BETTER TOGETHER

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Toward Further Understanding of Criminogenic Needs in SOMMI

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The current presentation will discuss the use of the Structured Risk Assessment – Forensic Version, version 2 (SRA-FV-Version 2) with individuals with histories of sex offenses and major mental illness (SOMMI) in the combined Sand Ridge/Bridgewater sample.

In an ongoing attempt to address the fact that previous research has suggested that evaluators have poor inter-rater reliability when using structured psychological instruments to assess individuals with histories of Sex Offending and Major Mental Illness (SOMMI; Sachsenmaier et al., 2011), the combined Sand Ridge/Bridgewater SOMMI study used a modified set of scoring instructions for the Structured Risk Assessment – Forensic Version, Version 2 (SRA-FV-V2) and examined the inter-reliability between researchers. In the preliminary data on Inter-rate reliability, three of the four raters demonstrated good inter-rate reliability, but the fourth rater's cases were consistently discrepant from the other three raters'. That coder's cases were re-coded by the other three raters in order to get a better sense of the inter-rater reliability of the SRA-FV-V2; this updated data will be presented.

The current presentation will also provide preliminary data suggesting that the individuals assessed in the Sand Ridge/Bridgewater SOMMI study appear to be able to be broadly characterized by two distinct typologies; those for whom acute symptoms of their respective mental illnesses appear to activate a number of long-term vulnerabilities (LTV), and those whose LTVs are seemingly not impacted by their mental illness. This apparent dichotomy can be seen as being consistent with disparate findings in the extant literature regarding the relationship between major mental illness and risk of violent or sexual offending. While some studies have reported findings that mental illness bears no or minimal relationship to offense risk (Peterson et al., 2014; Smith & Taylor, 1999), Smith and Taylor (1999) found that in their sample of patients who were psychiatrically hospitalized post offense (N=80), reported that the frequency of various psychotic symptoms had a direct causal relationship to offending behavior. Recidivism studies have also demonstrated inconsistent results with respect to the role that mental illness plays, ranging from marked to little or no effect (e.g., Hanson & Bussier, 1998; Hanson & Morton-Bourgon, 2004). It appears that many of these discrepancies may likely be attributable to how "mental illness" is defined in each study; many studies included mentally disordered offenders, those diagnosed with such disorders as various personality disorders, substance use disorders, and Attention Deficit/Hyper Activity Disorder (ADHD), as opposed to those diagnosed only with psychotic-spectrum and bipolar disorders. The way in which mental illness is defined is important, especially in light of Douglas et al.'s (2009) findings which established that while individuals diagnosed with a psychotic spectrum disorder have a greater risk of violence than individuals in the general population or those diagnosed with

internalizing disorders (i.e., Generalized Anxiety Disorder), their risk is lower than individuals who carry externalizing disorder diagnoses (e.g., ADHD, Antisocial Personality Disorder, Substance Use Disorders). Characteristics of these two apparent typologies will be discussed, including differing aspects of their histories and their SRA-FV-V2 profiles.

The ability to accurately determine what role, if any, major mental illness (e.g., psychotic-spectrum disorders, Bipolar Disorder) plays in risk of sexual recidivism has significant implications for community-based treatment providers and interventions they can implement with the goal of risk management and/or reduction. More specifically, Van Dorn et al. (2013) found that providing appropriate mental health services (i.e., psychotropic medication) interventions to individuals diagnosed with Schizophrenia or Bipolar Disorder upon discharge from a psychiatric hospitalization reduced risk of offense significantly. The presentation will conclude by offering practice implications.

Kerry Nelligan, PsyD currently serves as the Assistant Director of Clinical Services at the Massachusetts Mental Health Center (MMHC), a community mental health center in Boston, MA, operated by the Massachusetts Department of Mental Health (DMH). In this role, she is the Assessment Coordinator of the MMHC Mental Illness/Problematic Sexual Behavior (MI/PSB) Team, a specialized outpatient treatment program offered by DMH to provide assessment and treatment services to individuals with co-occurring mental illness and problematic sexual behavior. In this capacity, she coordinates all referrals and completes or supervises the completion of all MI/PSB Assessments of Treatment and Risk Management Needs for all clients in the Metro Boston Area. Dr. Nelligan has worked with perpetrators of sexual aggression for over a decade and has done such work within the Juvenile Justice, Federal Prison, and State Correctional systems. Dr. Nelligan has also been member of the Executive Board of Directors of the Massachusetts chapter of the Association for the Treatment of Sexual Abusers (MATSA), which advocates and lobbies for the implementation of evidence-based legislation regarding registration and communication notification practices regarding sexual offenders, for a number of years, and is now the President of this chapter. Dr. Nelligan completed her undergraduate education at Clark University and then earned a Master's of Science in Criminal Justice at Anna Maria College before completing her doctorate in Clinical Psychology at Antioch University New England in 2013.