Offenders with Dual Diagnosis:
Intellectual Developmental Disabilities/Autism Spectrum Disorders & Psychiatric Disorder

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Dual Diagnosis Program (DDCP)

- Regional inter-professional academic-service team of faculty from psychiatry, psychology and rehabilitation
- Serve children/adults with dual diagnosis: intellectual disabilities and/or autism spectrum disorders with mental health problems or challenging behaviour
- Offer consultation, diagnosis, assessment, intervention and therapy across uni-disciplinary & interprofessional clinics
- Hybrid funding model of university, OHIP, insurance and F.F.S.contracts
- Specialized clinics for TAY, ASD, Sensory, Dual Diagnosis and Forensic Disability (Complex ASD/Offending/Sexuality)

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Outline

- Overview of the literature on offenders with intellectual disabilities and/or autism spectrum disorders
  - prevalence, characteristics and offence type
  - salient issues in the CJS at arrest, interview and court

- Review of clinical risk framework
  - Clinical assessment
  - Risk assessment
  - Risk-informed treatment & supervision
  - Community risk management plans
Susan

Susan 35, with Mild ID, lives in a group home and has a long history of depression and physical aggression due to low frustration threshold and impulsive behaviour. She has assaulted another resident on numerous occasions and staff who have tried to intervene. They have brought her to emergency several times due to her level of aggression.

1. Should she be admitted? or charged?
2. What is her actual level of risk?
3. Who is responsible for her future care?
John 23, with HF/ASD, lives at home with his parents and has history of anxiety disorder and poor communication skills. He has recently finished school and works part-time. He met a girl at work and sexually assaulted her on their first date by grabbing her breasts.

1. *Should he be charged? admitted?*
2. *What is his actual level of risk?*
3. *Who is responsible for his future care?*
Why important to identify?

- Recognition that offenders with ID/DD should be dealt with differently in the CJS
  - due to vulnerabilities and risk of exploitation in custody
  - high prevalence of comorbid psychiatric disorders (4x)
  - offence mitigating factors of cognitive deficits and sheltered experiences

- Specific challenges for police, courts and corrections
  - competing outcome goals of treatment vs punishment
  - difficulty in assessing capacity and competence for CJS process
  - complex inter-ministerial support needs in minimizing recidivism
Why important now?

- Impact of deinstitutionalisation and social inclusion suggests resettlement is difficult
  - increased exposure to high risk situations that enhance vulnerability
  - with increased choice there is increased risks i.e. dignity of risk
  - new legal pathways as facilities are closed “trans-institutionalisation”

- Presents service implications for caregivers/agencies
  - lower caregiver tolerance threshold
  - system culture change i.e. custody to community, inpatient charges
Research Impact

- Policies of community integration and normalization significantly impact future prevalence and incidence rates

- Literature regarding offenders with developmental disabilities has evolved
  - Gradual change from prevalence to identifying subtypes
  - Understanding ‘pathways’ to offending and legal outcomes i.e. impact of IQ level, gender, prior setting and supports
  - Focus on valid community risk assessment and management tools
Prevalence

- Offending behaviour is much more common than is actually reported.

- Persons with cognitive impairments are generally over-represented in the CJS so ‘special needs’ offenders large group (<80 IQ).

- Estimates in CJS vary (2-40%) due to setting, methodology and/or narrow or broad definitions of diagnosis and offending.
  - Different study samples along CJS continuum
  - File review vs prospective studies
  - Historically custody/conviction rates rather then reoffending or recidivism rates

- Likelihood of CJS involvement decreases as level of disability increases.
Ministerial Terminology: Service Differences and Overlap

* Some overlap with FASD, ABI and ASD (>70, sig AB problems)
* Some overlap with ‘Special Needs Offenders’ (<80)
Characteristics

- Most in mild range and very few with moderate/severe ID
  - less likely found competent or charged
- General risk factors similar to non-disabled population*
  - young, male
  - psychosocially disadvantaged
  - familial offending/adversity
  - history of academic/emotional/behaviour difficulties
  - Anti-social peers/social network
- Also less likely to be socially supported and more likely to have prior legal contact, ASD protective factor (Lunsky et al, 2012)

* Lindsay et al 2011a,b
Characteristics

- More likely to have history of impulsivity, ADHD and conduct disorder
- More likely to have a history of childhood environmental and emotional deprivation
- More likely to have history of personality disorder and anti-social traits
- More likely to have substance abuse issues
- Age of index offence and gender predicts severity of legal consequence

*Lindsay & Holland et al (2013, n=477, tiers 1-4, 345 NSO, 128 SO)*
Offence Type

- Majority are misdemeanors and public nuisance offences
- Less likely to commit ‘white collar’ crime or traffic offence
- High rates of verbal threats and physical aggression
- Secondary offences are property destruction, theft & arson
- Sex offenders majority have only sexual index offence
- Non-sex offenders have both sexual/ violent index offences
- Victims more likely to be other individuals with disabilities, family members or staff
- Sex offenders more likely to have male victims
Aggression and ID/DD

- Offenders more likely to have difficulties with anger dyscontrol and aggression management than premeditated violence i.e. reactive aggression
  - Highly associated with ADHD and impulsivity
  - Impact of high mental illness rates 38% e.g. poor emotion regulation
  - Associated behavioural phenotypes i.e. Fragile X

- Compounded by external biases
  - Attitudes of others and ‘over-control’ e.g. staff power struggles
  - Punishment for ‘normal’ behaviours i.e. anger expression
  - Distorted social expectations based on false trust assumptions with staff

- Main reason for ER visits
  - Likelihood of psychiatric diagnoses decreases with level of ID
  - Diagnostic overshadowing
**ASD Offenders**

- Prevalence studies reflect around 1-3% of mentally disordered offenders in community*
- High rates in young offenders
  - Siponmaa et al 2001, 12%PDD, 3%AS
- Higher rates with HFA and AS in secure hospitals
  - Hare et al. 1991, 3% ASD, 90% AS
- Current research divided about specific vulnerabilities to offending due to unique neuropsychiatric symptoms and behavioural phenotype of ASD

*Lindsay, 2011
Phenotype of ASD and Risk

- **Social impairments**
  - diffs in reading social cues within peer interactions
  - diffs in interpreting intent of others

- **Communication impairments**
  - Expressive pragmatic difficulties
  - Overestimated by language ability, inflated comprehension level
  - Dysprosody and affect modulation difficulties

- **Rigidity and repetitive activities:**
  - Rote pursuit of circumscribed interests e.g. perseveration
  - Inflexibility of black and white thinking style e.g. ‘friend or foe’

* RCP (2006) Risk Variables in ASD
Offence Type: ASD

- Physical/verbal aggression and targeted violence
- Low base rate of arson, theft & traffic offences
- Sexualized offences linked to:
  - Breaking societal norms
  - Impaired social perspective-taking i.e. harassment, stalking
  - Rule based world: rote learners vs intuitive reactions
  - Lack of flexibility in social reciprocity
  - Persistence/rumination provokes situations

*Allen et al 2008*
Sexual Offences and ID/DD

- Risk similar to the general population given a ‘normative’ learning experience however high rates of childhood neglect, trauma and sexual abuse

- People with ID are less likely to have healthy social sexual experiences and adequate knowledge
  - higher risk of developing sexually inappropriate behaviour

- Sexual deviance or paraphilia is distinctly different, does exist but often misdiagnosed
Sexually Inappropriate Behaviour

Offenders more likely to exhibit less violent but more sexually inappropriate behaviours (i.e. public masturbation, exhibitionism, voyeurism)

- Essential to differentiate deviance from inappropriate behaviour that occurs in ID due to historical and developmental context

Result of external or medical factors

- lack of privacy
- poor or distorted sexual knowledge
- Poor access or inappropriate partner selection
- Polypharmacy
Interface between CJS & DS sector

- Wide range of variability ‘when, why and what for’ CJS is accessed due to:
  - service policies & philosophy of care (e.g. normalization vs accommodations)
  - agency risk tolerance & management approach (e.g. risk averse to mngt)
- No clear message of what to expect
  - either authoritarian or paternalistic approach by agencies
- Complex individuals have varied experiences of contact with the law as most get moved around service system
- Fitness assessments are poor estimates of CJS capacity
  - low bar for UN criteria (defense, instruct, follow & challenge)
- Faulty presumption of effective deterrent approach
  - requires insight, consequential learning and ability to generalize
CJS Inequities for ID/ASD

Inter-ministerial barriers

Minimal accommodations

Lack of advocacy

Limited understanding by police, lawyers and judges throughout the process; at best seen within a mental health court
Vulnerabilities: Arrest / Interview

- Most relate to understanding of legal rights
  - limited understanding of caution/ rights
  - more suggestible and more likely to acquiesce and yield to person in authority (Gudjonsson)

- Difficulties in understanding basic legal terms
  - Guilty or not guilty; truth or whole truth

- Lack of understanding of criminal process
  - false confessions to escape pressure/duress
  - transparency of truth expected by authority figures
  - More likely to confabulate in interviews to gain approval
Challenges: Court

- **Issues regarding capacity and fitness to plead**
  - Court diversion commonly occurs only after arrest or later in court when an individual is identified
  - Less likely to be identified by lawyers due to balance of outcomes i.e., quick sentence versus indefinite psychiatric assessment

- **Culpability or criminal responsibility based on knowledge of right and wrong at the time of the offence and ability to control oneself**
  - Diminished appreciation: refers to moral and intellectual understanding that is age or developmentally related
  - Impacts on level of insight into nature and seriousness of offence
Clinical Risk Framework

Clinical Assessment:
identify mitigating factors

Risk Assessment:
outline actuarial & dynamic risk profile

Community Risk Management Plan:
Define setting in legal context
Risk informed treatment
Supervision/monitoring plan
Clinical Assessment

- Clinical assessment to set foundation for risk appraisal
- Outline implications of ID on offending behaviour
  - identify level of comprehension and cognitive profile
  - recognize pace of individual’s understanding
  - assess for co-morbid mental health issues
  - Possible contributory offence specific behaviours e.g. impulsivity
- Set realistic risk setting in context of legal outcomes
- CRMP must facilitate the treatment and supervision plan
Clinical Assessment in ID: Red Flags

- **CLOAK OF COMPETENCE:**
  - tendency to overestimate ability level due to perceived adequate social skills, discrepancy between verbal and performance ability

- **ACQUIESCENCE/SUGGESTIBILITY**
  - tendency to give an affirmative response/tendency to be swayed and open to suggestion

- **COMMUNICATION DIFFICULTIES:**
  - limited verbal expression of subjective states, emphasis on concrete concepts, personalised vocabulary

- **BEHAVIOURAL MASKING:**
  - diagnostic difficulty with increased disability severity
  - emphasis on behavioural cues and subjective reports

- **DIAGNOSTIC OVERSHADOWING**
  - tendency to attribute symptoms to MR/DD despite MH high rates (40%)

- **SOCIAL/SEXUAL BOUNDARIES:**
  - lack of insight into social understanding & social roles
  - increased prevalence of abuse and trauma history
  - Attitudinal differences e.g. QASCO
Risk Assessment and ID/DDx

- Validity debates between actuarial and clinical judgement models
- Limitations due to base rate biases and population differences
- Decade of work by Lindsay, Boer, & Haaven et al developing models to include environmental variables for ID offenders (e.g. ARMIDILLO-S, DRAMS)
- Risk needs to be seen in context of community setting (Boer, 2007)
Community Risk Management

- Offender risk may not change but risk created by environment can
  - i.e. new staff, victim access
- Can have same risk level offender in two different environments that either significantly increase or decrease risk manageability
  - e.g. group home vs SIL
- Need to include environmental risk factors
  - e.g. impact of staffing model
- Support network dictates threshold of risk tolerance
  - Agencies range from risk averse to active risk management
  - Oversight capacity (supervision, security, staff ratio, medication)
Agency Risk Tolerance

- Determine agency risk outcomes & supervision expectations
- Range from community exposure to residential confinement:

1. Risk averse: Low Expectations
e.g. no outings, no exposure

2. Risk minimisation: Moderate Expectations
e.g. avoid risk situations, partial exposure

3. Risk management: High Expectations
e.g. planned risk situations, supervised exposure
Agency Risk Management

- Identify risk management options
  - Level of supervision
    - seg, 1:1, proximity, eyes-on, los, intermittent, transparent
  - Security
    - secure unit (isolation/restraint capacity)
    - 24hr, 18hr, group home, FM, ESIL, SIL, APSW
  - Staff ratio
    - 1:1, primary, shift primary, zero resp. shift model
  - Medication
    - address behaviours eg PRN for aggression
    - address symptom and/or etiology eg ASD & anxiety
  - PBSP
    - Address behavioural crisis e.g reactive approaches (CPRI)
    - Identify triggers and contingency plan e.g proactive strategies
Risk Informed Treatment

- Individualized treatment programs - mainstream approach requires considerable modification and adaptation/flexibility
  - language – simple, chunked
  - pace of information
  - concrete vs abstract concepts
  - repetition, in-vivo learning
  - caregiver generalization e.g. guided homework

- multi-disciplinary/ inter-agency work essential given they straddle multiple sectors (MCSS, MOHLTC, MCSCS, MOE)

- Plan must be linked to natural support network and service sector for system monitoring
Treatment Plan

- Find balance between public protection and individual vulnerabilities/victimisation

- Three areas of intervention (ISS)
  A. Direct treatment with individual to eliminate/reduce offending behaviour
  B. Direct work with support services to enhance care and promote alternative behaviours
  C. Direct work with system to minimise recidivism
ISS Community Risk Management

Individual:

Target behs

Services:

Build supports

System:

Reduce Recidivism

Direct

Indirect
A: Individual Treatment

- Develop ‘tailor made’ and ‘client-centred’ plans
  - Clinical assessment to facilitate intervention options
  - address co-morbid MH and possible psychotropics/PRN
  - offence specific treatment (i.e. anger management, DBT, social/sexual education, PPG & relapse prevention)
  - environmental interventions (i.e. PBSP, tolerance training, skills development)
  - identify offending profile to outline risk probability (e.g. impulsive, opportunistic or planned)
B: Service Planning

- Minimise risk of re-offending in near future
  - vocational opportunities: supported employ (job coach)
  - social-sexual education: age appropriate relationships, dating, healthy sexuality
  - develop relapse prevention plan: identify triggers, learn consequences through modeling (in vivo practice)
  - group work: share and generalise information, role play, positive social experiences
C: System Intervention

- Risk management based on accepted risk outcomes
  - education and training with families and staff
  - program consultation and case conference with support agencies, services and relevant sectors
  - Assess caregiver expectations and environmental risk by all stakeholders
- Evaluate supervision options and possible novel settings
  - case management (APSW)
  - structured-support (SIL)
  - semi-supervised (day not night)
  - 24 hr supervised and/or secure (restraint capacity)
Community Risk Management Plan

Past History and Offence
- Clinical Assessment
- Risk Assessment
- Legal Consequences & Context

Risk Informed Treatment & Support Plan
- Individual Treatment
- Service Planning
- System Intervention
Thank you

- Questions or comments?
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