Section 8: Case Studies

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Virginia Department of
Behavioral Health &
Developmental Services

Case Study #1

Mr. K

Mr. K is a 38 year old single (never married, no children) male who experienced his first symptoms of mental illness in 2005, 11 years ago. He was living out of state at the time and sought treatment at his local hospital. At this time he reported having feelings of déjà vu experiences off and on for the past two years and these experiences were intensifying. He received some medications (unknown) in the emergency room but was not admitted. He had completed college and had worked full-time ever since. At the time of the NGRI offense, Mr. K was employed full-time in an occupation that required him to travel from state to state. Mr. K reported that he smoked marijuana once per week and drank alcohol occasionally.

In June of 2007, at the age of 29, Mr. K was hospitalized for 6 days in his home town. At this time he was experiencing delusions, paranoia and isolation. Examples of his delusions included the following: beliefs that the television was sending him messages; belief that mythological creatures were trying to entice him to battle; belief that a celebrity on TV wanted to marry him; misinterpretation of numbers to indicate that he was GOD. Again he received medication but stopped the medication once he felt better. Mr. K contends that he was never instructed to get the medication refilled once he left the hospital.

Mr. K was again hospitalized for one week in January of 2008. Records indicate that upon admission Mr. K reported feeling down, depressed, and crying a lot and that he believed he was not himself. He also expressed beliefs that he had been in the military but that he was not sure. In actuality, he had been in the Navy for approximately 4 months but was discharged due to reported feelings of suicide. At the hospital he reported that his thoughts seemed jumbled. Records indicate that he was treated with Risperdal and diagnosed with Psychotic Disorder, NOS. Again, he took the medication until the prescription ended but did not seek a renewal.

In April 2008, at the age of 30, Mr. K was travelling through Virginia and had stopped to get some dinner at a restaurant. He reported feeling very paranoid as if someone was going to harm him. He stated that he believed some of the people in the restaurant looked like devils and were possessed by demons. Mr. K went back to his vehicle and

secured a knife for protection. He reentered the restaurant and sat down to have dinner. Another patron approached him and began a casual conversation. At this time Mr. K responded by pulling the knife and stabbing the bystander to death. Mr. K left the restaurant but stopped to talk to the cashier on his way out the door as if nothing out of the ordinary had transpired. He was arrested a short time later driving on Interstate-95.

After Mr. K's arrest he spent time at Central State Hospital for restoration to competency. After receiving medications, he was able to be restored and he was also evaluated for a second opinion sanity evaluation requested by the Commonwealth's Attorney. In December, 2009 he was found Not Guilty by Reason of Insanity and subsequently committed to the custody of the commissioner to begin the privileging process. Mr. K's initial progress in the hospital was slow and was laden with numerous medication changes in order to maximize his treatment efficacy. Psychiatric treatment was complicated with the medical problem of brittle diabetes. Additionally, once Mr. K was stabilized and was able to fully appreciate the gravity of the fact that he had committed murder, he was despondent, isolated and overwhelming remorseful thus requiring further medication adjustments. He began to work with a therapist to address the guilt and shame that he felt due to his actions. Slowly, Mr. K began to make progress and by November, 2011 he was able to receive approval from the Forensic Review Panel for Unescorted Community Visits (up to 8 hours) to a day program.

Although Mr. K's psychiatric stability remained constant, his insulin levels were unpredictable and often dangerous. At one point his passes for unescorted community were held for two months in order to regain control of his medications for his diabetes. However, by March, 2012 Mr. K was ready to request 48 hour overnight passes. Until that time, he had continued to do well psychiatrically and was especially vigilant of his blood sugar levels and has learned to administer his own insulin and other medications. After several months, he was able to begin 48-hour passes to a local crisis stabilization facility (because his housing was not yet available). Mr. K has never experienced any aggression or loss of privileges during his hospitalization. He has been totally compliant with all aspects of treatment. At this time the treatment team and CSB are preparing for conditional release to a shared apartment (with a roommate who is also NGRI).

Case Study #2

Mr. O

Mr. O is a 55-year-old Caucasian male who was adjudicated NGRI for felony arson. He grew up in a rural part of Virginia, dropping out of high school prior to completion due to attendance problems and challenges learning due to an intellectual disability. He has a limited work history, only maintaining consistent employment for a brief time while enrolled in a supervised work program. The onset of his illness occurred when he was 21 years old, at which time he started experiencing command auditory hallucinations and suicidal ideation. Since that, time he has been hospitalized on multiple occasions, each the result of treatment non-adherence and rapid psychiatric decompensation. Over the years, Mr. O engaged in dangerous behavior while psychiatrically unstable. He has a lengthy history of arson and assaulting family members in response to paranoia and command auditory hallucinations, thus his relationship with his mother and siblings is strained. Despite this, his mother does allow him to live in her home for periods at a time, before kicking him out when he becomes psychotic and then allowing him to return after stabilization at the hospital. Mr. O has had a long history of treatment with his local CSB. He has a case manager however he has not achieved stability, and most of his interactions with the CSB have been through Emergency Services and Acute Care. His most recent diagnosis is Schizoaffective Disorder, Bipolar Type.

In the months leading up the NGRI offense, Mr. O stopped taking his medications reportedly because he could not afford them. He did not report this to his case manager at that time, nor did he contact Emergency Services. He started to experience auditory hallucinations and paranoia that others were laughing at him. He set fire to his mother's home in an attempt to get rid of the "demons and voices."

Mr. O was found Not Guilty by Reason of Insanity in 2013 for arson. He has been hospitalized for three years. During the course of his hospitalization he has been adherent to his medications and he has not had any residual symptoms of his illness. There have been no episodes of aggression. While he attended treatment programming both in the hospital and the community on escorted and unescorted 8-hour passes, his participation has been minimal. While he has acknowledged having a mental illness that requires continued treatment, he has limited insight with regard to benefits of medication and/or consequences for stopping the medication. He has struggled with

identifying structured activities that are meaningful to him, and thus chooses to attend day treatment five days per week.

Mr. O has completed 48-hour passes successfully to an assisted living facility, although he has difficulty accepting that he needs this level of residential care and often speaks about his eventual discharge to an apartment. However, his passes have been uneventful and staff at the ALF report that he is doing well and interacting with his peers. At this time the treatment team and CSB are preparing for conditional release.

Case Study #3

Mr. N

Mr. N is a 37 year old single (never married, no children) male who experienced his first symptoms of mental illness at the age of 16 and subsequently was hospitalized on three occasions and received medication. Mr. N was in special education throughout his primary and secondary education. He was diagnosed with borderline intellectual functioning and doctors believed he was experiencing symptoms of Schizophrenia. Precursors to hospitalizations included feelings of paranoia and impulsiveness regarding thoughts of harm to self or others. On one occasion, Mr. N attempted suicide by cutting his wrists because the voices told him to do so. Mr. N was always compliant with his medications but at times his mother had difficulty refilling prescriptions due to lack of funding. At the time of his NGRI offense in 1997, Mr. N, then 18, reported feelings of isolation as his older sister had left home for college and his dog had recently died. He was unable to get his medication refilled. He began to experience sounds and visions that he could not understand (auditory and visual hallucinations). He was frustrated that his sister had abandoned him and could not stand living in his mother's home another day. He expressed that the house was closing in on him so he believed that if he burned down the house he would be free. He set the house on fire and then went next door to a neighbor and called 911. A few days prior to this offense, he had also set fire to a neighbor's porch but no charges were filed.

Mr. N was found Not Guilty by Reason of Insanity and was committed to DBHDS in November 1997 and subsequently admitted to Central State Hospital under temporary custody. He was eventually transferred to a civil hospital where he remained hospitalized for the next 19 years.

Mr. N's initial progress in the hospital was very slow. He often engaged in attention-seeking behaviors highlighted by increasing somatic complaints and threats of suicide. Due to his cognitive impairment, his understanding of his symptoms and the NGRI process is also limited. Mr. N has had several altercations with staff during his hospitalization. One such altercation resulted in charges being filed for assault and a sentence of 120 days in jail all of which was suspended. Mr. N's lengthy hospitalization coupled with his cognitive impairment has created an environment of dependency and

fear of leaving the hospital. When he begins to near the point of conditional release, he will begin acting out and threatening suicide, which has slowed the process of release. As a result of this, he also requires frequent prompting and reassurance in order to gain full compliance and participation with treatment. He has been medication adherent and enjoys attending groups and activities. He has no history of substance use. After a lengthy process, he achieved the privilege level of Unescorted Community-8 hour passes, which he used to attend a psychosocial day program operated by the CSB 4 days per week (and by all accounts has been very active there).

Mr. N is notorious for giving away his money to peers. Although Mr. N has made progress in understanding his mental illness, the need for medication adherence, and some living skills such as personal hygiene, he continues to demonstrate poor interpersonal skills which makes him vulnerable to exploitation. He also has a very low frustration tolerance and higher levels of anxiety that require frequent reassurances from staff. Over the course of his hospitalization his diagnoses was modified to Schizophrenia, Disorganized Type, Borderline Intellectual Functioning and Personality Disorder, Dependent Type.

At this time, he has begun 48-hour passes to a local supervised group home, where he will ultimately be conditionally released. It appears that he is excited about this placement (he reports that he will be living with friends that he knows from the day program) and he has not demonstrated any of the previous attention seeking behaviors that have stalled his progress in the past. The team and CSB have begun to draft the conditional release plan and will move forward with that request after two more 48-hour passes to the group home.

Mr. J

Mr. J is a 41-year-old married male who experienced his first symptoms of mental illness in 1997, at the age of 22. He spent most of the early years of his illness untreated, experiencing episodes of anger, mood changes, and some psychotic symptoms. He was living with his parents at that time, and eventually was hospitalized and treated with medications. During that hospitalization he was diagnosed with bipolar disorder. Upon discharge he continued his medications, however in the years following he would often stop medications and resume after an incident that prompted police intervention. He also struggled with substance use, which led to several arrests for possession of controlled substances or driving while intoxicated. He eventually married, and resided in an apartment with his wife for several years prior to the NGRI offense in 2013. He has a spotty employment record, mostly part-time employment and often of short duration.

Eight months prior to the NGRI offense, he reportedly went on a 7-day amphetamine binge, subsequently becoming paranoid and possibly experiencing auditory hallucinations. He was boarding up his apartment, plastering holes in the ceilings and claiming cameras were watching him. His NGRI offense occurred when he assaulted his wife and the responding police officer, for which he was charged with one count of misdemeanor assault and battery and one count of felony assault on a law enforcement officer. He was first admitted in 2013 to the state hospital from jail for competency restoration prior to his trial. On admission he was suspicious and guarded. He refused to answer questions, was isolative, and his behavior was bizarre. Upon admission, he was detoxing from benzodiazepines. He had limited insight, and reported that he was arrested for no reason. He was initially diagnosed with Amphetamine Induced Psychotic Disorder. According to the psychiatrist, his history was consistent with substance abuse problems and personality disorder. Mr. J also had a history of some mood disturbance that included impulsive outbursts of aggression, some depressive symptoms and reported psychotic symptoms. At the time of discharge back to the jail following his restoration to competency, he was diagnosed with Schizoaffective Disorder, Bipolar Type. Mr. J was later found NGRI and committed to the custody of DBHDS in January 2014.

Upon his current admission, Mr. J complained of nicotine addiction as he was smoking several packs of cigarettes a day prior to incarceration and state hospital admission. He was prescribed nicotine chewing gum, a nicotine patch and was requesting additional nicotine withdrawal support. He initially demonstrated some denial of mental illness and denial of substance abuse, and often refused to participate in group activities and treatment team meetings. His privileges were often suspended due to rule violations, such as bringing cigarettes into the facility after passes. Although his mental illness was well managed with medications, he continued to deny substance abuse problems and tended to minimize his need for treatment. He has been prescribed mood stabilizing medications, which appear to have had positive results on his mood swings and angry outbursts, and he has been adherent to his medications. Upon approval of his unescorted community visits, he was able to obtain part-time employment as a mail clerk at a local engineering firm and began to work on GED courses. Mr. J has maintained a relationship with his wife, who appears to be supportive and willing to have him return home upon discharge.

Mr. J was able to eventually able to successfully use his 8-hour and then 48-hour passes. Despite his ongoing minimization of his substance abuse issues, he reports that he will comply with all conditions and has been able to manage at greater levels of independence through the privileging process. At this time the treatment team and CSB are preparing a conditional release plan and will be submitted a request to the FRP.

Case Study #5

Mr. Q

Mr. Q is a 28-year-old single, separated male with three children from two separate relationships. Mr. Q has no established history of major mental illness, and had never struggled with psychiatric illness in the past. The sanity evaluation conducted prior to his acquittal indicated that a late-onset mental health condition was likely and that it directly resulted in the NGRI offense. In the events leading to his arrest and subsequent NGRI finding, he experienced several incidents of substance-induced domestic assault on his partner and his mother-in-law; these were the most recent in a series of domestic assaults, all primarily occurring during times of intoxication, but have occurred in the absence of substance abuse as well. At the time of his NGRI offense, Mr. Q reported "hearing voices" and feeling that he was "commanded" to assault his family members, as they were "going to hurt my children." Mr. Q was found Not Guilty by Reason of Insanity in 2002 and subsequently committed to DBHDS. Later, while hospitalized, it was determined that, while possibly predisposed to psychiatric symptoms under certain situations, the symptoms he experienced were likely due solely to substance abuse at the time of the offense.

Mr. Q was transferred between three state facilities over the course of his hospitalization due to ongoing issues with violence toward staff and peers, and general non-compliance. During his current civil hospital placement, a more pro-social approach to treatment was taken, expressly based on forming therapeutic alliances, and he began to establish the first therapeutic relationships since his NGRI commitment. He was entrusted with more freedoms and he seemed to do better with a collaborative approach than with a corrections approach of consistent negative consequence for maladaptive behavior. He remained psychiatrically stable and over a period of several years, achieved the Unescorted Community – 8 hour pass level and began working full time in the community. He reestablished relationships with family members, and adhered to hospital rules. He engaged in individual therapy to address antisocial behavior, specifically domestic violence, and through prosocial treatment, began to understand the benefits of sobriety and prosocial living. He took pride in his AA/NA participation and built a very healthy support system through the AA/NA community. Previously noted as having a weak self-concept, he gravitated to AA/NA principles and appeared to integrate them into a stable identity. He progressed to the point of

initiating and then facilitating his own AA group in the community. During times of stress in particular he continued to push boundaries in the hospital and act against his treatment providers, but a flexible approach that highlighted support was typically successful in preventing these periods from escalating into patterns. His treatment team and CSB were able to locate a housing placement at an adult foster home, where he was able to complete his 48-hour passes. The team is now preparing to submit a request for Conditional release.