Recovery and Person-Centered Approaches with Persons with IDD and Mental Illness: the Forensic Path Forward

OHIO FORENSIC CONFERENCE

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DISCLOSURES:
Dr. Pinals consults to various federal, state, and local governments and their contracted agencies and provides forensic expert witness work in systems and individual matters

Objectives

1) Describe recovery and various meanings and misconceptions about it

2) Delineate how recovery principles can fit neatly into risk management

3) Describe some of the lessons learns in applying recovery principles for people with intellectual and developmental disabilities and mental illness within the forensic system

1) Describe recovery and various meanings and misconceptions about it

What is “Forensic Psychiatry”

Forensic psychiatry focuses on interrelationships between psychiatry and the law (civil, criminal, and administrative), including the psychiatric evaluation of individuals involved with the legal system….[and] the specialized psychiatric treatment required by those who have been incarcerated in jails, prisons, or special forensic psychiatric hospitals;

Forensics

What image or words do people think of when they think about “Forensic Patients”?

Recovery: What are your definitions?

Who are forensic patients?

- People primarily currently involved in the criminal justice system
- Crime types varies from minor to serious (but more often minor)
- Requiring evaluation and/or treatment
- Often had prior mental health histories, though some “emerge” for the first time through criminal justice routes
- Increasing emphasis on community rather than state hospital

Forensically involved as the "Crossover" Population

Care delivered across settings:

- Community
- Emergency departments
- Forensic Hospitals
- Correctional settings

Clinical Issues Among Forensic Patients

- Mental Illness
- Substance Use Disorders
- Intellectual and Developmental Disabilities
- Traumatic brain injuries
- Medical Conditions
- Often have trauma histories
- May have complex personality issues- but not all do

RECOVERY

a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential (SAMHSA 2014)

E.G., SYMPTOM RESOLUTION, SOBRIETY, REDUCED RECIDIVISM, SOCIAL CONNECTEDNESS, EMPLOYMENT, EDUCATION, INDEPENDENT LIVING, SELF-RELIANCE

Misconceptions

- Recovery as “cure”
- Recovery as an end goal
- Recovery as lack of responsibility

What are the key recovery dimensions?

1. Health
2. Home
3. Purpose
4. Community

(SAMHSA)

SAMHSA 10 Guiding Principles of Recovery

Hope	Relational
Person-Driven	Culture
Many Pathways	Addresses Trauma
Holistic	Strengths/Responsibility
Peer Support	Respect

2) Delineate how recovery principles can fit neatly into risk management

What is risk?

Not all violence is criminal

Not all crimes are violence

Risk can mean many things….

Mental Illness and Violence

Most persons with mental illness not violent

Most violence caused by persons without mental illness

Small increased risk of violence among persons with mental illness

- Co-occurring substance use greatly increases risk

Past juvenile detention, history physical abuse, parental arrest record, victimization, etc all contribute

Persons with mental illness may be violent for the same reasons as persons with no mental illness

- Complex pathways to violence and violence prevention

Criminogenic Factors Need Better Understanding

For the most part, but not always, persons with mental illness commit crimes for the same reasons that persons without mental illness commit crimes.

Relationship between crime and Symptoms (Peterson et al 2014)

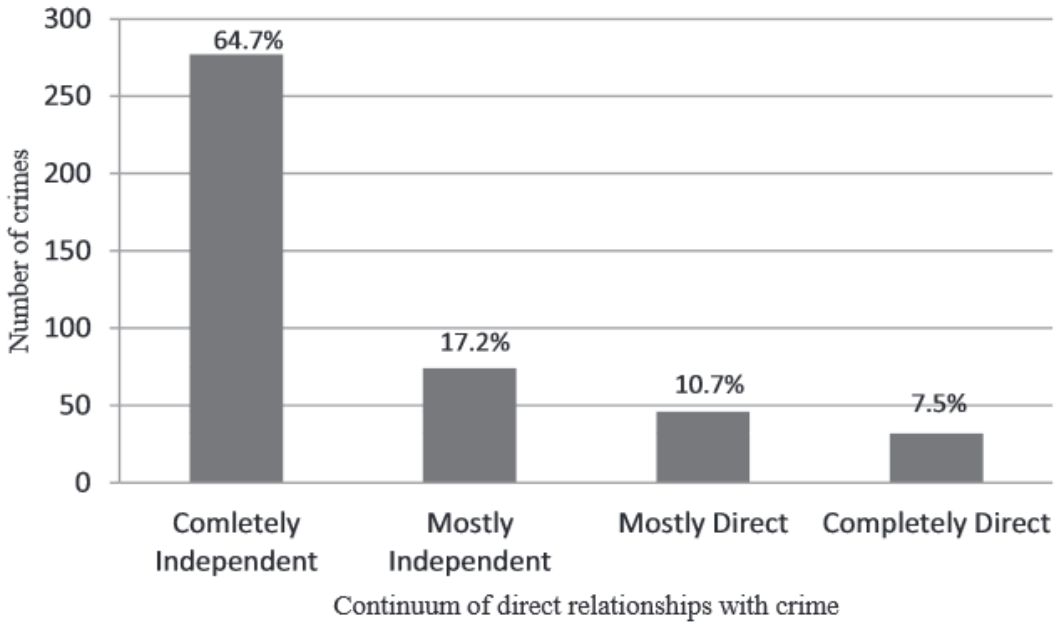


Figure 3. Distribution of crimes along the direct continuum from independent to direct.

Criminogenic Risk Factors: The Risk-Need-Responsivity Paradigm and Sup

Risk Factor
History of antisocial behavior
Antisocial personality pattern
Antisocial cognition
Antisocial attitudes
Family and/or marital discord
Poor school and/or work performance
Few leisure or recreation activities
Substance abuse

Source: Andrews (2006)

Responsivity Factors

Mental Illness

Trauma

Culture

Housing

Etc.

Caveats with regard to MI
(Skeem, Steadman, Manchak 2015)

- Risk assessment tools likely helpful in assessing risk of recidivism in population with MI
- CBT type treatments may be more effective than psychiatric treatment alone in appropriate populations
- Further research is needed to see how RNR principles specifically treat a population of individuals with mental illness and criminal justice involvement
- Symptomatic treatment is still critical as some individual incidents may or may not be linked to symptoms
- Responsivity as a principle needs further researched support

Risk Assessment and Risk Management

Routine part of clinical care

Identify risk factors for violence and suicide

Identify mitigating factors

Identification of modifiable risk factors

- Structured professional judgment
- Evidence-based practices (e.g., HCR-20)

Identify personal goals, strengths and barriers

Case formulation=risk analysis

Applying Recovery to Risk Management: “Sam”

Man in his 40s with schizoaffective disorder and IDD

Hospitalized after being found incompetent to stand trial and unrestorable on a forensic unit

Frequent assaults

Concerns about his “antisocial behaviors”

Many “failed” community placements

Refusing medications…..

Background…

Refusing medication but has court order…

Staff reluctant to engage Sam…

Sam has goals…wants pizza, and wants opportunities to wear his cowboy boots

Sam has long history of institutional care from being in an ICF facility from a young age…

Applying Recovery to Risk Management: “John”

“Dr. Pinals, we need to get John off the unit! He needs to be arrested….He is terribly assaultive, just sent a patient out in an ambulance in an unprovoked, deliberate assault…”

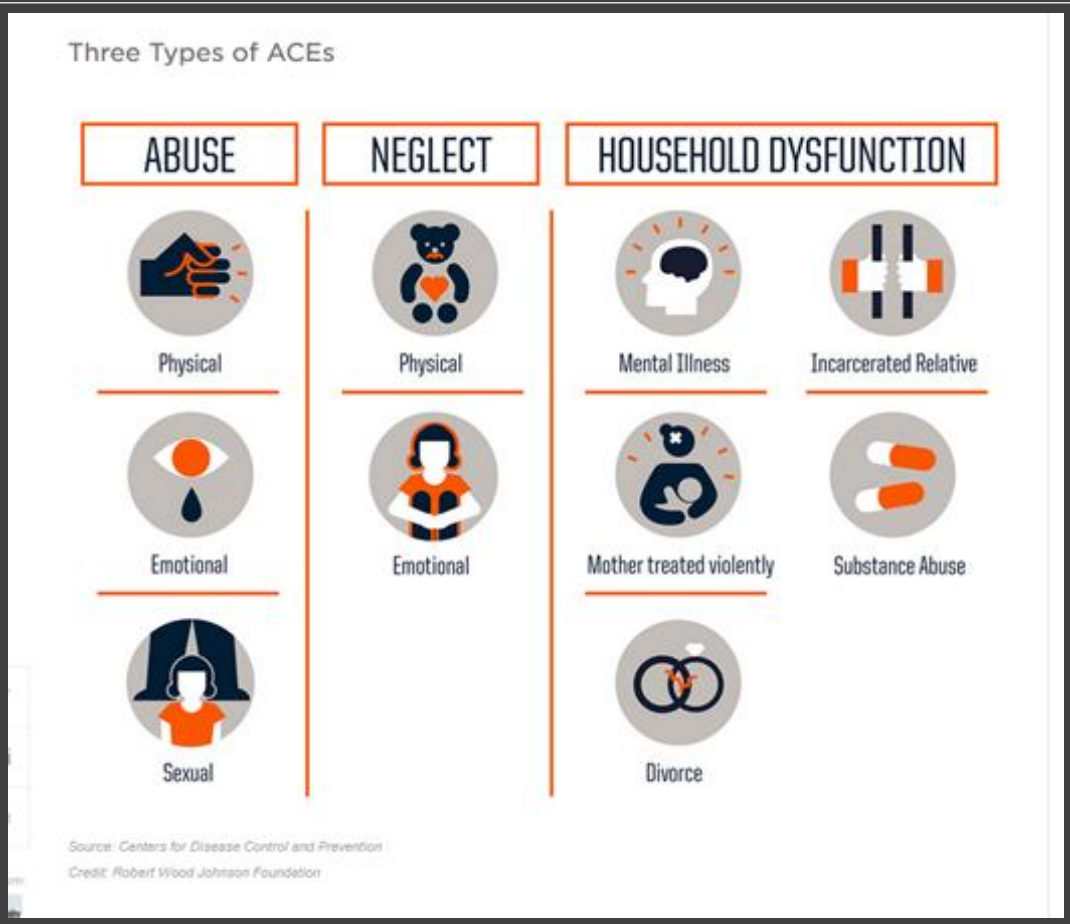
“He is antisocial, does not really have mental illness, unable to form any close bonds, no alliance.”

Are there other ways of looking at John?

3) Describe some of the lessons learns in applying recovery principles for people with intellectual and developmental disabilities and mental illness within the forensic system

Lesson 1: Trauma as a risk modifier

ACEs


Three Types of ACEs
ABUSE
NEGLECT
HOUSEHOLD DYSFUNCTION
Physical
Physical
Mental Illness
Incarcerated Relative
Emotional
Emotional
Mother treated violently
Substance Abuse
Sexual
Divorce
Source: Centers for Disease Control and Prevention
Credit: Robert Wood Johnson Foundation

Adverse Childhood Events Data for Youth Referred to Massachusetts Juvenile Court Clinics

Six Month Data 10/2/12-3/31/13

ACES data scores 1-10

Findings:

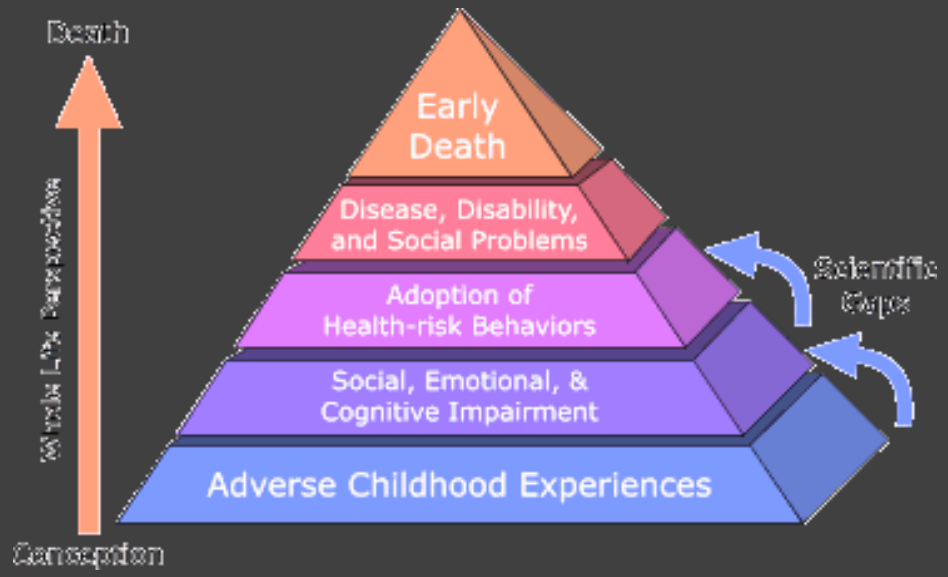
	CDC Study of General Population	JCC Referred Youth
Median Score	**1**	**5**

63% had scores of 4 or more (compared with 12.5% in the CDC sample)

Short and long-term outcomes: health and social difficulties

(Source: Massachusetts Alliance of Juvenile Court Clinics data report 2013)

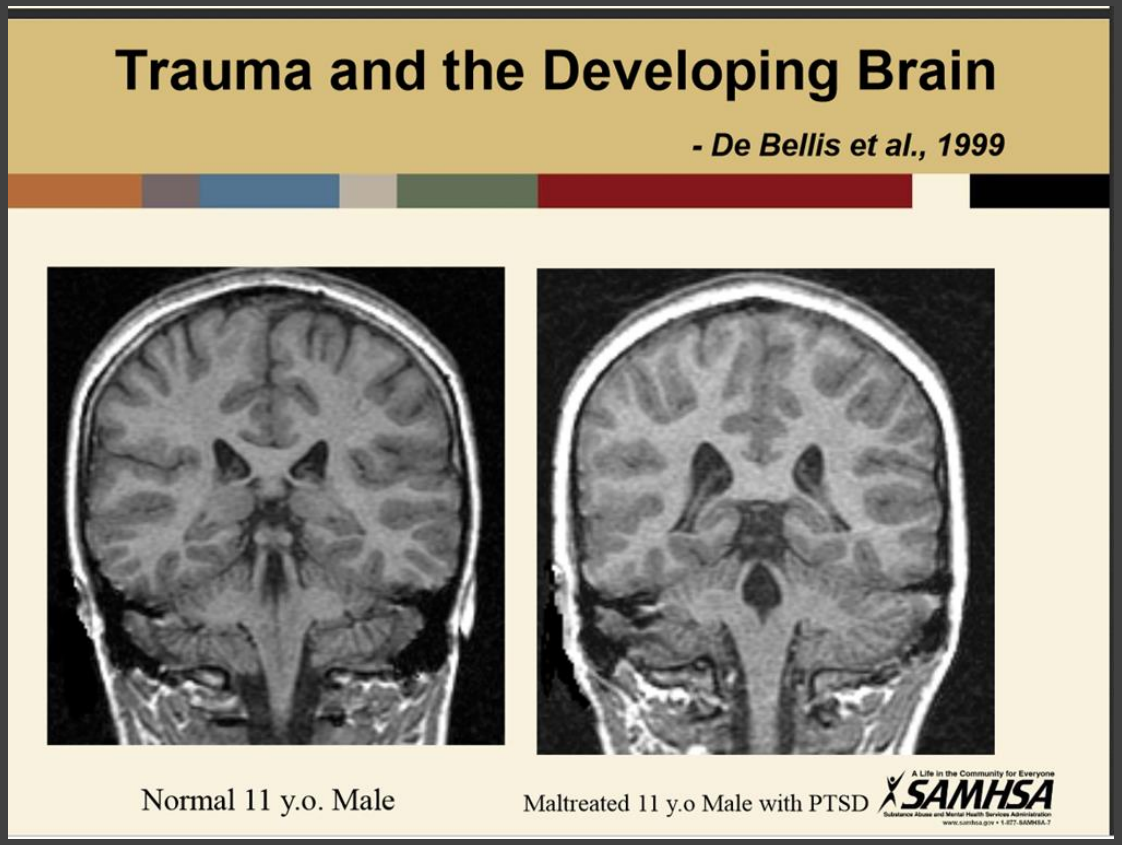
ACE Study Conceptual Framework



http://www.cdc.gov/ace/pyramid.htm

Trauma and Neurocircuits

Trauma exposure and
Overactivity
Numbing



Trauma as a Disruption in the Natural Alarm System

Normal Stress- Action, focus, goal-directed behavior

Extreme Stress- high alarm mode, cognitive processes shut down, emotions increase

Chronic aftermath- high alarm mode becomes constant

Trauma, Behavioral Health and Justice Populations

High level of trauma exposure in juvenile justice involved youth

High levels of trauma for those receiving care in psychiatric settings

High levels of trauma among individuals in jails and prisons

High levels of trauma, victimization, and offending, along with substance use, seem to interplay

Earlier and more prolonged trauma leads to greater biological/developmental disruption

Hodas 2004; Muesar et al., 1998, Lipschitz et al., 1999, NASMHPD, 1998, SAMHSA 2015

Trauma and Violence

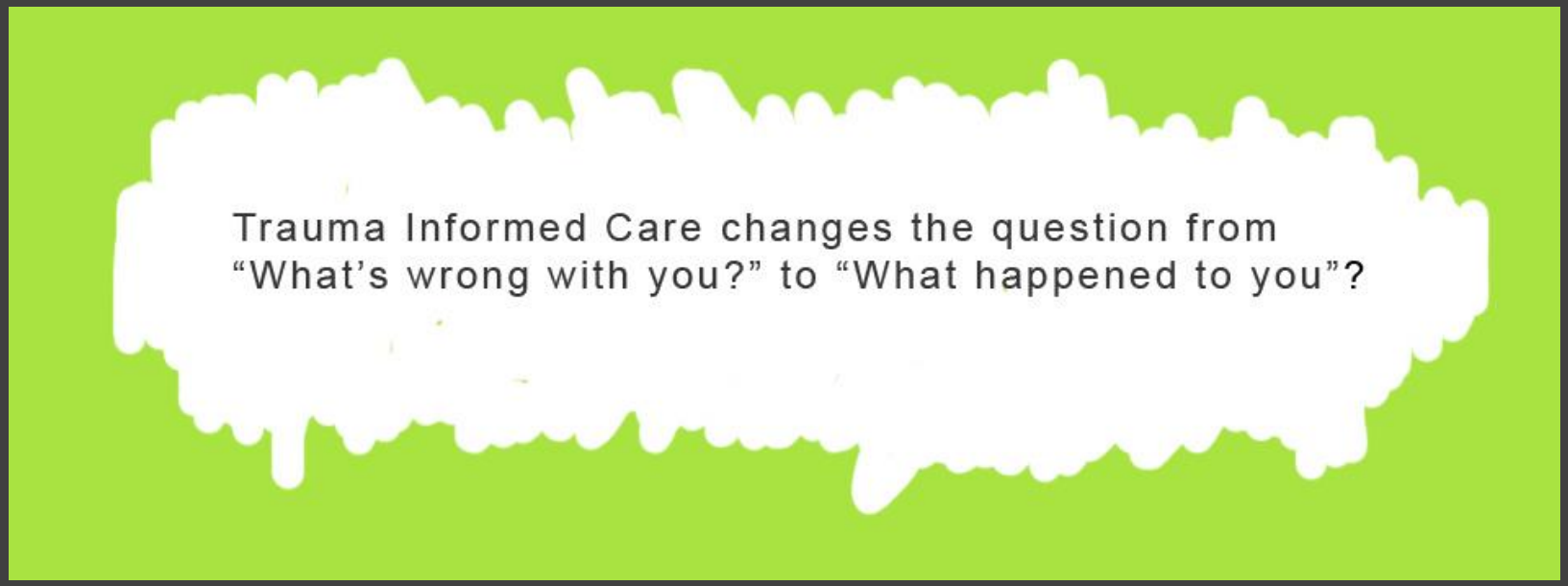
- PTSD symptoms associated with perpetration of violent crime and more substance use, with hyperarousal as an independent mediator (Barrett et al 2014)
- Lifetime history of aggression related to childhood traumatic experiences (Carli et al 2014)
- Prisoners with substance use had higher numbers of prior incarcerations, more juvenile convictions, more institutional violence, suicide attempts and higher scores on childhood trauma, impulsivity, hostility, worse resilience (Cuomo et al 2008)
- Childhood trauma as one determinant of aggression in prisoners (Sarchiapone 2009)
- Childhood maltreatment worsens response to exposure to adult violence in post-conflict regions (Nandi et al 2015); appetitive aggression buffers against PTSD (Hecker et al 2013) in war/combatant experiences

Criminal Justice and Institutions as Traumatizing

- Pre-arrest circumstances
- Arrest circumstances
- Disruptions in social networks
- Exposure to high noise level
- Exposure to individuals with traumatic and tragic life circumstances
- Exposure to individuals with antisocial and violent propensities
- Loss of control
- Humiliation
- Public exposure
- Fear of unknown

Pinals 2015; Miller and Najavits 2012

Trauma Informed Approaches Across Behavioral Health and Justice Systems

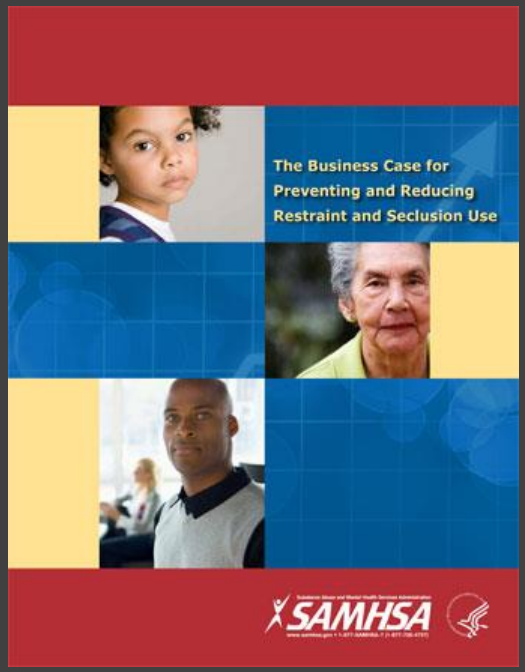


“Universal Precautions”

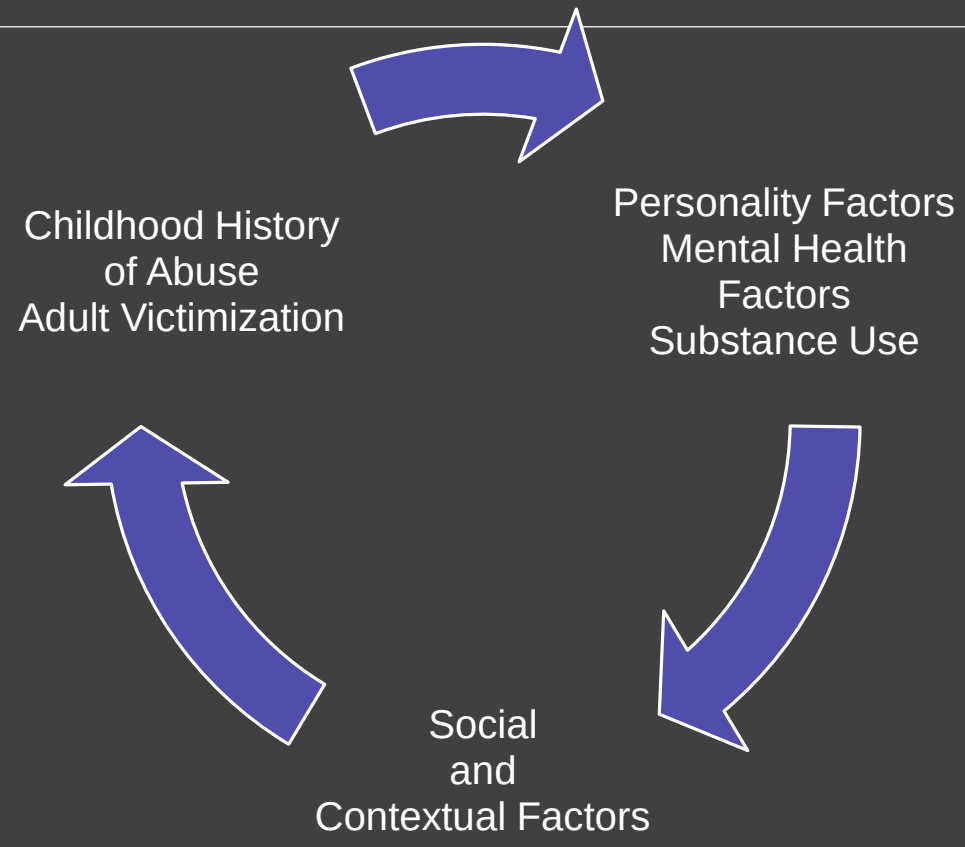
Lesson 2: Minimize coercion and maximize choice

Psychiatric Experience with Restraint and Seclusion Prevention Efforts

- Mechanical restraint was formerly considered a treatment intervention
- Now considered a treatment failure
- Culture shifts require
  - Focus on prevention
  - Recognition of trauma and triggers
- Staff and patient Injury decreases when effective prevention and de-escalation measures are used
- Scenarios in the Justice System (police, courts, etc) are NOT the same as treatment scenarios, but can we learn from each other?



Contributory Factors for Violence



Cultures of Violence

Early and frequent trauma exposure

Expectation of the norm involves trauma

Responsiveness includes hypervigilance, lack of control, provocation

Unpredicted responses sometimes explained by trauma reactivity

Approaches:

- Patience
- Suspect trauma responsiveness
- Grounding
- Safety messaging

Lesson 3: Strength-based planning and resiliency support

Minimize Trauma on Top of Trauma

Strategies to build resilience

- Build self esteem
- Model behavior desired
- Stress-busters
- Self-reflection
- Mindfulness
- Peer support

System Adaptations

- Changes in environments
- Balance task demand with capabilities
- Peer support
- Workforce development
- Procedural modifications

Lesson 4: Attend to Themes Driving Recovery Focus and Individualism

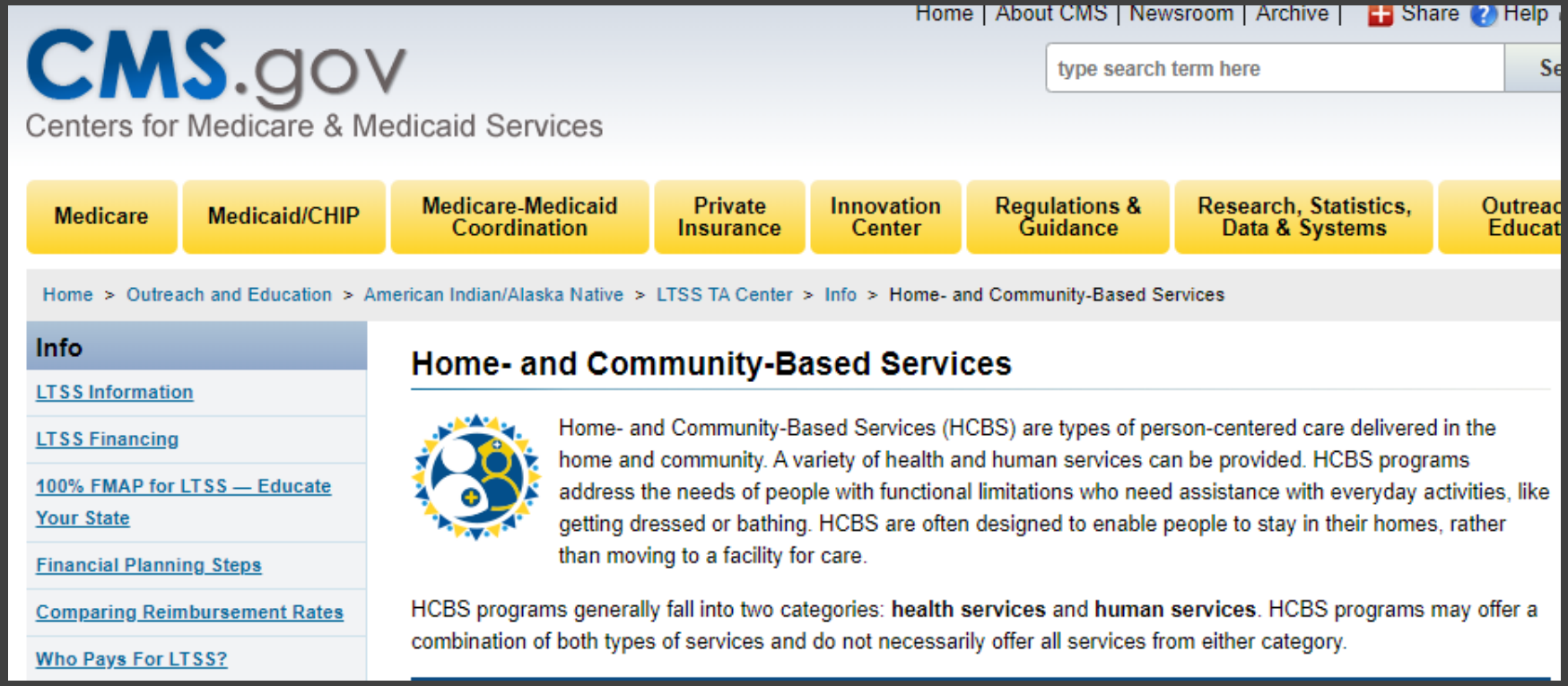
Olmstead v. L.C. (1999)

- Unjustified segregation of persons with disabilities constitutes discrimination in violation of Title II of the ADA
  - Requires public entities to provide community-based services to persons with psychiatric and developmental disabilities when such services are appropriate, wanted by the individual and can be reasonably
- Increasing recognition that this applies to forensic patients and persons in justice settings

Endrew F. v. Douglas County School Dist. (2017)

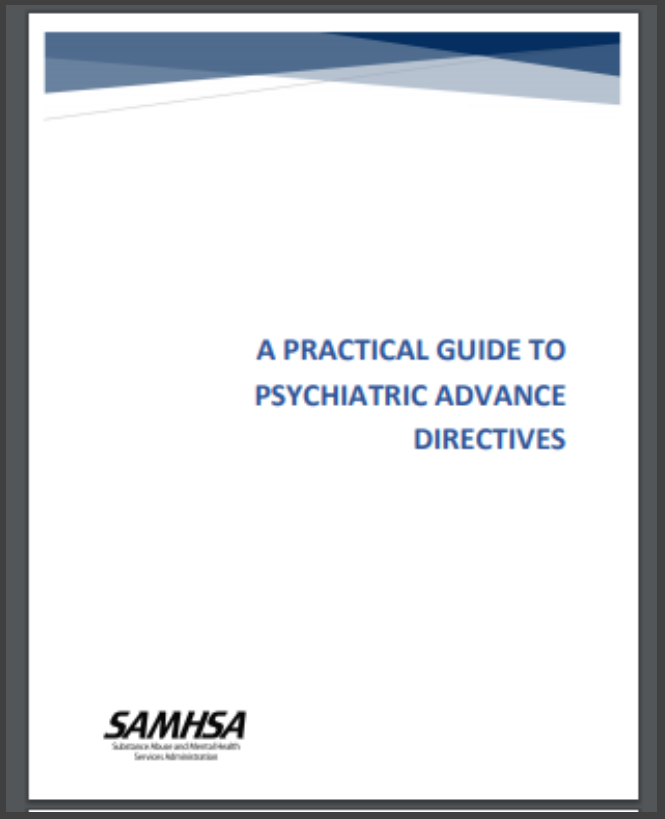
- IDEA requires schools to provide an education that is "reasonably calculated to enable a child to make progress appropriate in light of the child's circumstances"
- Sets the standard and articulates the IDEA requires a test "markedly more than the is markedly more demanding than the 'merely more than *de minimis*' test."
- Supports full integration
- And IEPs that support the youth's best potential, not just "good enough" potential

Home and Community Based Services Rules



Psychiatric Advance Directives (SAMHSA 2019)

"a legal tool that allows a person with mental illness to state their preferences for treatment in advance of a crisis…"



Supported Decision-Making and Personal Autonomy

US Examples

American Bar Association and Center for Public Representation efforts on on supported decision making

- Approx 8 states have supported decision-making laws

SAMHSA Efforts to expand psychiatric advance directives

Lessons from the International Community

United Nations examination of human rights in health care delivery

EUNOMIA study examining coercion in psychiatric care across 11 countries

National Institute for Health Care Excellence Guidelines for supported decision-making

Article 12 of the UN convention on the Rights of Persons with Disabilities

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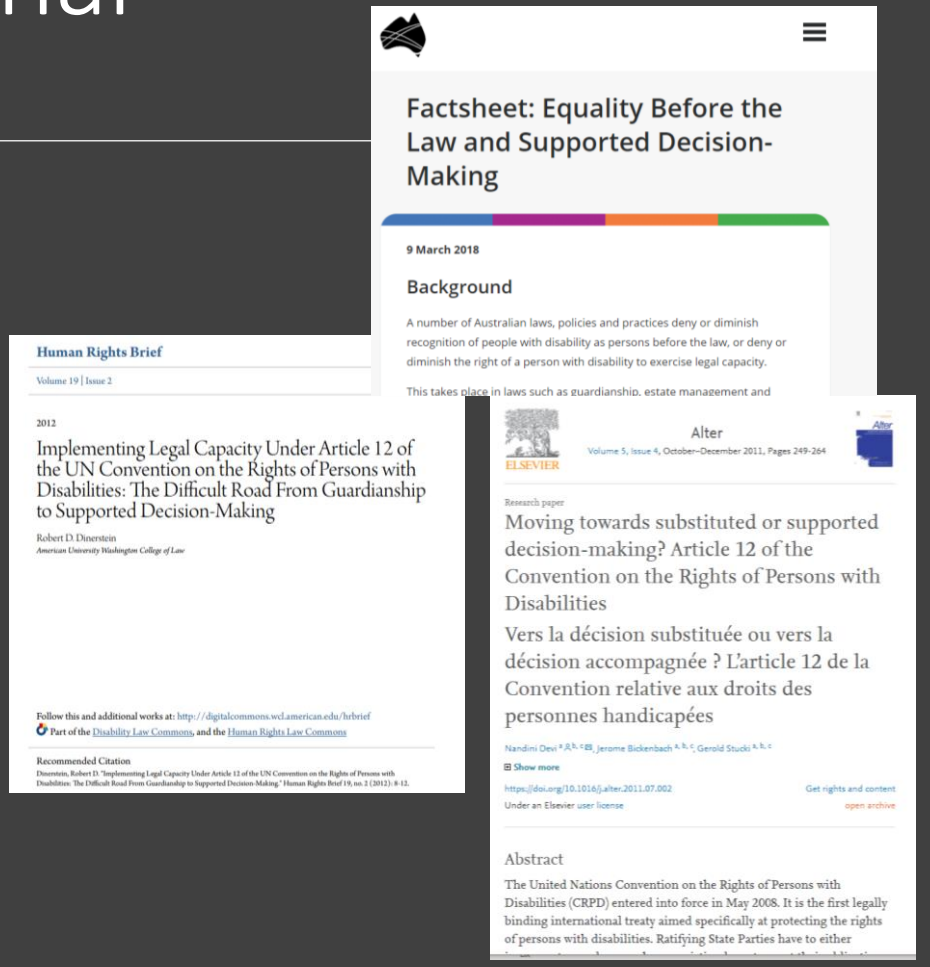
Supported Decision-Making and Personal Autonomy

Article 12 of the UN Convention on the Rights of Persons with Disabilities

Examined around the world as a point for maximizing the opportunities for persons with disabilities to make personal choices



BEYOND THE BORDERS

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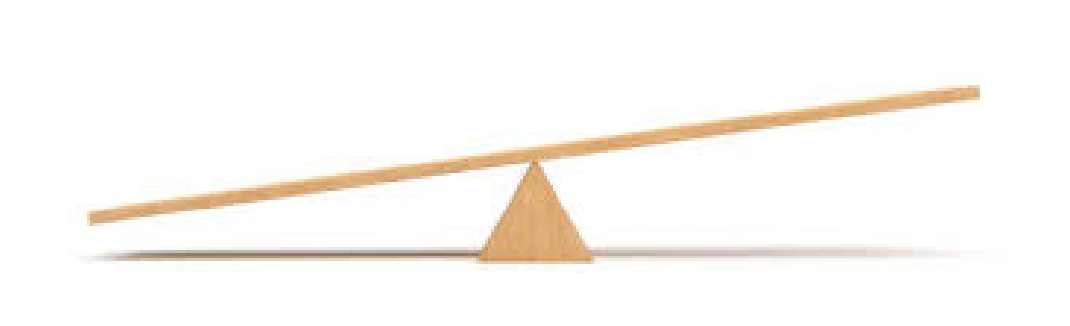
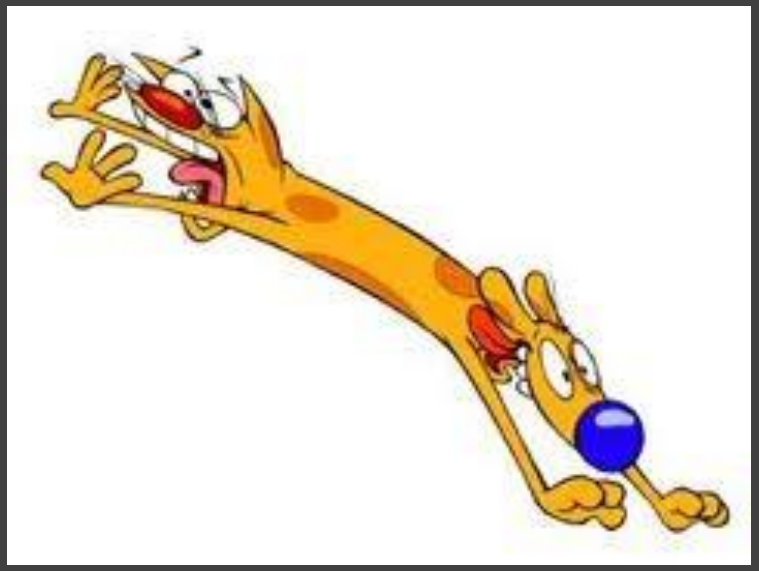
Lesson 5:
Support Balancing….

MAXIMIZING RIGHTS WHILE PROTECTING INDIVIDUALS WITH VULNERABILITIES AND INTOLERABLE RISKS…



The Push Me - Pull You Dilemma

Bad outcomes →
Increased public safety concerns →
Tighter oversight laws →
Limiting community autonomy



Advocate focused→
Person Centered →
Maximized autonomy →
Increased community access

Recovery Themes

Self-determinism

Full community integration

Maximal civil rights

Nothing about me without me

Persons not diagnoses

Empowerment

Strength-based

Forensic/Risk Assessment Themes

Loss of free will as causative agent

Lack of capacity permits autonomy override

Monitoring

Limited community access

Diagnoses, risk factors traditionally primary

Coercive elements

Deficit-based

Person-Centered approach to Risk Mitigation

Traditional “High, medium, low risk” label has limited value in fully supporting individuals with recovery principles

Instead: How did they get here???

Join the client wherever they are on the journey to recovery

Hold hope of individual potential and identify small and big steps

Understand goals then, goals now

Understand barriers to goal attainment

Example of Risk Mitigation

Ex 1 Goal: Attending college

- Barriers: repeated arrests related to substance use
- Anxiety significant related to prior trauma
- Plan: Trauma-focused care, substance use treatment

Ex 2 Goal: Obtain employment

- Barriers
  - Beliefs about government conspiracy and hears distracting voices causing intermittent aggression and criminal charges
- Plan: Medication, Rehabilitation supports, CBT, partner with criminal justice oversight entity

Harm Reduction: Building Safety Networks

Individual

Family/Friends

Peer supports

Community at Large

Spiritual connections

Criminal justice partners

Recovery Themes

Self-determinism

Full community integration

Maximal civil rights

Nothing about me without me

Persons not diagnoses

Empowerment

Strength-based

Shifting Focus: Forensic/Risk Assessment Themes

Coercion and “fairness”

~~Forward thinking responsibility~~, even after moments of loss of free will

Accept some may lack capacity but maintain respect for persons

“Monitoring” as part of supporting, engaging, and motivating

Diagnoses, risk factors as part of a personal story

Deficit awareness, resilience and strength focused

Conclusions

- Evolving standards for caring for individuals within forensic services
- Principles of autonomy, rights and fairness continue to be key themes
- Balancing with public safety, unit safety, personal safety for the individual requires taking both long and short views
- Seeking support and consultation may be required
- Review and assess progress, make refinements….

THANK YOU!