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ASSESSMENT OF INDIVIDUALS WITH SEX OFFENSES & MAJOR MENTAL ILLNESS (SOMMI)

WCA & Wi-ATSA Workshop
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DURING THIS PRESENTATION

- We will talk about current approaches to assessing individuals identified with SOMMI,
- Discuss relevant research related to this group including the results of the Sand Ridge SOMMI study, and
- Apply this information to specific recommendations for risk and treatment needs assessments.

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THE CASE OF MR. ZEA: READY FOR RELEASE?

- 59-year-old, twice divorced man residing in secure psychiatric hospital
- Schizoaffective d/o, pedophilic d/o, exhibitionistic d/o, & transvestic d/o
- History relatively normal until about age 24
  - Healthy family system and childhood
- Military age 18 – 21
- Married age 24 – 28; common-law marriage age 28 - 35
  - Father of 2 daughters, 1 son from these two relationships

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THE CASE OF MR. ZEA: READY FOR RELEASE?

- Began receiving psychiatric evaluations age 24
- Inconsistent opinions (Schizoid Personality Disorder v Bipolar Disorder)
- By mid-30s was displaying markedly bizarre behavior and reporting CAH.

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THE CASE OF MR. ZEA: READY FOR RELEASE?

- Convicted of 1st sex offense (intra-familial) at age 32. Placed in residential treatment and probation.
- 2nd sex offense age 36: non-contact of prepubescent stranger
- 3rd age 38: non-contact in government building while wearing female undergarments (no victim specifically targeted)
- 4th age 40: non-contact in public bathroom while wearing female undergarments (adult female stranger)
- 5th age 43: Entered an apartment while naked and sexually assaulted a female acquaintance
- Undetected: exposure to PO and others; sexual contact with adults & prepubescent son

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THE CASE OF MR. ZEA: READY FOR RELEASE?

- Sent to prison and then inpatient treatment since age 53 (6 years)
- SOT group disclosures lead to psychiatric destabilization, tx attrition
  - Specifically triggered by listening to peers presenting offenses and being asked to talk about his own offenses
- Continued poor tx motivation when individual sessions offered
  - Has been intermittently participating in SOT and supplemental groups
  - MMI symptoms interfere with participation
- PPG indicates pedophilic preference and some arousal to adults
- Proposed release environment: supervised group home

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THE CASE OF MR. ZEA: READY FOR RELEASE?

- Intermittent medication non-compliance
- Notably large fluctuations in mental status
- When decompensated: hypomania, AH, disinhibited and bizarre behavior, hypersexual, grandiose delusions, fixated on numerology (numbers have special meaning), changes his name (usually to a number), odd verbalizations, and unable to care for himself (eating worms; not dressing for weather)
- Best baseline: soft spoken, organized thoughts, no bizarre speech or behavior, restricted affect with possible anxiety (socially reserved), insight into need for medication, residual delusional beliefs (developed MMI because when he was laying in a crib when a farm cat jumped on his chest and prevented air from going into his lungs)

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HOW WOULD YOU ASSESS MR. ZEA'S RISK & MANAGEMENT NEEDS?

- What additional information would you want to know?
- Which risk assessment tools would you use?

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RESEARCH: RELATIONSHIP OF MAJOR MENTAL ILLNESS TO OFFENDING

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INCONSISTENT RELATIONSHIP BETWEEN VIOLENCE & MMI

- Persecutory delusions are sometimes seen as related to violence
- Relationship between MMI & violence is usually present when compared with individuals without psychosis
- Risk factors empirically related to violence (e.g., ASPD) are most predictive regardless of the presence of MMI
- These risk factors may be strengthening the relationship between MMI and violence (Douglas et al., 2009; Monahan et al., 2001)

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INCONSISTENT RELATIONSHIP BETWEEN VIOLENCE & MMI

- Small group of individuals who demonstrate psychosis just before engaging in violent acts
- Skeem, Kennealy, Monahan, Peterson, & Appelbaum (2016)
  - 19.2% of 182 violent incidents among 56 pts w/ both hx of psychosis and violence
  - 8.9% consistently demonstrated psychosis prior to each incident
- Peterson, Skeem, Kennealy, Bray, & Zvonkovic (2014)
  - *N* = 143 with schizophrenia, bipolar, and major depressive disorder
  - 7.5% of crimes directly related to mental illness

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INCONSISTENT RELATIONSHIP BETWEEN VIOLENCE & MMI

Skeem, J. L., Winter, E., Kennealy, P. J., Louden, J. E., & Tatar II, J. R. (2014). Offenders with mental illness have criminogenic needs, too: Toward recidivism reduction. *Law and Human Behavior, 38*, 212-224.

- MMI symptoms were not predictive of re-arrest in parolees, but did predict return to custody for technical violations

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INCONSISTENT RELATIONSHIP BETWEEN SEX OFFENDING & MMI

- Some studies have shown a relationship regardless of more commonly known empirical risk factors
- Mental health concerns predictive among parolees even after controlling for homelessness, place of residence, and employment (Singer, Maguire, & Hurtz, 2013)
- Psychosis, ASPD, and paraphilic disorders each make significant, independent contributions to the prediction of risk (Moulden, Chaimowitz, Mamak, & Hawes, 2012)

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INCONSISTENT RELATIONSHIP BETWEEN SEX OFFENDING & MMI

Langstrom, Sjostedt, & Grann, 2004

- *N* = 1,215
- Sexual recidivism associated with psychosis, diagnosis of a psychiatric disorder, and any psychiatric hospitalization
- Stronger relationship with substance use and personality disorder

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RELATIONSHIP BETWEEN SEX OFFENDING & MMI: **SMITH & TAYLOR, 1999**

- 84 pts with schizophrenia hospitalized after conviction for a S.O.
  - 80 pts committed offenses when actively psychotic
  - 4 pts had onset of psychosis following offense

	Direct	**Indirect**	**Coincidental**	**Not present**	**Total**
% Delusions	18%	25%	51%	6%	*N* = 80
% Hallucinations	15%	18%	45%	22%	*N* = 80

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Overall, research indicates some relationship between psychosis and sex offending.

Can this be explained by the density of criminogenic factors or are there risk factors unique to MMI?

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CRIMINOGENIC NEEDS & MMI

- Well established risk factors were more predictive of violence than psychosis in MDO and NGI groups (Bonta, Blais, & Wilson, 2014)
- MMI symptoms and factors unique to MMI did not predict re-arrest (Skeem, Winter, Kennealy, Louden, & Tatar, 2013)
- Formal risk assessments like the LSI tend to predict well for this group (Kingston et al., 2016; Skeem et al., 2013)

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CRIMINOGENIC NEEDS & MMI: **LEE & HANSON, 2016**

- *N* = 947 Dynamic Supervision Project (DSP) sample
- 11% identified as having a previous psychiatric hospitalization
- Sexual recidivism – any charge or conviction that was sexually motivated
- Base rate = 10.6% over an average follow-up period of 7.4 years

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CRIMINOGENIC NEEDS & MMI: **LEE & HANSON, 2016**

- Psych hosp was associated with a significantly higher rate of sexual re-offense (*HR* = 1.9)
- Once controlling for Static-99R and STABLE-2007 scores, this effect disappeared
- Those having a history of psych hospitalizations had more criminogenic needs, which made them at increased risk

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THEORETICAL QUESTIONS

- Research indicates SOMMI cases are best assessed through an identification of the density of criminogenic needs predictive of sexual re-offense
- How should we make sense of the small proportion of individuals whose MMI symptoms appear related to re-offense (Smith & Taylor, 1999) and some studies suggesting that psychosis may independently predict sexual risk? (Langstrom et al., 2004; Moulden et al., 2012)

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THEORETICAL QUESTIONS

- Perhaps MMI plays an indirect role in increasing sex offending via its influence on criminogenic needs
- Psychotic symptoms may exacerbate risk by worsening the expression of underlying criminogenic needs (e.g., reduced self-regulation)
- But psychotic symptoms could also mitigate the relevance of criminogenic needs (e.g., catatonia)

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THEORETICAL QUESTIONS

- Consider scoring Mr. Zea using the STABLE-2007 to determine his current risk for sexual recidivism.
  - Would his mental status matter?
  - Would his score and sexual recidivism rate be predictive?
- If psychosis potentially exacerbates (or mitigates) the expression of criminogenic needs, could Mr. Zea have different STABLE-2007 scores depending on his mental status?

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SAND RIDGE SOMMI STUDY

Kelley, S. M., Thornton, D., Mattek, R., Johnson, L., & Ambroziak, G. (Oct. 16, 2019). Exploring the relationship between major mental illness and sex offending behavior in a high-risk population. *Criminal Justice and Behavior*. Accepted for publication.

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SAND RIDGE SOMMI STUDY AIMS

1. Identify when MMI sxs are proximal to sex offenses
2. Examine criminogenic needs in high-risk SOMMI sample
3. Determine whether criminogenic needs pre-existed MMI and are made worse by MMI
4. Determine if there is a way to identify SOMMI individuals whose criminogenic needs can be expected to be made worse by MMI

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SOMMI SAMPLE

- *N* = 55 with a total of 176 different sex offenses that were coded
- Average age 50.75 (*SD* = 10.07)
- Average Static-99R = 5.44 (*SD* = 1.85), Above Average Risk
- Coded sex offense charges:
  - 13.1% involving substantial force/abduction
  - 56.3% involving attempted or completed penetration
  - 13.6% involving attempted or completed sexual contact
  - 6.3% involving non-contact
  - <1% involving consensual but illegal (statutory)
  - 10.2% "other" involving institutional violations, court diversions

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SOMMI SAMPLE

- Schizophrenia 34.5%
- Schizoaffective 30.9%
- Other psychotic spectrum 25.5%
- Bipolar I 7.3%
- Pedophilic 47.3%
- Other Specified Paraphilic Disorder 23.6%
- Sexual Sadism Disorder 5.5%
- Antisocial Personality Disorder 50.9%
- Other Specified Personality Disorder 23.6%

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SOMMI SAMPLE

	Mean (*SD*)	**Median**
Age of MMI onset	23.75 (8.54)	19.50
Age at 1st psych hospitalization	21.40 (7.24)	22.00
Previous hospital stays	6.49 (9.30)	4.00
Age at 1st sex offense	17.40 (6.23)	16.00
Contact sex offenses	4.47 (2.34)	4.00
Non-contact sex offenses	1.56 (2.94)	0
Non-sexual offenses	7.89 (5.83)	8.00

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SOMMI DATA COLLECTION FORM

1. Demographic data
2. Psychiatric history
3. Offense pathways
4. Criminogenic needs and MMI

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OFFENSE PATHWAYS

Age at sex offense	Med compliance	Use of planning
Relation to victim	Effect of MMI on sex offense	Emotional state
Victim age category	Motivation for sex offense	Severity of victim injury
Psychosis present	Alcohol use at sex offense	Instrumental aggression vs. reactive aggression
Mania present	Drug use at sex offense	

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OFFENSE PATHWAYS

IRR = 29 cases

Kappa interpretation:

<0.20	**0.20-0.39**	**0.40-0.59**	**0.60-0.79**	**>0.79**
Unacceptable	Questionable	Good	Very good	Almost perfect

Regier et al., 2013

- MMI effect = 0.79
- Direct effect = 0.59
- Indirect effect = 0.31
- MMI = 0.72
- Deviant arousal = 0.66
- Criminogenic = 0.25
- Disinhibited = 0.24

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CRIMINOGENIC NEEDS AND MMI

Criminogenic need regardless of MMI	Did criminogenic need exist prior to onset of MMI?	Effect of acute MMI symptoms on expression of criminogenic need
Sexual preoccupation	Emotional congruence with children	Oppositional reactions to rules or supervision
Offense-related sexual interests	Grievance thinking	Poor emotional control
Lack of stable intimate relationships	Poor empathy	Poor problem-solving

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% AGREEMENT: PRESENCE OF CRIMINOGENIC NEEDS

- Sexual preoccupation 89.7%
- Offense-related sexual interests 93.1%
- Lack of stable intimate relationships 93.1%
- Emotional congruence with children 86.2%
- Grievance thinking 86.2%
- Poor empathy 79.3%
- Opposition to rules and supervision 79.3%
- Poor emotional control 86.2%
- Poor problem-solving 100%

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CRIMINOGENIC NEEDS AND MMI

IRR using ICC_1 = 29 cases

- Pre-existence of criminogenic need = 0.68, $p < .001$
- Criminogenic need impacted by MMI = 0.69, $p < .001$

(Moderate IRR)

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CHARACTERISTICS WITHIN THREE SEX OFFENSES (*n* = 151)

Characteristic	Frequency	Characteristic	Frequency
Relationship		**Victim type**	
Stranger	37.1%	Prepubescent	33.1%
Acquaintance	21.2%	Pubescent	21.2%
Specific, close	39.1%	Adult	44.4%
Gender			
Male child	21.9%		
Female child	32.5%		

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CHARACTERISTICS WITHIN THREE SEX OFFENSES (*n* = 151)

Characteristic	Frequency	Characteristic	Frequency
Planning		**Aggression type**	
Extensive	1.3%	Instrumental	34.4%
Moderate	8.0%	Reactive	10.6%
Minimal	29.1%	None	51.7%
None	57.0%	**Violence severity**	
		Serious injury	4.0%
		Minor injury	17.2%
		Assault w/o injury	27.2%
		None	49.0%

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CHARACTERISTICS WITHIN THREE SEX OFFENSES (*n* = 151)

Characteristic	Frequency	Characteristic	Frequency
Alcohol Use		**Drug Use**	
Substantial	9.3%	Substantial	4.0%
Moderate	24.5%	Moderate	17.2%
Minimal	8.0%	Minimal	1.3%
None	48.3%	None	61.6%

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MMI WITHIN SEX OFFENSES (*n* = 151)

Characteristic	Frequency	Characteristic	Frequency
Psychosis at S.O.		**Mania at S.O.**	
Mod - High	25.2%	Mod-High	9.9%
Not psychotic	64.9%	Hypomanic	1.3%
MMI on S.O.		Not manic	84.1%
Direct	12.6%	**Primary influence**	
Indirect	9.3%	Direct MMI	9.3%
Coincidental	6.6%	Disinhibited	2.0%
No symptoms	62.9%	Deviant arousal	55.0%
		Criminal lifestyle	31.8%

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SUMMARY OF MMI WITHIN SEX OFFENSES

- Overall, the majority of the sample was not demonstrating acute MMI symptoms at the time of sex offenses
- Approximately a third of the sample demonstrated a moderate to high level of acute symptoms
- When symptoms were present, they only had a direct influence on sex offending in 12.6% of the cases
- The majority of the sex offenses appear related to an underlying deviant arousal pattern and/or criminal lifestyle.
  - This is consistent with the sample's diagnoses

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	General Existence	Pre-existed MMI			Effect of MMI		
		Yes	Partially	No	None	Mitigated	Exacerbated
Sexual Preoccupation	92.7%	63.3%	22.4%	14.3%	54.9%	3.9%	41.2%
Deviant Interests	67.3%	71.1%	13.2%	15.8%	73.7%	0%	26.3%
Difficulty with Intimacy	92.7%	73.5%	14.3%	12.2%	47.1%	0%	52.9%
Emotional Congruence with Children	16.4%	77.8%	0%	22.2%	80.0%	0%	20.0%
Grievance Thinking	87.3%	59.1%	15.9%	25.0%	25.0%	0%	75.0%
Poor Empathy	92.7%	67.3%	24.5%	8.2%	54.9%	0%	45.1%
Rules & Supervision	96.4%	71.2%	9.6%	19.2%	45.3%	0%	54.7%
Emotional Control	87.3%	64.4%	15.6%	20.0%	31.3%	8.3%	60.4%
Problem Solving	98.2%	63.0%	22.2%	14.8%	25.9%	1.9%	72.2%

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Grievance Thinking	87.3%	59.1%	15.9%	25.0%	25.0%	0%	75.0%
Poor Empathy	92.7%	67.3%	24.5%	8.2%	54.9%	0%	45.1%
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Problem Solving	98.2%	63.0%	22.2%	14.8%	25.9%	1.9%	72.2%

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SUMMARY OF CRIMINOGENIC NEEDS AND MMI

- Most criminogenic needs were rated as relevant and existed prior to the onset of MMI
  - Makes sense given this is a high risk sample who began displaying problematic sexual behavior before the onset of MMI symptoms
- Emotional congruence with children was infrequently present
- MMI symptoms rarely suppressed the expression of risk factors
- Criminogenic needs most likely to be exacerbated: grievance thinking, poor emotional control, and poor problem-solving

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SYMPTOM DENSITY SCALES

Hallucinations & Delusions Scale (HALDEL)

- Command auditory hallucinations
- No command AH
- Visual hallucinations
- Grandiose delusions
- Paranoid delusions
- Somatic delusions
- Erotomanic delusions

Score = 0 – 7

α = .77

Scale for manic symptoms (MANIA)

- Grandiosity
- Decreased need for sleep
- Hyperverbal/pressured speech
- Flight of ideas/racing thoughts
- Distractibility
- Increased goal activity
- Stimulation seeking activities

Score = 0 – 7

α = .82

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SYMPTOM SEVERITY AND MMI INFLUENCE ON SEX OFFENSES

	Direct Influence	Indirect Influence
HALDEL	*r* = .47 *p* < .001	*r* = .24 *p* = *NS*
MANIA	*r* = -.06 *p* = *NS*	*r* = .40 *p* = .007

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SYMPTOM SEVERITY ON CRIMINOGENIC NEEDS

- On average, about 4 of the 9 criminogenic needs became exacerbated by acute MMI symptoms (*M* = 3.93, *SD* = 2.76)

	HALDEL	MANIA
Exacerbated criminogenic needs	*r* = .53 *p* < .001	*r* = .23 *p* = *NS*

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RELATIONSHIP OF SYMPTOM DENSITY TO CRIMINOGENIC NEEDS

Exacerbated Need	HALDEL	MANIA
Sex preoccupation	*r* = 482, *p* < .001	*r* = .379, *p* = .012
Deviant interests	*r* = .381, *p* = .022	*r* = .040, *p* = ns
Difficulty with intimacy	*r* = .511, *p* < .001	*r* = .213, *p* = ns
Congruence w/ children	*r* = -.391, *p* = ns	*r* = .801, *p* = .005
Grievance thinking	*r* = .558, *p* < .001	*r* = -.050, *p* = ns
Poor empathy	*r* = .557, *p* < .001	*r* = .022, *p* = ns
Rules & supervision	*r* = .528, *p* < .001	*r* = .092, *p* = ns
Emotional control	*r* = .404, *p* = .007	*r* = .025, *p* = ns
Poor problem solving	*r* = .390, *p* = .006	*r* = .124, *p* = ns

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SUMMARY OF SYMPTOM DENSITY RATING SCALES

- More severe psychotic symptoms will be seen in sex offenses that appear to be directly related to MMI
- Cases with histories of more severe psychotic symptoms may be more likely to demonstrate higher density of expressed risk factors when acutely ill

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CAN WE IDENTIFY WHICH INDIVIDUALS ARE MORE LIKELY TO DEMONSTRATE WORSENED CRIMINOGENIC NEEDS IN PRACTICE?

Number of Exacerbated Criminogenic Needs	Frequency of Cases
None = 0	21.8%
Mild = 1 - 3	18.2%
Moderate = 4 - 5	25.5%
High = 6 - 9	34.5%

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	Exacerbated LTVs				
Sample Characteristic	None	Mild	Moderate	High	Linear-by-Linear Association
Problem sex behavior ≤ 12	27.3%	13.6%	31.8%	27.3%	0.40
Problem sex behavior 13-17	30.6%	22.2%	25.0%	22.2%	8.79**
Psychiatric hospitalizations					4.99*
None or one	53.8%	23.1%	15.4%	7.7%	
Repeated, 2+	11.9%	16.7%	28.6%	42.8%	

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	Exacerbated LTVs				
Offense Characteristic	None	Mild	Moderate	High	Linear-by-Linear Association
Psychosis near time of sex offenses					27.46**
Not psychotic	37.5%	31.3%	21.9%	9.4%	
Moderate to substantial symptoms	0%	0%	30.4%	69.6%	
Mania near time of sex offenses					8.57*
Not manic/hypomanic	26.7%	22.2%	24.4%	26.7%	
Moderate to substantial symptoms	0%	0%	30.0%	70.0%	

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	Exacerbated LTVs				
Offense Characteristic	None	Mild	Moderate	High	Linear-by-Linear Association
Medication Compliance at sex offenses					15.96**
Compliant or N/A	32.4%	26.5%	26.5%	14.7%	
Non-compliant	4.8%	4.8%	23.8%	66.7%	
Effects of MMI on sex offenses					27.46**
No symptoms or coincidental	37.5%	31.3%	21.9%	9.4%	
Indirect/Direct	0%	0%	30.4%	69.6%	

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IDENTIFICATION OF SUBTYPES

CRIMINOGENIC NEEDS STABLE DESPITE PSYCH DE-STABILIZATION

- Juvenile onset of PSBs (before MMI)
- 0 – 1 psychiatric hospitalizations
- Mild to no MMI symptoms at time of past sex offenses
- Generally compliant with medication (or not prescribed meds) at time of sex offenses

CRIMINOGENIC NEEDS BECOME EXACERBATED WHEN PSYCHIATRICALLY DE-STABILIZED

- MMI before PSBs
- Repeated psych hospitalizations
- Mod-High MMI symptoms at time of past sex offenses
- Non-compliance with meds
- Sex offenses affected by MMI

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SOMMI TYPES

Three variables appear best to differentiate types:

1. Repeated psychiatric hospitalizations
2. Influence of MMI symptoms on past sex offenses
3. Indication that a moderate-high number of criminogenic needs are worsened by acute MMI as captured on the SOMMI Coding Form

- Each captures information that is significantly different from one another
- Cases with 0 – 1 variables = 43.6%
- Cases with 2 – 3 variables = 56.4%

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IMPLICATIONS

TRANSLATING RESEARCH INTO PRACTICE

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IMPLICATIONS

"SOMMI-Traditional Type"

- MMI symptoms likely will not be a causal factor in sex offending
- Changes in mental status will likely not result in different scores on criminogenic need measures
- Risk, treatment needs, and interventions will be consistent with that seen in SOT
- MMI treated as a responsivity factor per RNR

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IMPLICATIONS

"SOMMI-MMI Type"

- Risk as measured by criminogenic needs instruments will likely fluctuate as a function of mental status
- Score instruments twice: (1) at best psychiatric baseline, and (2) at worst psychiatric baseline.
- Consider protective factors in current in future release settings that will ensure best psychiatric baseline.

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IMPLICATIONS

"SOMMI-MMI Type"

- Treatment priority: Psychiatric stabilization
- Treatment interventions:
  - Cognitive Behavior Therapy for Psychosis
  - Improve Social cognition and theory of mind
  - SOT?

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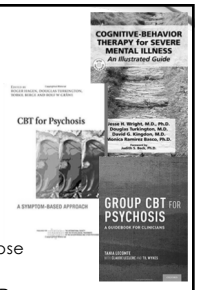
"SOMMI-MMI Type"

- Cognitive Behavior Therapy for Psychosis:
  - Understanding of, and insight into, own psychotic experiences
  - Improved coping with residual symptoms
  - Reduction in distress associated with AH
  - Reduction of degree of conviction & preoccupation with delusional beliefs
  - Maintenance of gains and prevention of relapse
- https://www.nasmhpd.org/sites/default/files/Psychosis%20Manual.pdf



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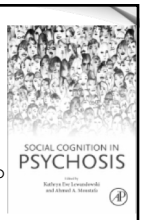
"SOMMI-MMI Type"

- Social Cognition for Psychosis:
  - Increased affect regulation
  - Theory of mind (the ability to ascribe mental states to others so as to predict and explain behavior)
  - Social perception and knowledge (social skills)
  - Attribution bias (help to increase internal locus of control)



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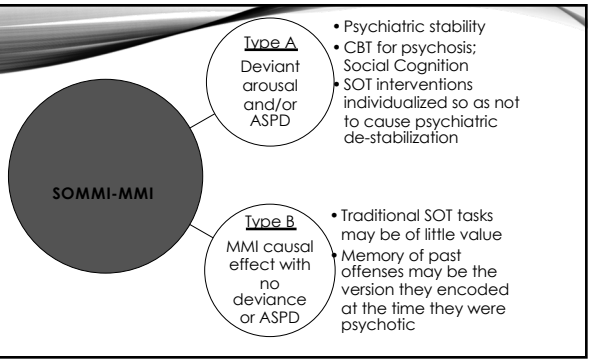

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INCREASING RECEPTIVENESS TO PROTECTIVE FACTORS

- Motivational interviewing and Good Lives
- Increase willingness to work alongside therapeutic / case management support to achieve short and long-term goals
- "What's in the way of you getting that?"
- Reward positive behavior by directly helping with goals
- Increase outcome expectancy for positive behaviors
- Increase internal locus of control & help-seeking behavior
- Coach how to interact with system to get needs met

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INCREASING RECEPTIVENESS TO PROTECTIVE FACTORS

- Therapeutic style that provides choices (with likely effects) and engenders feelings of autonomy will less likely trigger underlying persecutory beliefs and schema (e.g., authority figures are malicious)
- Simultaneous role: Education, guidance, and helping to manage anxiety of systems while advocating for increased opportunities to access existing protective factors (e.g., group homes)

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PROTECTIVE FACTORS TAILORED TO THE INDIVIDUAL

- Medication, psychiatric treatment
- Case management
- Structured activities
- Day programs
- Social alliances
- Housing
- Financial assistance
- Supervision

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MR. ZEA

- Would you assess Mr. Zea differently?
- What would you want to know?
- How would you get the information?

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IDENTIFYING SOMMI SUBTYPES IN PRACTICE

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STRUCTURED ASSESSMENT RESOURCE (STAR) FOR SOMMI

- Experienced SOMMI clinicians know how to identify the kind of interaction between MMI and risk that operates in an individual patient but passing this expertise on to others can be difficult
- A potentially helpful method for doing this was developed in the SOMMI research
- The intent of StAR for SOMMI is to provide a resource that will help professionals structure how they assess SOMMI in a clinically useful way
- At some point we will doubtless have better tools, StAR for SOMMI is not the last word, but we hope it will be a helpful bridge from the present taking us towards that future
- Now let's look at the instrument

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Demographic Data		
Patient Name		
Date of Birth		
Rater		
Date of Rating		
Age at the time of rating		
Live-In Relationships ≥ 2 years		
Any stable intimate relationships *(institutional relationships do not count)*		
Any consensual intimate experiences *(institutional relationships do not count)*		
Age at first arrest for any offense		
Age at first sex offense *(can use self-report)*		
Psychiatric History		
	Number, Age, or Yes / No	
Number of psychiatric hospitalizations *(transfers don't count; Do your best with the information you have)*		
Age at first psychiatric hospitalization		
Age of onset of major mental illness *(MMI only)*		
Childhood Diagnoses *(list all known)*		
Exhibited problematic sexual behavior as a child *(age 12 and below)*		
Exhibited problematic sexual behavior as an adolescent *(age 13 to 17)*		
History of Traumatic Brain Injury		

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MR. ZEA

What subtype does he fall into?

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MR. ZEA

- MMI symptoms had a direct causal effect in 2/3 sex offenses
- Deviant arousal pattern primary factor in 1st offense
- Relevant criminogenic needs:
  - Deviant arousal*
  - Sex preoccupation*
  - Lack of intimate relationships*
  - Poor empathy*
  - Opposition to rules & sup*
  - Poor problem-solving*

*Gets worse when decompensated

SOMMI-MMI TYPE A

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CONTACT INFORMATION

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