Risk Assessment for Individuals with Intellectual/Developmental Disabilities and Dual Diagnosis

Community Networks of Specialized Care:
Justice Series

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Outline

- Background to Offenders with ID/DDx
- Risk Assessment & Management
- Risk and ID
- Risk Tools
- Treatment & Management
- Case discussion

Susan

- Susan is 35 and has been living at the group home for five years after multiple previous placements deteriorated due to her aggressive behavior towards other residents. She has never been charged before. She has a history of getting attached to staff and then becoming jealous when their attention is shared with other residents. Staff feel that she physically attacks other residents when staff are not nearby. She has attended an anger management group and was able to learn various coping strategies but does not use them when angry and frustrated. She does feel sorry after an incident although she also loses privileges following any aggressive incident. She is currently not working and is at home most of the time. She has been treated for depression in the past but is not currently on any medication.

John

- John is 25 and has been living at home with his parents since he left high school. His older sister left for university two years ago. He works at a shredding company and has been there for over four years. His employer describes him as quiet, shy and has had no punctuality or behavior problems with John. John is currently being treated for his anxiety with medication and is being followed by his family doctor. John has recently met two new friends at work, one male and one female (victim). John has been talking a lot to his male friend about wanting a girlfriend. John's parents describe him as more anxious lately and irritable; they did not know about his date.

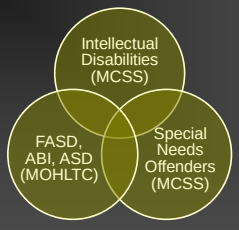
Background

- Deinstitutionalisation suggest period of resettlement is difficult
  - increased exposure to risk situations, new legal pathways
- Literature regarding offenders with developmental disabilities (DD)
  - Change from prevalence and type to community risk assessment
- Present specific service implications for caregivers and agencies
  - caregiver tolerance threshold, system culture change
- Specific issues for this population in navigating the CJS
  - at arrest, interview, court

Current CJS & ID/DDx

- Wide range of variability *'when, why and what for'* CJS is accessed due to:
  - agency policies & philosophy of care
  - behavior tolerance & risk management approach
- Most individuals have different experiences of contact with the law as most move around service system
- No clear message of what to expect (maternalistic/paternalistic approach)
- Faulty presumption of deterrent approach: requires insight into consequential learning and generalization
- Fitness assessments are poor estimates of CJS ability

Persons with Intellectual/Developmental Disabilities and Offending Behaviour



*Some overlap with FASD, ABI and ASD (>70, sig AB problems)

*Some overlap with 'Special Needs Offenders' (<80)

Prevalence

- Offending behaviour is much more common than is actually reported to police
- Estimates vary (2-40%) due to narrow or broad definitions of diagnosis and offending
  - Due to caregiver tolerance and agency philosphy
  - Different study samples and mostly conviction rates rather then reoffending or recidivism rates
  - 'special needs' larger population in CJS ie borderline IQ

Prevalence

- Estimates vary across settings ranging from community to prisons
  - Community services 2-5%
  - Police stations 5-10%
  - Courts 14-36%
  - Prisons 0.2-10%
- Research shifting from prevalence studies to understanding pathways of legal involvement ie setting outcome, gender diffs

Characteristics

- Very few individuals with severe/profound ID
  - Less likely charged or found competent (mens rea)
- Most offenders with ID are within the mild to moderate range of intellectual impairment
- General risks similar to non-disabled population
  - *young, male, psychosocially disadvantaged, familial offending, mental health/substance abuse, history of academic/emotional/behaviour difficulties*

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Characteristics

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

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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 (reactive rather and premeditated)
- Over reporting of sexual offences and arson due to biased sampling of convicted individuals
- Victims more likely to be other individuals with disabilities or staff and family and sexually more male victims

Risk Assessment

'The prevention of *vulnerability*, namely taking care not to place the individual in a situation in which he or she may be likely to re-enact the previous pattern(s) of dangerous conduct'

Prins, H. (1996) Risk Assessment and Management in criminal justice and psychiatry. Journal of Forensic Psychiatry, 7, 42-62.

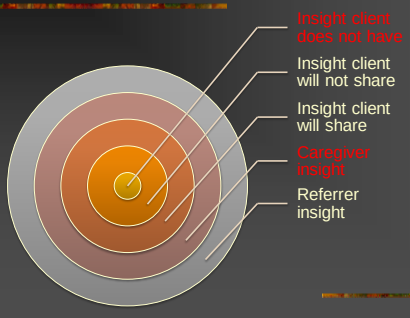
Risk Assessment

- Risks can present in many different ways
  - need to define behaviour, period and outcomes (vacation)
  - cannot be totally eliminated and will vary in response to a range of situations and events (weather)
  - important not to over-generalize risk and confuse the risk of one behaviour with another (threats/aggression)

Risk Assessment & ID/DDx

- Must determine risk outcomes before assessment
  - Risk averse : Low (eg. no outings)
  - Risk minimisation : Med (eg avoid risk situations)
  - Risk management: High (eg supervised exposure)
- Identify risk management options
  - Level of supervision
  - Security
  - Staff ration
  - medication

RA: Who will tell us the most?



Risk Factors

1. Static Variables (*historical/unchangeable)*
   - provide baseline of prediction or probability
2. Dynamic Variables (*current/changeable)*
   - Stable: treatment/intervention targets
   - Acute: immediate triggers/supervision level

Static

- Distal and Actuarial Factors:
  - previous history of the behaviour
  - age of onset for the behaviour
  - *stability and integrity of past relationships*
  - *employment/ accommodation History*
  - family history (csubstances, MI, PD)
  - *history of behaviour and academic adjustment difficulties*

Dynamic: Stable

- Clinical and Psychometric Factors
  - insight into problems and offence
  - acceptance of future potential risks
  - *Impulsivity*
  - *victim empathy*
  - *symptoms of mental illness*, substance abuse
  - degree of fixation/time spent on behaviour
  - response to intervention/ treatment

Dynamic: Acute

- Relapse Prevention & Maintenance Factors:
  - acceptance of need for current and future support/ service involvement
  - *avoidance of high risk situations*
  - *positive personal intimate relationships*
  - *medication and supervision compliance*
  - coping skills
  - *emotional stability*

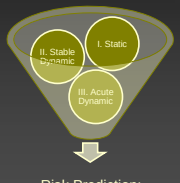
Risk Assessment Models

- Actuarial Models of Risk (static)
  - assessment tools in the prediction of risk of future violent and sexual behaviour e.g. VRAG, RRASOR
  - "*Client X has Y probability of re-offending in X yrs* "
- Clinical Judgement Models of Risk (dynamic)
  - Assessment of 'relative' dangerousness and risk
  - Risk Assessment Profile – likelihood of historical behaviour patterns interacting with an environmental context e.g HCR-20, STATIC 99
- Structured Professional Judgement (both)

Structured Professional Judgement

- A convergent approach to risk assessment
- A clinical risk assessment identifies *baseline* of recidivism and priorities for an overall *risk management* plan
  - probable risk of re-offending (if possible)
  - destabilising factors (substance abuse, MI)
  - stabilising factors (motivation, med compliance)
  - system issues (levels of supervision, supports)

Risk Assessment and ID/DDx



Risk Prediction:
Low/Medium/High

- Ongoing debate between models
- Actuarial measures are limited due base rate biases (wilcox, 09)
- Clinical risk limited to individual
- Decade of work by Lindsay, Boer, & Haaven (et al) developing models to include environmental variables for ID offenders (ARMIDILLO)
- Addition of Dynamic (stable/acute) Environmental Variables

ID/DDx Environmental Variables

Stable dynamic

- Staff attitudes
- Communication amongst staff
- Staff knowledge of offender profile
- Staff consistency – relationship boundaries
- Environment consistency – rules

Acute dynamic

- New staff – boundary testing
- Monitoring of mood, beh and routines
- Victim access – visitors
- Environmental changes in place or routine

ID/DDx Offender Variables

Stable dynamic

- Supervision and treatment compliance
- Insight into offense/relapse
- Offending profile/violence
- Sexual knowledge/profile
- Victim selection/grooming
- Mental health/SA
- Coping and self-regulation
- Time mngt & coping
- Dependency/relate to others

Acute dynamic

- Significant life events
- Re/shp changes
- Offending preoccupation
- MH or SA pattern change
- Changes in victim access
- Emotional dysregulation
- poor coping ability
- Compliance changes
- Schedule/Routine changes

Risk Assessment/Manageability in ID

- Overall level of risk posed by individual with ID is understood in context of the environment and current circumstances (Boer, 2007)
- Offender risk may not change but risk provided by environment can ie new staff, victim access
- Can have same risk level offender in two different environments that either increase or decrease risk manageability significantly

Risk Assessment & Treatment

- Following assessment, individualised treatment and management plans should include:
  - 'modified' treatment programs - mainstream approaches require considerable adaptation and flexibility
  - More successful individually than in groups
  - ethical issues: informed consent, confidentiality
  - support for carers, staff & families equally important to aid generalisation of plan
  - multi-disciplinary/ inter-agency work essential given they straddle multiple sectors ie MCSS, MOHLTC, MCCS, MOE

Summary: Risk Assessment in ID/DD

- Identify risk behaviour(s) objectively
- Set realistic risk outcomes in context of setting
- Comprehensive risk assessment of both static and dynamic factors (including environment)
- Risk assessment profile must facilitate the treatment and management plan
- Individual treatment plan must be linked to the natural support network and surrounding environment
- Management plan must include caregivers and support services to assist generalisation

Treatment Plan

- Find balance between public protection and individual vulnerabilities/victimisation
- Three areas of intervention;
  A. Direct treatment with client 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

A: Individual Treatment

- Develop 'tailor made' and 'client-centred' plans
  - identify level of comprehension and recognise pace of individual's understanding
  - assess for Dual Diagnosis and medication need
  - offence specific treatment (ie anger management, social/sexual education)
  - environmental interventions (i.e. tolerance training, skills development)
  - identify offending profile (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
  - relapse prevention: identify triggers, learn consequences through modeling (in vivo)
  - group work: share and generalise information, role play, positive social experiences

C: System Intervention

- Risk management interventions based on accepted risk outcome
  - education and training with families and staff
  - program consultation and case conference with support agencies, services and relevant sectors
  - environmental supervision
    - case management (APSW)
    - structured-support (SIL)
    - semi-supervised (day not night)
    - 24 hr supervised and/or secure (restraint capacity)

Offending and DD