2011

A Training Curriculum for Assessing and Treating Sex Offenders with Mental Illnesses

Shawna Elizabeth Walker Boles

A Training Curriculum for Assessing and Treating Sex Offenders with Mental Illnesses

by

Shawna Boles

B.A., New College Of California, 2001
M.S.W., State University of New York Buffalo, 2003
M.S., Antioch University New England, 2008

DISSERTATION

Submitted in partial fulfillment of the requirements
for the degree of Doctor of Psychology
in the Department of Clinical Psychology
of Antioch University New England

Keene, New Hampshire

ANTIOCH UNIVERSITY
NEW ENGLAND

Department of Clinical Psychology

DISSERTATION COMMITTEE PAGE

The undersigned have examined the dissertation entitled:

A TRAINING CURRICULUM FOR ASSESSING AND TREATING SEX OFFENDERS WITH MENTAL ILLNESS

presented on June 27, 2011

by

Shawna Boles

Candidate for the degree of Doctor of Psychology
and hereby certify that it is accepted*.

Dissertation Committee Chairperson:
Kathi A. Borden, PhD

Dissertation Committee members:
Kathy McMahon, PsyD
Frank Sacco, PhD

Accepted by the
Department of Clinical Psychology Chairperson

Kathi A. Borden, PhD

on 6-27-11

* Signatures are on file with the Registrar's Office at Antioch University New England.

Acknowledgements

This project would not have been possible without the love and support of many good friends and random acquaintances who have come and gone over the last many years. I would like to specifically thank those who have stood by me over the years: David Carmona, Kristie Boyce, Kelly Underwood, Kelly Lynett, and Fernando Godinez. I have also had recent support from my new friend Celine Nader and the Brew'd Awakening Café. In particular, I would like to thank Krishna Jain for his support over a very difficult period of months and for his ongoing nagging around finishing this project. He is an amazing influence in my most recent life. My parents and family have also been huge supports in this process and I thank them for all the ways that they have shown support during some very difficult times. I would also like to thank my dissertation committee for their input and for helping to guide me in this process. Specifically, I would like to thank my chair, Dr. Kathi Borden, for helping me through the dissertation process. I would like to thank Dr. Laurie Guidry for working with me one-on-one, and line-by-line to make sure that my finished product would be successful and useful to the world. I would also like to thank Dr. Kathy McMahon who checked in on me weekly and who helped me talk through areas of concern. I appreciate all of their commitment to helping me finish. All three of these women have worked as my supervisor at some point in my development. In addition, I thank Dr. Frank Sacco for helping me last minute and for providing excellent pre-doctoral training. Dr. Sacco was a mentor in many ways and taught me the importance of staying true to who we are. I would like to honor all of my former clients who have helped me become a better clinician and more thoughtful witness to their life stories.

Table of Contents

Abstract

The purpose of this paper was to develop a continuing education program to teach sex offender-specific treatment providers (SOSTP) in the community how to appropriately assess, treat and manage adults with severe mental illness who are also sex offenders (SMISOs) in an outpatient setting. This paper begins with an overview of the most relevant literature associated with the treatment of sex offenders and a presentation of some of the current programs developed to treat sex offenders with severe and persistent mental illnesses. This review also outlines the paucity of resources and the need for SOSTPs to receive expanded training to better serve the specialized and challenging needs of the SMISO population. Next, methods are used to develop a 7-hour continuing education training curriculum for SOSTPs aimed at increasing assessment and treatment skills of those working with adult men with severe and persistent mental illnesses who are have also been convicted of sexual offenses. The results section provides a written overview of the final curriculum, the details of which are attached in the appendix. Lastly, a discussion follows to explore the limitations and potential uses of this project and the developed training.

Keywords: sex offender, sex offender-specific treatment providers, curriculum development, severe and persistent mental illness

A Training Curriculum for

Assessing and Treating Sex Offenders with Mental Illnesses

Statement of Problem and Target Population

Sex offender-specific treatment providers (SOSTPs)[1] are trained to address the assessment, treatment, and management needs of sex offenders[2]. This training, although sufficient to educate clinicians to work effectively with most sex offenders, does not equip SOSTPs with the specific skills needed to assess, treat, and manage the risk of sex offenders who have been diagnosed with co-occurring severe and persistent mental illnesses. It also may not address the possible countertransference that can occur when working with such a challenging population. This is due, in part, to the fact that there are notable cultural differences and a lack of collaboration between the sex offender-specific treatment field and mental health field. This is also due to the lack of training resources available to SOSTPs on how to address severe and persistent mental illness in a person who is also a sex offender. This deficit in training could result in poor treatment outcome for individuals with severe and persistent mental illnesses and sex offending behavior, which would likely affect recidivism and future victimization.

One main thrust behind the apparent cultural split between sex offender-specific treatment and mental health treatment comes from the influence of the historically dominant criminal justice paradigm in the evolution of sex offender-specific approaches (Ward & Maruna, 2007). One point noted is that historically there has been a moral component that differentially influenced both the mental health and sex offender-specific treatment fields (Baumohl & Room, 1987; Ward & Maruna, 2007). This moral component is a necessary part of work within the

[1] The abbreviation SOSTP is used to refer to sex offender-specific treatment providers. These providers are usually master's level clinicians from a variety of mental health fields. These providers may also be doctoral level psychologists.

[2] The author defines a sex offender as a person who has been charged and convicted of a sexual offense.

criminology field, since the main goal of treatment in this field is often to stop behaviors that hurt or violate others. However necessary it may be to judge behaviors and work towards stopping behaviors that hurt others, this difference has repercussions as to how treatment is carried out in the two fields and in how the two fields developed culturally. An example of the cultural difference is that mental health workers are often trained to empathize, listen, reflect, and work with clients on client driven goals (Rogers, 1957). In sex offender-specific work clients may or may not have goals to stop offending, but the work has to be focused on this overarching goal, since the risk to society often outweighs client desires. Mental health practitioners are often tasked with working with clients to manage their mental illnesses. SOSTPs may be tasked with working with clients to manage their risk to reoffend (Marlatt, 1982; Laws, Hudson, Ward, 2000). Mental health practitioners often work with clients on life optimizing behaviors. SOSTPs may also work in this direction, but sex offender clients may not agree that stopping their inappropriate or criminal behavior is life optimizing. Mental health practitioners tend to view their client's presenting problem of mental illness as medical in origin, and not as a moral choice. SOSTPs can be trained to focus on the criminal aspect of their client's behavior (i.e. the sexual offense) and accountability is an emphasis in this work (Ward & Maruna, 2007). This does not mean that SOSTPs will not recognize the many factors that may be influencing a sex offender's offending behavior, but it can mean that the appreciation of a mental illnesses effect on offending is overlooked. Holding clients accountable for their behavior can be seen as more confrontational than most mental health work as well. These are just some of the many ways that the sex offender-specific field and the mental health field differ culturally. I posit that these differences have contributed to a lack of communication between the two fields at the cost to both fields.

In addition to cultural differences, a second factor that contributes to the lack of more in-depth knowledge regarding major mental illness for SOSTPs is the fact that there are limited resources available for SOSTPs on how to address the needs of individuals with severe and persistent mental illness with sex offending backgrounds. In fact, if SOSTPs were to look for guidelines on how to address the clinical and risk issues of seriously mentally ill sex offenders (SMISOs),[3] they would find few resources that help them effectively manage this population. With this gap in resources and training, there are two main sources that SOSTPs consult when they need direction in addressing the needs of special populations within the sex offender field: (a) the Association for the Treatment of Sex Abusers (ATSA) professional guidelines, and (b) the sex offender-specific literature. However, neither of these paths offer much direction for working with seriously mentally ill clients.

ATSA is an international organization dedicated to the dissemination of material and resources for the prevention of sexual abuse. This organization has strict guidelines for membership and accepts only clinicians and students if they have previously worked with sex offenders, participated in training related to the sex offender-specific field, and can provide references upon application. ATSA also provides general guidelines for the assessment, treatment, and risk management of sex offenders (Association for the Treatment of Sex Offenders, 2004). However, even this organization provides only limited guidelines specifically addressing the mental health issues of sex offenders. As stated in the guidelines:

(1) "Members screen clients for mental or physical disabilities, major psychiatric disorders, substance abuse, and suicide potential. These conditions may have to be

[3] The author has chosen the acronym SMISOs to refer to individuals with severe and persistent mental illnesses. These individuals include adults living with a psychotic disorder, or those with Bipolar diagnoses who are also severely disabled as a result of their diagnoses (i.e., receiving or are eligible for state services as a result of their diagnoses). For a more detailed explanation of this term please refer to Parabiaghi, Bonetto, Mirella, Lasalvia & Leese, 2006).

dealt with before assessment or treatment for sexually abusive behavior is initiated (pp. 16-17)" and

(2) "Members who work with special populations have additional training working with these populations" (pp. 16-17).

The ATSA guidelines stipulate the importance of treating mental health issues first, before beginning the assessment and treatment of any sex offender and the importance of having *additional training* to help SOSTPs work with special populations. However, they do not provide either resources or details on how to obtain this training nor how to approach treating a sexual offender who has special needs (e.g., diagnosed with a severe and persistent mental illness such as schizophrenia). ATSA might assume that this additional training already exists, or perhaps that general training relative to mental health issues is adequate to address the needs of SMISOs.

The second source of information available to SOSTPs looking to guide their clinical practices with SMISOs is the sex offender literature to date. However, there are scant resources to guide their work in this area. In fact, most treatment programs rule out individuals with severe and persistent mental illness, leaving few programs that specifically work with this population (Marshall, Fernandez, Hudson, & Ward, 1998). In surveys of providers both in the US and around the world, little attention is given to SOSTPs who work specifically with SMISOs. For example, the *Current Practices and Trends in Sexual Abusers Management* (The Safer Society Foundation, Inc., 2009) is an annual survey given to sex offender treatment providers across the United States; yet, none of the respondents describes their programs as geared towards individuals with chronic mental illnesses. Marshall et al. (1998) provide additional information on a variety of programs around the world that address the needs of sex offenders. However,

none of the programs detailed in their book, address the needs of SMISOs. In fact, the majority of these programs actually *rule out treatment* for individuals with chronic mental illnesses.

There are sex offender-specific treatment programs that are designed to work with SMISOs (Guidry, 2001, 2004; Schwartz, 2004). However, these programs are designed primarily for state services (i.e., Department of Mental Health, Department of Corrections; these include both residential and non-residential programs). While principles associated with these programs were used to inform the development of the present SOSTP training curriculum for working with SMISOs, these models are not wholly transferable to the outpatient sex offender treatment system. These programs will be discussed in more detail later in this paper.

The few available resources that address treatment for SMISOs do so in passing. Houston and Gallow, 2008, discuss a program, based in the United Kingdom, which was designed to address to treat sex offender with a variety of mental illnesses. They noted that it had only a small percentage of individuals with severe and persistent mental illnesses (e.g., 14% were diagnosed with schizophrenia, most were diagnosed with mood disorders such as depression). Unfortunately, this review only offers readers a description of the program and an example of assessment and treatment protocols for the program geared toward working with SMISOs. This description is helpful to those seeking to understand what components of assessment or treatment may be useful in working with SMISOs (e.g., "childhood experiences," "sexual development," "mental health problems," and "personality functioning" p. 12-20). These factors are particularly applicable to SMISO individuals. However, this chapter does not give specific assessment approaches or interventions to help SOSTPs appropriately manage their clients.

Another resource is a book chapter entitled *Mental Illness and Sex Offending* (Berlin,

Saleh, & Malin, 2009). It provides an overview of the Axis I, II, and III diagnoses from the Diagnostic and Statistical Manual–Fourth Edition–Text Revised (DSM-IV-TR) of the American Psychiatric Association (APA; 2000) associated with paraphilic[4] behavior. It also presents a discussion of the systemic issues that arise when working with sex offenders with a host of mental health issues. However, this source still offers no information specifically related to sex offenders with severe and persistent Axis I disorders. In addition, its coverage of other mental illnesses offers too broad a discussion to give community-based SOSTPs guidance relative to structured interventions for their SMISO clients.

Based on a review of this literature, there appears to be a lack of sufficient, clear guidelines that are devoted to the outpatient assessment, treatment and management of sex offenders with severe and persistent mental illnesses from the primary professional organization (i.e., ATSA), as well as a lack of literature or continuing education resources designed to assist SOSTPs in making the best practice decisions for their outpatient clients with severe and persistent mental illnesses. This is especially true for SOSTPs in a community setting (as opposed to prison or jail, or state funded service settings). This paper presents a continuing education training curriculum created to equip SOSTPs in the outpatient, community mental health setting with the special skills needed to better address the assessment, treatment, and risk management needs of SMISOs in the community. First, this paper will discuss how a lack of resources for serving SMISOs is a problem for society at large; second, an overview of the SMISO population based on available research will be presented; third, a literature review of some of the current models used in sex offender treatment as well as treatment of SMISOs will be provided; and lastly, a description of the curriculum and evaluation procedures for a

[4] The author is using the word paraphilia to refer to DSM-IV-TR Paraphilic diagnoses, such as Exhibitionism, Fetishism, Frotteurism, Pedophilia, Sexual Masochism, Sexual Sadism, Transvestic Fetishism, and Voyeurism (American Psychiatric Association, 2001).

curriculum developed specifically to train outpatient SOSTPs in the specific treatment of SMISOs is proposed.

It is also hoped that additional training on working with SMISOs will help SOSTPs continue to process and reflect upon their own attitudes and countertransference in working with this population.

Why is this Gap in Training a Problem and Who is Affected?

As stated earlier, the sex offender-specific treatment field has overlooked the special needs of sex offenders with severe and persistent mental illnesses and failed to provide enough resources to SOSTPs regarding how to work with the SMISO population. There are four main groups who have suffered as a result of this gap in training: (a) the chronically mentally ill sex offender; (b) the mental health system that contains these individuals; (c) the society that supports the inpatient hospitals, jails, prisons, and other resources geared at containing the SMISO; and (d) survivors and potential victims of sexual assault.

SMISOs. The SMISO clearly suffers from this scarcity of treatment approaches directed at working with these specific issues. The programs that do exist are often located in prisons or state run hospitals making them not accessible to the larger community and they were not created with the intention of training SOSTPs in the community (L. Guidry, personal communication, November 23, 2009; Schwartz, 1998; The Safer Society Foundation, 2009). Without this professional training, individuals with a severe and persistent mental illness, who are also sex offenders, are likely not receiving treatment tailored to their specific needs. As such, they may be at increased risk for reoffending and its consequences (e.g., hopelessness and incarceration; L. Guidry, personal communication, November 23, 2009). Some benefits of a curriculum that could equip SOSTPs in the community setting to work with sex offenders with severe and persistent

mental illness are that more of these individuals could be served, the treatment could be more effective, and the risk management needs could be better addressed. At the same time, if the treatment needs of a SMISO is not sufficiently met, possible reoffending is a risk and with sex offending behavior that could be incredibly detrimental to society at large.

Outpatient Community-based Mental Health Systems. The outpatient community-based mental health systems that are currently working to contain and treat mental illnesses in the community (i.e., community mental health clinics, group homes, and clinicians in private practice, etc.) are not necessarily designed to address the needs of sex offenders with major mental illnesses. The circumscribed focus of the mental health system does not necessarily address the risk management needs of sex offenders, much less the specialized issues associated with SMISOs. However, many clinics are likely dealing with individuals displaying risky sexual behavior, hypersexuality, or paraphilic behavior, since these can be symptoms of mental illnesses. Again, the risk of not working to expand the knowledge and skills of outpatient providers around working with SMISOs is that the client or consumer reoffends. One major benefit of a curriculum designed to teach basic skills involved with working with SMISOs in the outpatient clinic is that treatment providers are likely to feel better equipped to deal with a variety of sex offending behavior. Another benefit is that the treatment may be more effective and therefore it may reduce the likelihood of reoffending. A third benefit is that a culture of reflection and processing around countertransference issues can be established as a result of the training in a given agency.

The Society. Inadequate treatment for the special needs mental health/sex offending population may result in a decrease in public safety. Programs could lose funding, public support, or be terminated based on a single high-profile case involving a chronically mentally ill

sex offender. A continuing education curriculum could fill the gaps in training for SOSTPs and could help SMISOs get the full array of services they require to recover and rehabilitate in order to function optimally and safely in society. In addition, the curriculum could contribute to increased public safety by improving the care and management of SMISOs in the community. Another benefit is that good treatment could lower rates of recidivism and prevent potential victimization.

Survivors and Potential Future Victims of Sexual Assault. In addition to the SMISO individuals themselves, the systems that manage them, and the general public, other major stakeholders in effectively treating SMISOs are survivors of sexual assault. This proposal emphasizes that the prevention of sexual abuse is always the most important goal in sex offender treatment. The sex offender treatment field was not developed to offer apologies or excuses for the acts of sexual violence committed by sex offenders, nor was it created to garner sympathy for these crimes. Instead, the sex offender treatment field exists because the early pioneers sought to understand, stop, and prevent sexual violence. In this light, rape prevention can be seen as a form of sex offender treatment and vice versa. As such, survivors of sexual abuse are the most important stakeholders in any sex offender treatment. A curriculum designed to address a gap in training within the sex offender treatment field, will directly benefit survivors of sexual assault by preventing future victimization. Not only would a curriculum increase the knowledge and skills of clinicians serving the SMISO population, but also it would help increase the number of clinicians capable of working with SMISOs. This would make treatment not only more effective but also more available.

Many segments of society would benefit from a curriculum designed to increase the ability of SOSTPs to serve the assessment and treatment needs of SMISOs in the community.

Such a curriculum and training could help prevent future victimization by optimizing the treatment outcome of SMISOs. By training clinicians in outpatient, community settings a curriculum training would also allow for treatment to be more widely available and increase SMISO access to treatment.

Overview of SMISO Population

Sex offenders living with severe and persistent mental illnesses represent a small but challenging portion of individuals charged with and convicted of sexual offenses. Some researchers have estimated that as few as 0.3% of men charged with rape had a psychotic illness (Henn et al. 1976). Other researchers (McElroy, Soutullo, Taylor, Nelson, et al., 1999) have found that up to 83% of their sex offender study participants had struggled with an Axis I disorder. However, the majority of these disorders were either substance abuse disorders (58%) or mood disorders (36%). Raymond, Coleman, Ohlerking, Chistenson, and Miner (1999) found high rates of Axis I disorders (lifetime rates of mood disorders were 67%) in their sample. They also found that only 2.2% of their sample carried a diagnosis of a psychotic disorder while another 2.2% of their sample carried a diagnosis of Bipolar Disorder. The above data would suggest that while sex offenders have particularly high rates of general mental health issues, most sex offenders do not struggle with lifetime psychosis or severe and persistent mental illness (Smith & Taylor, 1999). More research is needed to fully understand the SMISO population, since there have only been a handful of studies that even look at mental illness and sex offending behavior (L. Guidry, personal communication, November 2009).

Equally noteworthy, there are populations of individuals who are not convicted sexual offenders in the legal sense but who have problematic sexual behavior and have severe and persistent mental illnesses. One example would be individuals who have committed illegal acts

in institutional settings. This paper and the attached curriculum are not designed with these individuals specifically in mind, in large part due to the additional complicating factors involved with this particular group. One example of complicating factors might be the protection offered by institutional setting who serve clients who sex offending while in residences. Had they engaged in the same behavior outside the institution, they may have easily been convicted of a sexual offense. Little published research exists on this population, however, those who have mental illnesses and sexual behavior problems will likely share many traits with the SMISO population.

As stated earlier, what is known is that, in the prison setting, about 4.4% of all sex offenders have either a psychotic disorder or bipolar disorder (Raymond et al., 1999). According to the DSM-IV-TR (APA, 2000), "the prevalence of Bipolar I Disorder in community samples has varied from 0.4% to 1.6% (p. 385)." The DSM-IV-TR notes that about 0.5% to 1.5% of adults worldwide have diagnoses of Schizophrenia; but the data are lacking on other psychotic disorders, making prevalence difficult to estimate. It therefore appears that a slightly higher rate of severe and persistent mental illness exists in both the community and in the prison sample of sex offenders. But it is not known how many people would be sex offenders were they were not protected by institutional settings within the mental health system.

Overview of Sex Offender-Specific Treatment Literature

Sex Offender-Specific Treatment Providers

The Safer Society Nationwide Survey (The Safer Society Foundation, Inc., 1986 – 2009) is a survey conducted annually by the Safer Society Foundation. This project has collected data from sex offender treatment sites across the United States and Canada and compiled the results into a free online document. According to the 2009 Safer Society Nationwide Survey,

approximately 75% of the programs that treat sex offenders are located in the community while the other 25% are found in residential settings. Of the 75% of the community located treatment programs, about 69-78% were in private practices (from the United States results). This means that according to survey respondents, most of the treatment for sex offenders in the United States takes place in outpatient private practice settings. Another 15% of the treatment for adult male sex offenders takes place at community mental health centers.

The majority of respondents reported using treatment based on cognitive behavioral theory (65%), while others reported using the relapse prevention theory (14%). Around 5% of respondents reported using the Good Lives model (Ward & Maruna, 2007; Ward & Steward, 2003). Other models mentioned (in less than 3.1% of the cases) were: (a) multisystemic therapy, (b) Risk-Needs-Responsivity, (c), self-regulation, and (d) psychodynamic treatment. Many treatment programs reportedly integrate concepts from a variety of models.

Over the years many other models have been developed and used in treatment for sex offenders. However, this dissertation focuses attention on models of treatment most frequently mentioned in the above study and most commonly used today for the adult SMISOs. These include: (a) the Relapse Prevention model (RP; Pithers, Marques, Gibat, & Marlatt, 1983), (b) Cognitive-behavioral Therapy (CBT; Marshall, Anderson, & Fernandez, 1999; Williams, 1971); (c) the Self-regulation model (SR; Ward & Maruna, 2007), (d) the Risk-Need-Responsivity model (RNR; Andrews & Bonta, 2003; Ward & Maruna, 2007), and (e) the Good Lives model (GL; Ward & Maruna, 2007; Ward & Steward, 2003). The curriculum developed in this paper does include a problem solving tool from multisystemic therapy (MST), one of the most frequently used community models in the Safer Society Survey (2009). MST is a treatment that is intended for juveniles under the age of 17 (for more information see Letourneau, Borduin &

Schaeffer, 2009). Due to the focus on adolescence this literature review does not cover MST specifically. A brief overview of the roots of sex offender treatment and the treatment of sexual deviancy is also provided before discussing each specific model.

Sex Offender Treatment

According to Laws and Marshall (2003a), sex offender treatment today is strongly rooted in psychology and the early study of human sexuality and sexual deviancy. The authors stated that as early as 1886, Robert Von Krafft-Ebing wrote a book entitled *Psychopathia Sexualis*, which provided descriptions of deviant sexual behavior. A decade later, Freud discussed human sexuality and theorized that many of his patients had been sexually abused (Laws & Marshall, 2003a). Researchers such as Von Krafft-Ebing apparently rejected Freud's conjectures as did many of Freud's colleagues (Laws & Marshall, 2003b). Although Freud retracted this notion, it at least pointed to the fact that human sexuality and sexual deviancy were being thought of and investigated at the dawn of the field of psychology.

Since this time, there has been a subgroup of individuals who have worked to understand sexual deviancy. These individuals have developed a number of different theories about the etiology of sexual deviancy including what constitutes deviant sexual behavior. For example, much of the early research focused on eliminating the "deviant behavior" of what is now understood as non-deviant homosexuality. Eventually, in the second quarter of the 20th century, behaviorism[5] became an important paradigm in the understanding and treatment of deviant sexual behavior. Using concepts from behaviorism, clinicians used classical conditioning methods to try and modify sexually deviant behavior (Laws & Marshall, 2003b). At the same time, many of the states within the US enacted laws governing the sterilization of individuals

[5] Behaviorism refers to a psychological theory that behaviors are learned through interactions with the environment. Behaviorists belief that individual thoughts, feelings, and actions are all behaviors capable of modification. (Watson, Tolman, Titchener, & Lashley, 2009)

caught sexually abusing children or raping adults (Largent, 2007).

Sex offender treatment diverged from other forms of mental health treatment when treatment became not only a psychological issue but a legal issue, as well. When a person is sexually deviant and this deviancy impacts the human rights of another person (i.e., they rape, molest, or expose themselves to any another person), it becomes a legal issue. In addition, atypical deviant sexual behavior is in itself considered offensive or immoral to many individuals, further complicating the psychological and legal issues involved in sexual offending. Because of these issues, sex offender treatment has been influenced by and is imbedded in the criminal justice field, as well as the mental health.

Cognitive Behavioral Therapy. To parallel the trend in general psychology in the 1970s, sex offender treatment tended to shift its focus from straight behavioral techniques to the use of cognitive-behavioral techniques (Laws & Marshall, 2003b). Researchers and clinicians alike began to realize the importance of addressing cognitive processes in working toward changing their client's behavior (Laws & Marshall, 2003b). In other words, researchers at this time started to study the effects of working to sex education, increase victim empathy, or increasing self-esteem in sex offenders, as well as addressing their deviant arousal patterns through behavioral means. Also at this time, researchers began to realize the importance of improving offender social skills and increasing offender arousal to appropriate situations or individuals (Laws & Marshall, 2003b).

Cognitive-behavioral therapy in general views thoughts, behaviors, and actions as interconnected (Beck, 1995). SOSTPs used this model to help their clients recognize core beliefs and distorted cognitions that might impact offending behavior. These included areas like the offender's cycle of offending, their self-esteem, or their empathy for clients. Clinicians who

applied this model focused on changing thoughts, emotions, and therefore actions after distorted or dysfunctional cognitions are identified.

Relapse–Prevention Model. The Relapse–Prevention (RP) model grew out of the substance abuse treatment field and the early cognitive behavioral therapy field (Marlatt and Gordon, 1985). Marlatt and Gordon had been writing in the field of relapse and behavior change prior to their 1985 book entitled *Relapse Prevention: Maintenance strategies in the treatment of addictive behaviors* . The RP approach originally focused on behavior in general and was later adapted for treatment of substance abuse. Pithers et al. (1983) adapted this model for use with sex offenders. Their hypothesis was that, like substance abusers, sex offenders often re-offend, and the focus of treatment should be on the relapse phase of offending and avoiding sexual re-offense. The goal of RP is to help offenders identify the sequences of events that lead to relapse. RP sex offender treatment focuses on five main areas: (a) accepting responsibility for past offending behavior, (b) developing victim empathy, (c) learning their cycle of offending, (d) identifying high-risk situations, and (e) creating a relapse prevention plan (Laws, 1989).

This model assumes that offenders will face high-risk situations that will require them to mitigate their behavior and that offenders must learn how to recognize and avoid these high-risk conditions. The RP model was one of the first treatment models to give individuals specific strategies for in-the-moment interventions to help prevent relapse. In addition, it intuitively made sense to most treatment providers, despite the fact that it ultimately did not have positive empirical support (Cortoni, 2008). RP has more recently fallen out of favor in the sex offender treatment field partially because of the lack of empirical evidence of its effectiveness with sex offenders (Marshall & Anderson, 2006).

There was a time when RP was the standard of treatment for drug and alcohol use and

abuse treatment; however criticisms of the model have led to its decreased use in both substance abuse and sex offender treatment. Although this model provided straightforward, concrete interventions to be used by sex offenders to prevent relapse, some experts in the sex offender treatment field have criticized the emphasis in RP, on the relapse phase. In the 2000, book *Remaking Relapse Prevention: A Sourcebook* (Laws, Hudson, and Ward (eds.), a variety of authors in the field of sex offender-specific research criticize the usefulness of the relapse prevention model as it was originally applied to the sex offender field using Marlatt's (1985) model. Critics question some of the basic tenants of RP (specifically the abstinence violation effect or AVE, or the fact that working to prevent relapse perhaps should not be the target of treatment) as well as the lack of outcome studies on the effectiveness of this model on sex offenders. Additionally, how the model was applied to sex offenders has often meant changes in the integrity of the model. For instance, in the addiction field, RP views a lapse as when a person uses drugs or alcohol. In the sex offender field, a lapse has historically been viewed as when a person engages in behaviors that may trigger sex offending (i.e. looking at pornography, fantasizing about deviant sexual acts). These changes to the integrity of the model have been questioned by some critics. Addictions treatment providers have also critiqued RP as applied to substance abuse (Laws, Hudson, & Ward, 2000). In fact, Prochaska and DiClemente's (1997) research identified a process of change that is inconsistent with the RP model. The inconsistency results from RP's failure to consider motivational issues that influence relapse. In addition, the RP model focuses on relapse when perhaps it would be more effective to intervene at other points in the addiction cycle.

Self–Regulation Model. The Self–Regulation model (SR) of treatment was developed by Ward & Hudson (2000), largely in response to the limitations of the RP model. As such, Ward

and Hudson laid out four offense and relapse pathway goals associated with sex offending behavior (Lindsay, Ward, Morgan, & Wilson, 2007). These included: (a) avoidant–passive, (b) avoidant–active, (c) approach–automatic, and (d) approach–explicit. Avoidant–passive offenders will seek to avoid sexual offending "but lack the coping skills to keep it from happening (Lindsay, Ward, Morgan, & Wilson, 2007, p.38)." Avoidant–active offenders will also work toward the goal of not offending, but as they attempt to control their behavior, they end up using "ineffective" measures and this inadvertently leads to the behavior they are trying to avoid (Lindsay, Ward, Morgan, & Wilson, 2007, p. 38). Avoidant offenders in general may try to keep themselves from areas that they consider risky, or they may avoid looking at material that could provoke arousal. Approach–automatic offenders will seek to sexually offend in impulsive and unplanned ways. The approach–explicit offender will seek to sexually offend in clear and planned ways. An example of this approach is an offender who seeks out jobs to work with children because they are aroused by children. Today, the SR model laid the foundation and is often used in conjunction with the Good Lives Model (Ward & Maruna, 2007; Ward & Steward, 2003).

The SR model is largely an offense process descriptive model laid out to help explain why individuals re-offend but it gives no suggestions for treatment (Cortoni, 2008). Unlike RP, the SR model views offending as involving multiple dynamic factors as well as contextual factors. One of the strengths of this model is that there is some empirical evidence to support the idea of pathways to offending (Bickley & Beech, 2001; Lindsay, Ward, Morgan, & Wilson, 2006). In contrast to the RP model, the SR model recognizes that there are individuals who try to avoid reoffending. It seems logical that the different pathways to offending might differentiate treatment needs. However, because this model is conceptual rather than

intervention-focused, it offers no treatment guidelines, nor does it suggest how the model might impact treatment.

The Good Lives Model. The good lives model (GL) is a strength-based treatment approach for sex offenders developed from a mental health rehabilitation model (Ward & Steward, 2003). Unlike the other models presented here, the GL model was created specifically for sex offenders but it can be and has been used within the general criminal population for all types of offenders. It proposes that sex offenders share most of the characteristics, goals, and needs of all human beings. In other words, contrary to popular belief, non-sex offenders and sex offenders have a lot in common. This model is highly influenced by Shadd Maruna's (2001) work within the criminology field and his finding that those who have desisted from offending have done so by creating more fulfilling lives.

This theory integrates biological, psychological, and social factors in its understanding of sexual offending etiology. Unlike other models, the GL model assumes that sex offenders are goal-directed and not normally focused on risk avoidance. The central idea behind this treatment approach is to aid sex offenders in leading "good lives," achieved by emotionally supporting them and providing them with the skills and resources for obtaining social goods. Like the SR model (also developed by Ward), the GL model includes the concept of approach and avoidance goals. The primary goals involved in the model include: (a) knowledge, (b) excellence at play and work, (c) spirituality, (d) inner peace, (e) relatedness, and (f) life, (g) excellence in agency, (h) happiness, and (i) creativity.

This model defines knowledge as the seeking "wisdom" and information (Collie, Ward, Gannon, 2007, 195). Excellence at play and work is defined as when one has "mastery" of their experiences. Spirituality is defined as when people engage in the process of looking for meaning

in their lives. Inner peace is defined as "freedom from emotional turmoil and stress." The goal of relatedness encourages individuals to seek positive relationships with family, intimate partners, and friends. The life goal concentrates on emphasizing health and "optimal living." Excellence in agency defined as working towards "self-directed" behavior. The additional goals of happiness and creativity are self-defined by the author (Collie, Ward, Gannon, 2007).

Many of the key concepts developed in the GL model were responses to the lack of strength-based treatment in the sex offender-specific treatment models that preceded it. However positive the GL model may appear, it is still a fairly new model and has not been thoroughly researched and therefore lacks the empirical support to date (Cortoni, 2008). In addition, many practitioners and researchers alike view it more as a model for increasing motivation for treatment than as an actual treatment method itself (Cortoni, 2008). Critics of the GL model say that it is too complex, while others criticize its seemingly humanistic-psychodynamic conceptualization of sex offending behavior (Cortoni, 2008). In addition, this model is essentially useful for higher functioning offenders or those who do not also confront many external realities such as homelessness, residency restrictions, GPS tracking, and a host of other less than ideal circumstances such as major mental illnesses (Cortoni, 2008).

Despite these criticisms, the basic spirit of the GL model is a useful frame for working with all offenders, including sex offenders, and perhaps SMISOs even more specifically. The GL model stresses the importance of the therapeutic relationship and empathy for the client. In addition, its goal is to help sex offenders increase the extent to which they value prosocial goals over antisocial goals and, thus create more fulfilling lives that do not include sexual offending behavior. These goals reflect the values of the mental health field and therefore create a great bridge between the sex offender-specific treatment and mental health fields.

The models presented above do not address the complex and special needs of sex offenders with severe and persistent mental illnesses. In fact, none of the models presented were created specifically for the SMISO population. In their current forms, these models can be challenging to apply to individuals diagnosed with severe and persistent mental illnesses who might also struggle with cognitive limitations because some of the models require clients to be able to think through their offending cycle, read, write, predict problematic situations, or be able to identify high-risk situations. SMISO clients are likely to struggle with these skills because they are limited by their mental illnesses (e.g., command hallucinations, disinhibition, poor executive functioning in general, and lack of reading or writing skills). Many of these individuals will also struggle with overall cognitive disorganization.

Risk–Need–Responsivity Model. The Risk–Need–Responsivity (RNR) model was based in social psychology literature (Andrews & Bonta, 2006). It is principally influenced by the larger, more general criminology field and has recently been embraced by the sex offender treatment field (Ward & Maruna, 2007). The premise behind RNR is that treatment providers must first identify the individual's level of risk to reoffend, and then identify the treatment areas that may prevent future offending or mitigate that risk, and finally, provide treatment that focuses on those areas. RNR states that treatment providers should focus more of their resources on higher-risk individuals who are more likely to reoffend.

Within this model, the concept of "risk" is defined purely as the statistical likelihood of reoffending. Individuals are assessed based on static and dynamic risk factors and then treatment intensity is appropriately matched to an individual's criminogenic needs or dynamic factors associated with risk. Dynamic factors are factors associated with risk for sexual re-offense and may be amenable to change. They can include (a) positive and negative social influences, (b)

capacity for relationship stability, (c) emotional identification with children, (d) hostility toward women, (e) general social rejection, (f) lack of concern for others, (g) impulsivity, (h) poor cognitive problem solving, (i) negative emotionality, (j) sexual drive/preoccupation, (k) sex as coping, (l) deviant sexual interests, and (m) cooperation with supervision (Hanson, Harris, & Helmus, 2007). These factors have been empirically identified as having an association with sexual offense recidivism (Hanson et al., 2007).

Cortoni (2008) described the RNR model as one that focuses on shifting the balance of behavior from criminal to noncriminal activities. Unlike RP interventions, offenders learn "how to plan to handle" high-risk situations, rather than avoiding them, through role-playing and other methods. There are empirical studies and meta-analyses that demonstrate the usefulness of an RNR approach to reducing criminal recidivism (Hollin & Palmer, 2006b).

Sex Offender-Specific Programming and Severe Mental Illnesses

There are a few models identified in the sex offender-specific treatment field that were created specifically for working with individuals with severe and persistent mental illnesses. These include: (a) the MIPSB (mentally ill problematic sexual behavior) program operating out of the State of Massachusetts which was at one point directed by Dr. Laurie L. Guidry (2000), and (b) the JRI program, developed by Barbara Schwartz (2008), which is currently used in The Justice Resource Institute out of the Massachusetts Treatment Center.

Mentally Ill/Problematic Sexual Behavioral Program. In 2000, the Department of Mental Health (DMH) in Massachusetts initiated a program called MIPSB (mentally ill/problematic sexual behaviors). This program was developed by Guidry (2000) in response to the need for services for those with severe and persistent mental health issues and co-occurring sexual behavior problems. The Massachusetts DMH, being responsible for low or no income

individuals with mental health issues, saw the need for programming that addressed this specific population. The MIPSB program serves three main groups: (a) non-adjudicated individuals who had sexual violations in institutional settings, (b) those who have been charged but found not guilty of sex crimes for reasons of insanity (NGRI), or (c) those that have served time in prison for sexual crimes and are registered sex offenders with mental illnesses. This program primarily serves males and individuals over the age of 18.

The MIPSB program was created with a network of residences at hand, provided through the DMH. In other words, the program had access to group homes, shelters, and inpatient hospital settings that are associated with the DMH. Clients are referred to the program, assessed thoroughly, and then provided with pharmacological as well as individual and group treatment. The key to the MIPSB program lies mainly in the assessment process. This process leads to a report that often contains a full record review, collateral information, a clinical interview, and a range of psychological measures, including a penile plethysmograph and other measures geared towards determining deviant arousal patterns. The assessment also looks at individual risk factors for reoffending with each client. The information and recommendations derived from the comprehensive assessment is then used to create an individualized treatment.

The individual and group treatment provided in this model use three phases as well as a Dialectical Behavioral Therapy group. Phase I of treatment focuses on social skill development. This phase is important in allowing clients to feel comfortable and safe in sharing their life histories and sexual behaviors. Phase II focuses more specifically on inappropriate sexual behaviors and relapse prevention, while Phase III focuses on maintenance of treatment gains. Clients are also involved in pharmacological treatment to help manage their severe and persistent mental illnesses. The MIPSB does presently exclude clients who have high scores for

psychopathy on Hare's Psychopathy Check List (PCL; Hare, 2003).

This program has been quite successful in its ten years (L. Guidry, personal communication, December 2010) . It provides clients with social skills, a team of clinicians, and regular management of their specific factors associated with their own risk for a re-occurrence of problematic sexual behavior. These clients often need case management in addition to clinical interventions and the program provides this level of supervision. It also allows clients to have individualized treatment that really takes into account their past histories, their level of social skills, and their mental health concerns. It assumes that treatment and management are possible with even those suffering the severest mental illness.

Although this program seems to manage SMISOs well, it only works with SMISOs who have access to the Department of Mental Health resources. It serves mainly individuals living in group homes or inpatient settings. This means that it does not fully address the community's needs of providing this treatment for individuals who are community based and involved in outpatient clinics.

Justice Resource Institute Program. Since the early 1990s, the Justice Resource Institute (JRI) of Massachusetts has been serving the treatment and management needs of sex-offenders who pose problems to other agencies (Schwartz, 2008). The JRI developed a model for addressing the needs of females, males, adolescents, adults, mentally ill, and developmentally disabled sex offenders. In addition, their model is also intended to work with sex offenders deemed as psychopathic sex offenders. It even includes those individuals who have not been charged or convicted of their sexual offenses, but display inappropriate sexual behaviors. This model takes into account a person's deviant arousal patterns (i.e., Are they violent?; Do they groom victims?; How do they select victims?) and their functional

impairment. These two concepts are seen as continuums and treatment is determined based on a matrix that takes into account an offender's level of deviance and level of functional impairment. For example, Schwartz (2008) argued that those with higher level of functional impairment should only receive individual therapy, while those with higher functioning should be in group treatment as opposed to individual treatment. Treatment is, thus, individualized.

This model currently serves individuals with severe and persistent mental illness in hospital and residential settings where there is a high level of supervision and care. Like the MIPSB model it is not intended to work with individuals who are receiving treatment in the community. In addition, it confounds those with severe and persistent mental illness with those who have developmental disabilities. On the scale of functional impairment, the two groups are lumped together and their treatment is presumed to be the same. Some individuals with severe and persistent mental illness may make wrong choices because of their illnesses; however, their mental illness may make them intermittently functional. In addition, many individuals with severe and persistent mental illness can, in theory, benefit from a group dynamic where they can practice their social skills.

This model does recognize that there are differences in treatment with sex offenders who have specialized needs. It also provides a straightforward way to tailor the treatment needs of SMISOs. In addition, this model asks practitioners to look at several domains such as past trauma, family issues, and spirituality that are often overlooked in other sex offender treatment programs.

After careful examination of the different treatment models for adult sex offenders, the developed curriculum pulls from the Good Lives Model and the MI/PSB model in particular, to train SOSTPs in an outpatient community setting (recognizing that both of these models

integrate many concepts from other useful models). The following section will articulate these tools into an integrative training program for sex offender treatment focusing on sex offenders with severe and persistent mental illness. Due to its integrative nature, this program would benefit beginning clinicians by expanding their skill and strategy sets, rather than circumscribing them to a particular model, to the detriment of other valid, effective forms of treatment.

Methods

This paper presents a 7-hour continuing education curriculum to train beginning sex offender-specific treatment providers (SOSPTs) working in a community setting. It teaches participants how to assess, treat, and manage sex offenders with severe and persistent mental illness (SMISOs). This curriculum adapts the Mentally Ill/Problematic Sexual Behavior Program (MIPSB; Guidry, 2000) as well as concepts from the Good Lives Model (Ward & Steward, 2003) to address the previously stated gap in training. These two models were chosen because they are easily integrated into mental health treatment due to their strengths-based nature and in the way they align with the values and culture of the mental health field. In addition, since strengths-based and client-centered work seems to have demonstrated efficacy in the outpatient setting, it seems appropriate to integrate similarly valued sex offender treatment models (Hubble, Duncan, Miller, 1999). The curriculum addresses three major areas of didactics: (a) the cultural differences between the mental health and sex offender-specific fields, (b) necessary adaptations to assessment, and (c) specialized treatment considerations. The curriculum was designed primarily to train clinicians on how to work with individuals who have sexual behavioral problems as part of their symptom presentation of a mental illness. However, even clinicians working with a sex offender with an underlying paraphilia would likely benefit from such a training.

Who is Eligible to Attend the Training?

This curriculum is intended to train master's or doctoral level clinicians who serve sex offenders in community settings. These individuals would be clinicians or have clinical training and not likely be probation officer or parole officers. The training is intended for SOSTPs who have the following: a) a basic understanding of sex offender treatment (cognitive behavioral treatment and the use of assessment) and, (b) some experience in working with sex offenders, although this experience can be limited. It would be expected that participants could complete an intake interview, run a group for sex offenders, be familiar with at least one model of sex offender treatment, and be familiar with current trends in the field. This training is intended for beginners in the sex offender-specific field, however, it may be relevant for individuals at all level of training and experience.

Who Will Present the Curriculum?

Those qualified to present or teach the curriculum would have a master's degree or doctorate in a related mental health field (e.g., psychology or social work), and would have experience working directly with individuals with severe and persistent mental illnesses. They would also have to be well versed in sex offender-specific treatment field and with the current trends in this field. It is important that trainers be able to solve problems on multiple levels if presented with questions by the participants and having experience may be the best way to allow them to do so.

Competency-Based Curriculum Development

Many psychological training programs have adopted a competency-based model in order to develop and assess curricula for their students (Borden & McIlvried, 2010). Epstein and Hundert (2002) defined competence as "the habitual and judicious use of communication,

knowledge, technical skills, clinical reasoning, emotions, values, and reflections in daily practice for the benefit of the individual and community being served" (p. 227). The concept of competency comprises three areas: knowledge, skills, and attitudes. Each one of these is learned and developed throughout the course of a training program. The SMISO curriculum was developed using this model. The curriculum focuses on the following goals: (a) Expanding participants' knowledge of options to meet assessment and treatment needs for SMISOs, (b) improving participants' attitudes towards SMISOs during treatment, and (c) improving participants' assessment and treatment skills when working with SMISOs. For a more detailed explanation of the individual competencies within each of these areas please refer to Appendix B.

The SMISO curriculum is a didactic program designed to be presented to a small group of less than 12 individuals to allow participants to become competent through the learning of knowledge as well as through the practicing of skills (learned through the group work). Participants will also learn about attitudinal shifts that may be necessary to be more effective with the SMISO population.

Effective Training

In addition to the competency training model, the curriculum incorporates ideas presented by Fauth et al. (2007) on effective psychotherapy training. Fauth et al. described two main components of effective training: "a (a) limited number of 'big ideas' and (b) psychotherapist metacognitive skill development via experiential practice. (p. 385)." The authors also recommended that any training take into account the culture of the group it serves. In the case of the SMISO curriculum, I recognize the differences between the culture of SOSTPs versus the culture of mental health providers. Fauth et al. also recommended that ongoing supervision in

the area of training is necessary for effective and long-term integration of psychotherapy skill development. The curriculum presented below will utilize the concept of having a few main ideas as well as small group activities throughout the training to help participants internalize the material.

Curriculum Description

The 7-hour curriculum to teach sex offender-specific treatment providers how to work with sex offenders with severe and persistent mental illness is divided into three sections. Each section is presented in Powerpoint format and consists of didactic as well as experiential group activities. The first section will cover cultural differences between those in the mental health and the sex offender-specific fields as well as an introduction to the SMISO population. This section is approximately one hour in length. The second section covers adaptations to assessment. In this section trainers will cover basic concepts in sex offender assessment as well as some of specific assessment items that may improve understanding when working with those living with severe and persistent mental illnesses. The goal of this section is to help participants learn tools to assess for mental illnesses, including the assessment of additional needs of their clients with severe and persistent mental illnesses as well as differential diagnostic issues that may arise. The assessment section was developed to help increase effective screening for severe and persistent mental illnesses as well as to address differential diagnoses issues. This part of the curriculum is approximately two and a half hours in length. The third section covers adaptations to treatment and management of SMISOs and is approximately two and a half hours in length. This section will focus on treatment considerations and adaptations to help manage and work with individuals with severe and persistent mental illnesses, and it will provide concrete tools for clinicians to use. See Appendix C for the full curriculum.

Before providing a description of each section, it is important to note that the training is intended to have an informal atmosphere. The curriculum encourages the participants to ask questions as the training unfolds and expects the trainer to adapt the training to the specific needs of the participants. Because the trainer will collect information at the beginning of the training in regard to what each individual would like to learn, the trainer will have the ability to skip through some slides quickly and focus more time on other slides as necessary. In addition, the training is intended be respectful of the knowledge of the participants. It is important that the trainer note throughout that the participants have experience working with sex offenders and to validate their experience and mental health, psychology, or social work graduate training. It is also important that the trainer be able to provide examples, and display a lighthearted spirit while conducting the training. I believe this is important to keep the participants engaged in the training and the information.

Section I: Introduction

The introduction portion of the curriculum provides an overview of the SMISO population. This includes limited data on sex offenders and mental illnesses, and basic symptoms common in severe and persistent mental illnesses. In addition, this part of the training covers the legal terminology specific to offenders with a mental illness (e.g., not guilty by reason of insanity [NGRI]). The introduction also serves to help illuminate some of the cultural differences between the sex offender-specific field and the mental health field. Participants are asked to work in small groups as they consider and then verbally reflect on their personal feelings about situations in a provided vignette (See Appendix D for vignette).

Section II: Assessment

The second part of the curriculum focuses on assessing sex offenders with severe and persistent mental illness. This part of the training is influenced by the Mentally Ill/Problematic Sexual Behavior program (Guidry, 2007, 2008) as well as by The Good Lives Model (Ward & Steward, 2003). Participants will learn about the following: (a) the consent process, (b) systemic treatment, (c) assessment of severe and persistent mental illnesses and mental status, (d) and strength-based questions (i.e., Good Lives' focused, Ward, Mann, & Gannon, 2007). In addition, the participants will learn about the advantages of using a risk assessment measure, as well as some of the barriers to completing self-report measures or using penile plethysmographs with clients who have mental illnesses. Participants will also learn the limits to assessment based on training of the SOSTP.

Section III: Treatment

Section III of the curriculum focuses on teaching participants how to use the information gathered in the assessment phase to help them individualize treatment for their SMISO clients. This section starts off by presenting a treatment stance of working with SMISO clients that is influenced by the recovery model of mental health treatment (Fischer & Happell, 2009; Warner, 2009). In addition, this part of the training focuses on consent issues, substance abuse issues, trauma issues, and working with the client system. The third part of the training covers specific interventions.

Curriculum Evaluation

In order to evaluate how well the curriculum improves competencies of its participants, participants are asked to complete four self-report measures during the training. The first three measures are given after each section is presented. Each includes the same questions: (a) What

part of this section did you find most helpful in your learning process? (e.g., small group activities, power point didactic, discussion and questions, references), (b) What part of this section do you think could have been improved? (e.g., content, skills of presenter, small group activities, etc.), and (c) What three things you will take away from this section and use in your work? In addition, participants are asked to add additional comments at the bottom of the anonymous evaluation.

The assessment takes approximately 5-7 minutes to complete and it covers how well the curriculum was able to help each participant (Appendix E). At the end of training, participants are asked to complete a self-report measure to assess the usefulness of the entire training program (Appendix F). These measures will be used to improve future training curricula. For instance, if the majority of participants respond that the small group activities were very helpful and where most of the learning took place, then the training might be adapted to include more time in small group activities. If, however, participants responded that they did not learn very much from the didactic portion of the training, adaptations would be made to better address the needs of the participants. This will allow the curriculum to be constantly assessed and changed as needed. In addition, this process assesses the knowledge and attitudes learned by each participant and serves to reinforce learning by asking participants to think about how they will use what was learned in practice and what their main "take aways" were.

Discussion

This paper presented the development of a continuing education curriculum intended for sex offender-specific treatment providers (SOSTPs) in the community-based mental health setting who may serve sex offenders diagnosed with severe and persistent mental illnesses. The population of SMISOs requires individualized and specialized treatment that is informed by both

the sex offender-specific and mental health fields. However, currently there is scarce literature that addresses the complex assessment, treatment, and management needs of the SMISO population. In addition, the sex offender-specific treatment models that were created to address sex offenders with major mental illnesses are not necessarily intended to apply in the outpatient community mental health setting. The goal for those completing this curriculum training is to improve their clinical effectiveness and better serve the needs of the SMISO population.

One of the limitations of the developed curriculum is that it is largely didactic. Research on psychotherapy training has shown that this method is rather ineffective because it does not "durably improve the effectiveness of psychotherapy" (Fauth et al., 2007, p. 384). What this means is that, although it may improve training participant's adherence to a model or theme while participants are in training, in the long run it does not improve psychotherapists' "effectiveness beyond the training period itself" (p. 384). According to Fauth et al., successful training often has a component of the curriculum that occurs after the initial training has been completed. This can be in the form of ongoing supervision focused on the area of training. This curriculum does not include supervised training; however, it could easily be adapted to include a supervision component. One way to remedy this limitation of the curriculum is to provide ongoing consultation options to those interested after their training has ceased. In addition, references for supervision with this particular population could be provided to interested participants.

Another limitation of this project is that it was not developed based on an assessment of treatment provider needs. As such, it covers a broad array of topics from basic mental illness symptoms to systemic treatment. The training was created assuming that participants have a broad background and some may not have any experience working with severe and persistent

mental illnesses. This limitation caused the training to lack some depth in covering specific issues with SMISOs. I have tried to provide some concrete examples of intervention strategies, but recognize that this curriculum only touches the surface of treatment with SMISOs.

The evaluation design is limited in that it does not give a true idea of how much participants learned in the curriculum. The easiest way to assess for learning would be to give a pre- and posttest to participants or to observe and evaluate role plays of assessment or treatment with SMISOs clients. I opted to refrain from both of these assessment options. I assume that paying participants would not likely engage in the idea of having their knowledge evaluated in a test format and that this might impede buy-in to the training. For this same reason, mandating that clients participate in evaluated role plays would likely cause consent issues and undue stress to participants.

Instead of the above options, I have opted to utilize evaluation procedures similar to those used by universities to evaluate courses after their completion. These measures look at the participant's points of view exclusively, and, curricula are modified based on this information.

Although this project does have limitations, it also has many strengths that could serve the field of psychology and the field of sex offender-specific treatment. First, the developed curriculum provides basic skills to those learning how to work with severe and persistent mental illness. Clinicians who work to develop these skills will likely better serve all clients as they will be better able to identify and work with all levels of mental illnesses. Second, this project aims to fill in a gap of training, and by doing so, provides the field with more competent practitioners who can provide more comprehensive treatment to all offenders. This will positively impact both society and the field of psychology. These two factors alone create reason enough to pursue the training of SOSTPs to work with individuals with severe and persistent mental illnesses.

References

Abel, G.G., Becker, J.V., Cunningham-Rathner, J., Mittelman, M., & Rouleau, J. L. (1988). Multiple paraphilic diagnoses among sex offenders. *Bulletin of the American Academy of Psychiatry and the Law, 16,* 153-168.

Abel, G. G. (1989). Paraphilias. In H.I. Kaplan & B. J. Sadock (Eds.), *Comprehensive Textbook of Psychiatry V (pp.1069-1085)*. Baltimore: Williams & Wilkins.

Abel, G.G., & Osborn, C. (1992). The paraphilias: The extent and nature of sexual deviant and criminal behavior. *Clinical Forensic Psychiatry, 15,* 675-687.

Ahlmeyer, S., Kleinsasser, D., Stoner, J., & Retzlaff, P. (2003). Psychopathology of incarcerated sex offenders. *Journal of Personality Disorders, 17,* 306-318.

American Psychiatric Association. (2000). *Diagnostic and statistical manual (4th ed.) (revised)*. Washington, DC: American Psychiatric Association.

Andrews, D.A. (1983). Assessment of outcomes in correctional samples. In M.L. Lambert, E.R. Christensen, & S.S. DeJulio (Eds), *The Measurement of Psychotherapy Outcome in Research and Evaluation* (pp.160- 201). New York: John Wiley & Sons.

Andrews, D.A. (1989). Recidivism is predictable and can be influenced: Using risk assessments to reduce recidivism. *Forum on Correctional Research, 1*, 11-18.

Andrews, D.A. (2001). Principles of effective correctional programs. In Motiuk, L.L., & M.C. Serin. (Eds.), *Compendium 2000 on Effective Corrections, 1*, 9-17.

Andrews, D.A. & Bonta, J. (2003). *The psychology of criminal conduct*. Cincinnati, Ohio: Anderson.

Andrews, D.A. & Dowden, C. (2006). Risk principle of case classification in correctional treatment: A meta-analytic investigation. *International Journal of Offender Therapy and*

Comparative Criminology, 50, 88-100.

Association for the Treatment of Sex Offenders. (2004). *Association for the treatment of sex offenders practice standards for evaluation, treatment and management.* USA: Association for the Treatment of Sex Offenders.

Bader, S. M., Schoeneman-Morris, K. A., Scalora, M., & Cassidy, T.K. (2008). Exhibitionism: Findings from a Midwestern police contact. *International Journal of Offender Therapy and Comparative Criminology, 52,* 270-279.

Baker, M., & White, T. (2002). Sex offenders in high-security care in Scotland. *The Journal of Forensic Psychiatry, 13*, 25-297.

Beck, J. (1995). Cognitive Therapy: Basics and beyond. New York: The Guilford Press.

Berlin, F.S., Saleh, F. M., & Malin, H. M. (2009). Mental illness and sex offending, In F.M. Saleh, A.J. Grudzinskas, J.M. Bradford, & D.J. Brodsky (Eds.), *Sex offenders: Identification, risk assessment, treatment, and legal issues.* (pp. 119-129). New York: Oxford University Press.

Bickley, J., Beech**,** A. R. (2001). Classifying child abusers: Its relevance to theory and clinical Practice. *International Journal of Offender Therapy and Comparative Criminology,1,* 51-62.

Blackburn, M. (2002). *Sexuality and disability*. Boston: Butterworth/Heinemann.

Blasingame, G. D. (2005). *Developmentally disabled persons with sexual behavioral problems (2nd ed.).* USA: Gerry D. Blasingame & Wood 'N' Barnes Publishing.

Borden, K. & McIlvried, E. J. (2010). Applying the competency model to professional psychology education training, and assessment: Mission Bay and beyond, In R. Peterson (Ed.), *The competency based education for professional psychology*. (pp 43-53).

Washington, D.C.: American Psychological Association.

Bryan, J., Davey, L., & Casey, S. (2006). The process of change in offender rehabilitation programmes. *Psychology, Crime, & Law, 12*, 473-487.

Buckley, P.F. (Ed.) (1999). Sexuality and serious mental illness. Canada: Harwood Academic Publishers.

Carich, M. S., & Mussack, S. E. (Eds.) (2001). *Handbook for sexual abusers assessment and treatment.* Brandon, VT: Safer Society Press.

Cortoni, F. & Carich, M.S. (2007). The how and why of building coping skills in treatment. In D. Prescot (Ed.), *Applying Knowledge to practice: Challenges in the treatment and supervision of sexual abusers* (pp. 222-238). Oklahoma City, OK: Wood'N'Barnes.

Cortoni, F. (2008). Making sense of treatment models. Association for the Treatment of Sexual Abusers Conference. Atlanta, Georgia.

Craissati, J., & Hodes, P. (1992). Mentally Ill sex offenders: The Experience of a regional secure unit. *British Journal of Psychiatry, 161*, 846-849.

Devon, T.W., Polaschek, L.L., & Beech, A.R. (2006). *Theories of sexual offending*. Hoboken, NJ: John Wiley & Sons Inc.

Dowden, C., Andrews, D.A. (2004). The importance of staff practice in delivering effective correctional treatment: A meta-analytic review of core correctional practice. *International Journal of Offender Therapy and Comparative Criminology,* 48, 203-214.

Drake, C.R., & Pathe, M. (2004). Understanding sexual offending in schizophrenia. *Criminal Behaviour and Mental Health, 14,* 108-120.

Dunsieth, N.W., Nelson, E.B., Brusman-Lovins, L.A., Holcombs, J.L., Taylor, P.T., Soutullo, C.A, & McElroy, S.L. (2004). Psychiatric and legal features of 113 men convicted of

sexual offenses. *Clinical Psychiatry*, *65*, 293-300.

Epstein, R. M., & Hundert, E. M. (2002). Defining and assessing professional competence. *Journal of the American Medical Association, 287,*226–235.

Fauth, J., Gates, S., Vinca, M. A., Boles, S., & Hayes, J. (2007). Big ideas for psychotherapy training. *Psychotherapy: Theory, Research, Practice, Training, 44*, 384-391.

Finkelhor, D., Araji, S., Baron, L., Browne, A., Peters, S.D., & Wyatt, G. E. (1986). *A sourcebook on child sexual abuse*. Thousand Oaks, CA: Sage.

Fisher, J.E., & Happell, B. (2009). Implications for evidence-based practice in mental health nursing. *International Journal of Mental Health Nursing, 18*, 179-185.

Forgac, G. E., Cassel, C. A., & Michaels, E. J. (1984). Chronicity of criminal behavior and psychopathy in male exhibitionists. *Journal of Clinical Psychology, 40*, 827-832.

Garfinkel, S. & Liberzon, I. (2009). Neurobiology of PTSD: A review of neuroimaging findings. *Psychiatry Annals, 39 (6),* 370-372.

Grisso, T. (2000). Ethical issues in evaluations for sex offenders re-offending. Invited Address for Sex Offender Re-Offence Risk Prediction Seminar. Madison, Wisconsin.

Grossman, L.S., & Cavanaugh, J.L. (1989). Do sex offenders minimize psychiatric symptoms? *Journal of Forensic Sciences. 34,* 881-886.

Guidry, L. L. (2000, fall). *Addressing the victim/perpetrator dialectic: A treatment for sexually victimized sex offenders*. Presentation given in Psychopathology class, Keene, New Hampshire: Antioch University.

Guidry, L.L. (2009). Sex offender-specific treatment: historical foundations, current challenges, and contemporary approaches, In J. T. Andrade (Ed.) *Handbook of violence risk assessment and treatment* (pp. 179-220). New York: Springer Publishing Company.

Guidry, L.L. & Saleh, F. (2004). Clinical considerations of paraphilic sex offenders with comorbid psychiatric conditions. *Sexual Addiction and Compulsivity,11*, 21-34.

Hanson, R.K., & Bussiere, M.T. (1998). Predicting relapse: A meta-analysis of sexual offender recidivism studies. *Journal of Consulting and Clinical Psychology, 66,* 348-362.

Hare, R. D. (2003). *Manual for the Revised Psychopathy Checklist (2nd ed.).* Toronto, ON, Canada: Multi-Health Systems.

Harrigan, S.F., McGorry, P.D., & Krstev, H. (2003). Does treatment delay in first episode psychosis really matter? *Psychological Medicine, 33*, 97-110.

Hartwell, S. (2003). Short-term outcomes of offenders with mental illness released from incarceration. *Journal of Offender Therapy and Comparative Criminology, 47,* 145-158.

Heilbrun, K., Nezu, C.M., Keeney, M., Chung, S., & Wasserman, A.L. (1998). Sexual offending: linking assessment, intervention and decision making. *Psychology, Public Policy, 4,* 138-174.

Henn, F., Herjinic, M., &Vanderpearl, R.H. (1976). Forensic psychiatry : Two types of sex offenders. *American Journal of Psychiatry, 133*, 694-696.

Hilarski, C., & Wodarski, J. (Eds.) (2006). *Comprehensive mental health practice with sex offenders and their families.* New York: The Hawthorn Press.

Hollin, C.R., & Palmer, E.J. (2006b). Offender behaviour programmes: Controversies and resolutions. In C.R. Hollin, & E.J. Palmer (Eds.), *Offending behavior programmes: Development, application, and controversies* (pp. 247-278). Chichester, UK: Wiley & Sons.

Houston, J. & Galloway, S.(eds.) (2008). *Sexual offending and mental health: Multidisciplinary management in the community.* London: Jessica Kingsley Publishers.

Hubble, M. A., Duncan, B. L., & Miller, S. D. (Eds.) (1999). *The heart and soul of change: What works in therapy.* Washington, DC: American *Psychological Association.*

Hudson, S. M., Ward, T., & McCormick, J. (1999). Offense pathways in sexual offenders. *Journal of Interpersonal Violence, 14,* 779-798.

Hyde, J., & DeLamater, J. (2007). *Understanding Human Sexuality*. New York: McGraw.

Ilgen, M. A., Burnette, M. L., Conner, K., Czyz, E., Murray, R., & Chermack, S. (2010). The association between violence and lifetime suicidal thoughts and behaviors of individuals treated for substance use disorders. *Addictive Behaviors, 35*, 111-115.

Jackson, R.L., & Richards, H.J. (2007). Diagnostic and risk profiles among civilly committed sex offenders in Washington state. *International Journal of Offender Therapy and Comparative Criminology, 51,* 313-323.

Jones, B., Huckle, P., & Tanaghow, A. (1992). Command hallucinations, schizophrenia and sexual assaults. *Irish Journal of Psychological Medicine, 9,* 47-49.

Kafka, M.P., & Prentky, R.A. (1993). Preliminary Observations of DSM-III-R Axis I comorbidity in men with paraphilias and paraphilia-related disorders. *Journal of Clinical Psychiatry, 55*, 481-486.

Kafka, M. P., & Prentky, R. (1992). A comparative study of nonparaphilic sexual addictions and paraphilias in men. *Journal of Clinical Psychiatry, 53,* 345-350.

Kafka, M. P., & Prentky, R. (1997). Compulsive sexual behavior characteristics. *The American Journal of Psychiatry, 154*, 1632.

Kafka, M.P., & Prentky, R.A. (1998). Attention-Deficit/Hyperactivity Disorder in males with paraphilias and paraphilia-related disorders: a comorbidity study. *Journal of Clinical Psychiatry, 59,* 388-396.

Largent, A. (2007). *Breeding Contempt: The history of coerced sterilization in the United States*. New Jersey: Rutgers Press.

Laws, D.R. (Ed.) (1989). *Relapse prevention with sex offenders*. New York: Guilford Press.

Laws, D.R., Hudson, S.M., & Ward, T. (Eds.)(2000). *Remaking relapse prevention with sex offenders: A sourcebook.* New York: Sage.

Laws, D. R., & O'Donohue, W.T. (2008). *Sexual Deviance: Theory, assessment and treatment (2nd ed.).* New York: The Guilford Press.

Laws, D. R., & Marshall, W. L. (2003a). A brief history of cognitive and cognitive behavioral approaches to sex offenders: Part One early developments. *Sexual Abuse: Journal of Research and Treatment, 15,* 75-92.

Laws, D.R., & Marshall, W. L. (2003b). A brief history of cognitive and cognitive behavioral approaches to sex offenders: Part two the modern era. *Sexual Abuse: Journal of Research and Treatment, 15,* 93-120.

Laws, D.R., Hudson, S.M., & Ward, T. (2000). *Remaking relapse prevention with sex offenders: A sourcebook*. Sage Publications: New York.

Lee, J.K., Pattison, P., Jackson, H.J., & Ward, T. (2001). The general, common, and specific features of psychotherapy for different types of paraphilias. *Criminal Justice and Behavior, 28,* 227-256.

Letourneau, E. J., Borduin, C. M., & Schaeffer, M. (2009). Multisystemic therapy for youth with problem sexual behaviors, In A. Beech, C. Leam, K. Browne (Eds.) *Assessment and treatment of sex offenders: A handbook*. New York: John Wiley & Sons Ltd, 2009. pp. 453-472.

Lindsay, W.R., Steele, L., Smith, A.H.W., Quinn, K., & Allan, R. (2006). A community forensic

intellectual disability service: Twelve year follow up of referrals, analysis of referral patterns and assessment of harm reduction. *Legal and Criminological Psychology, 11*, 113-129.

Lindsay, W.R., Smith, A.H.W., Law, J., Quinn, K., Anderson, A., Smith, A., & Allan, R. (2004). Sexual and nonsexual offenders with intellectual and learning disabilities. *The Journal of Interpersonal Violence, 19*, 875-890.

Lindsay, W.R., Ward, T., Morgan, T., & Wilson, I. (2007). Self-regulation of sex offending, future pathways and the good lives model: Applications and problems. *Journal Of Sexual Aggression, 13,* 37-50.

Marlatt, A. & Gordon, J. (1985). *Relapse Prevention: Maintenance strategies in the treatment of addictive behaviors.* New York: The Guilford Press.

Maletzky, B.M., & Steinhauser, C. (2002). A 25 year followup of cognitive behavioral therapy with 7275 sexual offenders. *Behavior Modification, 26,* 123-147.

Marshall, W. L., Fernandez, Y. M., Hudson, S. M., Ward, T. (Eds.) (1998). *Sourcebook of treatment programs for sexual offenders.* New York: Plenum Press.

Marshall, W. L., Anderson, D., &Fernandez, Y. (1999). *Cognitive behavioural treatment of sexual offenders.* New York: John Wiley & Sons, LTT.

Marshall, W. L., Fernandez, Y. M., Marshall, L.E., & Serran, G.A. (2006). *Sexual offender treatment: Controversial issues*. Hoboken, NJ: John Wiley & Sons Inc.

Marshall, W. L., Marshall, L. E., Serran, G. A., & Fernandez, Y. M. (2006). *Treating sexual offenders: An integrated approach.* New York: Routledge.

Marshall, W. L., Marshall, L. E., Serran, G.A., & O'Brien, M.D. (2011). *Rehabilitating sexual offenders: A strength based approach*. Washington D.C.: American Psychological

Association.

Marques, J.K., Wiederanders, M., Day, D.M., Nelson, C., & van Ommeren, A. (2005). Effects of a relapse prevention program on sexual recidivism: Final results from California's sex offender treatment and evaluation program. *Sexual Abuse: A Journal of Research and Treatment, 17,* 79-107.

Maruna, S. (2001). *Making good: How ex-convicts reform and rebuild their lives*. Washington, DC: American Psychological Association.

Maruna, S. & Immarigeon, R. (Eds.). (2008) *After crime and punishment: Pathways to offender reintegration.* New York: Willan Publishing.

McElroy, S.L., Soutullo, C.A., Taylor, P., Nelson, E.B., Beckman, D.A., Brusman, L.A., Ombaba, J.M., Strakowski, S.M., & Keck, P.E. (1999). Psychiatric features of 36 men convicted of sexual offenses. *Journal of Clinical Psychiatry, 60,* 414-420.

Melton, G. B., Petrila, J., Poythress, N. G. & Slobogin, C. (2007). *Psychological evaluations for the courts: A handbook for mental health professionals and lawyers. (3rd. ed.)* New York: The Guilford Press.

Morin, J. W. & Levenson, J. S. (2008). Exhibitionism: Assessment and treatment. In R. D. Laws, & W. T. O'Donohue (Eds.). *Sexual Deviance: Assessment and Treatment.* New York: Guilford Press. 76-107.

Nelson, E., Brusman, L., Holcomb, J., Soutullo, C., Beckman, D., Welge, J.A., Kuppili, N., & McElroy, S.L. (2001). Divalproex sodium in sex offenders with bipolar disorders and comorbid paraphilias: an open retrospective study. *Journal of Affective Disorders, 64,* 249-255.

Ogloff, J.R.P., & Davis, M.R. (2004). Advances in offender assessment and rehabilitation:

Contributions of the risk-needs-responsivity approach. *Psychology, Crime, & Law, 10*, 229-249.

Packard, W. S., & Rosner, R. (1985). Psychiatric evaluations of sexual offenders. *Journal of Forensic Sciences, 30,* 715-720.

Parabiaghi, A., Bonetto, C., Ruggeri, M., Lasalvia, A., & Leese, M. (2006). Severe and persistent mental illness: a useful definition for prioritizing community-based mental health service interventions, *Social Psychiatry and Psychiatric Epidemiology*, *41 (6)*, 457-463.

Phillips, S.L., Heads, T.C., Taylor, P.J., & Hill, G.M. (1999). Sexual offending and antisocial sexual behavior among patients with schizophrenia. *Journal of Clinical Psychiatry. 60,* 170-175.

Pithers, W.D., Marques, J. K., Gibat, C.C, & Marlatt, G.A. (1983). Relapse prevention with sexual aggressive. In J. G. Greer & I. R. Stuart (Eds.), *The sexual aggressor* (pp.214-239). New York: Van Nostand Reinhold.

Raymond, N.C.,Colman, E., Ohlerking, F., Christenson, G.A., & Miner, M. (1999). Psychiatric Comorbidity in pedophilic sex offenders. *American Journal of Psychiatry, 156,* 786-788.

Rogers, R. (2000). The uncritical acceptance of risk assessment in forensic practice. *Law and Human Behavior. 24,* 595-605.

Rosenthal, D. (1963). *The Genain quadruplets: a case study and theoretical analysis of heredity and environment in schizophrenia*. New York: Basic Books.

The Safer Society Foundation Inc. (2002). *Current practices and trends in sexual abuser management: The Safer Society 2002 nationwide survey.* Vermont: Safer Society Press.

The Safer Society Foundation Inc. (2009). *Current practices and trends in sexual abuser*

management: The Safer Society 2009 nationwide survey. Vermont: Safer Society Press.

Safran, J. D. & Muran, C. (2000). *Negotiating the therapeutic alliance: A Relational treatment guide.* New York: The Guilford Press.

Sahota, K., & Chesterman, P. (1998). Mentally ill sex offenders in a regional secure unit II: cognitions, perceptions and fantasies, *The Journal of Forensic Psychiatry, 9,* 161-172.

Sahota, K. & Chesterman, P. (1998). Sexual offending in the context of mental illness. *The Journal of Forensic Psychiatry, 9*, 267-280.

Saleh, F. M.,& Guidry, L.L. (2003). Psychosocial and biological treatment considerations for the paraphilic and nonparaphilic sex offender. *Journal of American Academy of Psychiatry, 31,* 486-493.

Saleh, F. M., Dwyer, R.G., & Grudzinskas, A. (2006). An integrated look at dually diagnosed female sex offenders and the law. *Journal of Dual Diagnosis, 3,* 23-32.

Saunders, B., & Houghton, M. (1993). Relapse revisited: A critique of current concepts and clinical practice in management of alcohol problems. *Addictive Behavior, 21*, 843-855.

Schwartz, B. K., & Canfield, G. M. S. (1998). Treating the "sexually dangerous person": The Massachusetts treatment center. In W. L. Marshall, Y. M. Fernandez, S. M. Hudson, & T. Ward (Eds.) *Soucebook of treatment programs for sexual offenders*. New York: Plenum Press, pp. 235-245.

Schwartz, B.K. (Ed.). (2008). *The sex offender: Evaluation and program strategies volume VI.* New York: The Civic Research Institute.

Smith, J. D. (1985). *Minds made feeble: The myth and legacy of the Kallikaks*. Rockville, Maryland: Aspen Systems Corporation.

Smith, A.D., & Taylor, P.J. (1999). Serious Sex offending against women by men with

Schizophrenia: Relationship of illness and psychotic symptoms of offending. *British Journal of Psychiatry, 174,* 233-237.

Smith, A.D. (2000). Motivation and psychosis in schizophrenic men who sexually assault women. *The Journal of Forensic Psychiatry, 11,* 62-73.

Ward, T. & Brown, M. (2004). The good lives model and conceptual issues in offender rehabilitation. *Psychology, Crime, & Law, 10,* 243-57.

Ward, T., & Hudson, S. M. (2000). A self-regulation model of relapse prevention. In D.R. Laws, S. M. Hudson and T. Ward (eds), *Remaking relapse prevention with sex offenders: A sourcebook.* Newbury Park, CA: Sage.

Ward, T., Mann, R. E., & Gannon, T. A. (2008). The good lives' model of offender rehabilitation: Clinical Implications. *Aggression and Violent Behavior, 12*, 87-107.

Ward, T. & Stewart, C. (2003). Criminogenic needs and human needs: A theoretical model. *Psychology, Crime & Law, 9,* 125-43.

Ward, T., Polaschek, D.L.L., & Beech, A.R., (2006). *Theories of sexual offending*. New York: John Wiley & Sons, Ltd.

Ward, T. & Maruna, S. (2007). Rehabilitation: Beyond the risk paradigm. New York: Routledge.

Warner, R. (2009). Recovery from schizophrenia and the recovery model. *Current Opinions in Psychiatry, 22*, 374-380.

Watson, J., Tolman, E., Titchener, E., & Lashley, K. (2009). *Behaviorism: Classic studies.* CA: IAP.

Wood, R.M., Grossman, L.S., & Fichtner, C.G. (2000). Psychological assessment, treatment, and outcome with sex offenders. *Behavioral Sciences and the Law, 18,* 23-41.

Zubin, J. & Spring, B. (1977). Vulnerability: A new view of schizophrenia. *Journal of Abnormal Psychology, 86*, 103–126.

Appendix A

Time Breakdown: Seven Hour Training

Introduction and Section I: One Hour

Introduction: 15 Minutes

Exercise: 15-30 Minutes

Section I: 30 Minutes

Break/Evaluation: 15 minutes

Section II- Assessment: Two and a half hours

Break/Evaluation: 15 minutes

Section III-Treatment: Two and a half hours

Appendix B

Competencies that Participants Will Learn and Develop in Continuing Education Curriculum

Knowledge:

1. Participants will increase knowledge of severe and persistent mental illnesses.
2. Participants will be able to assess mental health issues as they pertain to sex offending behavior.
3. Participants will be able to identify ways to work with the mental health system.
4. Participants will learn specific issues and concerns to assess with SMISOs.
5. Participants will be able to modify treatment to work with SMISOs.
6. Participants will learn to identify their own barriers to working with SMISOs.

Attitudes:

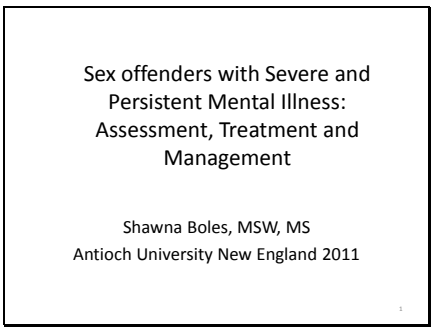
1. Participants will be able to incorporate appropriate attitudes about mental illness and offending into their work with clients
2. Participants will be able to reflect upon their biases in regards to severe and persistent mental illness.

Skills:

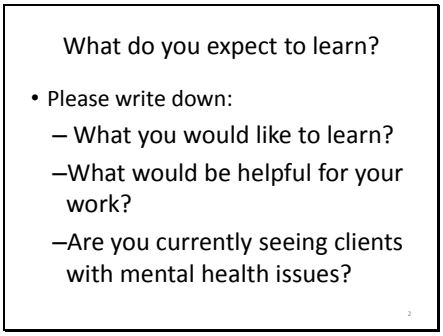
1. Participants will hone their assessment skills with role plays
2. Participants will hone their treatment skills with role plays

Appendix C

Slide 1

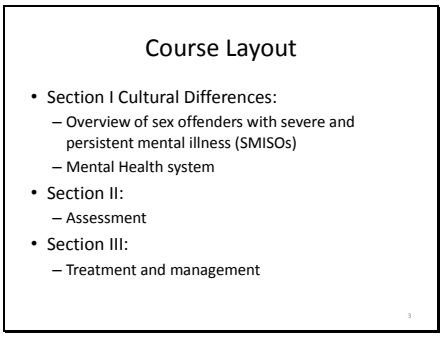


Slide 2

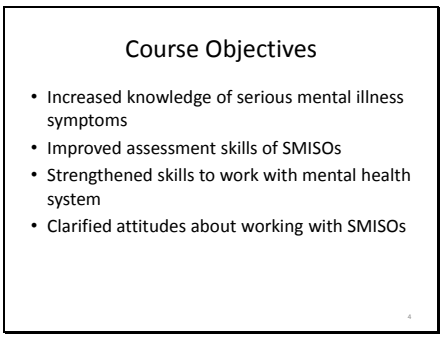


Collect notes and read during first break. Address at that point with group. The goal will be to tailor the rest of the training to the needs of this particular group thus spending more or less time on each slide given the needs of the group.

Slide 3



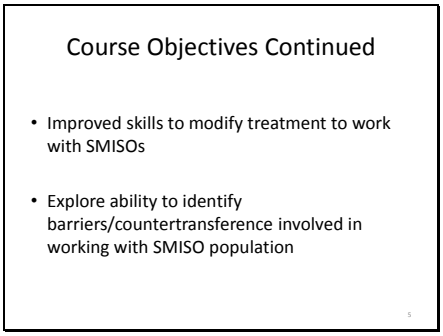
Slide 4



SMISO- Severely Mentally Ill Sex Offenders

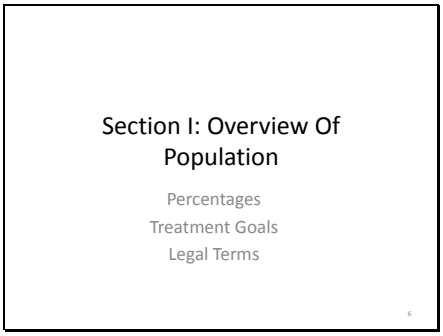
I am intending this training to help participants increase knowledge of serious mental illnesses, as well as increase knowledge of how to assess and treat severe and persistent mental illness.

Slide 5

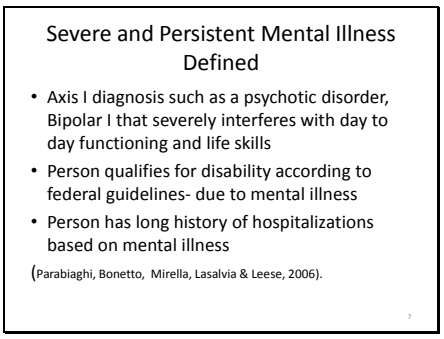


Participants will also be honing their assessment and treatment skills in role plays, small group exercises, and large group exercises.

Slide 6



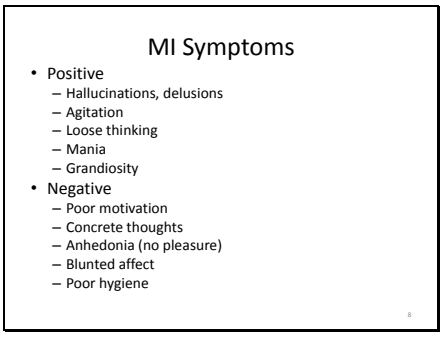
Slide 7



DSM-IV-TR diagnostic system
Federal guidelines: Social Security- SSI, Social Security Disability- SSDI

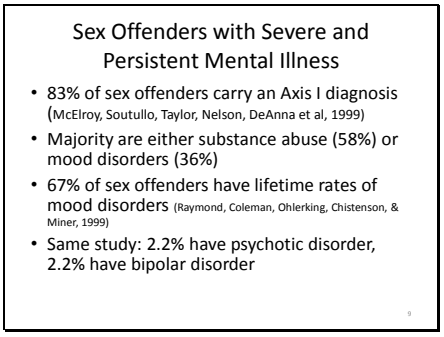
Psychotic Disorders: Schizophrenia, Schizoaffective Disorder, Schizophreniform Disorder, Brief Psychotic Disorder,
Mood Disorders: PTSD, Bipolar I
Comorbidity: Depression, Anxiety, OCD, PTSD, Trauma history, Drug and Alcohol use and abuse, Life circumstance issues (effects of leveling, etc.)

Slide 8



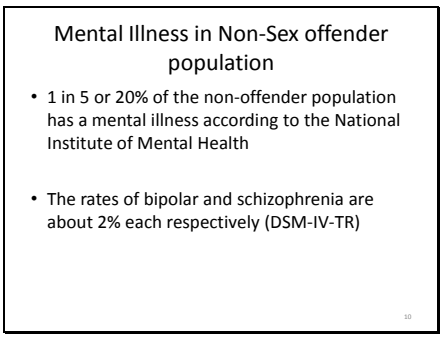
We see that this is a small percentage of the offending population, now the question is what does this look like? How does a person present who has a severe and persistent mental illness?

Slide 9



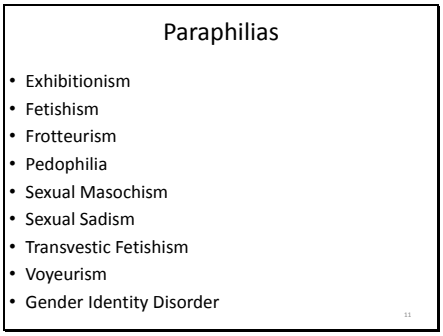
What does this tell us? It tells us that many sex offenders will struggle with some mental illness in their lifetime, however, most will not struggle with a severe and persistent mental illness.

Slide 10



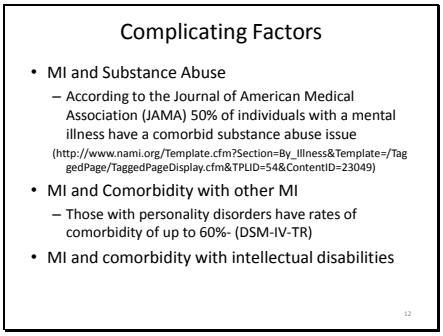
What do the rates mean on the last slide? "compared to what" Let's look now at the non-sex offender mental illness rates. In general, the non-offender and offender populations seem to have similar rates for severe and persistent mental illnesses.

Slide 11



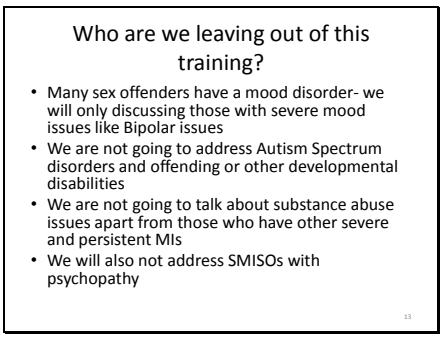
Note on paraphilias: This is a listing from the DSM-IV-TR. However, underlying paraphilias can also be present in an individual with a severe and persistent mental illness. It is possible that once a person is receiving treatment for their mental illness, some level of deviant sexual arousal may still be present or may become more of an issue. This is just another area to assess thoroughly as a result.

Slide 12



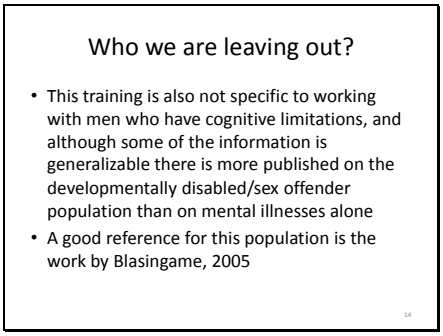
Co-morbid or co-occurring…note to clarify and define for participants
There is a clear link between substance use and abuse and suicidality as well as increased violence. According to Ilgen et al, up to 70% of those seeking substance abuse treatment have a history of prior violence.
Just want to mention that someone with a mental illness can have an intellectual disability or a cognitive impairment that adds to the complexity of their presentation. This additional factor should be assessed as it will impact how treatment is carried out.

Slide 13

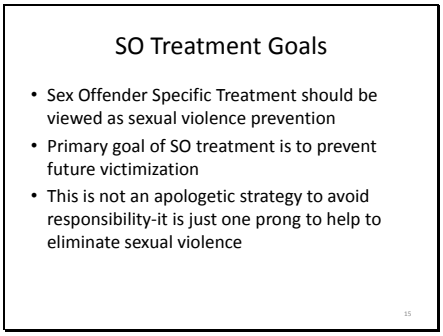


List off: Mild mood disorders, Autism, Pervasive Developmental Disorder (PDD), Substance abuse disorders, or cognitive limitations. However, all of these issues will often be secondary foci of treatment with SMISO population (comorbidity is high and needs to be stressed).

Slide 14

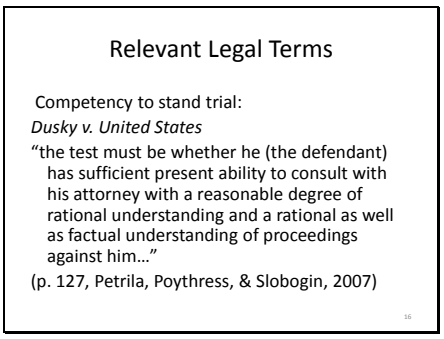


Slide 15



"just one prong" of a multiple impact strategy

Slide 16

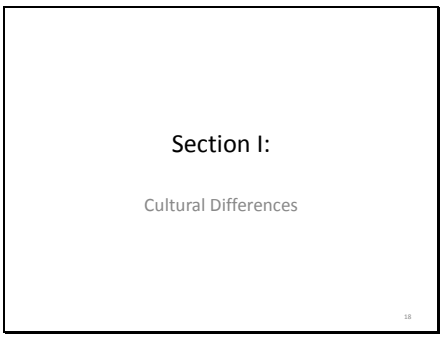


I will assume that participants are familiar with these terms, however, I am including these slides just to provide a refresher)
Defendants need to understand the nature of the charges against them, be able to give relevant information when they testify and to their attorney, be appropriate in the courtroom. If client was evaluated for trial, you should be able to obtain evaluation for your treatment if necessary.

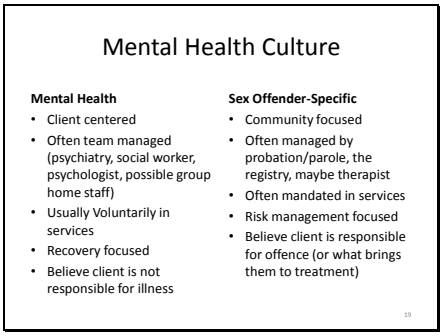
Slide 17

For more information I refer people to the book *Psychological Evaluations for The Courts* (Petrila, Poythress, & Slobogin, 2007). Keep in mind that most people (90%) plea bargain instead of going to trial. This is important to note because you may have clients that were mentally ill at the time they offended, but they have accepted pleas and reduced sentences rather than go to court.
NGRI- Not guilty for reason of Insanity- this is based on state to state data mostly from the 1990s which varies widely.
Guilty but mentally ICC (?)

Slide 18

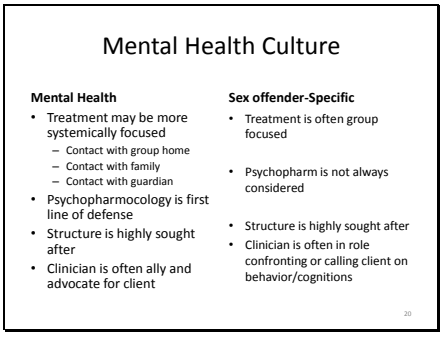


Slide 19



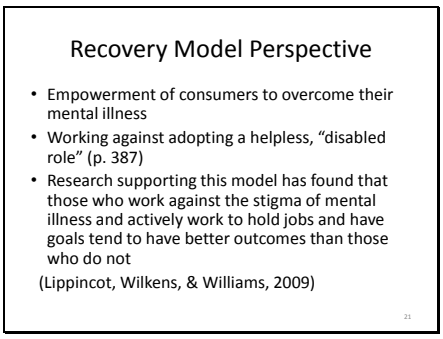
There are probably many reasons why the sex offender literature does not often address how to work with individuals with severe and persistent mental health problems. I believe part of that has to do with the divide between the culture of sex offender-specific culture and the mental health culture. To better understand this divide I am going to spend some time discussing mental health cultural perspectives.

Slide 20



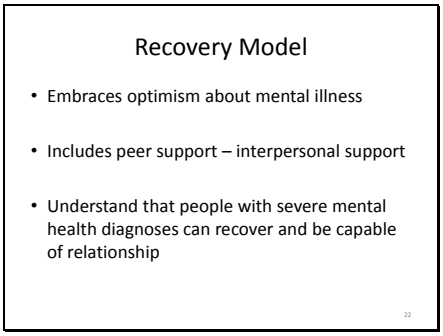
Mention Recovery Model, will discuss further in treatment.

Slide 21



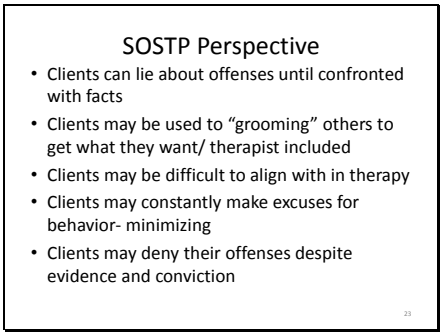
Many mental health professionals will have a Recovery Model stance with their clients. As a result, I am going to present some ideas from this model in order to help clarify some of the differences.

Slide 22



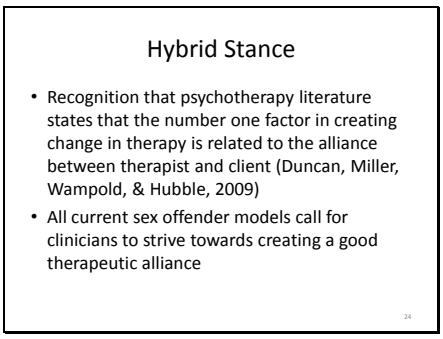
Peer support can include having consumers or clients involved in day programs and groups that focus on empowerment and development of skills and creativity.

Slide 23



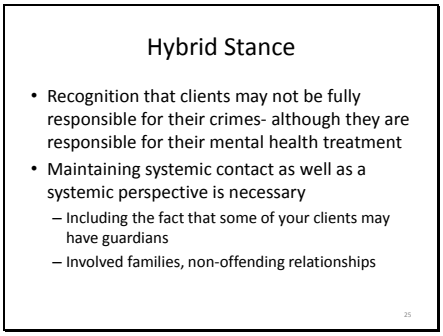
SOSTP- Sex offender-specific treatment provider
Align: clients may have not empathize with victims, clients may have personality disorders or symptoms that make alignment difficult
Excuses: clients may defend their sex offending behavior

Slide 24



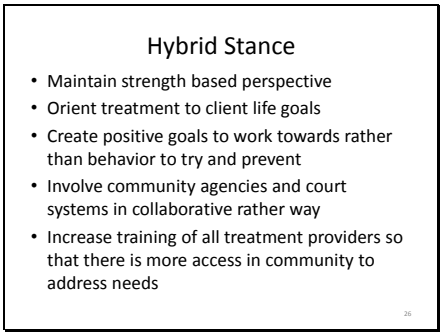
I am referring to the second edition of the book The Heart and Soul of Change, originally edited by Hubble, Duncan, & Miller, 1999.

Slide 25



Responsibility may be seen as a spectrum that is highly influenced by different factors.

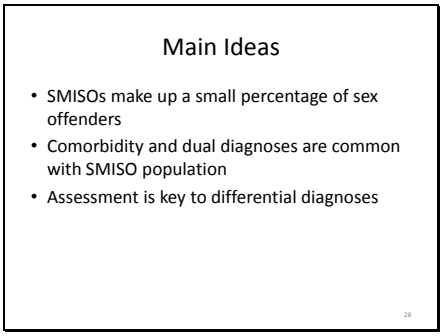
Slide 26



Slide 27

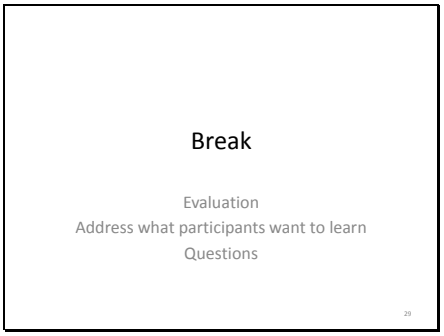
After group activity: I was hoping that this activity would provoke you to think about how you currently reacting to clients based on the initial information you receive and how your viewpoint can change as you learn more about how they came to be in this world. This is an exercise around how information can change how we view client behaviors.

Slide 28



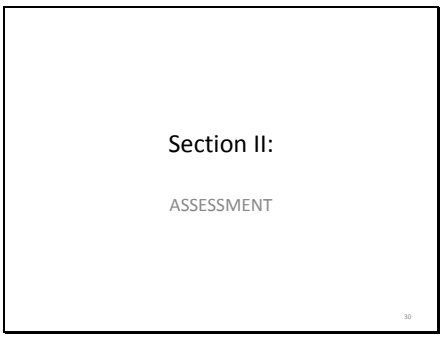
Reinforce main Ideas and then hand out assessment forms, give additional break if necessary.

Slide 29

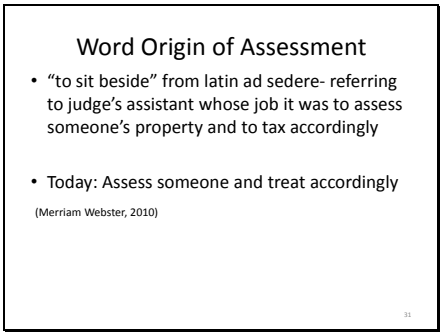


10-15 minutes depending on time
Address participant questions
Provide Evaluation Forms from Appendix E

Slide 30

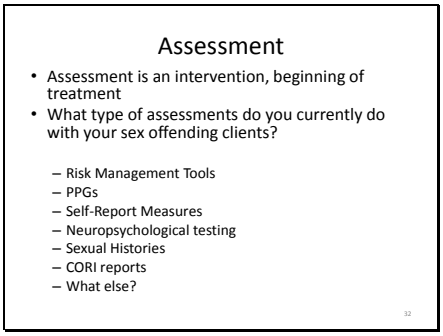


Slide 31



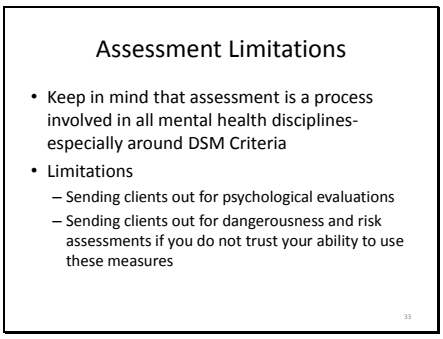
What is Assessment? Where did it come from?

Slide 32

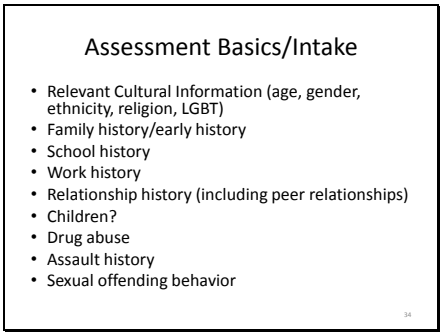


What I learned from my training is that Assessment is treatment, it is an intervention in itself.
Most people use assessment to help determine areas of focus or areas of management for sex offending clients
Out of interest what are people using for assessment?
Is there an assessment process?
Diagnostic interview or Intake process?
What areas would be helpful to you all for me to address?

Slide 33

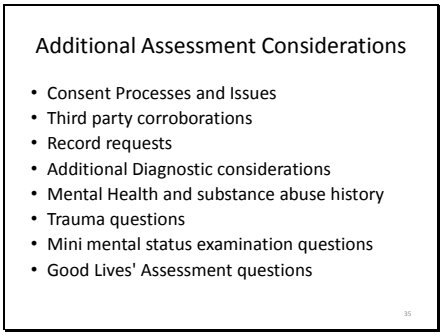


Slide 34



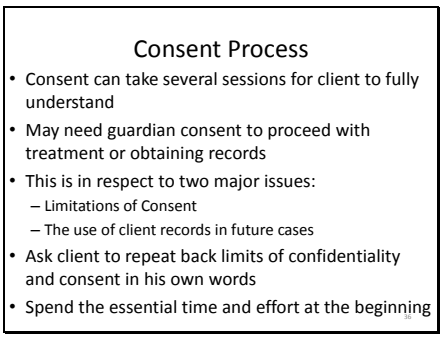
(SOSTPs may be very familiar with these concepts therefore provide slide but it may not be necessary to read over it) Relationship history includes current intimate partner status.

Slide 35



We will be focusing on some of the differences that SOSTPs may need to consider when working with SMISOs.

Slide 36



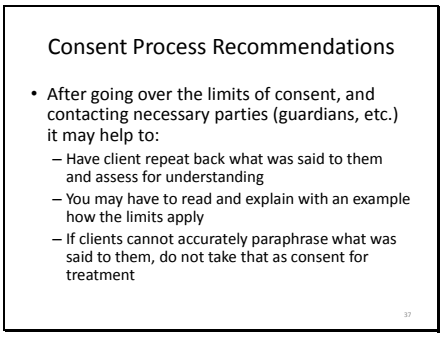
Limitations of Consent: if client discusses past crimes for which they have not been charged and they mention the names of the clients and the clients were under the age of 18 at the time of the offense, clinician must notify police.

If client is suicidal or homicidal clinician must hospitalize, call crisis team, notify police

If client discloses current abuse-of minor, elderly, or disabled, clinician must break confidentiality

If client becomes involved in future court case for a charge in which they have not been sentenced, their records could be subpoenaed and used against them in court

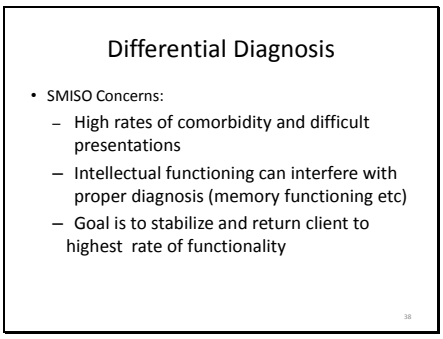
Slide 37



You may have to role play what consent means. The word consent means that you give me permission to do something. Like if I say "do you give me consent to talk to your probation officer, it means that you allow me to share personal information with your probation officer." If you say that you give me consent to complete an assessment that means that you allow me to ask questions and to give tests that can help me learn how you think.

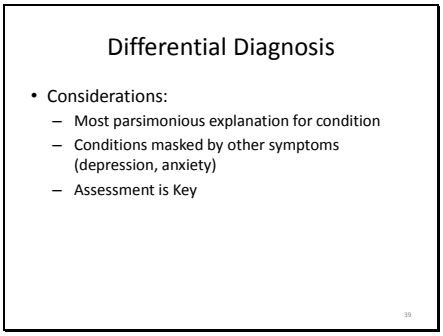
What do you think about this idea? Would you like some time to think about it? Do you need me to explain it again with better examples?

Slide 38

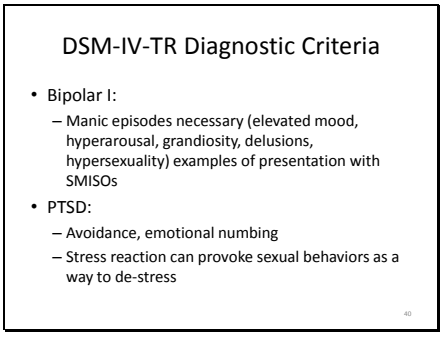


The next few slides address major differential diagnostic issues with some of the main SMISO diagnoses.

Slide 39



Slide 40



Slide 41

Diagnosis

- Schizophrenia:
  - PDD- before age 3, absence of delusions and hallucinations, speech differences
  - Medical Conditions- physical exam/history
  - Substance use- history (drug use or medication)
  - Mood Disorder- psychotic features only during mood disorder
  - Schizoaffective- mood issues main concern, delusions present for 2 weeks without mood issues
  - Schizophreniform- time- between 1-6 months only, no decline in functioning

41

Slide 42

Differential Diagnosis

- Schizophrenia:
  - Brief Psychotic Disorder- between one day and one month
  - Delusional Disorder- nonbizarre delusions, absence of hallucinations, disorganized speech, or negative symptoms)

42

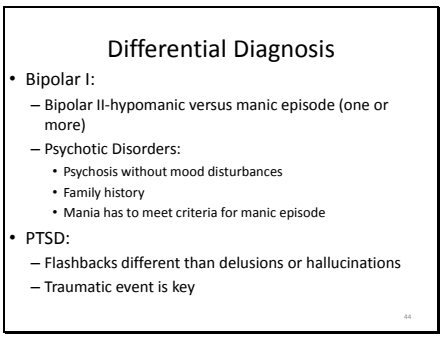
Slide 43

Differential Diagnostic Issues

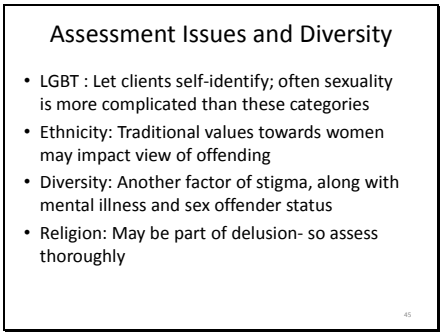
- Delusional Disorder(erotomanic, grandiose, jealous, persecutory, somatic, mixed, unspecified):
  - Mood Disorder with Psychotic Features- severity of mood concern
  - Shared Psychotic Disorder- only in context of relationship

43

Slide 44

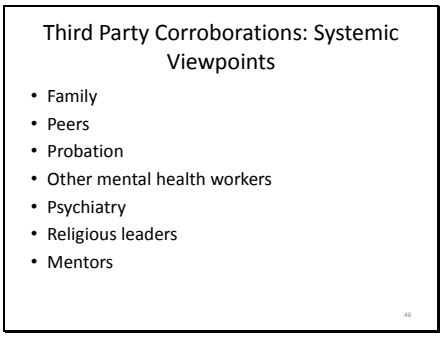


Slide 45



LGBT: Example: client is sexually attracted to adolescent men, but has only been "in love" with adult females.
Healing: use of sweat lodges with aboriginal populations as a healing ritual
Proper assessment of client culture and of areas of oppression and diversity can help clinician create more effective treatment plans and goals.
Religion: issues around grandiosity and religiosity can be part of overall delusional thinking. May need to question client around their religious views in depth. (give example)

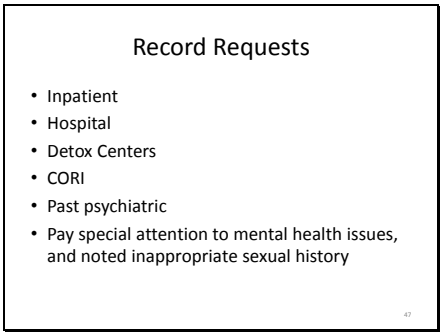
Slide 46



Although this is common practice in sex offender treatment, I would like to reiterate that you may need to contact other agencies or other people to get more information about client or to establish relationships for the purpose of treatment…this is a common practice in mental health work and it is often an important one.
You will need consents to contact these people, and you should discuss the nature of your conversations with the system with your clients, clarify what

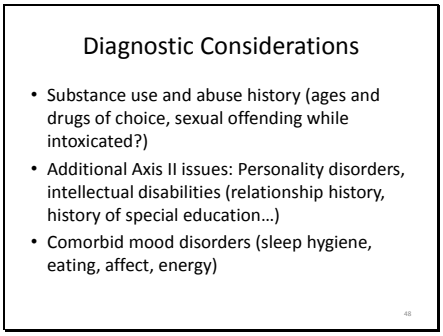
you will and will not be sharing and what they are comfortable with you sharing.

Slide 47



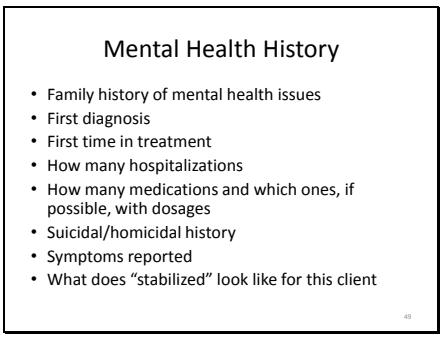
Many of your clients come with some information from their record in regards to their offense and severe and persistent mental illness. I suggest gathering information about past hospitalizations and offense documents.

Slide 48



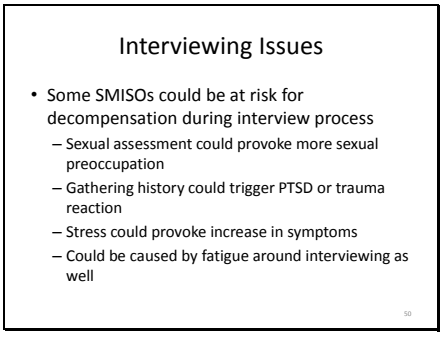
This is where we start to piece out dual diagnosis or differential diagnostic issues.

Slide 49

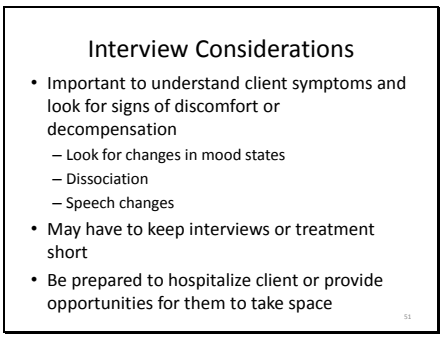


What you will want to do is use this information to paint a picture of a client who may have been influenced by grandiosity, hallucinations, or delusions to act inappropriately. It is important to at least consider that these forces may have contributed to client's acts. On the other hand, client when stable may be more at risk to offend. Assessment needs to consider whether or not client has paraphilia while stable, or whether client deviant sexual acts are related to mental illness. This may be gleaned from the record, from interview, or from seeing client stabilized with medication.

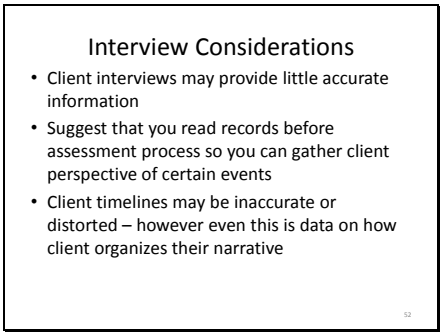
Slide 50



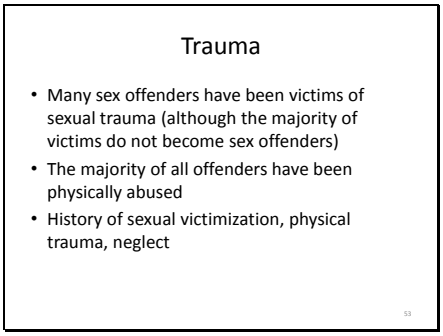
Slide 51



Slide 52

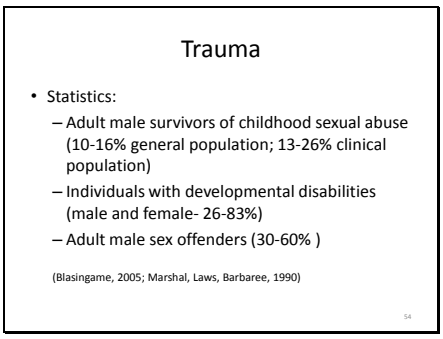


Slide 53



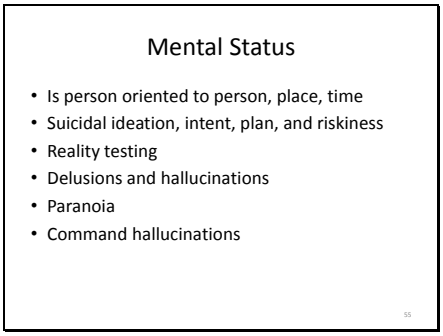
I am not asking you to ask details regarding client trauma so as not to elicit decompesation. However, it is important to understand whether or not client has unaddressed trauma issues.

Slide 54

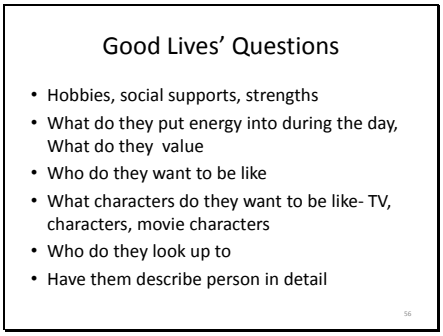


The trauma history of any individual client is important for treatment. I just want to give you an idea of what the statistics look like around sexual trauma and sex offenders. You may already be aware of this information, but sometimes it is good to have a reminder of just how prevalent abuse rates are.

Slide 55



Slide 56



The spirit is to find other ways for a person to get their needs met in a healthy way. This is a strength based interview process.

Slide 57

Good Lives' Problem Clusters

- cognitive distortions
- empathy deficits
- social difficulties
- emotional problems
- deviant sexual arousal

57

Slide 58

In Office Assessment Tools

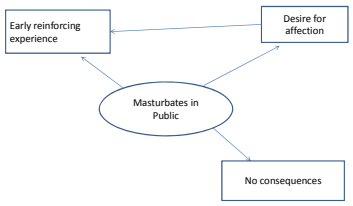
- Multisystemic Therapy 'Fits'
  - Look for any potential causes or meaning behind behavior or symptoms
  - Identify potential reasons for each individual cause
  - Address accordingly in treatment
  - Key here is to brainstorm broadly about anything that could possibly cause the behavior

58

One quick assessment tool that can help clarify issues quickly is the MST fit. I am introducing this tool only because it is easy and helps me visually brainstorm while completing assessments.

Slide 59

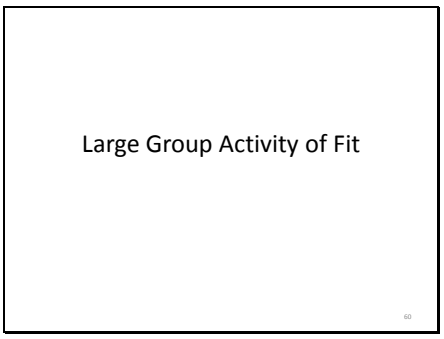
MST Fit



59

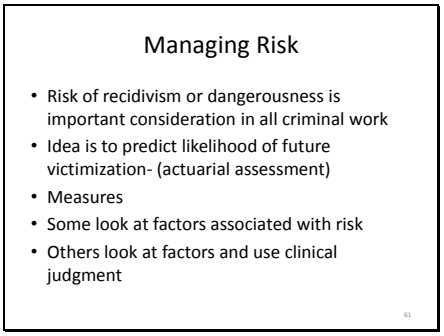
Complete 'fit' with group that is more extensive. Complete secondary 'fit' with group as well.

Slide 60



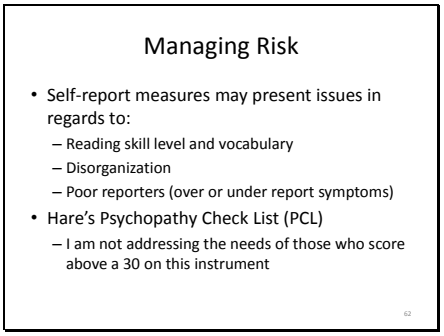
Ask for a behavior from group and operationalize to begin fit. Ask participants to brainstorm things that could cause behavior.

Slide 61



There are a number of measures used to formally assess risk such as the Static-99R or the RSVP. Factors associated with risk such as age, kind of abuse, number of sex offenses, and gender of victim. Clinical judgment measures (RSVP) will also consider history of abuse, or trauma, range of deviancy and violence involved in crimes.

Slide 62



Mention that scores on the PCL above 30 often indicate psychopathy that needs to be addressed.

Slide 63

Managing risk

- Risk in mental health is associated with behaviors that could end in hospitalization or a person being a threat to themselves or other
- Risk Assessment
  - Pay attention to additional risk factors for decompensation such as medication compliance, mental status, sleeping patterns, poor hygiene, and mental health symptoms

63

Many risk assessments were not created especially to deal with the SMISO population. Therefore, sometimes it may leave out some considerations particular to this population.

Slide 64

Managing Risk

- May need to assess for level of supervision and possible supports
- PPG
  - Many medications can cause offenders to flat-line or test below interpretable results

64

When considering risk, some providers may choose to have client assessed for deviant arousal by having a Penile Plethysmograph- PPG- performed. Psychiatric medication can interfere with test results.

Slide 65

Psychopathy vs. Mental Illness

- Psychopathy is not a disorder present in the DSM-IV-TR, however, all psychopaths would also meet the diagnostic criteria for Antisocial Personality Disorder – it is a forensic distinction
  - Some characteristics include: criminal behavior, manipulation, glibness, charisma or charm, lack of intimate relationships or drive for intimacy, lack of empathy or remorse, untruthfulness (Hare, 1993)

65

Since I noted psychopathology, I would like to spend a few slides discussing the difference between the SMISO population and psychopathy. This training will not go into assessing or treating psychopathy, however, I would like to make the distinction between psychopathy and mental illness. Individuals that you work with may have both issues, and yet the treatment would differ if there is a level of psychopathy present.

Slide 66

Psychopathy vs. Mental Illness

- Individuals with severe and persistent mental illness may have a level of psychopathy or antisocial behavior
- SMISOs without this feature are more likely to have sex offending or violent behavior as a result of their condition or underlying sexual drives- but not based on their inability to be involved in a social group

66

If you have a real concern that you have a client with psychopathic features I recommend that you get a full assessment of risk and that you seek additional supervision or training in how to address these issues.

Slide 67

Decompensation and Mental Health

- Sleep changes
- Eating changes
- Delusional content, hallucinations
- Bizarre content
- Self reported or apparent increase in deviant sexual thoughts
- Mood changes in general
- Hyper/Hypo arousal patterns- restlessness

67

Looking for increase in symptoms. May take a while to learn base-line versus decompensated mental health status for each client. Early detection and treatment lead to better outcomes and prognosis. (Harrigan, McGorry, Krstev, 2003),

Slide 68

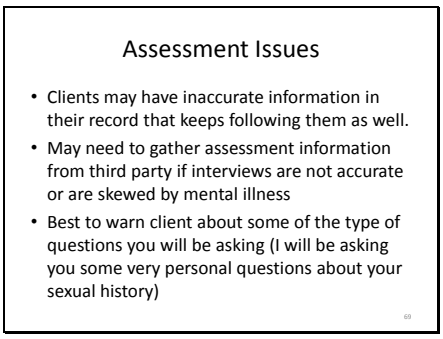
Assessment Issues

- Keep in mind that many individuals who have institutionalized backgrounds may be carrying inappropriate diagnoses or wrong information in their files
- Ongoing assessment is important since mental status can change rapidly
- Individuals may not be able to sit down for 3 hours to complete an extensive assessment

68

On point three: you may need to work with client for small chunks of time (15-30 minute intervals) to gather information.

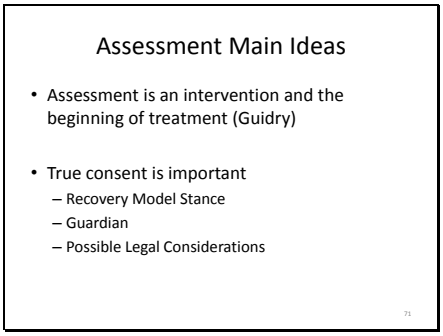
Slide 69



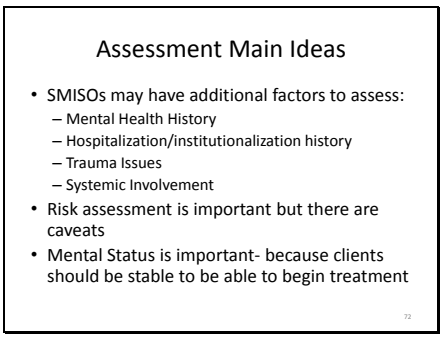
Slide 70

Have participants look at vignette and problem solve what they would want to assess and how?
When group returns to large group, ask individual small groups to add one comment about a problem area that they would like to know more about…go around the room in this way and track responses relative to the assessment shown previously.
Appendix D

Slide 71

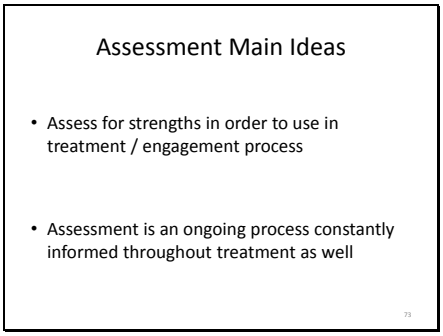


Slide 72



Actuarial measures give group data that is often normed on non mentally ill sex offenders. Debates are ongoing as to the use of predicting future risk and how this informs treatment of the individual client as well as public policy.

Slide 73

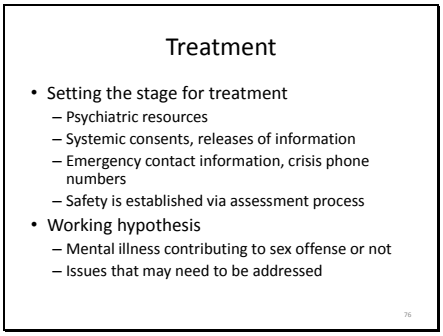


Slide 74

Refer to Appendix E for form

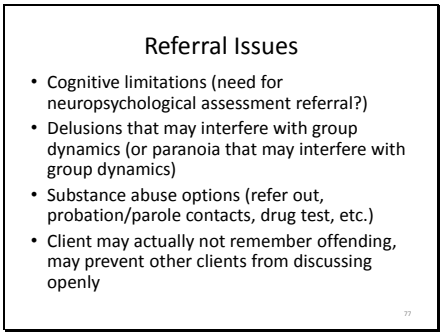
Slide 75

Slide 76



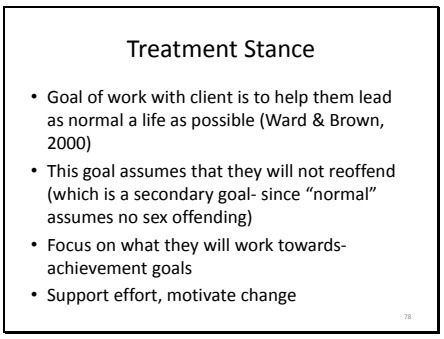
Now we have an idea of who SMISOs are and what types of issues we need to look at to properly treat them…We may have a PPG, forensic records, hospital records, or police reports. Now what do we do?

Slide 77



Do you need to refer out? Do you need to get more information? Do you have the contacts to work with this person? Will you need additional consultation or supervision to help manage?

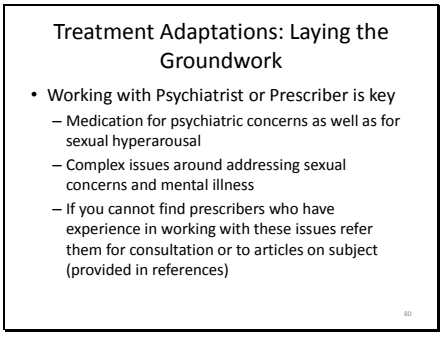
Slide 78



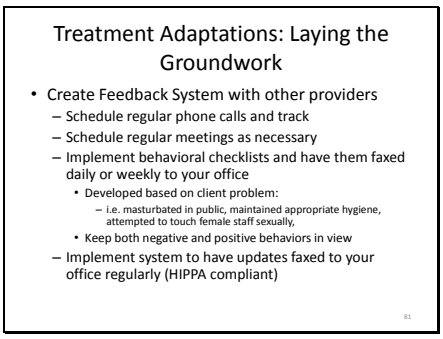
We talked earlier about a stance towards treatment with sex offenders that takes into account their mental illness. I believe that the recovery model and the Good Lives Model share similar stances towards clients.
GLM focuses on approach goals- not avoidance goals- hence the positive frame of the goal. This means what will they work towards?
Last point- DBT assumption: Clients are doing the best they can, but still need to change.

Slide 79

Slide 80

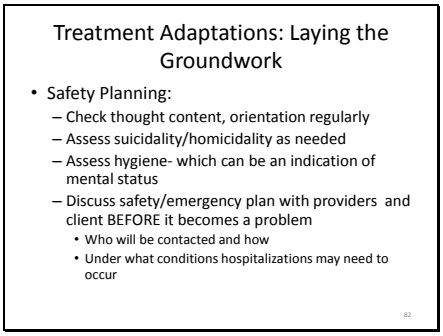


Slide 81



You want to establish a feedback loop with providers. Part of this feedback loop is to allow clinicians to have an idea of client's daily behaviors (neg. and pos.). This will better allow clinicians to identify and track treatment goals.

Slide 82



Slide 83

Just jot down the information you would want on the paper provided. Please take 15-20 minutes to complete this task. (after 15-20 minutes) Large group question: Each group please list a concern or behavior you would want to track…Then ask large group if they have anything else that they would like to add. Appendix D

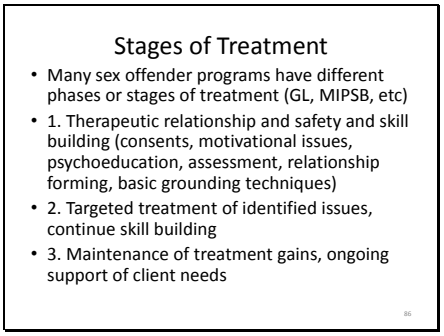
Slide 84

Everybody has their own treatment protocols and ways that you carry out treatment. I am assuming that you are looking to tailor what you already do to your individual client with a severe and persistent mental illness. As a result, I am not going to teach you how to carry out treatment, but instead how to make adaptations to what you already do…and possibly add some suggestions.

Slide 85

Groups: Will client learn? Will they contribute?

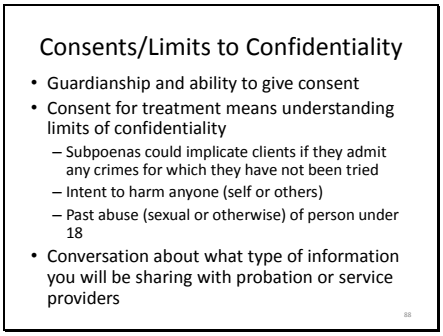
Slide 86



There are three major tasks that should take place in therapy with SMISOs

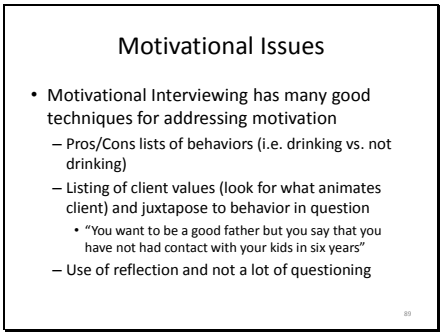
Slide 87

Slide 88



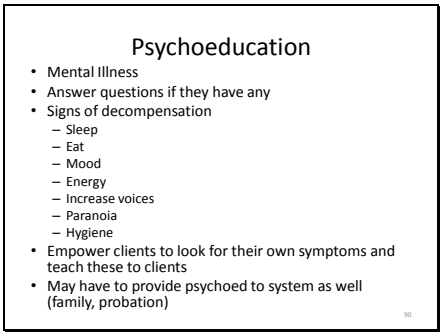
Going over consents and limits to confidentiality are a normal process that we all go through with clients. However, there are some differences when working with SMISOs.

Slide 89



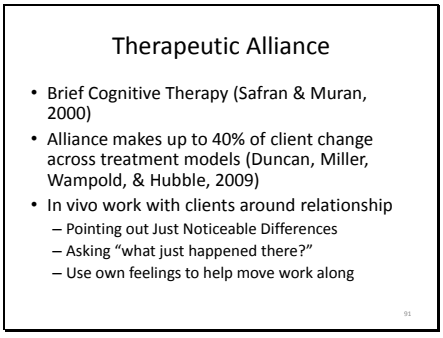
Assessment should provide you with information about what motivates client to allow clinician to best work towards client health based on client's overall motivation. Who is familiar with MI? (if a large amount of people raise hands then go over slide, if not, then discuss the change process in the Transtheoretical model: precontemplation, contemplation, preparation, action, maintanance. Discuss importance of clinician to work with client based on where client is at in the change process, recognizing that client needs to be ready, willing, and able to change.)

Slide 90



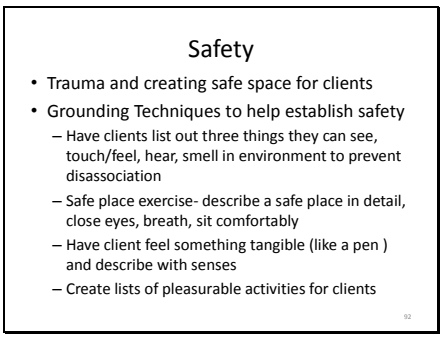
Once you have your client motivated to work, you may need to provide some psychoeducation on their mental illness. From my experience clients will often think that they are "crazy" but not fully understand their mental illness. Just as you may be used to finding triggers to offending- it will be important for client to see their own signs of decompensation and to learn how to identify some of these early signs.

Slide 91

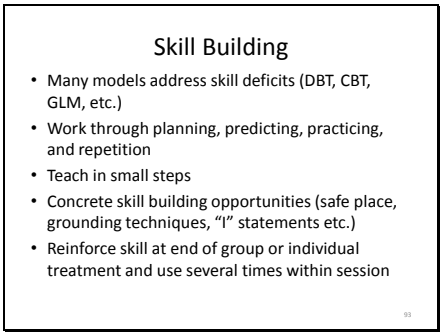


Negotiating the Therapeutic Alliance (Saffran & Muran, 2000) is a good resource for learning in vivo ways to address relationship in therapy.

Slide 92

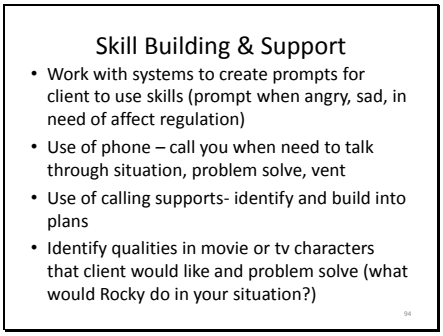


Slide 93



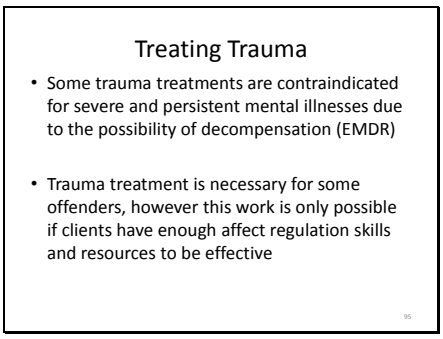
Task analysis: picking nose, what does this mean? Sticking finger up nose. try to replace with appropriate behavior. What can you substitute instead?

Slide 94

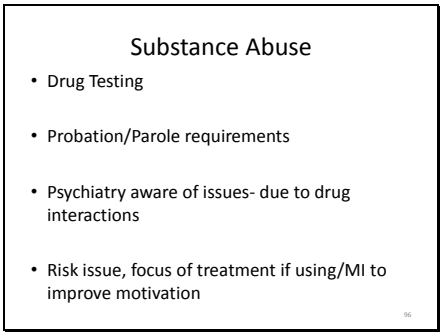


Note on last piece: Concrete not abstract- clients may not be able to discuss abstract concepts like love. GLM depends on the ability to think abstractly. Discussing qualities of real people or characters from movies or television is often possible with this group.

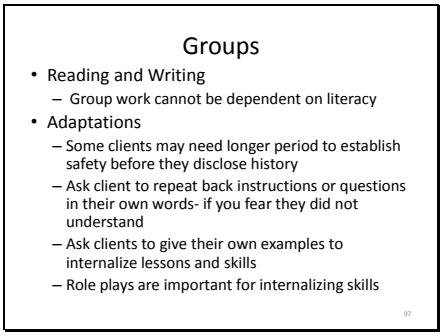
Slide 95



Slide 96

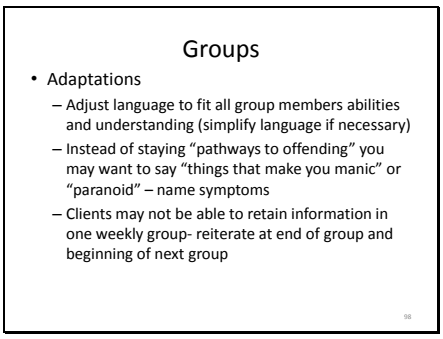


Slide 97

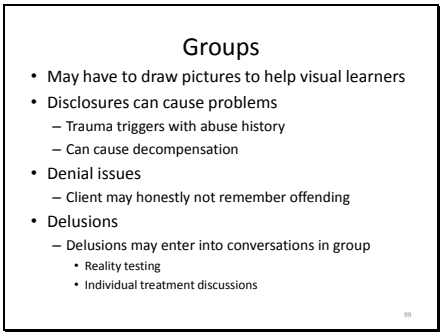


Repeating back: Remember these individuals are adults so one way to do this is to say- Can anyone tell me some of the main points covered today?

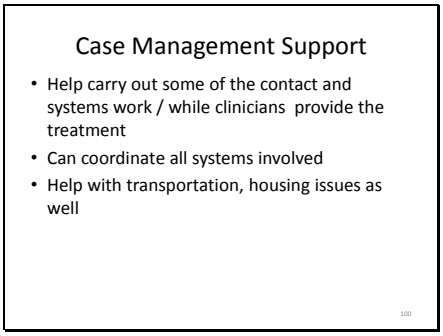
Slide 98



Slide 99

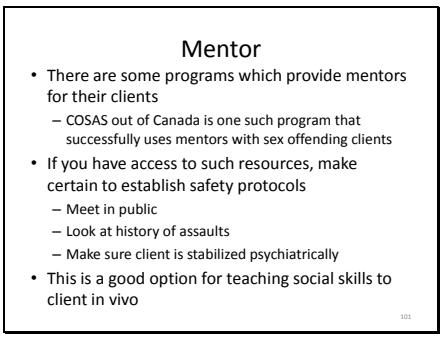


Slide 100

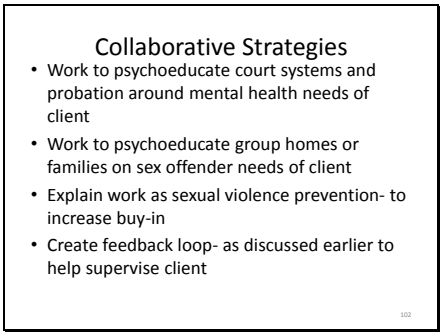


If you have access to one, use them.

Slide 101



Slide 102

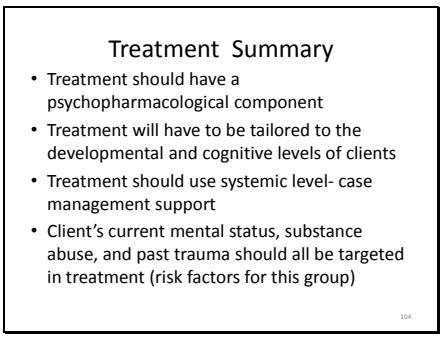


Often times courts and probation services are looking for face valid factors to address in therapy- victim empathy etc. These are not associated with increased risk for recidivism- but are face valid. Other concerns, like therapeutic alliance are not face valid and yet have favorable outcome. These issues may need to be explained.

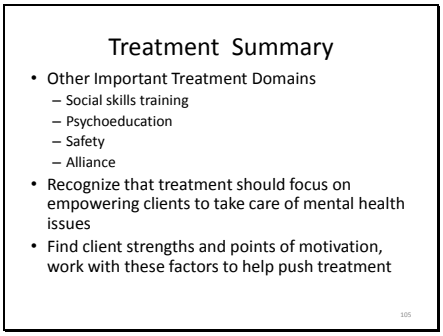
Slide 103

Refer to Appendix D for group activity

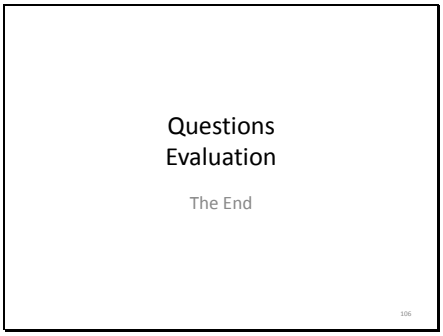
Slide 104



Slide 105



Slide 106



Closing remarks, Appendix F for evaluation

Appendix D

Skills Training Activities

Section I: Paired Activity

Get a partner and consider your personal reaction to this vignette.
The focus of this exercise is your personal reaction, your gut feelings, and any concern you may have if this client were referred to you.
The goal is to be nonjudgmental and let your mind reflect upon and play with the thoughts that emerge.

Level One

Reflection:

Charlie is a 44 year-old Caucasian man who was referred for sex-offender specific treatment following his release from prison. Charlie has recently become a level three sex offender who was incarcerated for 20 years. He was charged and convicted of indecent assault and battery of a female stranger in an alley.

Take five minutes to discuss your reactions: Physical reactions on your part, initial thoughts, intuition about example.

Level 2

Reflection:

Charlie has a history of paranoia and bizarre delusions. He was first treated for this condition at the age of 16 when he would expose his genitalia to strangers around his small community. He would often believe that strangers found him sexually attractive and was picked up by police several times for exposure. At this time Charlie was never charged or convicted of any sexual crimes, but was returned to his home. His parents were warned to "keep an eye on him," but he was never put into counseling or given consequences for his behavior. One of Charlie's main symptoms is his tendency towards grandiosity when his mental illness is poorly managed.

Take 5 minutes to think and discuss this new information in regards to Charlie.

How does this additional information change the way you view Charlie?

Level Three

Reflection:

Charlie reports that he was physically abused as a child by his mother, father, and grandparents. Charlie denied sexual abuse but did report significant bullying in school, and school reports mentioned that he was "caught giving oral sex" to another male student. Although the information is unclear, it appears that Charlie may have been forced into this interaction. He also shied away from discussing any sexual encounter that occurred within the prison stating, "I don't want to talk about that right now."

Charlie has a sixth-grade education and quit school at the age of 15 (after being held back several times). He has limited reading ability and poor comprehension skills.

On the night of the recent attack and sexual assault, Charlie was drunk and was without sleep for three days following a manic episode. Earlier in the day he was described by witnesses as "parading around" and masturbating in public. While in a grandiose state, Charlie believed the woman he assaulted found him sexually attractive and "wanted" to have sex with him. He was found guilty of indecent assault and battery only after several weeks of working to get him stabilized on medication so that he could be competent to stand trial. After his competency was restored Charlie took a plea bargain rather than go to trial.

Take a few minutes to process your reactions.

In what ways did your reaction to Charlie change? What new information influenced your reaction? Describe what information enables you to empathize with the Charlie's situation without condoning his behavior?

Section II: Small Group Activity—Assessment Activity

Juanpe is a 33-year-old male referred for treatment after serving two years in prison. This sentence was a result of a series of sexual assaults on the subway that occurred in one day. Juanpe has never before been in therapy, and he started to receive medication in the prison setting where he was diagnosed with a mental illness. It appears that Juanpe will sometimes talk to himself and that these conversations often do not often make sense. Juanpe also believed that he was "initiating" the women he assaulted into his religion. He believed that the women were "given" to him by God and that they were his for the taking. Juanpe has been medicated for a period of time and now knows that he was mentally ill when the crimes occurred. During the sexual interview Juanpe revealed that he has sexually assaulted women in the past, he has had sex with two dogs, and he tends to get aroused by a wide variety of situations.

Juanpe no longer believes that he has been given women, but he still believes that he and God have a "special relationship." Juanpe lives in a group home, but is independent and can come and go as he pleases. Juanpe has no work history, lives on disability, and goes to church regularly. He has two brothers, whom he is close to and whom he sees weekly. Juanpe has been compliant with all of his parole requirements and seems to be interested in sex offender treatment.

Juanpe is insightful and smart, despite his delusions. He is easily redirected, but sometimes will go on about his religious beliefs. Juanpe enjoys reading and writing.

Please answer the following questions about the above vignette:

1. What information is missing? What do you want to know more about?
2. What do you believe the diagnosis would be for this client? If you do not know, what types of questions do you need to ask him?
3. What is your hypothesis for this client's behavior? (Is it related to his mental health concerns? Is it related to deviancy? What questions would you ask to tell the difference?)
4. Can you imagine what assets and skills this client would need to develop in treatment to lead a better life (a Good life)?

Section III: Behavioral Checklist for Providers

David is a 55-year-old African American male who currently lives in a group home setting. David was incarcerated for rape of a minor 14 years ago and served the full sentence. David had a drinking and drug abuse history prior to his incarceration. He has a current diagnosis of Schizophrenia Paranoid type. Recently, David has been having issues at his group home, during which, in the evening, he will walk around without pants. This behavior tends to scare the night staff. In addition, David will sometimes display poor hygiene which is often an indication that he is on the verge of decompensation. At his home, David's other behaviors include discussing sexual relationships with and asking inappropriate questions to staff. Staff is also concerned that he may be asking people in the community inappropriate questions as well. Other group home residents have discussed the fact that David may again be using alcohol. Although he is no longer on parole or probation, you would like to know if he is using regularly and would appreciate any information on this topic.

Please write down what behaviors you would want to track on a weekly basis.

Please develop a simple behavioral checklist that could help you identify any drug/alcohol use, signs of decompensation, and inappropriate sexual behaviors so that you can best treat David. Also, please identify any safety concerns that you may have, and what you would do to address them.

Appendix E

Assessment of Section 1

This section of the training introduced the topic of working with individuals with severe and persistent mental illness who are also convicted sex offenders. In addition, it discussed the differences between the mental health and the sex offender fields of study and treatment.

What part of this section did you find most helpful in your learning process? (e.g., small group activities, power point didactic, discussion and questions, references) You may name more than one factor if multiple factors were helpful in your learning process

What part of this section do you think could have been improved? (e.g., content, skills of presenter, small group activities, etc.)

Name at least three things you have learned from this section (e.g., "take aways")?

Please rate how likely you think you are to work with individuals with severe and persistent mental illness after attending this section (1- not at all likely, 10- very likely).

1---2---3---4---5---6---7---8---9---10

Please rate how helpful this part of the training has been towards your overall understanding of working with individuals with severe and persistent mental illness who are sex offenders.

1---2---3---4---5---6---7---8---9---10

Please put additional comments on back of this paper. Thank you for your participation in this evaluation.

Appendix E
Assessment of Section 2

This section of the training discussed assessment considerations and some recommendations as well as adaptation of existing models of sex offender treatment.

What part of this section did you find most helpful in your learning process? (e.g., small group activities, power point didactic, discussion and questions, references) You may name more than one factor if multiple factors were helpful in your learning process

What part of this section do you think could have been improved? (e.g., content, skills of presenter, small group activities, etc.)

Name at least three things you have learned from this section (e.g., "take aways")?

Please rate how likely you think you are to work with individuals with severe and persistent mental illness after attending this section (1- not at all likely, 10- very likely).

1---2---3---4---5---6---7---8---9---10

Please rate how helpful this part of the training has been towards your overall understanding of working with individuals with severe and persistent mental illness who are sex offenders.

1---2---3---4---5---6---7---8---9---10

Please put additional comments on back of this paper.

Thank you for your participation in this evaluation. The information used from this measure will go toward improving future training.

Appendix E

Assessment of Section 3

This section of the training presented treatment options for individuals with severe and persistent mental illnesses who are also sex offenders.

What part of this section did you find most helpful in your learning process? (e.g., small group activities, power point didactic, discussion and questions, references) You may name more than one factor if multiple factors were helpful in your learning process.

What part of this section do you think could have been improved? (e.g., content, skills of presenter, small group activities, etc.)

Name at least three things you have learned from this section (e.g., "take aways")?

Please rate how likely you think you are to work with individuals with severe and persistent mental illness after attending this section (1- not at all likely, 10- very likely).

1---2---3---4---5---6---7---8---9---10

Please rate how helpful this part of the training has been towards your overall understanding of working with individuals with severe and persistent mental illness who are sex offenders.

1---2---3---4---5---6---7---8---9---10

Please put additional comments on back of this paper. Thank you for your participation in this evaluation. The information used from this measure will go toward improving future training.

Appendix F

Follow-up Assessment

Have the three main areas discussed in the training led to positives changes in your work?
If yes, what specifically have you incorporated in your work, based on the training?
If no, why do you think this is so? (e.g., was it not applicable, was it nothing new,etc.)

How has your assessment process changed when working with possible mental illnesses?

How have you worked to incorporate mental health culture into your work?

How have you begun to utilize some of the treatment strategies for the SMISO population including working with the mental illness first, and sex offender issues second?

Would you recommend this training to your colleagues?

If yes, why?
If no, why not?

What do you think would help you to effectively use the information presented in the training? (e.g., additional supervision on the topic, additional future training, book recommendations, consultations regarding the population)

Looking back do you have any recommendations for this training to improve its content or delivery?

Thank you for your participation in this evaluation. The information used from this measure will go toward improving future training.