Dual Diagnosis and the Law: Part I

SE Community Networks of Specialized Care

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Outline

- Overview of the literature regarding offenders with developmental disabilities (DD)
  - prevalence, characteristics and type
- Introduction to the prevalent issues for this population in the CJS
  - at arrest, interview, court

Case examples

- Susan lives in a group home and has a history of aggression due to low frustration threshold and impulsive behaviour. She has assaulted another resident on numerous occasions and staff who have tried to intervene.

1. *Should she be charged with physical assault? Y/N*
2. *If so, should she be diverted from court?*

Case examples

- John lives at home with his parents and has history of anxiety and poor communication skills. He has recently met a girl at work and sexually grabbed her on their first date.

1. *Should he be charged with sexual assault? Y/N*
2. *If so, should he be diverted from court?*

Why important to identify?

- Increased recognition that individuals with DD and/or mental health needs who offend should be dealt with differently from the general population
  - high prevalence of psychiatric disorders
  - sheltered experiences and poor learning
- Present specific challenges and vulnerabilities within the mainstream CJS for police, courts and corrections (treatment vs punishment)

Why important now?

- Process of deinstitutionalisation and bed closures suggest period of resettlement is often difficult
  - increased exposure to risk situations
  - new legal pathways
- Present specific service implications for caregivers and agencies
  - caregiver tolerance threshold
  - system culture change i.e. custody to community

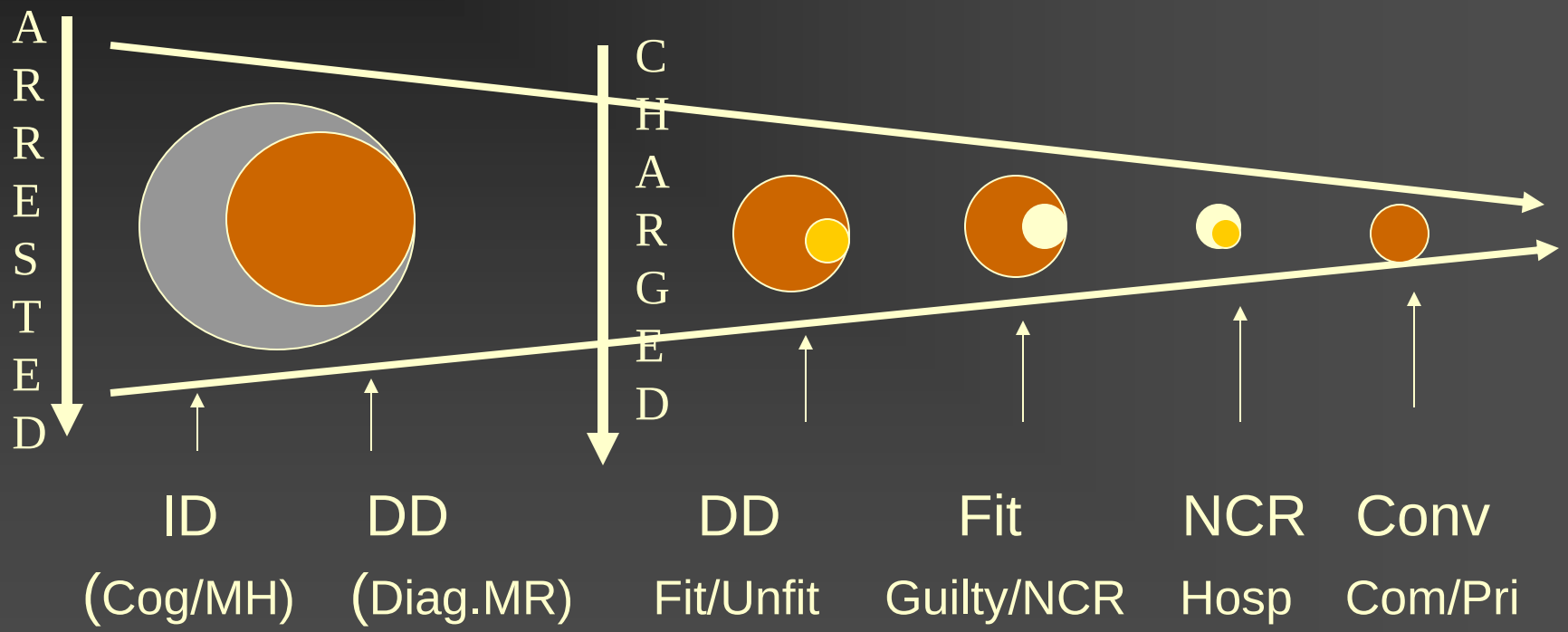
Risk Factors

- *Biomedical:*
  - higher likelihood of neurological disorders/cognitive deficits
  - higher likelihood of impulsivity and inattention
  - increased risk of mental illness
- *Psychological:*
  - poor attachment, empathy and social inhibition
  - faulty or poor consequential learning and insight
  - increased risk of childhood sexual trauma
- *Socio-environmental:*
  - Restrictive and/or repressive attitudes of others
  - punishment for normal sexual behaviour
  - lack of knowledge of the law or relevance of the law to their sexual misbehaviours

Prevalence

- Offending behaviour is much more common than is actually reported to police
- Individuals with ID due to the bio-psycho-social vulnerabilities and neuropsychiatric impairments are generally over-represented in the CJS
- Estimates vary (2-40%) due to narrow or broad definitions of diagnosis and offending

Prevalence through the CJS



Characteristics

- Very few individuals with moderate/severe DD
  - Less likely charged or found competent
- Most offenders with DD are within the mild to borderline 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*

Characteristics

- More likely to have history of 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

Offence Type

- Majority are misdemeanors and public nuisance offences
- Less likely to commit ‘white collar’ crime
- Higher rates of verbal threats and physical aggression
- 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

Sexual Offences and DD

- Risk similar to the general population given a ‘normative’ learning experience

- People with DD are more likely to experience abusive sexual events and are less likely to have experiences and knowledge that enhance sexual health

→ *higher risk of developing sexually inappropriate behaviour*

- Sexual deviance or paraphilia is distinctly different, rare and often misdiagnosed

Sexually Inappropriate Behaviour

- Offenders more likely to exhibit less violent but more sexually inappropriate behaviours (i.e. public masturbation, exhibitionism, voyeurism)
  - ‘counterfeit deviance’ refers to the unusual and inappropriate sexual behaviour that is more likely to occur in persons with DD

- Product of experiential, environmental, or medical factors (i.e. lack of privacy, poor sexual knowledge, inappropriate partner selection, or medication effects)

Aggression and DD

- Offenders more likely to have difficulties with anger dyscontrol and management then premeditated violence

- May be '*symptom'* of broader challenging behaviours
- Internally driven
  - presence of neurological disorders or behavioural phenotypes
  - Dual Diagnosis e.g. anxiety, depression, psychosis, ASD
  - history or childhood abuse influencing adult interactions
- Environmentally driven
  - restrictive or repressive attitudes of others and 'over-control'
  - punishment for 'normal' anger behaviours and expression
  - lack of knowledge of the law or relevance of the law

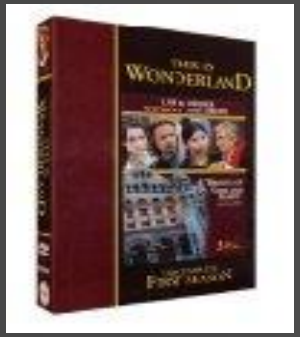
Legal system and DD

- Inequities of justice throughout the CJS
  - Poor recognition
  - Lack of advocacy
  - Minimal court accommodations
  - Poor service planning following legal outcome
- Limited understanding by police, lawyers and judges throughout the process

Vulnerabilities in the CJS

- ARREST
  - most relate to understanding of legal rights
  - more suggestible and more likely to comply
- INTERVIEW
  - difficulties in understanding basic legal terms and criminal process
  - more likely to acquiesce and confabulate in interviews to gain approval of authority figures
- COURT
  - issues regarding *capacity* as a witness/fitness to plead
  - *culpability* or responsibility as an offender

Capacity/Culpability



- Competence/capacity based on an individual's fitness to plead or ability to follow the courtroom process

- Culpability/criminal responsibility based on knowledge of right and wrong at the time of the offence and ability to control oneself

* *(it is more common for individuals to be judged not competent than not culpable and most individuals judged not culpable will also be not competent)*

Entering the CJS

- Identifies what is offending behaviour and against criminal law
- Does NOT teach *'right from wrong'* but what the *rules of behaviour* are
- Provides a message of *punishment* NOT support
- Provides a deterrent IF u*nderstanding* and *insight* is present

CJS & Dual Diagnosis

- 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
- SO no clear message of what to expect
- CJS not accommodating to DD as they are 'square peg in a round hole'
- CJS has a 'cookie cutter' approach to offenders

DD Red Flags in the CJS

- Limited training for police about DD and/or mental health
- Seen as not part of their job so choose ‘least time’ option
- Vicious cycle of breach of probation – *3 strikes your out*

- Message of punishment not treatment
- Rarely a teaching opportunity to change behaviour
- Misused as ‘leverage’

Clinical Issues

- Who is your client and their support system (CofC)
- Avoid mixed messages in protocols (TB is MH not beh)
- Use your MH system first (crisis teams & court diversion)
- Need to be clear what law is broken
- Involve client in treatment planning including various outcomes
- Clear risk assessment and management protocols
  - Define tolerance, expectation threshold and safety for each client

Thank you

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