

Assessment of Dangerousness for Mentally Disordered Offenders: A Structured Approach

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Mental Illness & Violence

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Disclaimers

- Although we all work for DSH, the views expressed in this presentation are our personal views and **NOT** those of DSH
- None of the presenters have a financial interest in this presentation
- Presenters can be “arrogant” and may “alienate” the audience at times
- Presenters are “Rock Stars” and you asked for “More.”

~FMHAC conference reviews 2018

Background

- July 1, 1986 Mentally Disordered Offender law became effective

Background

- July 1, 1986 Mentally Disordered Offender law became effective
- Does the prisoner represent a substantial danger of physical harm to others because of a severe mental disorder?
- What is the best way to answer the question?
 - What do we know about mental illness and violent behavior?
 - What are current practices?

Mental Illness & Violence

- In general, most individuals with mental illness are no more violent than the general population...
- ...unless they use drugs – a co-occurring diagnosis of a substance use disorder was strongly predictive of violence
- Even in those without a mental illness, people who abuse substances are nearly 7xs more likely to report violent behavior
- Base rate of serious mental illness is very low
- Only 3 to 5% of violence is committed by those with serious mental illness

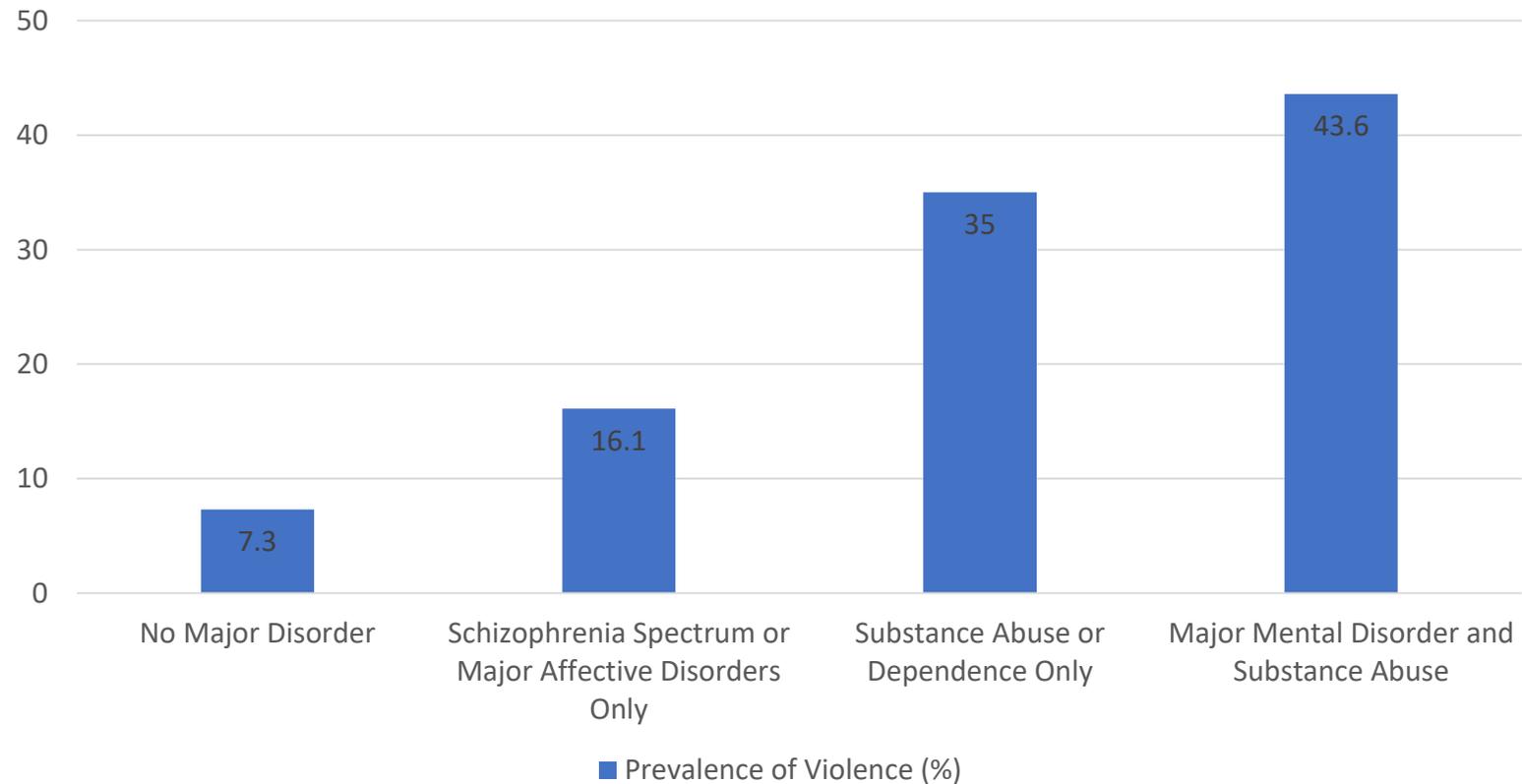
Who causes the 3 to 5%?

- Of those with mental illness, individuals with personality disorders or adjustment disorders were most likely to commit violent acts
- A diagnosis of a major mental disorder, especially schizophrenia, was associated with a lower rate of violence than a diagnosis of a personality disorder or adjustment disorder

Mental Illness & Violence

- A diagnosis of schizophrenia, major depression, or bipolar disorder increases risk 2-3Xs compared to those without such an illness
- Lifetime prevalence of violence 16%, compared to 7% among those without such an illness

Lifetime Prevalence of Violence

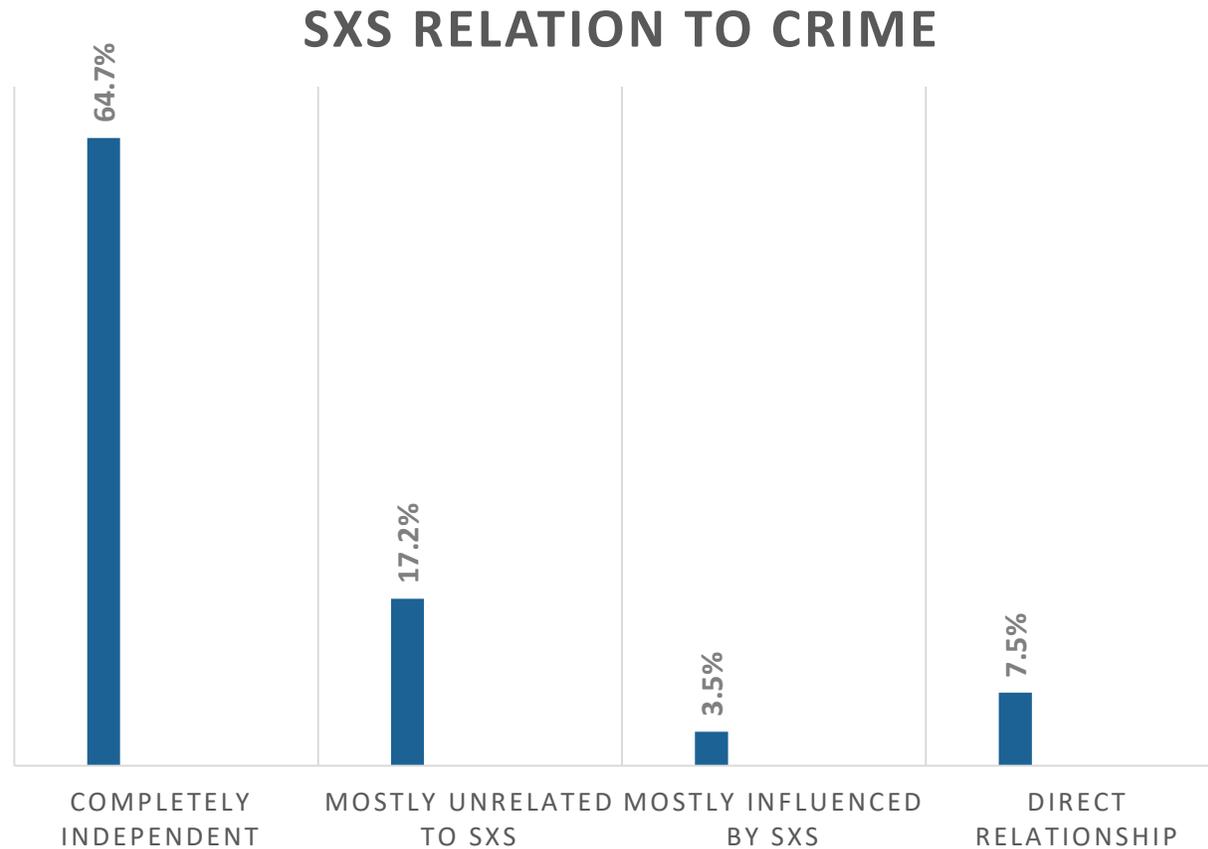


*Friedman, R.A., M.D. (2006) Violence and mental illness – How strong is the link? N Engl J Med 355; 20.

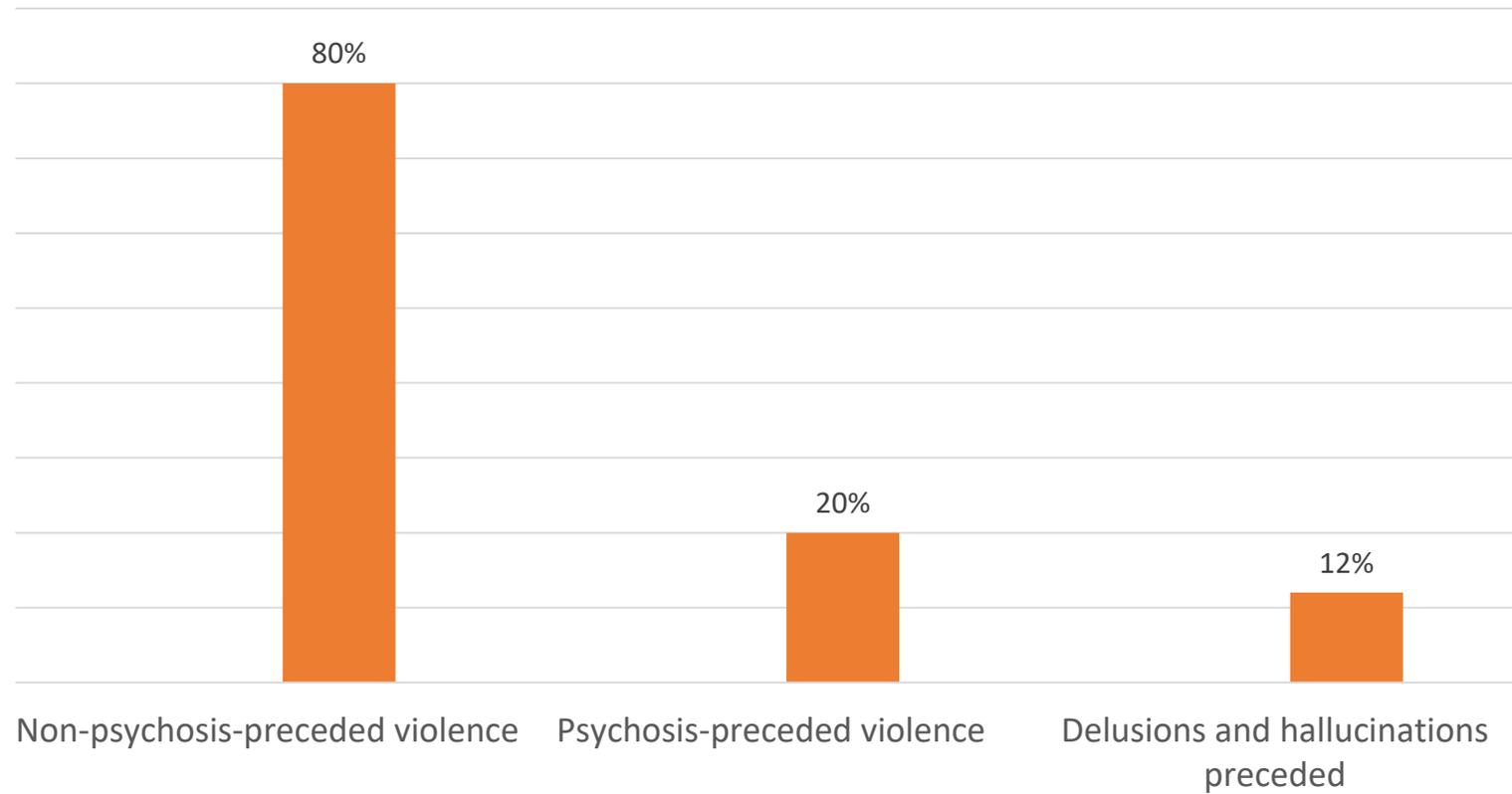
Remember the Question...

- Does the prisoner represent a substantial danger of physical harm to others **because of** a severe mental disorder?

Crime Due to Mental Illness



Violence Due to Psychosis



Current Practices

- There has been no “standard” method to answer this question
- Differences between agencies in which risk factors are considered
- Differences in how risk factors are considered
 - Present/absent
 - Weighted
 - Causal

Type I

- Current, recent, emerging behavior (kicking, threatening, acting out)
- Expressed or implied intentions
- Arising out of a Severe Mental Disorder

Type II

- Based on the Severe Mental Disorder
- The present mental state is the same or similar to the mental state that has led to violence in the past

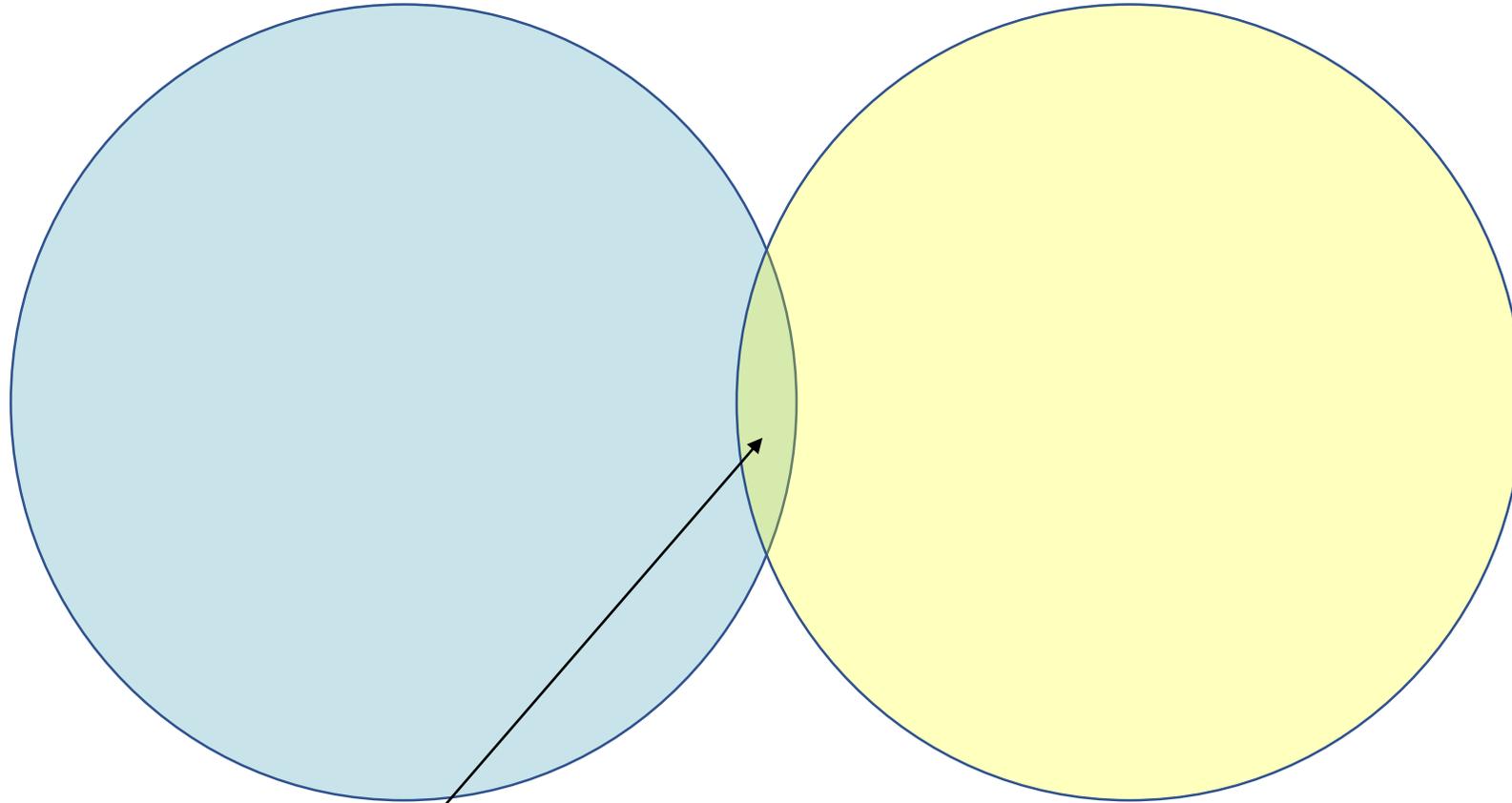
Type III

- The prisoner's personal history indicates a pattern of physical harm to others based on his or her Severe Mental Disorder
- The remission of overt signs and symptoms of his or her Severe Mental Disorder have historically been short lived*

*Mihordin, R.J., M.D., J.D. (2006) Fact-based, Fact-limited, Case-specific, and MDO-focused Forensic Evaluations.

	Agency 1	Agency 2	Agency 3	Agency 4
Hx of violence	✓		✓	
Hx of illness related violence	✓			✓
Prior performance on supervised release	✓		✓	
Treatment compliance	✓		✓	✓
Response to Tx	✓			
Insight	✓		✓	✓
Impulsivity	✓			
Substance abuse	✓			✓
Remission	✓		✓	✓
Environmental risk factors	✓		✓	
Non SMD related risk factors acknowledged		✓		
Danger to society risk factors			✓	
Release plans				✓

Agency 1 "Yes" Dangerous by Reason of Severe Mental Disorder



Agencies Agree Dangerous by Reason of Severe Mental Disorder

Agency 2 "Yes" Dangerous by Reason of Severe Mental Disorder

How to Measure Dangerousness due to a Severe Mental Disorder?



Risk Assessment: An Overview of the Options

Brandon Yakush, PsyD
Consulting Psychologist
Forensic Services Division
DSH-Sacramento

Three Main Categories

- Per the literature, there are three main methods of risk assessment:
 - “Clinical judgment”
 - Actuarial assessment
 - Structured Professional Judgment (SPJ)

“Clinical Judgment”

- Now (almost) entirely debunked, “clinical judgment” relied upon the clinician’s intuition, gut reactions, and/or “professional” judgment.
- “Clinical judgment” did not incorporate research or any structured assessment method.
- “Clinical judgment” has proven to be wrong more than it has been right.

“Clinical Judgment” (cont.)

- However, the phrase “clinical judgment” in this context is misleading.
- Everything we do involves clinical judgment; it should not be considered a “bad thing.”

“Clinical Judgment” (cont.)

- IMHO, this debunked form of risk assessment is better termed:
 - “uninformed” clinical judgment
 - clinical “intuition”
 - or “in my experience” judgment
- Such an approach places the greatest weight on the clinician’s own professional experience and not research.

Actuarial Assessment

- An actuarial approach to risk assessment is most known in the insurance realm.
 - Your cost for life/auto/home insurance is based on a formula derived from research about your risk of costing the insurance company money (e.g., dying young, getting into a car accident, or your house burning down).
 - Sometimes the variables considered by the insurance company lack any face validity.
 - Ultimately, the insurance companies do not care whether you die or have a car accident; they just want to make sure that on the whole, more people pay for their insurance than actually ever need to use it.

Actuarial Assessments (cont.)

- Actuarial assessments are *nomothetic* based, as the relevant variables (risk factors) are determined by studies of large groups of individuals.
 - First, measure numerous variables of a large sample of first-time offenders and after a set period of time (5, 10, 12, years, etc.), determine which of the variables were present in the offenders who re-offended.
 - Second, figure out which variables ultimately best distinguished between recidivists and non-recidivists.
 - Third, create a measure of those variables that results in a total score (e.g., 0 to 7).
 - Fourth, utilizing the original sample of offenders, calculate the percentage of offenders who re-offended for each total score or score range.

Actuarial Assessments (cont.)

- Strengths of actuarial instruments:
 - Usually straightforward to score, with very clear scoring rules, resulting in high interrater reliability
 - Do not require an advanced degree to administer
 - Can (mostly) be scored from a file review alone
 - Results in a quantified risk score that can be interpreted consistently
 - Allows additional scores to be calculated, such as percentiles
 - Research generally finds actuarials to have moderate predictive accuracy

Actuarial Assessments (cont.)

- Weaknesses of actuarial instruments:
 - Only capable of predicting group recidivism rates, not those of an individual.
 - The instrument ultimately only can say that of offenders with the same total score as the individual being assessed, X% went on to re-offend within XX years.
 - It cannot say that the individual undergoing assessment has an x% chance of re-offending within XX years.
 - The data is still very useful, but must be presented accurately.
 - Still there is a risk that the trier of fact will misunderstand or mis-apply the data.

Actuarial Assessments (cont.)

- Weaknesses of actuarial instruments (cont.):
 - Does not account for outlier scenarios or permit modification of the results due to extenuating circumstances
 - Says nothing about the etiology of the individual's risk
 - New research is consistently modifying the application of the results.

Structured Professional Judgment

- SPJ instruments, like actuarials, are derived from nomothetic research.
- Unlike actuarials, SPJ instruments do not result in a total score.
 - Items are rated as *present*, *partially present*, or *not present* without any numerical score.
 - However, numerical scoring is used in research studies to assess the validity of SPJ instruments.
- Ultimately, the rating of overall risk (high, moderate, low) is subjective.

Structured Professional Judgment (cont.)

- Strengths of SPJ instruments:
 - Can distinguish between *presence* and *relevance* of individual risk factors (e.g., the greatest improvement from the HCR-20^{V2} to the HCR-20^{V3})
 - Allows for emphasis on the most salient risk factor(s) or the addition of ideographic risk factors
 - “Other Consideration” items on the HCR-20^{V3}

Structured Professional Judgment (cont.)

- Strengths of SPJ instruments (cont.):
 - Allows the evaluator to weigh individual risk factors as best applied to each case.
 - Allows for a more ideographic understanding of the role of the various applicable risk factors, including of outlier scenarios.
 - Usually include dynamic risk factors that can undergo change to decrease risk.
 - The results of the SPJ instrument are entirely about the individual and not the group.

Structured Professional Judgment (cont.)

- Weaknesses of SPJ instruments:
 - While the scoring manual will include guidelines, the scoring process of the risk factors is much more subjective than actuarials, which lowers interrater reliability.
 - There is a disconnect between how SPJ instruments are applied in research (i.e., quantified results) and actually utilized in practice (i.e., no quantified results).

Structured Professional Judgment (cont.)

- Weaknesses of SPJ instruments (cont.):
 - The final risk rating is very subjective, as there are no guidelines to assist.
 - E.g., one or two very salient risk factors might lead to a moderate risk rating, while a half-dozen moderately salient ones might only warrant a low risk rating.
 - Can be hard to fully complete an SPJ instrument without an interview
 - But missing items really don't impact anything.

One other method: The Ideographic Approach

- In contrast to the debunked “clinical intuition,” an ideographic risk analysis supplements a typical actuarial and/or SPJ assessment, and identifies salient risk factors for the individual case not identified by the utilized instruments.
- The ideographic approach emphasizes *case-specific* risk factors that are revealed in the individual’s history of violence.
- While this added approach is probably controversial in the eyes of pure actuarialists, it is actually encouraged by those advocating SPJ instruments (e.g., “Other Consideration” items of the HCR-20^{V3}).

A comparison of methods

Method	Type	Origin of Data	Target of Data
Actuarials	Nomothetic	Group	Group
SPJ	Nomothetic	Group	Individual
Ideographic	Ideographic	Individual	Individual

Examples

- Common actuarial instruments:
 - Static-99R & Static-2002R (sexual offending)
 - VRAG-R (violent offending)
 - LS/CMI (general offending)
- Common SPJ instruments:
 - HCR-20^{V3} (violent offending; “gold standard” for SPJ)
 - SVR-20 (sexual offending)
 - SAPROF (protective factors)
 - SAVRY (juvenile violent offending)
 - SARA (domestic violence)

One last observation...

- Actuarial instruments are arguably the most accurate at rating or categorizing (low, moderate, high) an individual's risk.
- However, SPJ instruments are much better at providing information about the etiology of the individual's risk.
 - What risk factors are most salient to his or her risk?
- In the context of Criterion Six of the MDO law, etiology is critically important:
 - PC 2962(d)(1): "...and that by reason of his or her severe mental disorder the prisoner represents a substantial danger of physical harm to others."
 - The risk must be due to the severe mental disorder.

A Structured Professional Judgement Approach

Adapting an instrument for Criterion Six
Application with items on HCR-20 V3*

*Not an authorized or complete HCR-V3 training

HCR 20 V3

Description

SPJ risk assessment instrument

Replaces Version 1 (1995) and Version 2 (1997)

with more than 200 disseminations; > 33,000 cases; 25 countries)*

Version 3 (2013)

revised over 5 years: extensive clinical beta testing and empirical evaluation.*

Scales

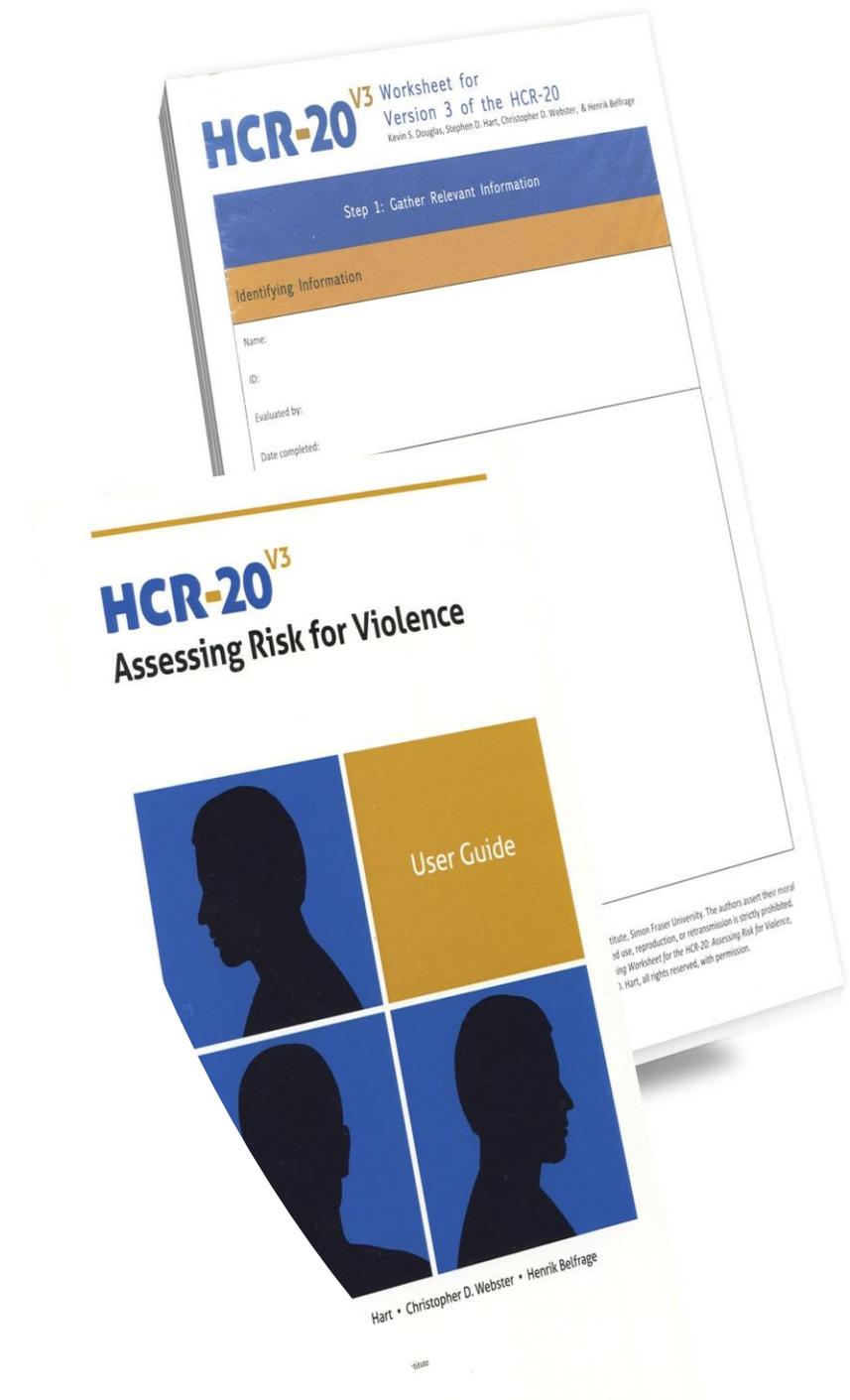
- Historical
- Clinical
- Risk Management

*Douglas, K. S., Shaffer, C., Blanchard, A., Guy, L. S., Reeves, K., & Weir, J. (2002-2016). *HCR-20 violence risk assessment scheme: Overview and annotated bibliography*. HCR-20 Violence Risk Assessment White Paper

Series, #1. Burnaby, Canada: Mental Health, Law, and Policy Institute, Simon Fraser University.

* Guy, L. S., Wilson, C. M., Douglas, K. S., Hart, S. D., Webster, C. D., & Belfrage, H. (in prep). *HCR-20 Version 3: Item by-tem summary of violence literature*. HCR-20 Violence Risk Assessment White Paper Series, #3. Burnaby,

Canada: Mental Health, Law, and Policy Institute, Simon Fraser University.



HCR 20 V3 Historical Scale

HCR-20^{V3}

Rating Sheet for Version 3 of the HCR-20

Kevin S. Douglas, Stephen D. Hart, Christopher D. Webster, & Henrik Belfrage



Click on Tools, Comment and Share to access additional features.

Name		Record Number							
DOB		Gender							
Nature/Purpose of Evaluation									
HCR-20 ^{V3} Items		Omit	Presence			Omit	Relevance		
			N	P	Y		L	M	H
Historical Scale (History of problems with...)									
H1.	Violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H2.	Other Antisocial Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H3.	Relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H4.	Employment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H5.	Substance Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H6.	Major Mental Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H7.	Personality Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H8.	Traumatic Experiences	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H9.	Violent Attitudes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H10.	Treatment or Supervision Response	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OC-H	Other Considerations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clinical Scale (Recent problems with...)		Rating Period: _____							

Risk Management and the Context of Parole

“Consider community based risk variables when considering forensic patients for release to community...[otherwise] jeopardize quality and thoroughness of their risk assessment.”*

* Vitacco, Tabernick, Zavodny, Bailey Waggoner (2016) Projecting Risk: The importance of HCR 20 Risk Management Scale in predicting outcomes w/ forensic patients. *Behavioral Science and Law*. 34. 308 - 320.



Why it works for Criterion 6

Aide Memoire (Review all known risk factors; apply to present case)

Base Rate Estimation/Group Identification

Empirical (not guessed) Risk Factors

Tested configuration

Potentiators & accelerators

Ideographic considerations

Transparency

Factors considered

Reasoning

Professional Standards

More Reasons it works for Criterion 6

Reference group resemblance

- Reanalysis of 5000 cases previous version
- 800 participants; mixed forensic; civil , correctional psychiatric

Cross validation

- Forensic; Civil Psychiatric, Correctional, Mixed

Validity

- Total AUC .75 to .81* (apart from prediction; indicate accuracy and relevance to violence)
- Extensive beta-testing draft revision; field testing
- Extensive research basis for previous versions

Reliability

- Anchored definitions
- Total ICC's .84-. 92*

Factors relevant to PC 2962

- Definition of violence and outcome variables similar to PC2962
- Ideographic factors
- Relevance (to violence) not just presence
- Causality
- Current mental status
- Context of parole
- Severity (serious physical violence) and Imminence

Permits distinction between SMD –related and other violence

Professional and Evidentiary Standards

Inclusion of a risk assessment tool (vs. idiosyncratic list) considered best practice for forensic MH assessment.

Hielbrun, Grisso and Goldstein (2009) *Foundations of Forensic Mental Health Assessment*

Heilbrun 2009 Evaluation for Risk of Violence in Adults

APA Amicus Brief to US Supreme Court Coble vs. State (of Texas) 2010

82% of forensic diplomates use a risk assessment measure for VRA

Lally (2003); What tests are acceptable for use in forensic evals? A survey of experts *Pro Psychology Research and Practice*

Rarely challenged

Challenges rarely successful

Cox, et al (2017). Update and expansion of the Role of VRAG and HCR 20 US Case Law 2010 to 2016 expanding on Vittaco et al 2012. **Behavioral Science and the Law.**

Research Base-Validity for the MDO Population

HCR-20 VIOLENCE RISK ASSESSMENT SCHEME:

- **Overview and Annotated Bibliography**
- **Kevin S. Douglas, LL.B., Ph.D**
- **CURRENT UP TO JANUARY 1, 2017**

Visit <http://kdouglas.wordpress.com> for updates

Some Limits

Procrustean Bed

- Historical factors (Over emphasis)
- Not specifically designed for MDO
- Risk Management Emphasis
- The SPJ approach is ultimately geared toward informing risk management plans so as to facilitate risk reduction, not civil commitment decisions per se.

Irrelevant data risk

- Relevance to violence & violence due to SMD
- Some may over-focus on preferred factors
- Overweighing data (variable item reliability)

Attributing presence to cause or relevance risk

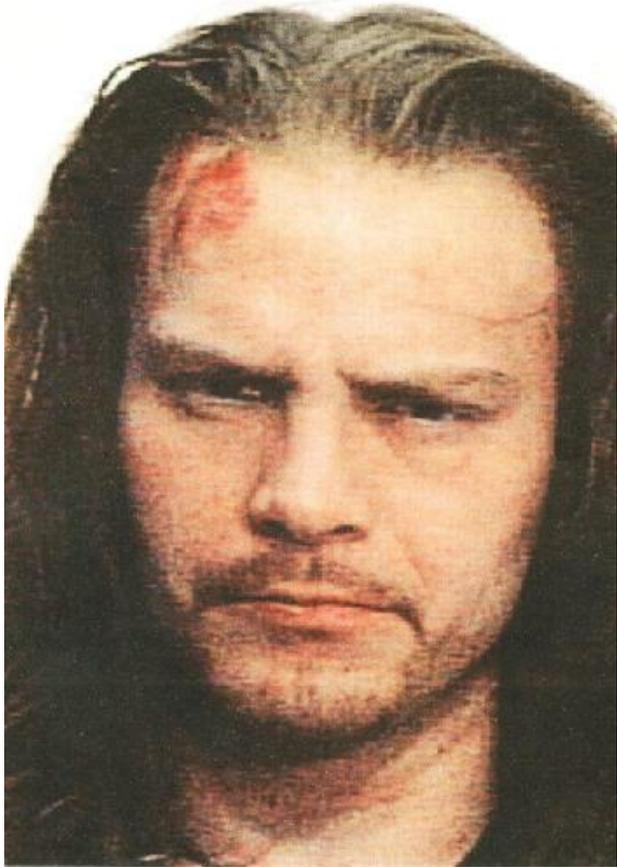
Not tested on California MDO's



Criterion 6

By reason of his or her PC 2962-defined SMD the prisoner represents a substantial danger of physical harm to others.

- By reason of SMD
- Represents
- Substantial danger of physical harm
- To others (not self)



Schmedlap

- Mr. Schmedlap is 45 year-old male serving a 10 year term for armed robbery at a Level 4 prison ...
- You are about to assess him as a MDO

Schmedlap Vignette *

Criminal history

- Onset age 17
- 7 arrests w/ probation for possession of a controlled substance 1995; 1996; 1999; 2001; 2002; 2005; 2006
- 7 Probation and parole violations; urinalysis 1995; 1996; 1999; 2001; 2002; 2005; 2006
- 5 previous terms for armed robbery, often with accomplices: "I needed money for meth and heroin" 1999; 2001; 2002; 2005; 2006
- 5 arrests for corporal injury to cohabitant "She hit me first; b/c I was doing heroin" 1999; 2001; 2002; 2005; 2006
- PORs and arrest records do not note unusual/bizarre behaviors upon arrests
- This term: 2 115s possession of an inmate manufactured weapon; "They weren't mine" 2014, 2015
- This term: criminal threats; told the Warden he would "kill any cellie" " I wanted single cell" 2016

Mental health history

- Previous PC 2684 (insane prisoner) DSH commitments on previous term; reported malingering; Diagnosed with Major Depression
- No history of adjudicative competence concerns; 5150 holds
- CCCMS LOC this term
- Diagnoses of depressive disorder, ASPD, methamphetamine and heroin use disorders, institutional remission

Current mental health status

- Adherent to medication regiment; Depakote 250 mg bid;
- Attends case management appointments; focus-SSI
- Calm, euthymic, denies VI-no indicators in file; notes show stability PY

Parole plans

- Stay with common-law wife (5 previous); old neighborhood
- Attend POC
- Live off SSI; never employed

*based on a composite of cases

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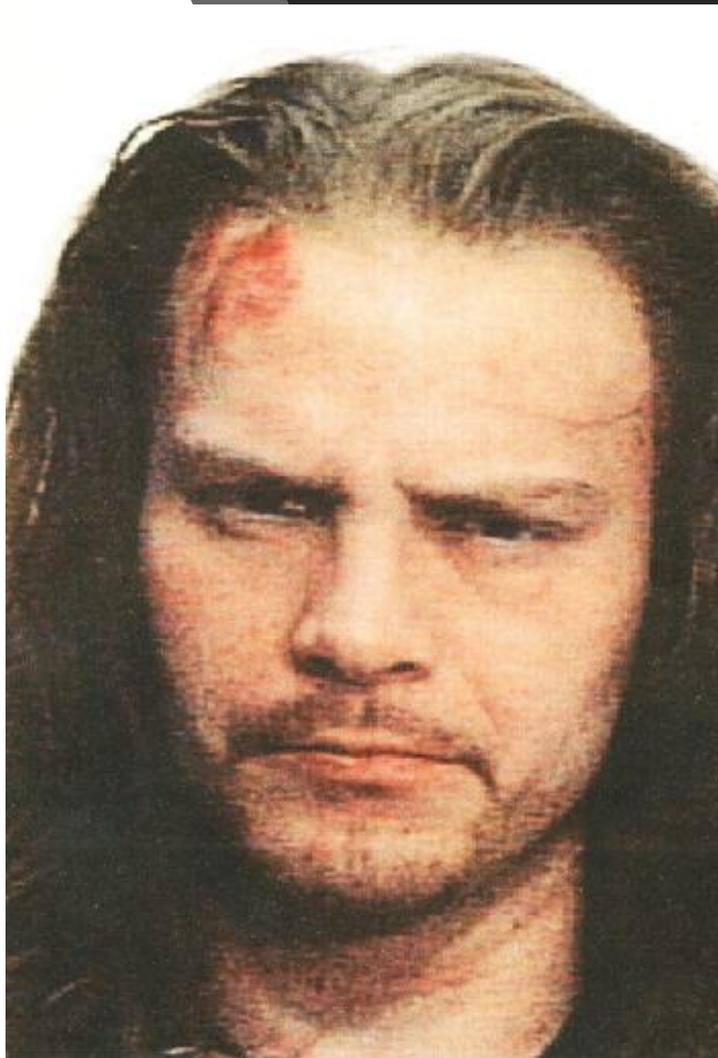
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Historical Scale Data (History of Problems with. . .)

- H1. Violence
 - Onset Child /Adolescent/Adult
- H2. Other Antisocial Behavior
 - Onset Child/Adolescent/Adult
- H3. Relationships
 - Intimate /Non-Intimate
- H4. Employment
- H5. Substance Use
- H6. Major Mental Disorder
 - Psychotic/Major Mood Disorder/Other Major
- H7. Personality Disorder
 - Antisocial, Psychopathic, and Dissocial/Other
- H8. Traumatic Experiences
 - Victim/Trauma & ACE
- H9. Violent Attitudes
- H10. Treatment or Supervision Response

	Presence	Relevance
Violence	✓	✓
AS BX	✓	✓
Relationships	✓	✓
Employment	✓	
Substance Use	✓	✓
MMD	✓	
PD	✓	✓
Trauma		
Attitudes	✓	✓
Supervision	✓	✓

Clinical Scale Data (Recent Problems with. . .)

Insight

Mental Disorder/Violence Risk/TX

Violent Ideation or Intent

Symptoms of Major Mental Disorder

Psychotic/Major Mood/Other

Instability

Affective/Behavioral/Cognitive

Treatment or Supervision Response

Compliance/Responsiveness

	Present	Relevance
Insight	✓	✓
Violent Ideation		
MMD Symptoms		
Instability		
Response		

Risk Management Scale Data (Future Problems with. . .)

Professional Services and Plans

Living Situation

Personal Support

Treatment/Supervision Response

Compliant/Responsive

Stress or Coping

	Presence	Relevance
Pro Plans		
Living	✓	✓
Support	✓	✓
Treat/Supv	✓	✓
Stress		

Violent Incidents

Use a disciplined, established approach

- Anamnestic Approach:
- Functional or Behavioral Chain Analysis

Via idiopathic review of incidents, find

- Triggers & drivers
- Reinforcers & Punishers
- Temporal relationships and context

Find patterns

- Ask—Is SMD a cause or aggravator?
- Ask—In what context—for this guy?

Analyze Severity

❖ *Consider offense paralleling behaviors/behavioral analogues when reviewing in prison episodes*



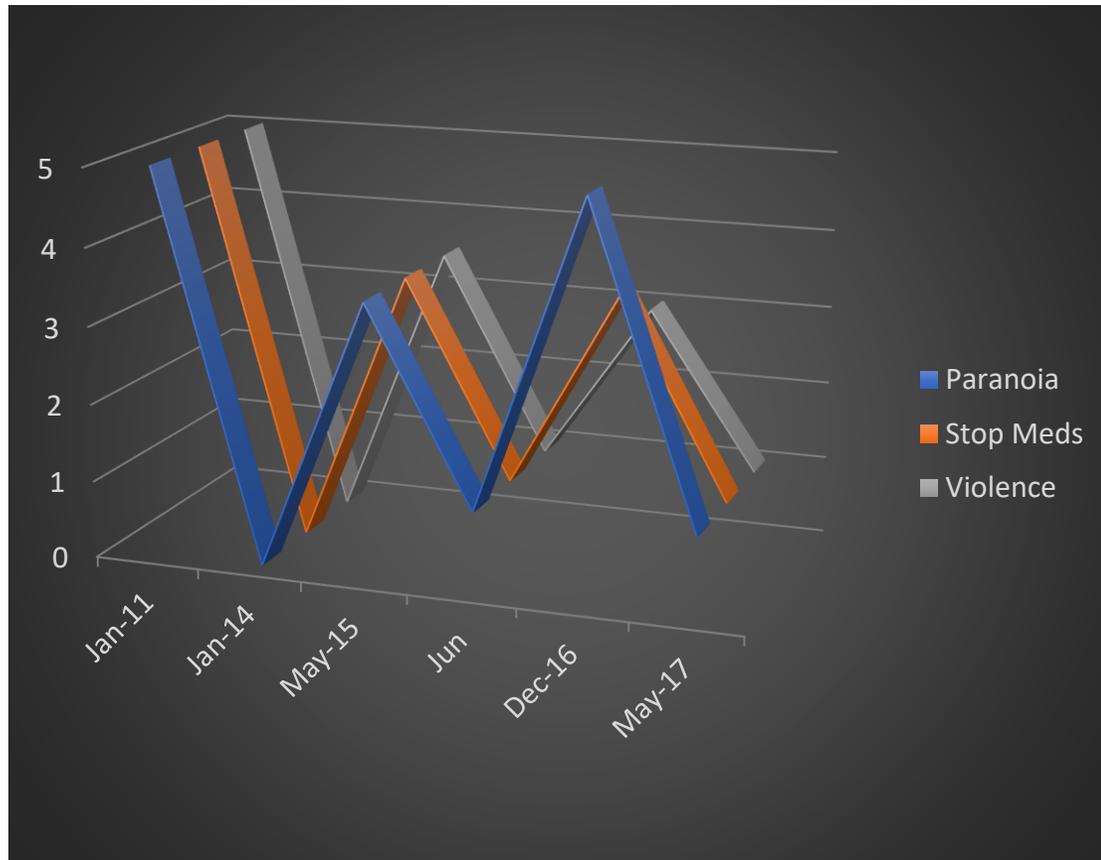
Review Violent Incidents

Motivators Disinhibitors Destabilizers

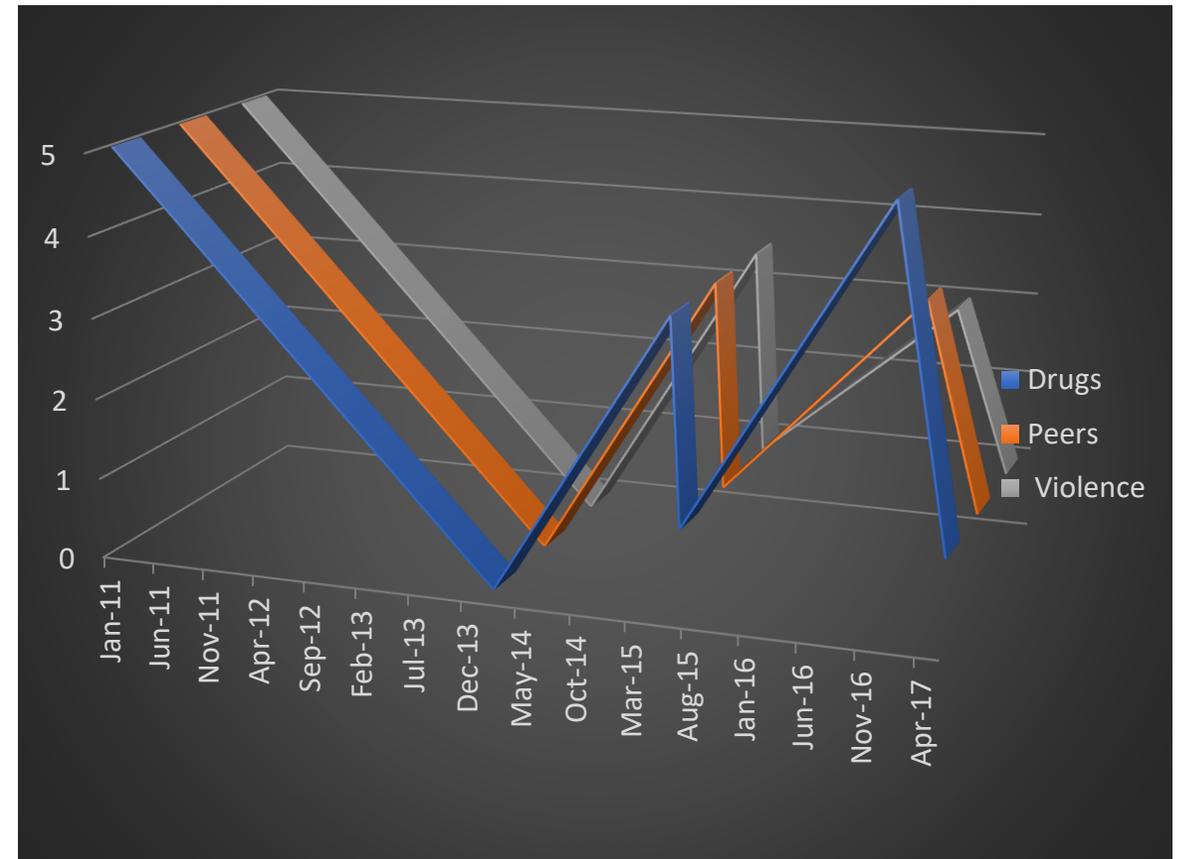
	Robberies	Threats	Domestic Violence
Triggers/ Drivers	Withdrawal Money Need Heroin Meth	Single Cell	Response to confrontation
Reinforcers/Punishers	Money Prison	Single Cell Safety	Parole Violation Submission
Temporal Relations/Context	Need Reinforced Community ASPD Peers	Cause Effect Prison	Stimulus respond Community Ex common law wife

Look for Patterns

Distinguish violence due SMD

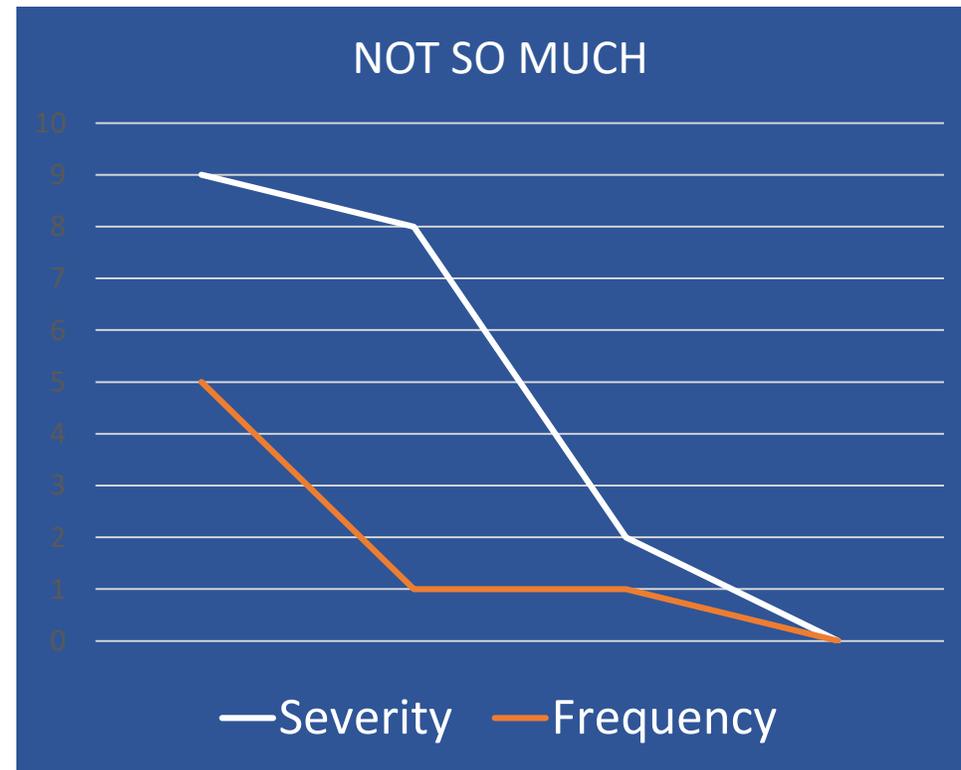


And to other factors



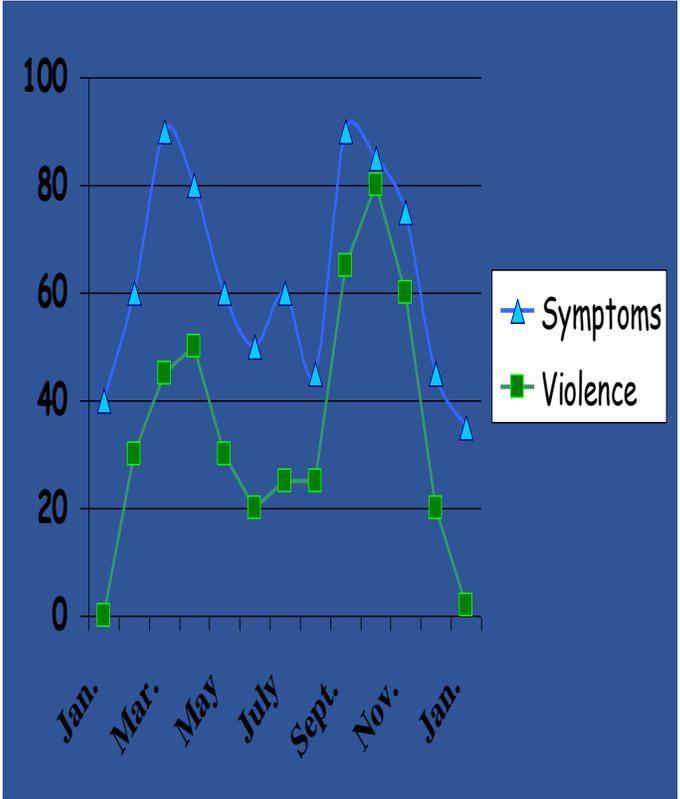
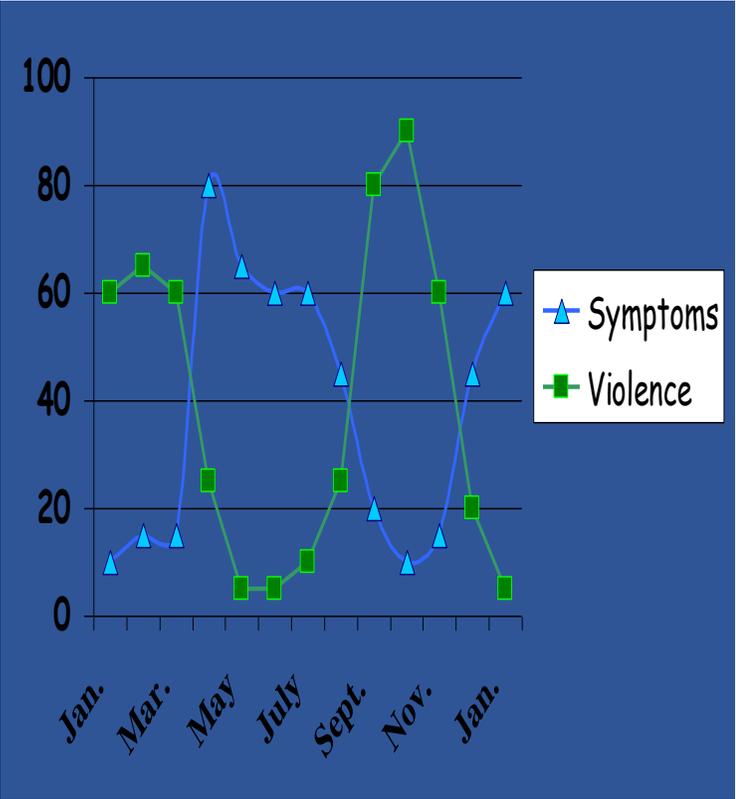
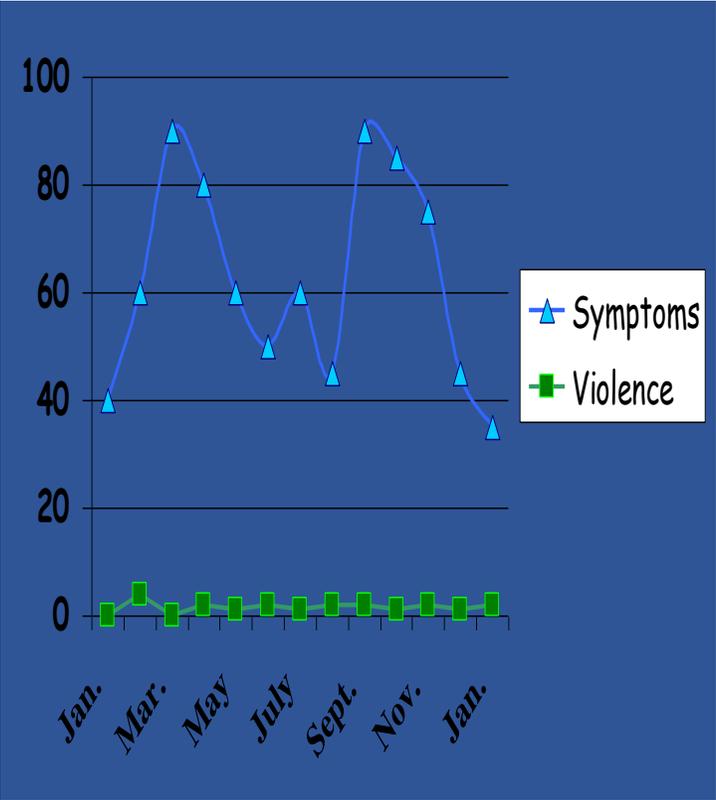
Look for Patterns

- Trajectory of Violence



Look for Patterns

Identify SMD-Related Violence



Analyze Severity and Imminence--On First

	Robberies	Threats	Domestic Violence
Onset	17	Prison	Mid 20's
Frequency	7	1	5
Intensity	high	low	high
Recency	200	2016	2006
Severity (injury)	Moderate; Threat, no injury	Low	Unk
Trajectory	Flat	Ascending	Descending
Conditions of Parole activate?	Yes	Yes	Yes

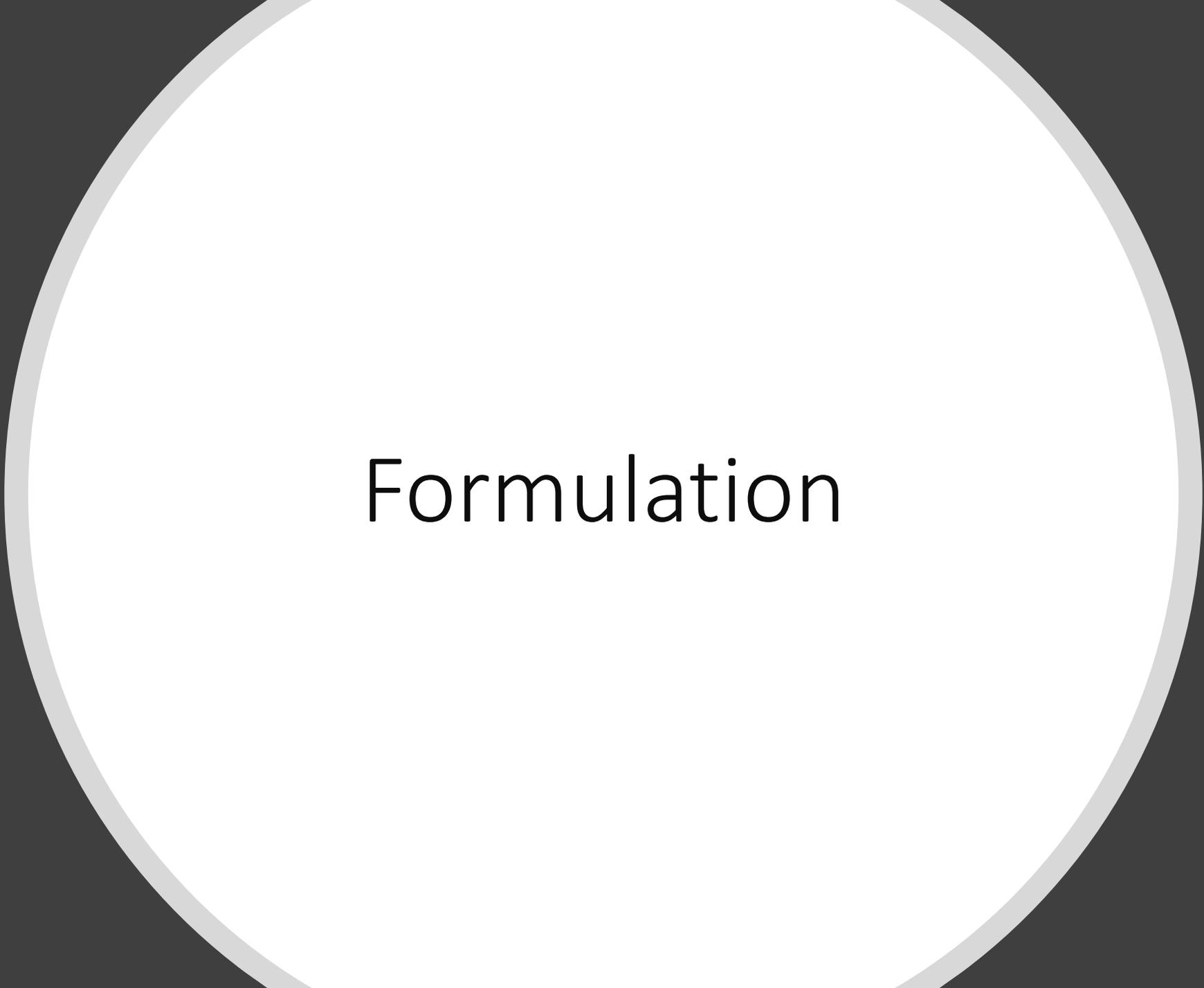
Relate Factors & Patterns to Risk

Explicitly state why you believe this prisoner represents a substantial danger of physical harm to others (or not):

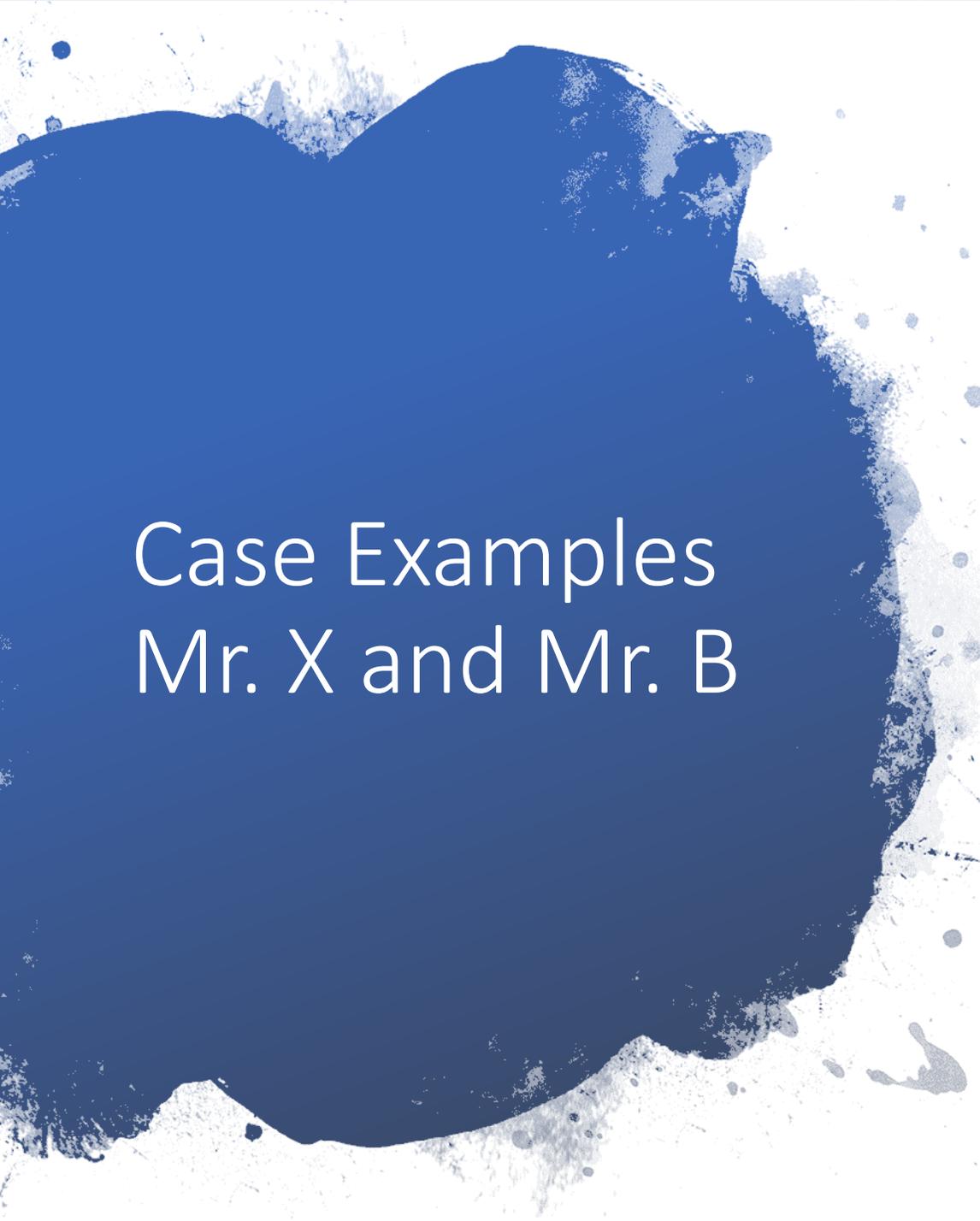
- Dangerous due to SMD
- Dangerous due to SMD and potentiators, accelerators, disinhibitors
 - Cause
 - Interaction
- Dangerous, but not due to SMD
- Dangerous, not for physical harm to others)
- Not Dangerous

Impact of Motivators, Destabilizers, Disinhibitors, Potentiators and Accelerators

- What makes violence more likely?
- What circumstances dis-inhibit or destabilizers?
- What makes them worse?



Formulation



Case Examples Mr. X and Mr. B

- Susan Napolitano, PhD
- Sexually Violent Predator Evaluator
- Forensic Services Division
- DSH-Sacramento

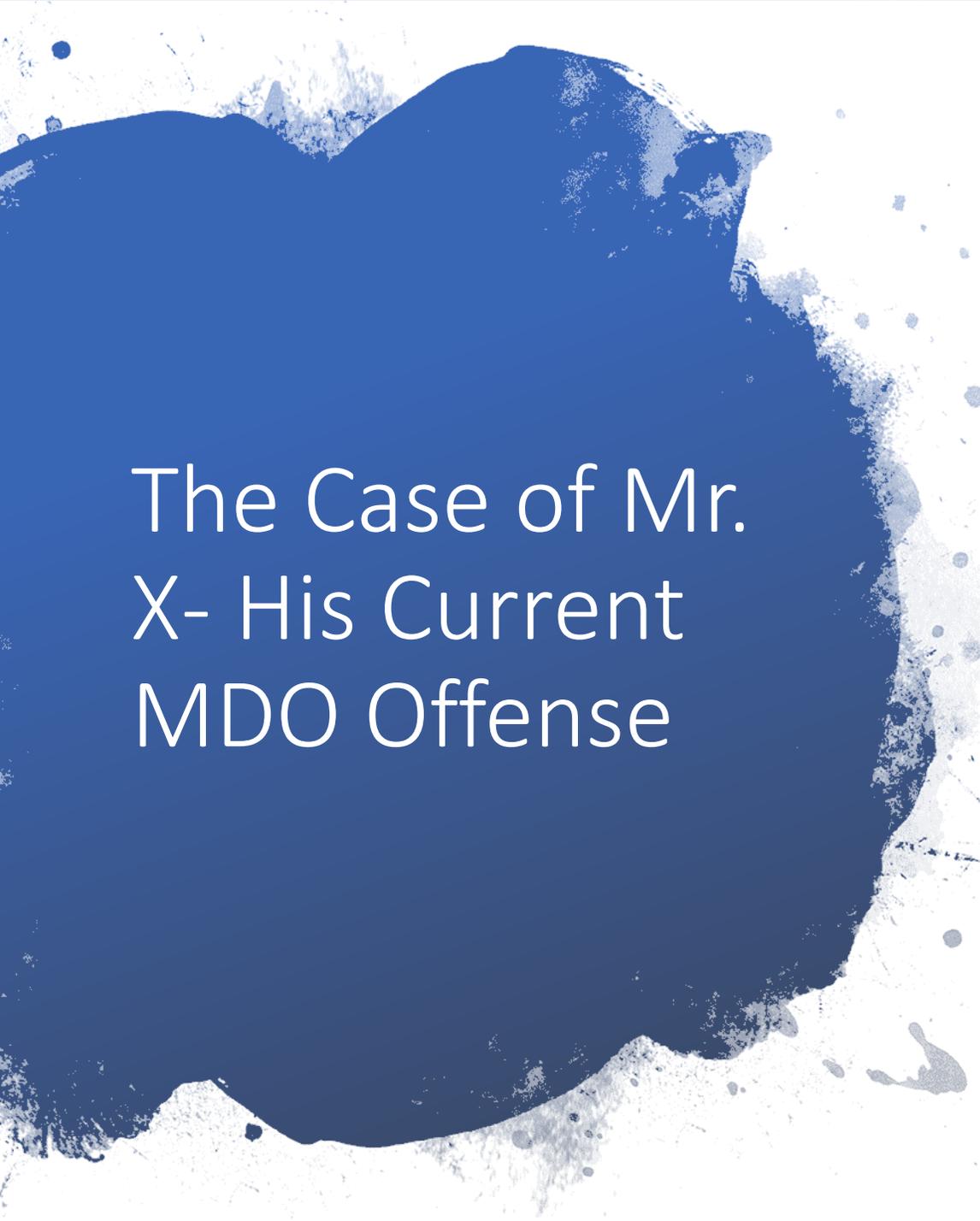


Mr.
X
Read
Vignette

The Case of Mr. X- His Current MDO Offense

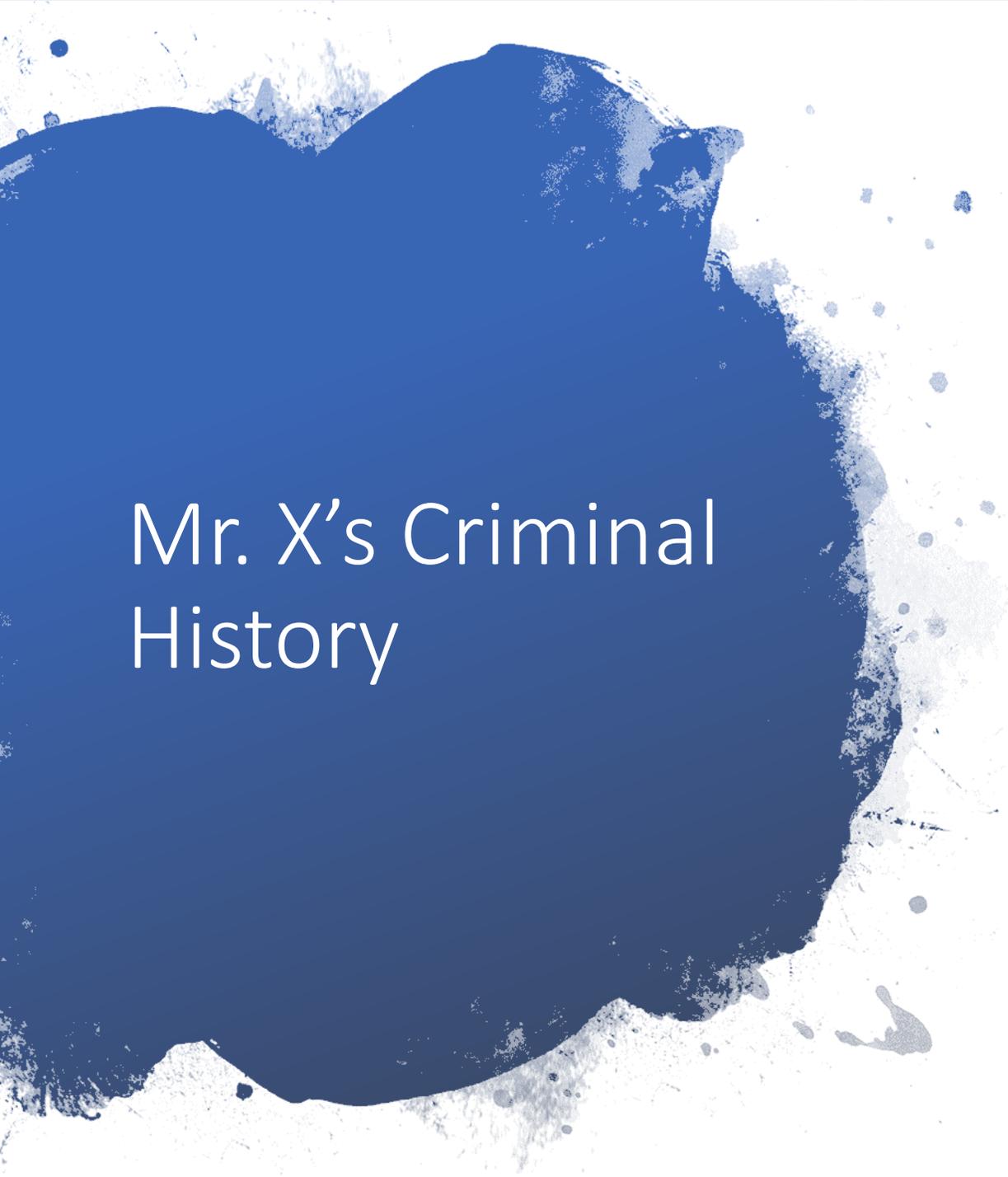
As deputies approached Mr. X, they observed him reach into his waistband and produce a black handgun.

Mr. X then ran into a residence, and exited through the back door. Mr. X unlawfully entered a victim's residence armed with a firearm and prevented victims from exiting the residence.



The Case of Mr. X- His Current MDO Offense

- Mr. X told me he was walking to toward a friend's house and was carrying a gun as he often did because he was a “gang banger.”
- He saw the police and ran because this is what you do when you are in a gang.
- He said he was hiding to avoid apprehension.
- He stated he was under the influence of PCP but does not believe it influenced his behavior.
- He said he was not hearing voices but he “felt paranoid” the police would arrest him.



Mr. X's Criminal History

- Mr. X was first arrested and convicted in 2008 for possession of a dangerous weapon. Also in 2008 he was convicted of concealing a dirk or dagger on two occasions and attempted grand theft. He was sent to prison for grand theft in 2008 and violated his parole in 2008, 2009 and 2011. In 2011 he was arrested and convicted of felon in possession of a firearm and in 2012 he was convicted of burglary.
- Mr. X told me he carried a weapon as part of his gang lifestyle. He said he needed to protect himself as he could be attacked by gang rivals at any time.
- He denied that hallucinations or psychotic paranoia influenced his past criminal behavior.

Mental Health History

- Made varied statements about mental health history
- He told me he did not receive mental health treatment until county jail and he had one prior psychiatric hospitalization
- He told CDCR staff he was diagnosed with bipolar disorder and schizophrenia in the community and first required mental health care as a child
- In CDCR he complained of voices and at times demonstrated paranoia and disorganized thoughts
- He also had polydipsia



Mental Health History - EOP May 2017 to present

He took antipsychotic medication and at times asked for medication changes and at times refused medication due to side effects

He endured many psychosocial stressors and deaths of family members while incarcerated

He has made several prior suicide attempts

For the last three months of his incarceration he functioned well with intermittent reports of voices

He has an extensive history of methamphetamine and PCP use

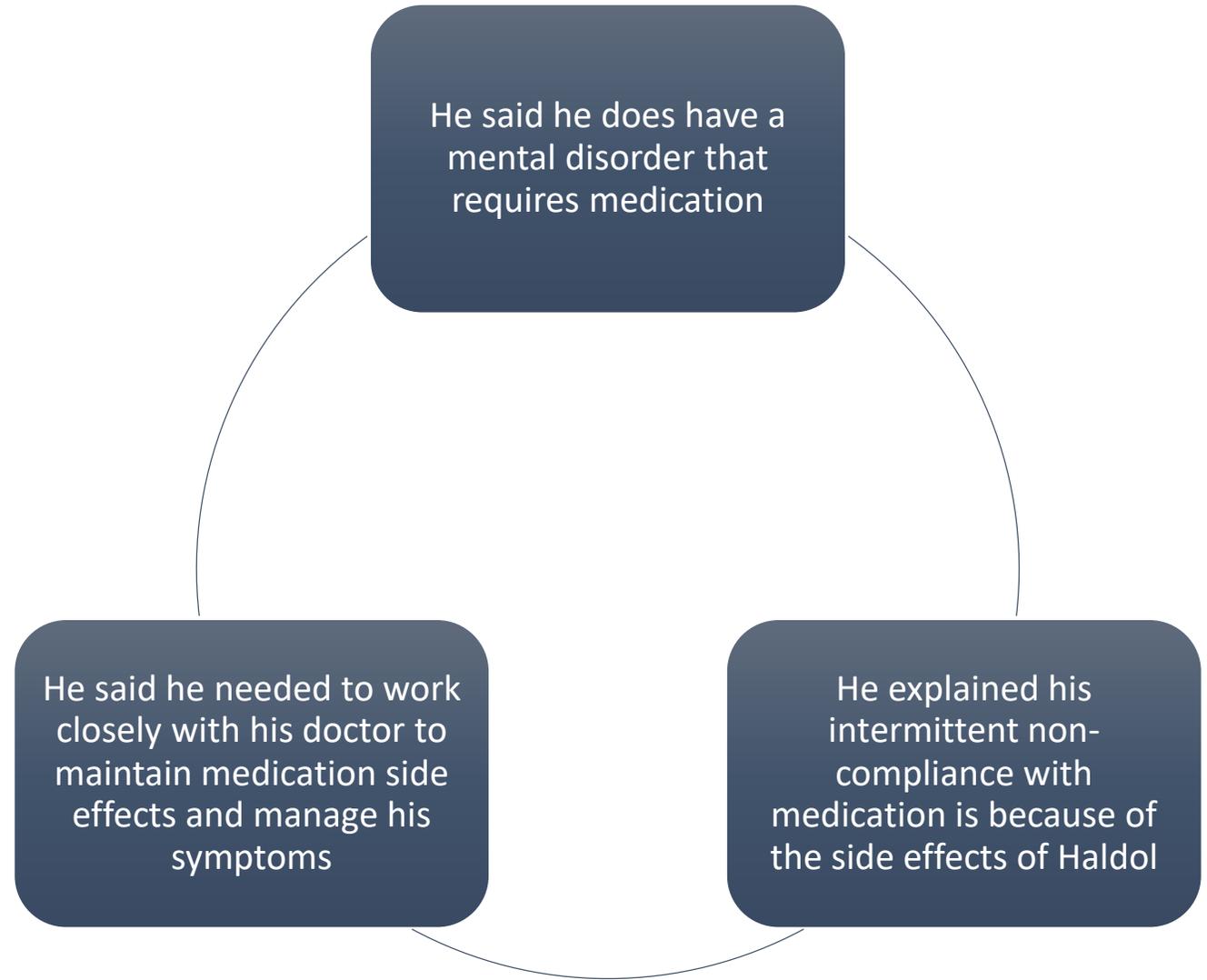
He never married, has no children and never held a job for more than 2 months



MSE/Interview

- The prisoner's thoughts were well organized
- His emotional presentation was unremarkable
- He said he hears voices of deceased family members. Voices sometimes make him edgy
- He sometimes feels like people are talking about him
- He did not appear to be responding to internal stimuli
- In the community he stops taking his medication and resumes drug use but this time he will follow his program

Interview



Parole Plan

- Mr. X told me he enlisted in a program called Safe Refuge in Long Beach where he will receive substance abuse treatment and other forms of psychosocial support. He said he is voluntarily attending so he can get back on his feet, earn money and help his family. He said he has sustained many losses while incarcerated and this has motivated him. He plans to stay sober and take medication as directed.

Historical Scale Data (History of Problems with. . .)

H1. Violence

Onset Child /Adolescent/Adult

H2. Other Antisocial Behavior

Onset Child/Adolescent/Adult

H3. Relationships

Intimate /Non-Intimate

H4. Employment

H5. Substance Use

H6. Major Mental Disorder

Psychotic/Major Mood Disorder/Other Major

H7. Personality Disorder

Antisocial, Psychopathic, and Dissocial/Other

H8. Traumatic Experiences

Victim/Trauma & ACE

H9. Violent Attitudes

H10. Treatment or Supervision Response

	Presence	Relevance
Violence		
AS BX		
Relationships		
Employment		
Substance Use		
MMD		
PD		
Trauma		
Attitudes		
Supervision		

Clinical Scale Data (Recent Problems with. . .)

Insight

Mental Disorder/Violence Risk/TX

Violent Ideation or Intent

Symptoms of Major Mental Disorder

Psychotic/Major Mood/Other

Instability

Affective/Behavioral/Cognitive

Treatment or Supervision Response

Compliance/Responsiveness

	Present	Relevance
Insight		
Violent Ideation		
MMD Symptoms		
Instability		
Response		

Risk Management Scale Data (Future Problems with. . .)

Professional Services and Plans

Living Situation

Personal Support

Treatment/Supervision Response

Compliant/Responsive

Stress or Coping

	Presence	Relevance
Pro Plans		
Living		
Support		
Treat/Supv		
Stress		

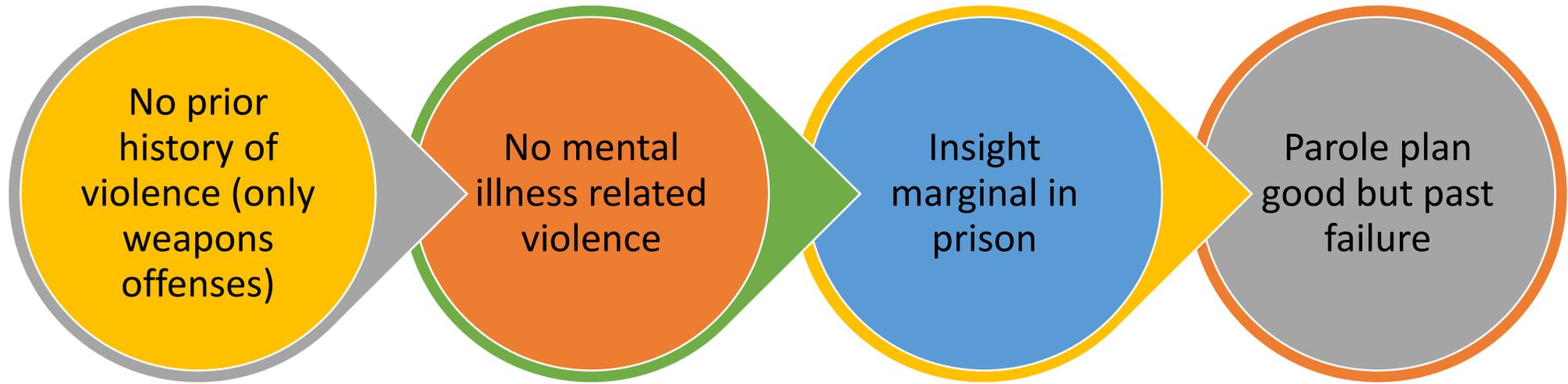
Analyze
Severity--On
First

	Violence	Illness-Related Violence	
Onset			
Frequency			
Intensity			
Recency			
Severity (injury)			
Trajectory			
Conditions of Parole activate?			

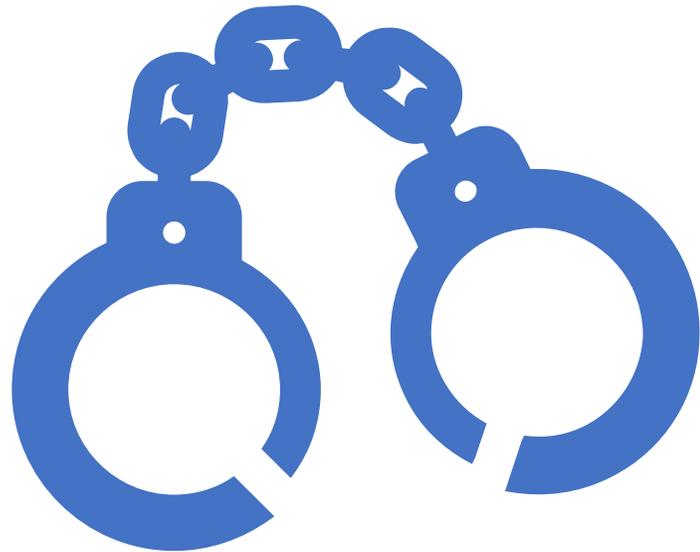


Violence Risk Factors

- Mental illness (Chronic psychosis currently stable)
- Substance addiction
- Insight marginal
- Poor treatment compliance in community
- Poor supervision compliance (PV 2008, 2009, 2011, recidivist)
- Violent attitudes (need a weapon to protect self, prior gang affiliation)



Protective Factors



Violence Risk/SMD Nexus

- Mr. X has no known history of violence, no violent rules violations while incarcerated and no known history of mental illness related violence. His qualifying crime is one which involved the implied threat of violence as opposed to actual violence.
- While he does have several general violence risk factors, there is no nexus between his severe mental disorder and his risk of violence.

Findings:

Findings: Based on his lack of history of mental illness related violence and his current symptom stability, Mr. X does not represent a substantial danger of physical harm to others based on his severe mental disorder.

Mr.
B
READ
VIGNETTE

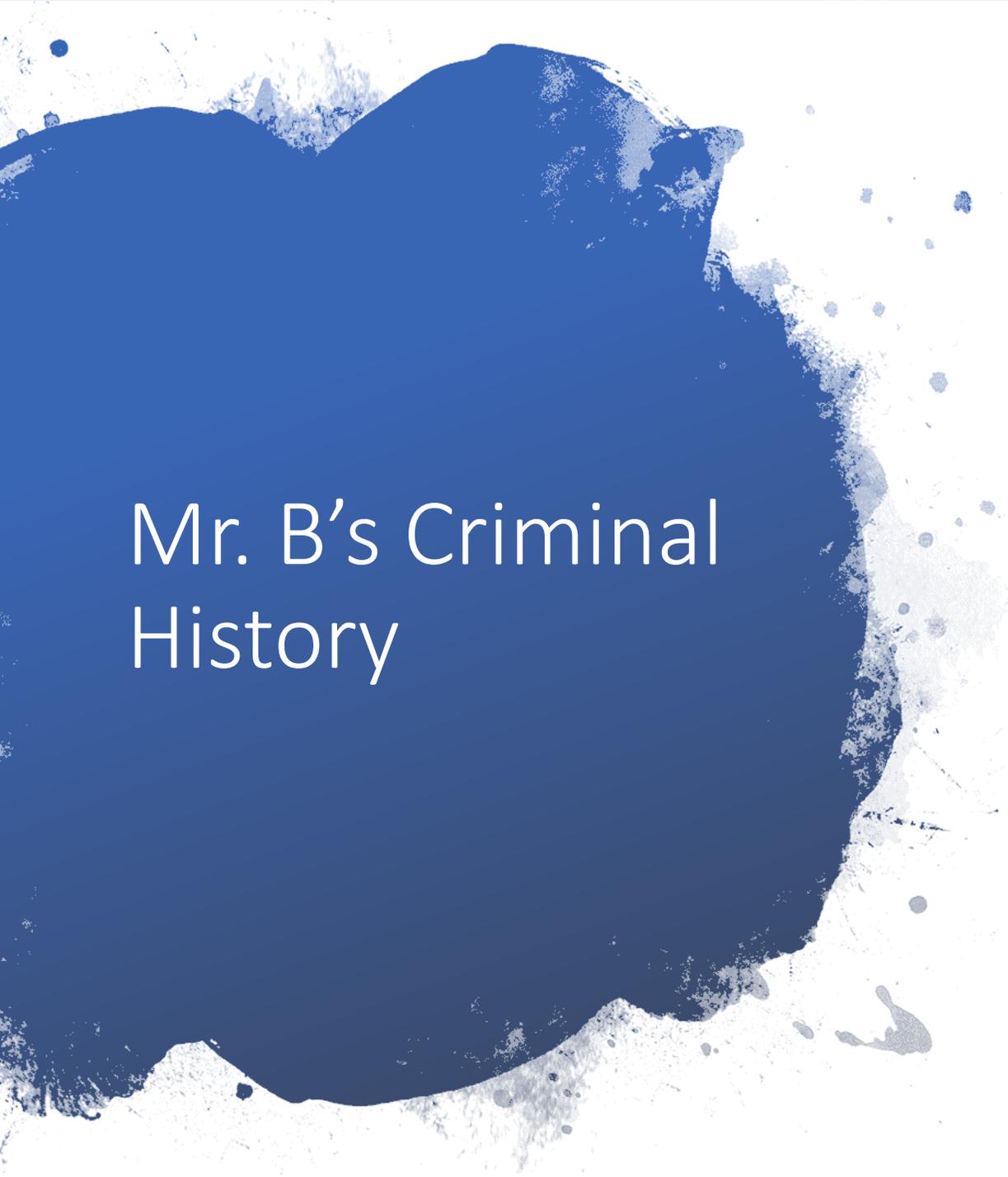


Mr. B beat his 67 year old mother severely after she asked him to attend his court date. He punched her in the head four times and threw her to the ground. He caused great bodily injury.

Days later his competency came into question due to delusions and disorganized thoughts

While evaluated for competency he made delusional statements about his mother

The Case of Mr. B- His Current MDO Offense



Mr. B's Criminal History

- Criminal history dates back 30 years to age 14
- He has theft offenses, drug offenses, sex offenses, probation violations, many failure to appear offenses and four violent offenses
- Two violent offenses have available details and three do not
- His two known offenses were influenced by his mental illness
 - His 2017 attack against his mother
 - His 2006 attack against a stranger female holding a baby
- In both instances his violence was precipitated by delusions

2006 Offense



His 2006 offense involved mental illness-related violence secondary to delusions and persecutory ideation.

Mr. B attacked a stranger while she was holding her baby because he felt she had sexually assaulted him. Although this crime occurred in 2006, Mr. B continues to express delusions of being sexually abused and he still believes this woman sexually assaulted him.

He was committed as a MDO after this offense in 2008 through 2013



Mental Health History- 2013 MDO Discharge Summary

- Mr. B said he sees shadows and felt he was being sodomized.
- He expressed grandiose delusions such as "I am God and at times I am Christ." He believed the government wanted to harm him.
- Mr. B refused to take medication in the past and he was placed on an involuntary medication order indicating a history of non-compliance with treatment.

Mr. B was rambling about being the leader of his church and a need to kill his followers because they were raping and killing babies. He appeared agitated and his speech was rapid.

He said, "I was murdered and resurrected...I was in the movie The Passion of the Christ...that was me on the cross.... I was in the Marines and blew me to smithereens."

Mr. B reported auditory hallucinations of someone accusing him of molest. He became more distractible as the interview progressed and stated it was blasphemy against God to say he was incompetent because he was God.

Mr. B complained of depression and stated, "I may end up killing them" (referencing the church followers) and then said, "It is my pleasure to kill." He blamed most of his problems on his mother.

He has been hearing voices, expressing delusions, disrupting others and displaying paranoia, disorganized thoughts and agitation

He has tried to minimize symptoms

He has been medication compliant

He has not threatened or assaulted anyone

As recently as November 2018 Mr. B told staff that his mother was a witch who murdered his deity. IDTT, 11/x/18

He reported a long history of methamphetamine and alcohol abuse

He never married, has no children and never held a job

CDCR Treatment in EOP June-December 2018

Parole Plan

Mr. B stated he plans to parole to a program which will provide activities such as making necklaces and puzzles. He said his case manager is searching for a place and he believes going to a program will be better than being homeless. He expects to have mental health treatment and take medication at the program.



He has not followed his outpatient treatment plan in the past and he could not explain what had changed to suggest he will follow it now.



When asked specifically about drugs and alcohol he said, "Quit doing them."
When asked how he planned to quit he stated, "I'm not going to promise to stay off but I will keep busy and do my program."

Historical Scale Data (History of Problems with. . .)

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H2. Other Antisocial Behavior

Onset Child/Adolescent/Adult

H3. Relationships

Intimate /Non-Intimate

H4. Employment

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AS BX		
Relationships		
Employment		
Substance Use		
MMD		
PD		
Trauma		
Attitudes		
Supervision		

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Insight		
Violent Ideation		
MMD Symptoms		
Instability		
Response		

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Professional Services and Plans

Living Situation

Personal Support

Treatment/Supervision Response

Compliant/Responsive

Stress or Coping

	Presence	Relevance
Pro Plans		
Living		
Support		
Treat/Supv		
Stress		

Analyze
Severity--On
First

ONFIRST	Violence	Illness Related Violence	
Onset	1993	2006	
Frequency	3, 1993, 2014, 2016	2, 2006, 2017	
Intensity	Unknown	Severe	
Recency	2016	2017	
Severity (injury)	?	Injured 67 y.o mother, punched 2006 victim numerous times	
Trajectory	?	Same	
Conditions of Parole activate?			



Violence Risk Factors

- Prior history of violence (age 14, antisocial behavior)
- Mental illness (Chronic psychosis not in remission)
- Substance addiction
- Lack of insight (mental disorder and violence risk)
- Poor treatment compliance and prior failures of supervised release.
- Inadequate parole plan
- Violent attitudes (aggression toward those who offend him)

Idiographic Considerations

Delusions related to sexual abuse

- Feels he is being sodomized
- Tactile hallucinations
- Believes mother sexually abused him and can control others
- Believes 2006 victim sexually abused him
- Currently believes he was sexually abused and his violence justified (violent attitudes)

Violence Risk/SMD Nexus

2006 violent crime

2017 violence crime

Current symptoms
and symptoms
during violence
meaningfully similar

Current delusions
about last victims

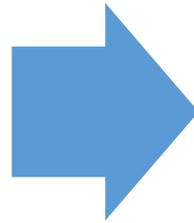
No plan to maintain
functioning once
paroled

Could not promise to
stop substance
abuse

History suggests he
will stop treatment

Violence Risk/SMD Nexus

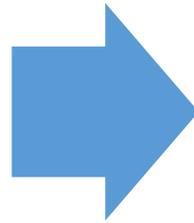
Despite treatment compliance he remains delusional, hears voices and expresses persecutory ideation related to his mother (his most recent victim).



While hospitalized at ASH in 2017, Mr. B stated he assaulted his mother as retribution for her beating him all of his life. During that same hospitalization he was quoted as saying, "My mom beat me my entire life and I finally retaliated." Staff opined that what he said was "highly questionable" because he also stated that his mother beat him into a fluid, poured him into a lunchbox and then served himself to himself.

Violence Risk/SMD Nexus

He told ASH staff he was only hospitalized because his mother lied and she was trying to rip him off because he would not buy her a baby to eat. He said his mother had everyone under a spell.



As recently as November 2018 Mr. B told staff that his mother was a witch who murdered his deity.



Findings:

Based on his recent and remote history of mental illness related violence, his current symptom presentation and his numerous general violence risk factors, I am of the opinion that Mr. B represents a substantial danger of physical harm to others based on his severe mental disorder. Criterion Six is met.



Discussion