

Hearings with Incarcerated Persons with Severe Mental Health Challenges

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Topics To Be Addressed

- Most relevant severe mental disorders
- Violence risk issues with persons with severe mental disorders
- Preparation for the hearing
- Gleaning key information from the records and the IP
- Building rapport with IPs with severe mental disorders
- Considerations in the hearing
- Post-hearing issues and how to prepare for future hearings

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Most Relevant Severe Mental Disorders

- Schizophrenia
- Bipolar I Disorder
- Schizoaffective Disorder

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Most Relevant Severe Mental Disorders

These disorders represent the most common conditions that compromise a person's ability to accurately perceive reality

Even though a person may have one of these disorders, the severity of the symptoms can vary tremendously

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Schizophrenia

- A chronic mental illness that affects how a person thinks, feels, and behaves
- The person may have a tenuous connection to reality
- Usually diagnosed between the ages of 18-30, rarely later, after first episode of psychosis
- Antipsychotic medication is essential

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Schizophrenia

- Marked by both Positive and Negative symptoms
- Positive symptoms include:
 - Hallucinations (auditory, visual)
 - Delusional beliefs (e.g., paranoid, grandiose)
 - Disorganized speech, thinking, and behavior
- Negative symptoms include:
 - Flattened affect (mood) and avolition (behavior)
 - Problems with concentration and memory

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Bipolar I Disorder

- A chronic mental illness that involves extreme mood swings, including manic episodes and depressive episodes
- The episodes usually cycle, becoming more severe for periods of time, with relative calm between extremes
- Mood stabilizing medication is crucial

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Bipolar I Disorder

- Manic episodes are periods of intense mood elevation, increased energy, and irritability
- Manic symptoms include:
 - Feeling very happy or excited
 - Intensely inflated sense of self-worth
 - Rapid speech, racing thoughts, and flight of ideas
 - Reckless and risky behaviors
 - Severe mania can include psychotic delusions

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Bipolar I Disorder

- Depressive episodes are periods of feeling sad, hopeless, or worthless
- Depressive symptoms include:
 - Low energy or feeling tired
 - Difficulty sleeping or sleeping too much
 - Eating too little or too much
 - Having suicidal thoughts

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Schizoaffective Disorder

- A chronic mental illness that combines symptoms of schizophrenia and a mood disorder
 - Most of the symptoms of schizophrenia may be present at times
 - In addition, mood symptoms such as mania (bipolar type) or depression (depressive type) will be present at varying degrees at different times

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Violence Risk Issues with SMDs

- Quite often, the severe mental disorder (SMD) may not have been related to their commitment offense / life crime
 - Sometimes the crime occurs before the SMD first appears, or it may occur when the symptoms of the SMD are not present/in remission
- People with SMDs usually are violent for the same reasons as those without SMDs
 - E.g., impulsive anger, frustration, revenge, fear, greed, peer affiliation, etc.

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Violence Risk Issues with SMDs

- The major difference with those with SMDs is that sometimes the symptoms of the mental disorder can alter the person's perceptions of the facts or reality underlying those motivating factors for either their crime or for violent behavior in prison
 - I.e., but for the SMD's symptoms altering the IP's perceptions, the IP would not have felt the need to engage in the criminal behavior

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Violence Risk Issues with SMDs

- You should think of IPs with SMDs as similar to other incarcerated persons, but they also have the additional issue of an SMD overlying the same underlying problems
- Not all people with SMDs are violent because of them
 - For some, when symptoms are acute, they can be less violent
 - E.g., the symptoms can interfere with their underlying antisocial orientation and make them less engaged in problematic behavior

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Violence Risk Issues with SMDs

- The primary concern for evaluators and commissioners is when those persons with SMDs are more violent because of their SMDs
- That usually happens with the symptoms cause problems with the perception of reality or frustration tolerance, and they lack both the self-awareness of the problem and the skills to avoid acting out violently

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Violence Risk Issues with SMDs

- They then may behave similar to your other IPs who act out violently, and for similar reasons, but based upon those errant perceptions
- For example, an IP with schizophrenia may have paranoid beliefs that others may be trying to harm him, and he strikes out violently out of fear to protect himself
 - This may not be that dissimilar from an IP who learns of an impending assault and attacks the would-be assaulter first

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Violence Risk Issues with SMDs

- There are two primary ways that those with SMDs become less at risk for violence:
 - They can learn about and understand their SMDs, including how to minimize their symptoms
 - They can learn the various techniques generally taught to other IPs to decrease their risk for violence

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Violence Risk Issues with SMDs

- Learning about their SMDs and minimizing their symptoms:
 - Insight/self-awareness is **ESSENTIAL** to increase treatment compliance and counter the effects of their symptoms
 - They should "own" and accept their SMD and relevant treatment
 - Psychotropic medications are **ESSENTIAL** for decreasing the intensity and frequency of symptoms

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Violence Risk Issues with SMDs

- Learning the various techniques of violence risk reduction:
 - Participate in self-help programming (e.g., AVP groups, victim awareness, CGA, AA/NA, etc.)
 - Usually, their symptoms will need to be under control first
- Please note: the most robust violence risk factor for those with SMDs is co-occurring substance abuse

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Preparing for the Hearing

- Preparation is crucial to find out that the IP has a SMD
- Sources from the C-File:
 - Current Comprehensive Risk Assessment (CRA)
 - Prior CRAs
 - PORs/Appellate Decisions (may reference mental health issues)
 - RVRs with chronos regarding mental health motivating factors
 - Board consultation documents
 - Any references to EOP, MHCB, hospital transfers, and type of housing

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Preparing for the Hearing

- You should be aware that the IP has an SMD at the time of the hearing
 - If they are symptomatic, it can be exceptionally difficult to speak with them, because they may not talk to you
 - If they are in treatment and taking their medications, it should be much easier

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Gleaning Key Information

- Ideally, we want to determine the following information from the IP or other sources:
 - What SMD do they have and what are their symptoms?
 - Have they been violent by reason of their SMD in prison or the community?
 - Do they understand about their SMD (i.e., diagnosis, chronicity, meds)
 - When they have been violent in prison or the community, to what do they attribute the cause?
 - With the CRA, you will have some key information from the mental health records (e.g., diagnosis, time in treatment, level of understanding, assessment of contribution of SMD to their risk)

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Gleaning Key Information

- We really want to know the following:
 - Does this person's SMD increase their risk for violence?
 - If so, how well managed is the person's SMD at this time?
 - As with other IPs, how well managed are their other violence risk factors?

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Building Rapport

- For those with insight and taking their medications, the challenges to rapport would be similar to most other IPs
- For those who are actively symptomatic, building rapport could be quite challenging
 - Especially for those who are paranoid, they may not trust you
 - For those who are tangential and focused on delusional ideas, it will be difficult to refocus on what is important

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Building Rapport

- It may take some time to convince those with SMDs that you are doing an objective determination of their risk
 - Be measured and consistent, letting them know your job is to objectively determine their risk for violence in the community
- To the extent that it is reasonable, be patient, especially if the IP derails into irrelevant topics
- Do not dismiss their delusions, but also do not engage their delusions
 - E.g., "I understand you believe that, but it might be best to focus on these other things."

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Building Rapport

- It is okay to ask a person with a SMD if they know their current diagnosis
- It also is okay to ask if they know their current medication, if they are taking it, and if they know what it is supposed to do
- For some, if you appear comfortable talking about their SMD (and not freaked out), they will also be comfortable

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In the Hearing

- Ideally, the IP should try to inform you that they have insight into their SMDs
 - Diagnosis; Chronicity; Need for Treatment; Need for Medication; Relationship to Risk
- Parole plans should include, *inter alia*, the treatment and management of the SMD
- Remember – it is not necessarily problematic that they have an SMD; rather, the IP should attempt to diffuse the concern that having the SMD will increase their violence risk

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In the Hearing

- There should be significant discussion about their SMD
- Nonetheless, the IP with SMD must also understand that non-SMD violence risk issues are crucial to understand, and they have the responsibility to demonstrate that they are managed and mitigated
- Due to the robust correlation of substance abuse to violence for those who have SMDs, any substance use should be scrutinized in the hearing

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In the Hearing

- An IP having an SMD should not, *ipso facto*, result in a denial of a parole grant, but the presence of an SMD in an IP can compromise the progress the Board likes to see in those IPs who do get grants
 - An active SMD generally prevents work on most other issues – for this reason, the SMD needs to be relatively well-controlled
 - When an IP has active symptoms, and the IP has been violent related to such symptoms, the IP's risk will be at least temporarily elevated
 - When positive symptoms are controlled, negative symptoms may still interfere with successful parole planning and group participation

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In the Hearing

- An IP having an SMD should not, *ipso facto*, result in a denial of a parole grant, but the presence of an SMD in an IP can compromise the progress the Board likes to see in those IPs who do get grants
 - Recall that for some IPs with SMDs, the SMD does not increase their risk for violence, and may lower risk in some cases
 - A well-managed and well-treated SMD can put the IP on a similar footing as other long-term IPs with hearings before the Board

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In the Hearing

- An IP having an SMD should not, *ipso facto*, result in a denial of a parole grant, but the presence of an SMD in an IP can compromise the progress the Board likes to see in those IPs who do get grants
 - The nature of the SMD may make self-awareness and risk reduction plans exceptionally difficult for the IP; this may mean that risk will remain elevated
 - While this may “feel unfair,” as the presence of an SMD is beyond the IP’s control, the primary consideration is unreasonable risk to the community, not whether this IP is doing the best they can under the circumstances

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In the Hearing

- As with non-SMD IPs, those with SMDs also need to demonstrate self-awareness into their general violence risk issues (beyond their SMDs)
 - As available, they should be enrolled in either self-help programming or taking relevant violence risk related groups in EOP or their other settings.
 - They should attempt to nurture strong personal support systems
 - They should develop robust relapse prevention plans for violence, substance use, and their SMDs
 - They should be prepared to discuss their relevant coping skills for dealing with stressors and triggers when they appear
 - They should take initiative to search for transitional housing settings

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Post Hearing / Future Hearings

- If an IP with an SMD does get a grant, it is imperative they understand how important their mental health treatment is to avoid getting revoked
 - Substance abuse and/or coming off meds is a recipe for failure/disaster
- For those who do not get a grant, it is crucial to stress the importance of adherence to mental health treatment and medication as a primary consideration
 - Decompensation with an associated increase in risk will be a major challenge at their next hearing

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Post Hearing / Future Hearings

- Also for those who do not get a grant, it is essential to emphasize that getting the SMD under control is not the only consideration to being ready for a grant.
- Rather, once the SMD is under sufficient control for the IP to work on other violence risk related issues, the IP should fully engage in programming and planning to prepare themselves to lower their general violence risk.

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Questions?

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