APPENDIX A

ANALYSIS OF AGGRESSIVE BEHAVIOR

Analysis of Aggressive Behavior

I. The Analysis of Aggressive Behavior (AAB) is a systematic means to (1) assess the risk(s) of aggression for an individual acquittee and (2) develop means by which to address the risk(s).

A. The AAB is a psychological evaluation that includes data collected on the acquittee's past aggressive episodes, treatment and social history, and current functioning and is used as a basis for

1. Treatment interventions,

2. Decision-making regarding the management of privileges and placement for the acquittee,

3. Making recommendations to the court regarding conditional release and release without conditions,

4. Conditional release planning, and

5. Community aftercare.

B. The AAB is an anamnestic (Miller & Morris, 1988; Melton, Petrila, Poythress & Slobogin, 1997) approach to risk assessment and management that integrates known statistics on risk factors and base rates for aggressive behavior with clinical approaches that relate these statistics with the context of the individual case.

C. The focus of the AAB is identification of relevant risk factors for future aggression and for the planning of risk management strategies, rather than an attempt to predict aggression. Each risk factor should have a management strategy (some management strategies will apply to more than one risk factor, and some risk factors will require more than one management strategy).

The AAB focuses on containment of future aggression rather than strictly static predictions of dangerousness.

1. The AAB emphasizes a more dynamic understanding of the acquittee's history of aggressive behavior, the variables that influence that aggression, and suggestions for decreasing and preventing aggression in the future.

2. The assessment of risk factors is integrated into treatment planning and conditional release planning so that specific risk factors are identified and addressed directly to contain future risk.

II. A comprehensive review of aggressive and/or dangerous behaviors is conducted which is not limited to the NGRI offense.

A. A description of the NGRI offense, using collateral sources of information, the mental status at the time of the offense evaluation, police, reports, victim/witness statements and the acquittee's account (which may be presented in a combined form or separately to highlight differences).

B. All criminal charge(s) including those associated with a patient's acquittal by reason of insanity should be reviewed, noting the relative frequency, type and age of onset of aggression.

C. Records of previous hospitalizations should be reviewed for incidents of aggression in the community as well as in treatment settings.

D. Collateral sources of information, such as family members and community treatment providers should also be considered sources of information on past aggressive behaviors that have not resulted in arrest, criminal charges or hospitalization.

E. Past and current psychiatric, psychological and social history assessments as well as observations of hospital staff, as well as a mental status examination are also sources of information for patterns of aggressive behavior.

III. Once the data on past aggressive episodes are collected from multiple sources (both collateral sources and self-report from the acquittee), an analysis of the following is performed, and described in detail

A. The relationship, if any, of existing or pre-existing mental disorder(s) to past aggressive episodes, especially including:

1. The presence of Threat/Control Override symptoms (paranoid delusions of persecution or beliefs that one's thoughts or behavior are being controlled by an outside agency (Link & Stueve, 1994);

2. The presence of auditory command hallucinations related to the aggressive behavior;

3. Affective dyscontrol related to mood disorders;

4. Impairment in impulse control due to neurological or developmental disorder (e.g. seizure disorder, brain injury or disease, mental retardation).

B. Common characteristics or patterns across aggressive episodes should be identified, including (but not limited to)

1. Time (month, year, time of day)

2. Nature of aggressive act (description of act; include role of self-defense)

3. Legal outcome

4. Cognitive correlates (thoughts before, during, and after the incident; include threat/control override delusions, hallucinations, low IQ, and poor judgment, reasoning and/or verbal skills)

5. Affective correlates (emotions experienced before, during, and after the incident; include anger and impulsiveness, impaired frustration tolerance, interpersonal conflict vs. predatory acts planned with particular goal) aggression (many patterns are mixed: See Meloy, 1988)

6. Apparent motivation (e.g. related to mental illness, drug/alcohol use, criminal behavior, sex offenses)

7. Location

8. Weapon(s) (type of weapon, include how/why weapon was selected, any specialized training in the use of weapons)

9. Victim(s) (who; relationship to acquittee; how selected including age and gender; behavior of victim including provocation, exacerbation, and reduction of aggression)

10. Substance abuse (include types of substances used, frequency of use, age at which substance use commenced, prior failed treatment and any history of distribution of illegal substances)

11. Medication compliance

IV. Initial AAB completed during Temporary Custody

A. The Analysis of Aggressive Behavior begins at the time of admission to temporary custody placement.

Some acquittees, e.g., those who were adjudicated NGRI prior to the initiation of the requirement for completion of an AAB on each new acquittee, may not have an Initial AAB. If this is found to be the case, an Initial AAB should be completed as soon as possible for this individual.

B. The staff of the Forensic Unit of Central State Hospital (or other any other DMHMRSAS facility housing an acquittee in temporary custody) shall make efforts to obtain the relevant Analysis of Aggressive Behavior information and complete the Initial AAB within 30 days after admission. (In cases wherein Commissioner Appointed Evaluators have been assigned to complete the Initial AAB, the staff of the Forensic Unit or forensic staff at the hospital in which the acquittee is hospitalized shall be responsible for obtaining the relevant information for the completion of the Initial AAB.)

1. Attempts to obtain information should

    a. Begin immediately upon admission by faxing written requests for all information that was not available upon admission,
    b. Be systematically and promptly followed up if information is slow in arriving,
    c. Include the acquittee's self-report, and
    d. Include a significant emphasis on obtaining data from collateral sources, to include the Community Services Board and other treatment providers, family members, and significant others, and
    e. Be well documented.

2. Information gathering is an extremely important aspect of the AAB and the process of assessing risk.

3. A suggested format and hypothetical cases are included later in this chapter.

C. The AAB shall be provided as soon as possible to the two evaluators appointed by the Commissioner to perform the temporary custody placement evaluation. It is expected that this information will be integral in making assessments and recommendations to the court regarding disposition.

1. AAB information available during the first 30 days after admission and before completion of the temporary custody evaluations shall be immediately transmitted by fax to the appointed evaluators .
2. In cases where the AAB information is not complete at the end of 30 days, the staff of the Forensic Unit of Central State Hospital (or other designated treating facility) shall document

a. Contacts made,
b. Why information is not available, and
c. How the missing information may have an impact on the Analysis of Aggressive Behavior.
d. Attempts to obtain this information shall continue even after the Initial AAB is completed by the Temporary Custody evaluators.

V. Format for Initial Analysis of Aggressive Behavior

1. Identifying Information

2. Purpose of Evaluation

3. Statement of nonconfidentiality

4. Sources of Information

5. Relevant Background Information

6. NGRI Offense

    a. Acquittee's Account of the NGRI Offense
    b. Collateral Accounts of the NGRI Offense

7. Behavioral Observations and Mental Status Examination

8. Psychological Testing Results

9. Diagnostic Impression

10. Patient Strengths Which Mitigate the Probability of Future Aggressions

11. Analysis of Aggressive Behaviors

    a. Narrative description of current risk factors
        (1) Include past instances of occurrence of that factor
        (2) Frequency of occurrence
        (3) Intensity
        (4) Conditions under which factor is exhibited
        (5) Dates of occurrence(s) if available
        (6) Any other relevant information regarding why this factor represents a risk for this particular acquittee

b. Current status of risk factors
   (1) Indicate whether or not the acquittee has exhibited recent behavior relevant to the risk factor
   (2) Indicate whether the acquittee demonstrates insight into the factor or any gains or losses towards managing the risk factor

c. Means of addressing risk factors
   (1) Include a detailed description of interventions to be utilized in order to assure, to the extent possible, that the probability of the individual exhibiting this factor will be minimized.
   (2) Strategies for managing risk factors may be extensive and could involve medications, different forms of therapy, sanctions, etc.
   (3) Some management strategies will apply to more than one risk factor, and some risk factors will require more than one management strategy.

12. Factors which Mitigate the Probability of Future Aggression
Positive findings about the acquittee that could contribute to a decrease in the acquittee exhibiting inappropriate aggression are also important and can be integrated into risk management and treatment planning.

VI. Risk Factors to consider in Analyzing Aggressive Behavior

Any factor related to an increased risk of aggression towards self or others shall be identified as a risk factor (see Current Trends in Assessing Risk in this Appendix).

A. Risk factors may be conceptualized in terms of their demographic, historical, clinical and contextual aspects.

1. Demographic factors may include: age, gender, marital status and socioeconomic factors

2. Historical factors may include: criminal history, juvenile delinquency, age of onset of aggression, psychiatric history, employment history, prior supervision failure.

3. Clinical factors may include: substance abuse, psychopathy, brain injury or disease, active symptoms of mental illness such as paranoia or command hallucinations, impaired insight, medical issues such as hypothyroidism, diabetes, etc.

4. Contextual factors may include: use of weapons, victim characteristics, social or community support/lack thereof.

VII. Updates to the Initial AAB

A. The acquittee's treatment team shall update the AAB within 30 days prior to the submission of any requests to the Forensic Review Panel, or to the Internal Forensic Privileging Committee for increased freedom within the facility and/or access to the community. This includes requests for

1. Transfer from the forensic unit to civil units,

2. Grounds privileges (escorted by facility staff or unescorted),

3. Community visits (escorted by facility staff or unescorted),

4. Overnight therapeutic visits (48 hours maximum),

5. Conditional release,

6. Conditional release from temporary custody, and

7. Release without conditions.

B. The Initial AAB acts as a baseline for risk factors, establishing the current status of those risk factors at the point of temporary custody and the initial risk management plans. The AAB Updates demonstrate progress or lack thereof for each risk factor reported, providing a continuity of risk assessment.

1. Risk factors identified in the Initial AAB, or added thereafter shall not be deleted in subsequent updates, even if the risk is not considered current, or is thought to have been inappropriately applied.

2. The Risk Management Plan section for each risk factor, the acquittee's facility Comprehensive Treatment Plan, and any Conditional Release plans should show evidence of a thoughtful continuum of care, risk assessment, and risk management for the process of graduated release

C. The AAB updates shall include:

1. A narrative description of all previously and currently identified risk factors with an assessment of the current status and risk management plan for each risk factor

2. In order to further clarify the risk factor for the individual acquittee the description of the risk factor may be modified to include information from previous updates

3. The Current Status of the Risk Factor shall include any incidents related to that risk factor, since the last update, and any treatments or interventions attempted to manage this risk factor.

4. The Means of Addressing Risk Factors plan shall include recommendations for management of risk at the level of privilege which is being requested.

5. A listing of behaviors that have occurred since the last AAB in each of the following categories, including the date(s) of occurrence

    a. Physical assaults towards others,
    b. Suicidal attempts/gestures c. Destruction of property,
    c. Escape attempts/escapes, and
    d. Behaviors resulting in significant loss or reduction of privileges, including verbal threats of aggression.

6. Risk factors should be added in updates with the addition of new information, clarification of existing risk factors or new behavior patterns.

D. Each risk factor should be labeled and described specifically for the individual acquittee, but should also be categorized for entry into the Forensic Information Management System (FIMS) (see FIMS Categories for Risk Factors, below).

E. The AAB Update is generally part of another comprehensive report, e.g., FRP or IFPC Submission Report or Annual Continuation of Confinement Report. When the AAB-Update is part of another report it is not necessary to repeat items such as background information, mental status, description of NGRI offense, etc. that were included in the Initial AAB. If the AAB – Update is required to be a stand-alone report this additional information should be included.

VIII. General Risk Factors to be considered in Assessing Aggressive Behavior

A. **HISTORY OF AGGRESSION IS THE STRONGEST SINGLE PREDICTOR OF FUTURE AGGRESSION.**

1. Great care should be given to documenting a complete history of aggression. Clinicians should take into account the acquittee's history of violence in the following roles

    a. Observer
    b. Victim
    c. Perpetrator

2. Acquittee's aggressive behaviors should be considered to be the most important. Experience as an observer or victim of violence may be important but it should be related to the perpetration of aggressive behavior if it is relevant.

B. Clinicians should take into account risk factors of two kinds

1. Static risk factors cannot be changed through treatment or monitoring. Static risk factors include static characteristics (such as age, sex, intelligence, and aggression history).

2. Dynamic risk factors can be altered through treatment or monitoring. Dynamic risk factors include characteristics (such as status of mental illness, substance abuse, and access to weapons and access to previous victims or identified victims) that can be altered through treatment or monitoring).

The focus on dynamic risk factors should be on how they have

a. Increased,
b. Been reduced, or
c. Been managed through hospital intervention or community treatment/ monitoring.

C. General dynamic risk factors include, but are not limited to…

1. Marital status (single --> higher risk)

2. Substance abuse (present --> higher risk)

3. Access to weapons (easy --> higher risk)

4. Access to victims (easy --> higher risk)

5. Employment (unemployed -->higher risk)

D. General static risk factors (not specific to any particular population) for committing violent behavior toward others include, but are not limited to…

1. Age (younger --> higher risk)

2. Socioeconomic status (lower --> higher risk)

3. Intelligence (lower --> higher risk)

4. Previous violence (higher --> higher risk)

E. Mental illness

1. Diagnosis (Current APA Diagnostic and Statistical Manual; DSM)

   a. Serious mental illness, such as schizophrenia and affective disorder, functions as a weaker risk factor.
   b. Psychopathy (as measured by the Psychopathy Checklist-R Scale) is associated with higher risk.

2. Medication noncompliance strengthens mental illness as a risk factor.

F. **SUBSTANCE ABUSE: RISK IS HEIGHTENED CONSIDERABLY WHEN A DIAGNOSIS OF SERIOUS MENTAL ILLNESS IS COMBINED WITH A DIAGNOSIS OF SUBSTANCE ABUSE**.

G. Base rates for re-arrest for insanity acquittee population

1. Ideally, clinicians should compare the individual acquittee's risk factors with base rate information describing the national insanity acquittee population.

2. Following release from hospital to conditional release: there is a re-arrest rate of 5% to 22% when followed over a period of two to five years

   a. Generally, the closer the NGRI is monitored in the community, the lower the arrest rate, but the higher the re-hospitalization rate.
   b. Acquittees who did well on conditional release
      (1) were employed before the offense;
      (2) were married;
      (3) had committed a less severe offense;
      (4) adjusted well to hospitalization;
      (5) showed a general assessment score on the GAF of less than 50; and
      (6) showed fewer than 7 symptoms on the SADS-C.

3. The first nine months of conditional release were particularly high risk periods for revocation of conditional release.

4. Following release without conditions, there are significant increases in re-arrest rates (42 to 56%), as compared to re-arrest rates while on conditional release.

H. More information about risk factors and their impact on violent outcomes is available through the MacArthur Research Network's risk data on mental illness and violence. Updates on this major research initiative are provided regularly through the training and conferences offered by the Institute of Law, Psychiatry and Public Policy.

IX. Treatment teams, Forensic Coordinators, and staff completing the Analysis of Aggressive Behavior must remain current in the research and practice of assessing risk.

A. The Department of Mental Health, Mental Retardation & Substance Abuse Services contracts with the Institute of Law, Psychiatry and Public Policy to provide

1. A wide range of forensic training programs including: risk assessment;

2. Semi-annual Forensic Symposia that bring in nationally recognized experts on related risk assessment topics;

3. Annual Mental Health and the Law Symposium which also brings in national experts and covers a broader range of relevant topics; and

4. Consultation to facility and community services board staff.

B. Ongoing training and review of the developing risk assessment literature is essential.

Format for Initial AAB:

1. Identifying Information

2. Purpose of Evaluation

3. Statement of Nonconfidentiality

4. Sources of Information

5. Relevant Background Information

6. NGRI Offense

    a. Acquitee's Account of the NGRI Offense
    b. Collateral Accounts of the NGRI Offense

7. Behavioral Observations and Mental Status Examination

8. Psychological Testing Results

9. Diagnostic Impression

10. Patient Strengths Which Mitigate the Probability of Future Aggression

11. Analysis of Aggressive Behaviors

    a. Description
    b. Current Status of Risk Factors
    c. Means of Addressing Risk Factors

EXAMPLE
Initial Psychological Evaluation and
Analysis of Aggressive Behavior

Name: Mr. N. Sanity Acquittee
SS#: XXX-XX-XXXX
Date of Birth: 3/17/56
Age: 43
Sex: Male
Reg. #: XXXXXX.003
Marital Status: Divorced
Education: High School Grad
NGRI Offense: Murder
Case No. 99-XXX
Date of NGRI Adjudication: 11/12/1999
Date of Admission: 11/17/1999
Court: Circuit Court City of Smalltown
Judge: Honorable He B. DeJudge
Date of Report: 12/17/1999

Purpose of Evaluation:

Mr. Acquittee was adjudicated Not Guilty by Reason of Insanity (NGRI) pursuant to Virginia Code Section 19.2-182.2 on 11/12/99, having been charged with murder. This is the report of a routine assessment protocol for newly admitted patients who have been found NGRI. This report will focus on the patient's current psychological functioning, the risk of aggression, and recommendations for the management of risk.

Mr. Acquittee was informed concerning the purpose of this evaluation and the limits of confidentiality. He indicated that he understood these limits and agreed to proceed under these conditions.

Sources of Information:

1. Clinical interviews conducted in the Maximum Security Unit of CSH.
2. Review of the patient's current CSH medical and legal records.
3. Consultation with the patient's current CSH treatment team.
4. Review of Forensic Evaluation of Mr. Aquittee's Mental State at the Time of the Offense completed by Dr. Knowitall and dated 11/10/99.
5. Review of Evaluation of Legal Sanity conducted by Ms. Snickers, and Drs. Bruce Good and Gary Plenty, dated 10/20/99.
6. Review of records from the Marion Correctional Treatment Center.
7. Review of records from two admissions to the Smalltown Regional Medical Center (SRMC).
8. Results of psychological testing with the WAIS-III, MMPI-2, MCMI-III, the RRASOR, the PCL-R, and Thematic Apperception Test (TAT).

Statement of Non-confidentiality:

The purpose of the evaluation was explained to Mr. Aquittee. He was told that a report would be developed concerning his psychological functioning to include analysis for possible aggressive behavior, and that this report would be utilized in treatment planning, as well as by individuals reviewing his situation for increasing privileges. He was also told that this report

could be seen by court officials. Mr. Acquittee agreed to proceed with the evaluation.

Relevant Background:

Mr. Acquittee was born as the younger of two boys into a middle class family. He was born with jaundice and several allergies, and has been described by his mother as a "sickly baby." The family relocated several times in the Southeast United States during Mr. Acquittee's childhood due to his father's job. When he was five months old, Mr. Acquittee was left with his aunt when the family moved to Louisiana, reportedly due to his mother's concern about the child's ability to tolerate the climate. Mr. Acquittee was reunited with his family at some point, and they spent the greatest amount of time living in the Maryland area. Mr. Acquittee suffered an allergic reaction to penicillin at age ten, this reaction included significant edema, reportedly causing his entire body to swell; he also contracted typhoid fever at age 14, and mononucleosis at age 18.

Mr. Acquittee has reported that he made average to above-average grades and had little conflict with teachers or peers. Mr. Acquittee reported that he was suspended once in 8th or 9th grade for skipping school. He graduated in 1975 and enrolled in the University of Maryland Instead of attending college, he began working and subsequently got married. Mr. Acquittee has subsequently worked a number of different jobs, including construction work, stocking supplies, delivering office equipment, selling life insurance, carrying U.S. mail, doing factory work, and delivering pizzas. He has had frequent financial difficulties with credit problems which he attributed to "living beyond my means." Mr. Acquittee has abused alcohol and marijuana on occasion, but has not shown symptoms of dependence. His pattern of abuse has included occasional weekend binges during young adulthood, with declining substance abuse as he has grown older. He was reportedly drinking the night of the NGRI offense, but was not considered intoxicated by arresting officers.

The patient and his wife had significant marital problems, resulting in a legal separation in the summer of 1988 after approximately 13 years of marriage. Reports indicate that the defendant was using alcohol extensively and was physically abusive to his wife. The marital conflict culminated in an incident which Mr. Acquittee refers to as a "misguided attempt at reconciliation." Mr. Acquittee was convicted of rape and served four and a half years in the Virginia Department of Correction (DOC), primarily at the Bland Correctional Center.

Mr. Acquittee's adjustment to the DOC was poor. He was engaged in several fights, one involving a knife. He admitted to instigating some of these fights. He participated in a sex offender treatment program for a time until he was requested to sign a "contract" committing to the principles of the program. He became suspicious of the contract, refused to sign and was returned to general population.

At that time, Mr. Acquittee became increasingly paranoid and began to search his

environment for signs and signals of any impending danger. He also began to believe that God was sending him messages through the television and radio. Records of psychiatric treatment (during and after his incarceration) support the patient's claim that he did not hear voices. Mr. Acquittee has subsequently described obsessional and delusional thinking about the meaning of signals, scriptures from the Bible, and whether the food or water was being poisoned. Some delusions were of a sexual nature, like his belief that he saw a "naked woman" on television, and when he sent a signal to her, she somehow returned his signal.

His behavior became more bizarre and uncooperative with correctional officers, and on 10/27/94 he drank some cleanser and rubbed his face and eyes with the cleanser. Mr. Acquittee has reported that this was in response to obsessions and delusions about his sinfulness and need for "cleansing" rather than an attempt at self-harm. On 10/31/99 he attempted to grab a nurse's genital area.

Mr. Acquittee was admitted to the Marion Correctional Treatment Center (MCTC), the psychiatric inpatient setting for DOC inmates on 11/8/94. He was described as extremely paranoid and was once considered "too regressed" to speak with his parents when they came from Florida for a visit. He was also described as masturbating compulsively and attempted, in separate incidents, to grab two more female nurses in the genital area and, on 11/15/94 he grabbed the genital area of a female officer. During his incarceration, he reported that he grabbed at female genital areas in order to allay rumors that he was homosexual. More recently, Mr. Acquittee has attributed these actions to psychotic experiences (e.g. believing he was receiving messages or signals from the females). Mr. Aquittee also engaged in an incident described as "inappropriate touching" of a female laboratory assistant's breast during an admission to the Riverside Liberty Forensic Unit.

Mr. Acquittee reported that he took medication offered to him at the MCTC, though records indicate that he may have been "cheeking" his medication some of the time. His mental status improved, but he remained in the MCTC until his mandatory parole date of 9/30/95 when he was released to the community. His diagnoses were Axis I : Dysthymia and Axis II: Borderline Personality Disorder.

Mr. Acquittee was next hospitalized at the Smalltown Regional Medical Center (SRMC) on 1/13/97 after he became agitated and was banging his head in his rented room. He'd been living in Smalltown VA and working at the Skinny River Mills factory since his release from prison. He has described being religiously obsessed and delusional concerning the identity of people around him and concerning persecution by the devil. Records indicate that he did not express delusions and he was discharged with a diagnosis of Depressive Disorder, not otherwise specified. Neurological studies (EEG) found no evidence of a seizure disorder.

In April of 1999, Mr. Acquittee experienced several days in which the radio and television appeared to be sending messages to him. He again became religiously obsessed and

"broke down" emotionally at work, crying and trembling and pleading for help. He was readmitted to SRMC on 4/19/99 where he was initially tremulous, mute and "catatonic." He was treated with Ativan and discharged on 4/22/99, the day of the NGRI offense. Mr. Acquittee apparently did not reveal any delusional or confused thinking prior to discharge, though his later accounts report that he was experiencing delusions concerning how his posture (e.g. not crossing his legs) affected his relationship to Christ and that he was listening to the radio for messages from Christ.

NGRI Offense:

Mr. Acquittee was charged with Murder for the stabbing death of his father. From the reports of the patient's mother and the arresting officer (as detailed in the Sanity at the Time of the Offense evaluation completed by staff of the Institute of Law, Psychiatry and Public Policy, dated 10/20/99), the patient was eating dinner with his mother and father when he began to look "like a caged animal" to his mother. He appeared menacing and held the steak knife he'd been eating with. After his father told him to put the knife down, Mr. Acquittee lunged at his father and began stabbing him in the genital area. Mrs. Acquittee called the police and the patient lay on the floor and began to cry. His father got on top of him and attempted to take the knife away from him, but the patient just slung his father off of him and continued to hold the knife.

At this point, Mrs. Acquittee went outside the apartment to get help and neighbors entered the scene to find Mr. Acquittee stabbing his father in the chest area several times and saying, "you better not do this again." As noted in the sanity evaluation, the patient "appeared unresponsive to calls for his attention and soon after the stabbing he was witnessed standing over his father shaking." The police soon arrived and reported hearing neighbors say "Hurry up, he's killing him," and then entered the apartment. The patient was noted to be standing over his father with a knife. The victim was bleeding from the groin area. The officer instructed Mr. Acquittee to drop the knife, and Mr. Acquittee began to walk toward him. He was again instructed to drop the knife, and this time he did drop the weapon and was placed under arrest. At the police station, the patient was observed rocking back and forth in a chair with his eyes closed, and he had urinated in his pants.

Mr. Acquittee has reported difficulty remembering exactly what happened to trigger his attack on his father. In a written account of his memory of the relevant events prepared at the suggestion of his attorney, Mr. Acquittee described believing that his father was the devil who'd taken on human form, and wondering if his "father" had always been the devil in disguise. He reported trying to remember how the devil had managed to appear in the Garden of Eden and how the devil had entered Judas Iscariot at the Last Supper. Then Mr. Acquittee described his father as standing "too close" and striking out at him with the knife. He recalled thinking, as he stabbed his father, that the devil had made himself vulnerable by taking on human form. Mr. **N.**

Acquittee indicated that he felt like Jesus being crucified when he was arrested. He recalled the story of Jesus being offered vinegar while on the cross and felt that he should experience a similar humiliation and urinated on himself. Mr. Aquittee reported that he had been drinking "heavily" that day.

Course of Hospitalization:

At Central State Hospital, Mr. Acquittee has been diagnosed as Psychotic Disorder, NOS, Rule Out Schizophrenia, Paranoid Type/Delusional Disorder. He has also had diagnoses in the past to include Dysthymia, Depressive Disorder, and Borderline Personality Disorder with paranoid and antisocial features. Mr. Acquittee has been generally calm and cooperative during this hospitalization. He has taken medication as prescribed, despite some doubts about how necessary this was or whether this was the correct medication or not. He has shown great concern that potential "errors" in his record be corrected; specifically he expressed concern that he would be inaccurately diagnosed as having a substance abuse disorder, and that "malingering" was mentioned in some of his initial evaluations, despite the ultimate finding that he was Not Guilty by Reason of Insanity. Although he has expressed remorse for "what happened," the patient has shown a great deal of concern about how he is perceived by others. Mr. Acquittee has attended all treatment groups which were recommended and has filled other time by playing cards and reading.

Current Mental Status:

Mr. Acquittee was generally well-groomed and healthy-looking Caucasian male with a moustache and "salt-and-pepper" graying dark hair. He was fully alert and oriented throughout the evaluation and showed no impairment in memory or concentration. His speech was coherent and goal-directed, though he had a distinctive "roundabout" way of speaking (his word) which seemed at times evasive but more often appeared circumstantial. He usually hesitated before responding to a question and did not offer a great deal of detail about the circumstances of any given event. He also appeared to have difficulty with briefly summarizing his memories of past events. On an occasion in which he did respond quickly and to the point, he then commented "I regret having answered so quickly," and proceeded to offer additional details which clouded the picture somewhat. It was frankly difficult to determine whether Mr. Acquittee was offering numerous details to minimize the seriousness of past events, to avoid responsibility, or because he was showing mild symptoms of a thought disorder marked by tangential and circumstantial speech. He did acknowledge that this has been his style for his entire adult life, and that his ex-wife used to complain about not being able to "nail him down" on anything.

Mr. Acquittee did not show any signs of delusional thinking, and was able to identify and describe past delusions. He denied that he was currently hearing voices or that he had ever heard

voices. He denied ever seeing things and did not appear to be actively hallucinating during the interview. His mood was calm and he showed a full range of affect during the interviews. Mr. Acquittee's affect was generally appropriate except that he seemed unusually confident and calm, given the circumstances. He denied and showed no evidence of suicidal thinking. Mr. Acquittee described having had bouts of depression throughout his life. Mr. Acquittee indicated he had experienced vague suicidal thoughts in the past, but had never developed a plan and never really considered actually completing the act. Mr. Acquittee indicated that his reason for drinking some cleanser and rubbing the cleanser in his eyes while incarcerated was his delusional belief that he could protect himself from the devil if he "washed his mouth out," rather than an attempt at self-harm. He denied having any homicidal thoughts at present.

The patient showed some insight into and understanding of his mental illness, though this would best be described as incomplete. When asked to describe the warning signs of a psychotic episode for him, Mr. Acquittee said "An insidiously increasing change in perception as to the relevance of things in the environment." This is a reasonable description of the gradual onset of paranoid and delusional thinking which Mr. Acquittee appears to have experienced on three separate occasions (10/94 while incarcerated, 1/98 and 4/99). He then went on to describe an example of, for instance, hearing staff jangle keys and not being able to tell whether a) it was just a coincidence that a number of people were doing it at once or b) it was an intentional experiment to see how he would react or c) he notices them more because he's looking for signals and special messages in his environment. He indicated that at present he was not experiencing the problem with alternative c), but he was unable to recognize the paranoid quality of alternative b). Mr. Acquittee also indicated that he was concerned that he could not know for certain that his symptoms were currently under control because he was not taking the right medicine for him, and he believed that he could help control his symptoms through the use of cognitive rational-emotive self-treatment. The patient indicated that he believes that he was receiving inspiration from God in committing the NGRI incident. He currently exhibits little insight. He believes the incident "should be considered a religious experience" and he then stated he intended to read the Bible this whole year so that he would know better the will of God. His memory appeared intact as indicated by his capacity to recall immediate, recent or remote events. There was no indication of cognitive impairments.

Results of Psychological Testing:

The defendant completed the WAIS-III, an individually administered test of intelligence. On this instrument, he scored a verbal IQ of 117, a performance IQ of 106, and a full-scale IQ of 111. This places him in the High-Average Range of intelligence. On the reading component of a screening test of academic achievement, he scored on a high school level.

Results of previous testing conducted at the MCTC during his incarceration, and later at

the Riverside Liberty Forensic Unit, during his pre-trial evaluation period have shown a consistent pattern of attempting to present himself in the best light while minimizing any problems or shortcomings he might have. He completed the MMPI-2 at the MCTC. The results of that test revealed, in addition to the minimizing of his problems, a pattern consistent with individuals who are rebellious toward authority, and who often have stormy or conflictual relationships with family and friends. Individuals with similar scores are often impulsive and act without adequate planning or consideration of the consequences of their actions.

The patient completed the MMPI-2 and the MCMI-III for his 10/20/99 evaluation at the Riverside Unit, .The results of those measures showed a guarded response pattern, and an unwillingness to admit common shortcomings. The MMPI-2 showed some tendency toward tightly controlling and inhibiting socially unacceptable responses, especially hostility and aggression, in direct contrast to his recent behavior. The acquittee, also on the MMPI, scored in a manner similar to those individuals who are experiencing paranoid symptoms, and who have a need to blame others for their problems, often denying and minimizing their own roles in their difficulties. Such individuals have also been shown to exhibit loss of reality contact and psychotic processes. On the Thematic Apperception test, the acquittee exhibited signs of underlying depression and feelings of inadequacy and hostility.

Mr. Acquittee again completed the MCMI-III for the current evaluation. The results indicated a distinct tendency toward avoiding self-disclosure which could be a characterological evasiveness, or a general unwillingness to avoid disclosure of a personal nature. It is noted that the patient has been described as vague and evasive throughout his adult life.

The Psychopathy Checklist-Revised (PCL-R) was completed using a combination of clinical interview and collateral information. This test reflects the relative degree of psychopathy or antisocial tendencies reflected in an individual's behavior and history. Mr. Acquittee's overall score of 12 is greater than 16% of adult male forensic patients, and is in the low range. His score on Factor 1 of the PCL-R, which reflects a selfish, callous and remorseless use of others, is greater than 55% of male forensic patients, which is in the moderate range and suggests that this pattern of interpersonal relationships may be clinically significant. The patient's Factor 2 score, which reflects a chronically unstable and antisocial lifestyle was in the 9% range, which is a low score. This pattern of scores does not reflect the presence of significant psychopathy but may be associated with individuals who show features of other personality disorders such as Narcissistic or Borderline personality traits.

The Rapid Risk Assessment for Sexual Offense Recidivism (RRASOR) was completed, That measure is a screening instrument used as an actuarial method for assessing future risk for sexual re-offending. Mr. Acquittee's score is associated with a 4.4% rate of recidivism in a five-year period, which is considered a low score.

N. Sanity Acquittee
Initial Analysis of Aggressive Behavior
Page 8 of 11

Diagnostic Impressions:

The evaluation indicates that Mr.Acquittee has experienced a Psychotic Disorder, NOS, with paranoid features, e.g. delusions. He also has signs of Depression and exhibits features of Narcissistic, Paranoid, Antisocial and Borderline Personality Disorders. The aquittee has also had significant problems with alcohol.

Features (Strengths) which Mitigate the Probability of Future Aggression:

Mr. Acquittee has several characteristics which could contribute to a decrease in the probability of future aggression. He is a high school graduate with some college, and on a test of intelligence he scored within the High-Average Range. When stable, he exhibits no indications of neurological/cognitive impairment. In addition, Mr. Acquittee has the capacity to exhibit good social skills. He is articulate and can express himself well when stable. These positive factors could be integrated into treatment and in the development of vocational/training for Mr. Acquittee.

Analysis of Aggressive Behavior/Risk Factors:

1. <u>Mental Illness</u> (FIMS - Major Mental Illness)

A. Description of Risk Factor and Current Status: Mr. Acquittee shows a highly atypical pattern of symptoms of mental illness. This pattern includes paranoid and delusional thinking, sometimes associated with bizarre and ritualistic behavior. He first experienced these symptoms when incarcerated at the age of 39. He denies ever having experienced auditory hallucinations, but reports experiencing delusions that he was receiving messages from the television and radio and beliefs that he could protect himself from persecution by the devil through certain ritualistic behaviors. These symptoms include Threat/Control Override symptoms, in which Mr. Acquittee believes he is threatened by the devil, delusions which were related directly to the NGRI offense.

Mr. Aquittee has also exhibited symptoms of a Psychotic Disorder, NOS with paranoid features. Mr. Acquittee additionally shows features of Narcissistic, Borderline, Paranoid and Antisocial Personality disorders, including consistent irresponsibility, impaired empathy for others, careless disregard for the safety of others, impulsivity, an exaggerated concern for how he is perceived by others, and the perception of threat or attack in benign remarks or events.

B. Means of Addressing Risk Factor: Mr. Aquittee should continue to receive anti-psychotic medication and participate in group therapies designed to help him identify and understand the symptoms of his mental illness. Individual psychotherapy in the context of external limits on behavior is considered the treatment of choice for long-standing personality disorders.

Differential diagnosis will be important to determine whether or not the defendant has an actual schizophrenic process or if his behavior is more a function of severe personality dysfunction with possible psychotic features. At this time, it appears the defendant is in need of inpatient hospitalization, given that he still continues to exhibit signs of psychosis.

2. History of Physically Aggressive Behavior: (FIMS - Aggression/Dangerousness to Others)

A. Description of Risk Factor and Current Status: Mr. Acquittee has exhibited significant acts of aggression in the past. He reportedly was physically abusive to his wife and had gotten in fights in prison. In addition, his inappropriate sexual behavior appears to have an aggressive component to it. The NGRI act itself involved the stabbing of his father repeated times in the genital area and chest. Psychological assessment indicates that he experiences significant hostility. His paranoia and emotional instability contribute to an increased probability of aggression. This history of aggression and psychological functioning places Mr. Aquittee at risk for future aggression.

B. Means of Addressing Risk Factors: Mr. Acquittee's aggression appears to be, at least partially, related to significant personality disturbance and can be exacerbated by periods of psychosis. It is imperative that Mr. Aquittee remain on his medication to control for emotional instability and distorted thinking. Mr. Acquittee should participate in Anger Management group in which he would identify the triggers to aggression and alternative behaviors. Assumption of responsibility for acts of aggression and for preventing future acts of aggression should be addressed directly with Mr. Acquittee. Individual therapy could assist in helping Mr. Acquittee explore the source(s) of his anger and vent his hostilities in a controlled environment. It should be made clear to Mr. Acquittee that inappropriate aggressive behavior can result in negative outcome for him to include possible legal ramifications. Issues related to sexual aggression are discussed below.

3. History of Sexually Aggressive Behavior: (FIMS - Sexual Assault)

A. Description of Risk Factor and Current Status: The acquittee has a history of inappropriate and aggressive sexual behavior towards females. He reportedly raped his wife and has on four different occasions attempted to grab female staff in the genital area. He has also been described as having approached females aggressively as possible compensation for issues of sexual identity. Past reports indicates that he has exhibited excessive masturbation. This pattern suggests a tendency towards sexually preoccupied aggression that sometimes occurs in conjunction with psychosis.

B. Means of Addressing Risk Factor: Mr. Acquittee should participate in a complete Sexual Offender Evaluation despite his low score on the RRASOR. Given his past history of aggressive sexual behavior, intervention directed towards assisting the acquittee in more effectively dealing with hostile feelings and aggression, as indicated above may also prove beneficial relevant to his sexual activity. Adherence to his medication regimen is also important. Group work directed towards appropriate sexual conduct in relating to the opposite sex is also recommended, as well as individual psychotherapy to assess, and if appropriate, to intervene relevant to sexual concerns, and identity issues.

4. <u>Denial of Mental Illness</u>: (FIMS - Denial/Lack of Insight)

A. Description of Risk Factor and Current Status: - Mr. Acquittee reportedly tends to minimize and deny his role in his difficulties. Psychological testing indicates he tends to project blame onto others, not accepting responsibility for his actions. He evades questions through becoming circumstantial. He also doubts the necessity of his medication and believes that his behavior during the NGRI incident was justified, e.g., he was acting for God. Therefore the defendant at this time seems to have little insight into his illness. This represents a risk factor in that he may, under similar circumstances to those surrounding the NGRI incident, react in the same manner as he did during the NGRI offense, exhibiting inappropriate aggressive behavior.

B. Means of Addressing Risk Factor: It is recommended that the defendant be maintained on his medication and participate in individual and group therapy to address his denial and minimization of his symptoms. It is important that he develop some insight into the fact that his symptoms can be destructive and are a component of his mental illness.

5. <u>Non-Compliance with Treatment</u>: (FIMS - Noncompliance with Treatment and/or Medication)

A. Description of Risk Factor and Current Status - Mr. Acquittee did not participate in follow-up treatment for mental illness following his discharge from either the MCTC while incarcerated, or from the SRMC. When asked about his legal history during his last admission at the SRMC, he refused to discuss his incarceration, and did not reveal that he was treated for psychosis, or that he was experiencing psychotic symptoms. During the present evaluation, Mr. Acquittee questioned how, in fact, he could be sure that he needed medication, or if he was on the right medication. He has been suspected of "cheeking" his medication in the past. Given this,

it is likely, particularly under stress, that Mr. Acquittee would be at risk for not taking his medication.

B. Means of Addressing Risk Factor: Mr. Acquittee should participate in Symptom Management and Understanding Mental Illness groups in which the importance of accepting the need for psychiatric treatment is addressed. Mr. Acquittee would also learn to identify his symptoms, warning signs of relapse and appropriate interventions for relapse prevention. It is also important that he maintain his medication compliance. Medication compliance should be monitored.

6. <u>Substance Abuse</u>: (FIMS - Substance Abuse)

A. Description of Risk Factor and Current Status: Mr. Acquittee has used alcohol in the past and has been aggressive under the influence of alcohol. He has also reportedly used marijuana in the past. He was drinking alcohol at the time of the NGRI offense. Although he currently does not appear to be experiencing alcohol or substance dependence, any substance use, however, increases the risk of future aggression. Alcohol can disinhibit emotional control and may place one in contact with other individuals who are likely involved with alcohol or drugs and illicit drugs and illegal activity. Also, substance use can impede psychological growth and can cause neurological damage. Given the defendant's history of substance involvement, especially alcohol, and the fact that he was using at the time of the NGRI incident, alcohol use represents a particular risk factor for Mr. Acquittee.

B. Means of Addressing Risk Factor: It is recommended that Mr. Acquittee participate in a Substance Abuse Education and Relapse Prevention group to gain information about the importance of remaining drug and alcohol free, despite the likelihood that he does not suffer from a dependence on alcohol or drugs, at this time. However when the defendant is no longer in a controlled environment, it is particularly imperative that he is not involved with alcohol/substance abuse. At that time, random drug screens may be necessary as well as continued intensive programming for substance abuse depending upon clinical need.

Clare Quilty, Ph.D.
Licensed Clinical Psychologist
Forensic Unit, Central State Hospital
JF/GW/sdl
February 28, 2001

UPDATED AAB FORMAT

It is generally not necessary for an Updated AAB to have all the components of the Initial AAB due to the fact that it is usually part of a more comprehensive report (e.g., submission to the Forensic Review Panel, Annual Confinement of Hearing Report, etc.) which already contains relevant background information, mental status, and other information that would complete the report as "stand alone." The Updated AAB, when part of another submission/report, should minimally include the following:

1. **Identifying Information**

2. **Risk Factor Updates**

    a. **Description of Risk Factor**
    b. **Update and Current Status of Risk Factor**
    c. **Means of Addressing Risk Factors**

Example AAB Update
Analysis of Aggressive Behavior
Risk Factor Update

Name: Mr. N. Sanity Acquittee
SS#: XXX-XX-XXXX
Date of Birth: 3/17/56
Age: 44
Sex: Male
Reg. #: XXXXXX.003
Marital Status: Divorced
Education: High School
NGRI Offense: Murder
Case No. 99-XXX
Date of NGRI Adjudication: 11/12/1999
Date of Admission: 11/17/1999
Court: Circuit Court City of Smalltown
Judge: Honorable He B. DeJudge
Date of Report: 1/12/2001

Analysis of Aggressive Behavior/Risk Factors:

1. <u>Mental Illness</u>: (FIMS - Major Mental Illness)

A. Description of Risk Factor: Mr. Acquittee has shown a highly atypical pattern of symptoms including paranoid and delusional thinking, sometimes associated with bizarre and ritualistic behavior. He first experienced these symptoms when incarcerated at the age of 39. He denies ever having experienced auditory hallucinations, but reports experiencing delusions that he was receiving messages from the television and radio and beliefs that he could protect himself from persecution by the devil through certain ritualistic behaviors. These symptoms include Threat/Control Override symptoms, in which Mr. Acquittee believes he is threatened by the devil, as well as delusions that were related directly to the NGRI offense.

Mr. Acquittee also shows features of Narcissistic, Borderline, Paranoid and Antisocial Personality disorders, including consistent irresponsibility, impaired empathy for others, careless disregard for the safety of others, impulsivity, an exaggerated concern for how he is perceived by others, and the perception of threat or attack in benign remarks or events. The features of Narcissistic Personality disorder appear most prominent, though he does not meet full diagnostic criteria.

B. Update and Current Status of Risk Factor: Mr. Acquittee currently has been given the diagnosis of Schizophrenia, Paranoid Type. This was determined after further psychological testing, observation and evaluation. His medication has been adjusted accordingly. In January and February of 2000 he showed some difficulty sleeping and expressed paranoid ideas that another patient might be somehow getting urine and feces into his tube of toothpaste. He responded to an adjustment in medication and has not shown psychotic symptoms since February 2000. However, he continues to exhibit some suspiciousness about the motives of others. He has participated in Group Psychotherapy and had individual psychotherapy from January 2000 through June 2000.

C. Means of Addressing Risk Factor: Mr. Acquittee should continue to receive anti-psychotic medication and participate in group therapies designed to help him identify and understand the symptoms of his mental illness. Given Mr. Acquittee's personality features, individual and milieu therapy in the context of external limits on behavior are also recommended Referral for more long-term individual therapy may be considered upon his transfer to the civil facility (XSH). Mr. Acquittee appears to be in need of further hospitalization given that he continues to exhibit some signs of his mental illness, although he has improved.

2. <u>History of Physically Aggressive Behavior</u>: (FIMS- Aggression -Dangerousness to Others)

A. Description of Risk Factor : Mr. Acquittee has exhibited a history of past physical aggression. He reportedly was physically abusive to his wife and participated in many physical altercations while in prison. In addition, he has exhibited inappropriate sexual behavior which seems to have an aggressive component. The NGRI act itself involved the stabbing of his father in the genital area and chest repeatedly. At the time of the Initial AAB, psychological evaluation indicated that Mr. Acquittee has harbored considerable hostility. His paranoia and emotional instability contribute to an increased probability of aggression. This history of aggression and psychological functioning places Mr. Acquittee at risk for future aggression.

B. Update and Current Status of Risk Factor: Mr. Acquittee has not engaged in threatening or physically aggressive behavior at any time during this hospitalization. He has participated in Anger Management and Handling Hassles groups to identify alternative means of dealing with frustration and anger. It appears Mr. Acquittee's risk for aggression increases when he is psychotic with associated delusions and impaired judgment. He may also have some risk for aggression in the context of intimate interpersonal conflict, as in the rape of his estranged wife. He has been compliant with his medication and is beginning to examine the efficacy of medication compliance. He is also involved in individual psychotherapy that focuses on anger management and exploring the sources of his hostilities. Mr. Acquittee continues to exhibit some anger in interpersonal relationships; this could contribute to a risk of future aggression.

C. Means of Addressing Risk Factor: Mr. Acquittee should remain compliant with medication and treatment. Assumption of responsibility for acts of aggression and for preventing future acts of aggression should be addressed directly with Mr. Acquittee in the context of ongoing psychotherapy. He will continue in Anger Management Training both on a group and individual basis. He is also to begin to examine, in individual and group therapy, his interpersonal relationships and his tendency to blame others for his difficulties. Cognitive Behavioral Intervention on an individual and milieu basis has also been initiated as a component of this behavior.

3. <u>Sexually Aggressive Behavior</u>: (FIMS - Sexual Assault)

A. Description of Risk Factor: Mr. Acquittee appears to have a history of sexually aggressive behavior towards females. He has reportedly raped his wife and on four different occasions

attempted to grab female staff in the genital area. He has also been described as approaching females aggressively as possible compensation related to issues of sexual identity. Past reports have indicated that he has exhibited excessive masturbation. This pattern suggests a tendency toward sexually preoccupied aggression, typically in the presence of active psychosis.

B. Update and Current Status of Risk Factor: Mr. Acquittee has not engaged in sexually aggressive behavior since being admitted to the hospital. Mr. Acquittee has also been compliant with medication. Mr. Acquittee has participated in group therapies and individual therapies with emphasis on appropriate interpersonal relating to include interaction with the opposite sex. Mr. Acquittee appears to be gaining some understanding of the impact of his behavior on others and seems to recognize that change in this area would be beneficial. He also participated in a sex offender evaluation, which indicated that he did not suffer from a paraphilia and showed no evidence of experiencing fantasies of sexual aggression. It appears Mr. Acquittee's risk for sexual aggression increases when he is psychotic with associated delusions and impaired judgment. Although he has made gains relevant to this risk factor, he continues to be at risk for inappropriate aggressive sexual behavior, especially should he experience a relapse of psychosis.

C. Means of Addressing Risk Factor: Mr. Acquittee should remain compliant with his medication. He should also continue in individual and group therapies focusing on appropriate sexual behavior and his own sexual issues. Assumption of responsibility for acts of sexual aggression and for preventing future acts of sexual aggression should be addressed directly with Mr. Aquittee in the context of ongoing psychotherapy. It appears that Mr. Acquittee's sexual difficulties may be, in part, a function of compensation for possible sexual identity concerns/inadequacy in the context of psychotic delusions and impaired judgment. He has begun to participate in individual and group therapy directed towards appropriate interpersonal interactions with emphasis on relating to the opposite sex. In individual therapy, he should begin to examine his own sexual issues, to the extent appropriate, given his clinical condition.

4. <u>Lack of Insight/Denial of Mental Illness</u>: (FIMS - Denial/Lack of Insight)

A. Description of Risk Factor: Mr. Acquittee denied and minimized his mental illness, increasing the risk for future relapse. When asked about his legal history during his last admission at the SRMC, he refused to discuss his incarceration and did not reveal that he was treated for psychosis or that he was experiencing psychotic symptoms. During his initial AAB, Mr. Wilson wondered whether he needed medication or if he was on the right medication. Mr. Acquittee did not complete follow-up treatment for mental illness following his discharge from either the MCTC while incarcerated or from the SRMC.

B. Update and Current Status of Risk Factor: Mr. Acquittee has participated in Symptom Management and Understanding Mental Illness groups in which he has acknowledged having a mental illness and has identified warning signs of relapse. He has been compliant with medication and treatment throughout his admission to the Forensic Unit. He appears to be gaining some insight into his mental illness and need for treatment.

C. Means of Addressing Risk Factor: Mr. Acquittee should participate in group therapies in which the importance of accepting the need for psychiatric treatment is addressed. He should be the subject of regular monitoring through blood tests for medication compliance. The acquittee is continue in Symptom Management Group as well as individual therapy to address his tendency to deny and minimize his problems, although he has shown some progress in this area.

5. <u>Treatment Non-Compliance</u>: (FIMS - Non-compliance with Treatment and/or Medication)

A. Description of Risk Factor: Mr. Acquittee did not participate in follow-up treatment with the community mental health center in the past. When asked about his psychiatric history, he did not reveal that he had been treated for psychosis in the past. He also periodically believes that he does not need his medication or that he is not on the right kind of medication. Given this, Mr. Acquittee is at risk for non-compliance (to include medication) with treatment in the future.

B. Update and Current Status of Risk Factor: Mr. Acquittee has participated in Symptom Management and Understanding Mental Illness groups and appears to be gaining some understanding of the need for him to maintain an accurate medication regimen and to participate in therapy. He continues, at times, to question whether or not he has been prescribed the correct medication. Given this, he continues to remain at some risk for non-compliance.

C. Means of Addressing Risk Factor: Mr. Acquittee should continue to participate in individual and group therapy which would focus on the importance of accepting the need for psychiatric treatment. Medication monitoring is also recommended. Mr. Acquittee needs to learn to identify warning signs of relapse and appropriate interventions for relapse prevention.

6. <u>Substance Abuse</u>: (FIMS - Substance Abuse)

A. Description of Risk Factor - Although, Mr. Acquittee does not appear to meet criteria for alcohol or substance dependence, any substance use, however, increases the risk for future aggression. Mr. Acquittee was drinking at the time of the NGRI offense. He has used alcohol prior to this, and has been aggressive while under the influence of alcohol. He has also reportedly used marijuana. Alcohol can disinhibit emotional controls, may contribute to exacerbation of mental illness. Given Mr. Acquittee's history of aggression and alcohol use, this represents a particular risk for him.

B. Update and Current Status of Risk Factor: Mr. Acquittee has participated in the Substance Abuse Relapse Prevention group and in Symptom Management group in which the importance of abstinence for maintaining a stable mental status was emphasized. Involvement with AA has been initiated. He appears to have gained some understanding of the relationship between the use of alcohol and his behavior, i.e., aggression. However, he continues to minimize his involvement with alcohol. This places Mr. Acquittee at continued risk for inappropriate substance involvement.

C. Means of Addressing Risk Factor: Mr. Acquittee should continue to participate in groups which support abstinence and is starting to make connection with the AA community. Once he earns independent privileges, Mr. Acquittee should be subject to random occasional blood or urine screens for drugs and alcohol. Also, when and if Mr. Acquittee returns to the community random drug screens may be necessary as well as continued programming for substance abuse, depending on clinical need at that time.

7. Use of a Weapon: (FIMS - Weapons)

A. Description of Risk Factor: Use of a weapon has been added as a risk factor given that the acquittee used a knife in committing the past NGRI offense. Mr. Acquittee used a steak knife to kill his father. He does not have a history of possessing or using weapons, but individuals who use a weapon in the commission of a crime are at risk for an increasing level of aggression in future crimes.

B. Update and Current Status of Risk Factor: Mr. Acquittee has not attempted to possess or fashion weapons during this admission. He has acknowledged that he will be prohibited from owning or possessing weapons in the future.

C. Means of Addressing Risk Factor: Mr. Acquittee will be reminded that he is not to have weapons in his possession as a component of his NGRI status and doing so could have negative outcomes to include legal consequences. Mr. Acquittee should be the subject of occasional searches of his person and property to insure that he is not in possession of weapons.

8. Community Supports: (FIMS - Family/Psychosocial Issues)

A. Description of Risk Factor: This risk factor was added after additional evaluation of Mr. Acquittee's familial dynamics and social supports. Although Mr. Acquittee was in frequent contact with his parents prior to the NGRI offense, he did not use this support to his advantage. He did not comply with the recommendations for outpatient treatment, and had no support system of mental health services.

B. Update and Current Status of Risk Factor: Mr. Acquittee has been able to reconcile with his mother in the wake of the murder of his father (the NGRI offense) with therapeutic visits to the Forensic Unit. The patient has acknowledged his understanding of the importance of establishing and maintaining a support network through the local Community Services Board in Smalltown.

C. Means of Addressing Risk Factor: Mr. Acquittee would benefit, in the future, from being transferred to XSH where he could begin to establish ties with the local Community Services Board during the graduated release process. His relationship with his mother will be explored and reinforced with therapeutic visits. In the meantime, individual and group therapy will focus on appropriate interpersonal behavior, which should increase his opportunities for forming positive social supports both within and outside the hospital.

9. <u>Hypothyroidism</u>: (FIMS - Medical Issues)

A. Description of Risk Factor : This risk factor was added after medical evaluation which indicated Hypothyroidism. Mr. Acquittee, when questioned about these findings, stated that he has a history of hypothyroidism first diagnosed in the mid-1980s (but not identified when first admitted to the Forensic Unit). While not directly related to an increased risk of aggression, hypothyroidism can include such psychiatric symptoms as depression, poor appetite, slowed speech, apathy, impaired memory, and, in rare cases, delusions and hallucinations.

B. Update and Current Status of Risk Factor: Mr. Acquittee's hypothyroidism has been treated with 0.15 mg of Levothyroxin daily, and has been stable. He has been compliant with medication and shown no symptoms during this admission.

C. Means of Addressing Risk Factor: Mr. Acquittee should remain compliant with his treatment for hypothyroidism and have regular physical checkups.

Sebastian Knight, Psy.D.
Licensed Clinical Psychologist
Forensic Unit, Central State Hospital

References

Appelbaum, P. S., Robbins, P. C., Monahan, J. (2000) Violence and delusions: Data from the MacArthur Violence Risk Assessment Study. *American Journal of Psychiatry*, 157, 566-572.

Bell, C. C. (Ed.) (2000) *Psychiatric Aspects of Violence: Issues in Prevention and Treatment* Vossey-Bass, Inc., San Francisco, CA.

Binder, Renee L. (1999) Are the mentally ill dangerous? *Journal of the American Academy of Psychiatry and Law*, 27, 189-201.

Boer, D. P., Wilson, R. J., Gauthier, C. M. & Hart, S. D. (1997) Assessing risk of sexual violence: Guidelines for clinical practice. In Webster, C. D. & Jackson, M. A. (Eds.) *Impulsivity: Theory, Assessment and Treatment* (pp. 326-342), the Guilford Press, New York, NY.

Borum, R., Fein, R., Vossekuil, B. & Berglund, J. (1999) Threat assessment: Defining an approach for evaluating risk of targeted violence. *Behavioral Sciences and the Law*, 17, 323-337.

Dolan, M. & Doyle, M. (2000) Violence risk prediction: Clinical and actuarial measures and the role of the Psychopathy Checklist. *British Journal of Psychiatry*, 177, 303-311.

Grisso, T., Davis, J., Vesselinov, R., Appelbaum, P. S. & Monahan, J. (2000) Violent thoughts and violent behavior following hospitalization for mental disorder. *Journal of Consulting and Clinical Psychology* 68, 388-398.

Hanson, C. K. & Thorton, D. (2000) Improving risk assessment for sex offenders: A comparison of three actuarial scales. *Law and Human Behavior*, 24, 119-136.

Hare, R. D. (1999) Psychopathy as a risk factor for violence. *Psychiatric Quarterly*, 70, 181-197.

Hare, R. D. (1998) The Hare PCL-R: Some issues concerning use and misuse. *Legal and Criminal Psychology*, 3, 99-119.

Hare, R. D., Cooke, D. J., & Hart, S. D. (1999) Psychopathy and sadistic personality disorder. In Millon, T. & Blaney, P. H. (Eds.) *Oxford Textbook of Psychopathology* (pp. 555-584), Oxford University Press, New York, NY.

Hare, R. D., Forth, A. E. & Strachan, K. E. (1992) Psychopathy and crime across the lifespan. In Peters, R. D., McMahon, et at (Eds.) *Aggression and Violence Throughout the Lifespan* (pp. 285-300) Sage Publications, Inc., Thousand Oaks, CA.

Hare, R. D. & Hart, S. D. (1993) Psychopathy, mental disorder and crime. In Hodgins, S. (Ed.) *Mental Disorder and Crime* (pp. 104-115), Sage Publications, Inc., Thousand Oaks, CA.

Harris, G. T., Rice, M. E., & Quinsey, V. L. (1993) Violent recidivism of mentally disordered offenders: The development of a statistical prediction instrument. *Criminal Justice and Behavior,* 20, 315-335.

Hart, S. D., Forth, A. E. & Hare, R. D. (1990) Performance of criminal psychopaths on selected neurological tests. *Journal of Abnormal Psychology,* 99, 374-379.

Heilbrun, K., Hart, S. D., Hare, R. D., Gustafson, D., Nunez, C. & White, A. J. (1998) Inpatient and post discharge aggression in mentally disordered offenders: The role of psychopathy. *Journal of Interpersonal Violence*, 13, 514-527.

Heilburn, K. (1997) Prediction versus management models relevant to risk assessment: The importance of legal decision-making context. *Law and Human Behavior,* 21, 347 – 359.

Hemphill, J. P., Hare, R. D. & Wong, S. (1998) Psychopathy and recidivism: A review. *Legal and Criminal Psychology,* 3 , 139-170.

Kernberg, O. F. (1992) *Aggression in Personality Disorders and Perversions.* Yale University Press, New Haven, CT.

Kropp, P. R. & Hart, S. D. (1997) Assessing risk of violence in wife assaulters: The Spousal Assault Risk Assessment Guide. In Webster, C. D. & Jackson, M. A. (Eds.) *Impulsivity: Theory, Assessment and Treatment* Guilford Press, New York, NY.

McNeil, D. E. & Binder, R. L. (1994) Relationship between acute psychiatric symptoms, diagnosis, and short-term risk of violence. *Hospital Community and Psychiatry,* 45, 133-137.

Michaud, S. G. & Hazelwood, R. (1998) *The Evil that Men Do*. St. Martin's Press, New York, NY.

Meissner, W. W. (1988) *Treatment of Patients in the Borderline Spectrum.* Jason Aronson, Inc. Northvale, N. J.

Meissner, W. W. (1986) *Psychotherapy and the Paranoid Process*. Jason Aronson, Inc. Northvale, N. J.

Meloy, J. R. (1988) *The Psychopathic Mind*. Jason Aronson, Inc. Northvale, N.J.

Monahan, J., Steadman, H. J., Appelbaum, P. S., Robbins, P. C., Mulvey, E. P., Silver, E., Roth, L. H. & Grisso, T. (2000) Developing a clinically useful actuarial tool for assessing violence risk. *British Journal of Psychiatry,* 176, 312-319.

Monahan, J. & Steadman, H. J. (1994) *Violence and Mental Disorder: Developments in Risk Assessment*. University of Chicago Press; Chicago, IL

Quinsey, V. L., Harris, G. T., Rice, M. E. & Cormier, C. A. (1998) Violent Offenders: *Appraising and Managing Risk*. American Psychological Association; Washington, D.C.

Roesch, R. & Hart, S. D. (1999) *Psychology and the Law: The State of the Discipline.* Kluner Academic/Plenum Publishers; New York, NY.

Screenivosan, S., Kirkish, P., Shoptaw, S., Welsh, R. K. & Ling, W. (2000) Neuropsychological and diagnostic differences between recidivistically violent not criminally responsible and mentally ill prisoners. *International Journal of Law and Psychiatry*, 23, 161-172.

Silver, E., Mulvey, E. P. & Monahan, J. (1999) Assessing violence risk among discharged psychiatric patients: Toward an ecological approach. *Law and Human Behavior*, 23, 237-255.

Skeem, J. L., Mulvey, E. P., & Lidz, C. W. (2000) Building mental health professionals' decisional models into tests of predictive validity: The accuracy of contextualized predictions of violence. *Law and Human Behavior,* 24, 607-628.

Soyka, M. (2000) Substance misuse, psychiatric disorder and violent and disturbing behaviour. *British Journal of Psychiatry,* 176, 345-350.

Soyka, M. (1999) Substance abuse as a risk factor for violence in major mental disorders. *Archives of General Psychiatry*, 56, 582.

Steadman, H. J., Mulvey, E. P., Monahan, J., Robbins, P. C., Appelbaum, P. S., Grisso, T., Roth, L. H., & Silver, E. (1998) Violence by people discharged from acute psychiatric inpatient facilities and others in the same neighborhoods. *Archives of General Psychiatry,* 55, 393-401.

Steadman, H. J. Silver, E., Monahan, J., Appelbaum, P. S., Clark-Robbins, P., Mulvey, E. P., Grisso, T., Roth, L. H. & Banks, S. (2000) A classification tree approach to the development of actuarial violence and risk assessment tools. *Law and Human Behavior*, 24, 83-100.

Taylor, P. J., Garety, P., Buchanan, A., Reed, A., Wessely, S., Ray, K., Dunn, G. & Grubin, D. (1994) Delusions and violence. In Monahan, J. & Steadman, H. J. (Eds.), *Violence and Mental Disorder: Developments in Risk Assessment*. (pp. 161-182). University of Chicago Press; Chicago, IL.

Tengstroem, A., Grann, M., Langstroem, N. & Kullgren, G. (2000) Psychopathy (PCL-R) as predictor of violent recidivism among criminal offenders with schizophrenia. *Law and Human Behavior*, 24, 45-58.

Webster, C. D., Douglas, K. S., Eaves, D. & Hart, S. D. (1997) HCR-20: *Assessing Risk for Violence*. Mental Health, Law and Policy Institute, Simon Fraser University. Burnaby, B.C., Canada.

RISK FACTOR CATEGORIES FOR FIMS

1 DEMOGRAPHIC/STATIC FACTORS

2 PSYCHOPATHY

3 MAJOR MENTAL ILLNESS

4 DEMENTIA/OTHER NEUROLOGICAL DISEASES

5 PERSONALITY DISORDER/TRAITS

6 TRAUMATIC HEAD INJURY

7 COGNITIVE IMPAIRMENT/MENTAL RETARDATION

8 THREAT CONTROL OVERRIDE SYMPTOMS

9 DENIAL/LACK OF INSIGHT

10 SUBSTANCE ABUSE

11 SUICIDE/SELF INJURY

12 ESCAPE

13 WEAPONS

14 AGGRESSION/DANGEROUSNESS TO OTHERS

15 SEXUAL ASSAULT

16 ARSON

17 FAMILY/PSYCHOSOCIAL ISSUES

18. EMPLOYMENT/DAY TIME ACTIVITY ISSUES UPON CONDITIONAL RELEASE

19. FAILURE ON PREVIOUS COMMUNITY RELEASE

20. NONCOMPLIANCE WITH TX. AND/OR MEDICATION

21. MEDICAL ISSUES

22. NON-VIOLENT CRIMINAL BEHAVIOR

23. VICTIMS

Further reading

Gardner, W., Lidz, C.W., Mulvey, E.P., & Shaw, E. C. A comparison of actuarial methods for identifying repetitively violent patients with mental illness. *Law and Human Behavior*, 20, 35-48.

Grisso, T. & Appelbaum, P. (1992). Is it unethical to offer predictions of future violence? *Law and Human Behavior*, 136, 216-221.

Halleck, N.H. & Petrila, J. (1988). Risk management in forensic services. International *Journal of Law and Psychiatry*, 11, 347-358.

Harris, G.T., Rice, M.E., & Cormier, C.A. (1991). Psychopathy and violent recidivism. *Law and Human Behavior*, 15, 625-637.

Harris, G. T., Rice, M.E., & Quinsey, V. L. (1993). Violent recidivism of mentally disordered offenders: The development of a statistical prediction instrument. *Criminal Justice and Behavior*, 20, 315-335.

Klassen, D. & O'Connor, W.A. (1988a). Predicting violence in schizophrenic and non-schizophrenic patients: A prospective study. *Journal of Community Psychology*, 16, 217-227.

Klassen, D. & OConnor, W.A. (1988b). A prospective study of predictors of violence in adult male mental health admissions. *Law and Human Behavior*, 12, 143-158.

Klassen, D. & O'Connor, W.A. (1988c). Crime, inpatient admissions, and violence among male mental patients. *International Journal of Law and Psychiatry*, 11, 305-312.

Klassen, D. & O'Connor, W.A. (1990). Assessing the risk of violence in released mental patients: A cross-validation study. *Psychological Assessment: A Journal of Consulting and Clinical Psychology*, 1, 75-81.

Lidz, C.W., Mulvey, E.P., & Gardner, W. (1993). The accuracy of predictions of violence to others. *Journal of the American Medical Association*, 269, 1007-1011.

Link, B.G. & Stueve, C.A. (1994). Psychotic symptoms and the violent/illegal behavior of mental patients compared to community controls. In J. Monahan & H. Steadman (Eds.). *Violence and mental disorder: Developments in risk assessment*. Chicago: University of Chicago Press.

Link, B.G., Andrews, H., & Cullen, F.T. (1992). The violent and illegal behavior of mental patients reconsidered. *American Sociological Review*, 57, 275-292.

Lowenstein, M., Binder, R.L., & McNiel, D.E. (1990). The relationship between admission symptoms and hospital assaults. *Hospital and Community Psychiatry*, 41, 311-313.

McNiel, D.E., Binder, R.L., & Greenfield, T.K. (1988). Predictors of violence in civilly committed acute psychiatric patients. *American Journal of Psychiatry*, 145, 965-970.

Monahan, J. (1981). *Predicting violent behavior: An assessment of clinical techniques*. Beverly Hills, CA: Sage Publications.

Monahan, J. (1993). Limiting therapist exposure to Tarasoff liability: Guidelines for risk containment. *American Psychologist*, 48, 242-250.

Monahan, J. & Steadman, H.J. (Eds.) (1994). *Violence and mental disorder: Developments in risk assessment*. Chicago: University of Chicago Press.

Monahan, J. & Steadman, H.J. (1994). Toward a rejuvenation of risk assessment research. In J. Monahan & H. Steadman (Eds.). *Violence and mental disorder: Developments in risk assessment*. Chicago: University of Chicago Press.

Otto, R. (1992). The prediction of dangerous behavior: A review and analysis of "second generation" research. *Forensic Reports*, 5, 103-134.

Poythress, N.G. (1990). Avoiding negligent release: Contemporary clinical and risk management strategies. *American Journal of Psychiatry*, 147, 994-997.l

Poythress, N.G. (1992). Expert testimony on violence and dangerousness: Roles for mental health professionals. *Forensic Reports*, 5, 135-150.

Steadman, H.J. (1982). A situational approach to violence. *International Journal of Law and Psychiatry*, 5, 171-186.

Swanson, J., Holzer, C., Ganju, V., & Jono, R. (1990). Violence and psychiatric disorder in the community: Evidence from the Epidemiologic Catchment Area Surveys. *Hospital and Community Psychiatry*, 41, 761-770.