations. Often we find that the providers are strongly aligned with a specific school of psychology such as the Behaviorists, the Developmentalists or the Addictionalogists. Many are not including the **spiritual** aspects of treatment and recovery. The program's approach to treatment has a significant impact on the success of the client's identification of the problem, the internalization of his responsibilities, and the acceptance of support resources needed to maintain his recovery process. Whatever the treatment provider's approach, it is our experience that a **successful treatment** must help the client identify the problem or problems, internalize responsibilities and accept the support resources needed to maintain the recovery process.

- As we face the uncertainty about future disclosures and the cautions that inevitably will accompany these events, we must consider that there is a diminishing possibility of perpetrators returning to active ministry in the traditional sense. Insurers and legal advisors have tightened the latitude within which Ordinaries can offer options to the recovering cleric. It is our position that we are thus urged to prepare these men for alternative occupations.

  At the same time we are bound to assure all that we as a Church have made every effort to rehabilitate these men. We believe that the managed recovery program is a good approach to accomplishing what is humanly possible in preparing these men to assume personal responsibility for their recovery and independent survival. The rest is up to God and the good will of the man himself.

- It is our experience that long term care is essential in cases of true pedophilia, or where there are many victims and a long history of violations. This is in contradistinction to the single victim, or single offense perpetrator who may have fallen into the victimization inadvertently.

  In view of the public attitude and the media focus on the perpetrator, it seems that post treatment managed care serves the perpetrator as well as the larger community and the Church. It takes more than a few months to substantiate the success of a treatment experience and the assurance that the perpetrator is truly in recovery. Our experience convinces us that the client needs to be placed in a managed program for a lengthened period of time so that spiritual renewal becomes an integral component of recovery, professional monitoring is reduced only gradually and the client is guided into healthy controls and resource reliance. Only then can all parties involved be confident that the perpetrator will not violate again.

- The Church has done an excellent job of beginning to remove itself from the evaluation and treatment process, so that the evaluation and treatment of the client is independent.

- The next problematic area is reentry or possible reentry of individuals who have been treated and rehabilitated. This is not simply a risk management issue, but includes issues regarding priest recruitment and the dwindling supply of priests and its impact on the Church providing guidance. In the past the Church may have approached denying priests as untrustworthy, and therefore untrustworthy forever. The use of psychophysiologic assessment in follow-up post-treatment, should the priest return to the religious life, is a valuable tool that in the estimation of the center can be most helpful to a bishop. At the same time, the combination of a tighter surveillance system that protects the parishioners, the community and the priest along with psychophysiologic assessment may provide the priest the opportunity to remain in the religious life. In other words, there is a possibility here for a win-win situation.

*****