COMMUNITY–BASED TREATMENT OPTIONS FOR PEOPLE WITH ID WHO BREAK THE LAW

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PLAN

- Prevalence of people with ID in the CJS & their vulnerabilities in CJS
- Diversion out of the CJS
- Support & treatment in the community
PREVALENCE: PERCENTAGES OF PEOPLE WITH ID IN PARTS OF CJS

People with ID may be somewhat over-represented:

- In police stations (5-9% of suspects in Gudjonsson et al, 1993 & Lyall et al 1995)
- In courts (14% in Hayes 1993; 21% in Hayes 1996; 3.5% in Vanny et al 2009)
- In prisons (19% in Canada, Crocker et al 2007; 7% in Norway, Sondenaa et al 2008; 1.3% in Australia, Holland & Persson 2011) – and see Fazel 2011 review
- On probation (about 6-7% in UK, Mason & Murphy 2002 a&b)
VULNERABILITIES & BARRIERS TO JUSTICE

- Not understanding police caution (UK); Miranda rights (US); Notice to Detained Persons (UK)
- Acquiescence & suggestibility in police interviews & in court, & false confessions
- Poor decisions in police interviews & in court
- Not understanding court words, lawyers’ language, formal letters (eg from probation)
  (Clare & Gudjonsson ’91,’92,’93, ‘95; Fulero & Everington, 1995; Perske, 2005; 2007; 2008; 2011; Mason,‘99; Smith ‘93; Kebbell & Hatton 01)
VULNERABILITIES & BARRIERS TO JUSTICE

- ‘No One Knows’: interviews with prisoners with ID (Talbot, 2008)

- Lawyer
  The solicitor tried to talk to me but used big words and I found it difficult to understand. The solicitor came and spoke to me in the cell and when she left I thought ‘What was all that about?’ (Prisoner talking about when his lawyer was talking to him, p. 23).

- Police station
  There was a solicitor, one police lady and two other people. I don’t know why they were there, police talk maybe. It was somebody I didn’t know before I got in trouble with the police. I didn’t know if it was someone who could have helped me’. (Prisoner with ID talking about being interviewed in the police station, p. 18)
VULNERABILITIES & BARRIERS TO JUSTICE

No One Knows research (Talbot 2008)

Court

‘The judges don’t speak English, they say these long words that I never heard in my life’

‘To be truthful, I couldn’t understand them. They talk so fast, they were jumping up and down saying things. I gave up listening.’
DIVERSION FROM THE CJS

- Police may decide not to proceed
- Lawyers may decide not to proceed (e.g. Crown Prosecution Service (E & W) or District Attorney (US))
- Court may decide: unfit to plead (E & W, Australia) / insanity in bar of trial (Scotland) / no capacity to stand trial (US, Canada)
- Diversion to hospital (before or after conviction) in UK under Mental Health Acts
- Secure care or mandatory care (after conviction) – Norway, Finland, New Zealand
FITNESS TO PLEAD (E & W)

- Based on Pritchard criteria, 1836: whether the accused could:
  - understand the proceedings so as to make a defence
  - challenge a juror
  - comprehend the evidence (Mackay, 1990).

- Nowadays (E & W) 5 criteria considered:
  - ability to plead;
  - ability to understand the evidence;
  - ability to understand the court proceedings;
  - ability to instruct a lawyer and
  - knowing that a juror can be challenged
    (Grubin, 1991a; Mackay & Kearns, 2000).
CAPACITY TO STAND TRIAL: US

‘Dusky’ criterion: ‘whether the defendant has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding and whether he has a rational as well as factual understanding of the proceedings against him’ (Dusky v. United States, 1960).

More recently three criteria:
- understanding the nature and seriousness of the charge
- understanding the nature and purpose of the court proceedings
- and being able to assist one’s lawyer in providing a defence (Baroff et al., 2004).

Very large numbers of competency hearings in US & Canada
PROBLEMS WITH FITNESS TO PLEAD

- With mental health needs: may become fit to plead, leave hospital, return to court (but often don’t)
- Research in UK showed people with ID often never got out of hospital (Grubin, 1991)
- New legislation: Criminal Procedure (Insanity and Fitness to Plead) Act 1991) in E&W required a trial of the facts & more flexible disposal, including to community.
CAPACITY TO STAND TRIAL IN US

- Similar events in US to in UK
  - 50% of those found ‘incompetent’ and sent to hospital in Michigan were never released (Hess and Thomas, 1963) and
  - McGarry (1971) if ‘incompetent’, more people left hospital, in Massachusetts, by dying, than by any other route.

- After *Jackson v Indiana*, in 1972, the US Supreme Court ruled that those held in hospital following an incompetency hearing could not be kept there for unreasonable time.
  - Average length of time in hospital ➔ six months to a year
  - Where considered ‘untreatable’, required to proceed with a civil commitment or drop the charges.
IN WESTERN AUSTRALIA

- Criminal Law (Mentally Impaired Accused) Act 1996 – MIA Act
- If found unfit to plead, there is no trial of the facts
- Court has two options: unconditional release or custody order
- Calls for reform 2003 by Prof Holman in government commissioned review
- 2012 Attorney General advised parliament that amendments would be introduced in 2013
- Little or no community consultation
SUPPORT & TREATMENT IN UK

- Mainly group CBT programmes, often adapted from programmes for non-disabled people
- Adapted Thinking Skills programme (A-TSP)
- Anger management programmes
- EQUIP
- SOTSEC-ID
- The Good Lives model & what else people need
SUPPORT & TREATMENT – A-TSP

- TSP runs in prisons & probation – not for pw ID
- Gill case (won claim under DDA 1995 by way of Judicial Review vs Ministry of Justice)
- Plan to adapt Thinking Skills Programme – most basic CBT programme & often done first
- DH funded; led by FPLD; NOMS was a partner
- Thinking Skills programme consists of 3 modules (each of 5 sessions), with 3 X 1:1 sessions
SUPPORT & TREATMENT – A-TSP

- Original Thinking Skills Programme (TSP) modules:
  - Self-control
  - Problem solving
  - Positive relationships

- NOMS required us to adapt it for pwID – we lengthened it & simplified it, kept modules same

- Identified three prisons, ran in 3 prisons in 2012 and 2013. Plans for community pilot too.
SUPPORT & TREATMENT – A-TSP

- Generally prison staff & prisoners very positive
- 24 men took part (1 drop out)
- Statistically significant change on Goodman et al (2007) Locus of Control test, pre-post (p<0.001)
- Statistically significant change on Goodman et al’s Problem Solving tasks, pre-post for:
  - ‘assertive’ solutions (p<0.01),
  - n.s. change in ‘passive’ & ‘aggressive’ solutions
- Will it be rolled out? NOMS is considering it…….
SUPPORT & TREATMENT – ANGER

- Anger management: broadly accepted intervention with all sorts of people (most well known researcher: Novaco)
- Form of group CBT typically involving psychoeducation; reducing cognitive distortions; relaxation & coping skills; problem solving.
- Has been used widely for pw ID, in the community and in hospital settings
LARGE RCT IN ANGER MANAGEMENT

- Selected 30 settings for people with ID, n=179
- Assessed on Provocation Index & Profile of Anger Coping Skills; depression & anxiety; self-esteem; ABC; and QOL
- Randomised settings to receive training or not
- Trained the staff in experimental group to deliver anger management groups (one day of training)
- 12 sessions delivered
- Measured fidelity to manual
LARGE RCT IN ANGER MANAGEMENT

- Results showed some drop outs; intention to treat analysis
- Provocation index: significant changes for intervention group on keyworker ratings (non-signif in SU ratings)
- PACS: significant improvements for intervention group for SUs and keyworkers
- Significant improvements in intervention group on 2 of the 3 measures of challenging behaviour
- No significant change on depression, anxiety, self-esteem

(Willner et al (in press) Group-based CB anger management etc BJPsychiatry)
SUPPORT & TREATMENT – EQUIP PILOT

- Equipping Youth to Help One Another Programme (EQUIP)
- Developed by Gibbs’ in US & intended to enhance moral development, challenge cognitive distortions & promote social skills of youth
- Adapted by Langdon for 7 men with ID & offending histories
- Hospital setting, 4 X 1hr sessions a week for 12 weeks
  - Mutual help sessions: where group discuss one man’s issues
  - Equipment sessions: anger management; reducing cognitive distortions; social skills training; social problem solving
SUPPORT & TREATMENT - EQUIP

- Sociomoral reflection measure – short form (SRM-SF) – significant improvement in total & most sub-scale scores
- How I Think scale – significant improvement in most sub-scale scores
- Problem solving task – significant improvement only on one sub-scale
- Anger inventory – no significant improvement overall
- Promising trial – larger trial now being conducted

(Langdon, Murphy et al (2013) An evaluation of EQUIP etc JARID, 26, 167-180)
SUPPORT & TREATMENT
– SEX OFFENDERS WITH LD

- Sex Offenders Treatment Services Collaborative – Intellectual Disabilities – see www.kent.a.uk/tizard/sotsec
- Funded by Dept of Health, & by Baily Thomas Fund
- Started by myself & colleagues over 10 years ago in Oxleas NHS Trust
- Shared assessments, training & treatment manual across sites, with peer support system
- Planned to have waiting list controls
SUPPORT & TREATMENT – SOTSEC-ID

- Group CBT – closed groups, one year long, 2 hr sessions, 1/wk
- Assessments: Once only: measures of IQ, adaptive behaviour, language, & autism
- Pre & Post group treatment:
  - Sexual Knowledge & Attitude Scale (SAKS)
  - Victim Empathy scale, adapted (Beckett & Fisher)
  - Sex Offender Self-Appraisal Scale (Bray & Foreshaw’s SOSAS)
  - Questionnaire on Attitudes Consistent with Sex Offending (Bill Lindsay et al.’s QACSO)
- Recidivism – all further sexually abusive behaviour
SUPPORT & TREATMENT – SOTSEC-ID

- Group purpose, rule setting
- Human relations & sex education
- The cognitive model (thoughts, feelings, action)
- General empathy & victim empathy
- Sexual offending model (based on Finklehor model)
- Relapse prevention

_Compared to non-LD programmes: Far more slow offence disclosure; more on sex education; far more pictorial material & less sophisticated on cognitive side_
SUPPORT & TREATMENT – SOTSEC-ID

- 18 sites; 27 groups; mean age 35 yrs (sd 11.7), mean IQ 66
- N>100; around half come by law (MHA, CRO)
- High rates of co-morbidity (esp ASD, PDs, depression)
- 96% of men who agree to join research complete groups
- 90% men: no further sexually abusive behaviour (6mths)
- Further SAB not related to age, IQ, personality disorders, pre-group & post-group scores on any process measure.
- Those with ASD more likely to re-offend (p<0.05)
SOTSEC-ID OUTCOME (OVER 100 MEN)
SUPPORT & TREATMENT – SOTSEC-ID FOLLOW-UP

Heaton & Murphy 2013

- 34 men from 13 treatment groups followed up (mean f-u 44 mths)
- SAKS, VE, QACSO all significantly improved p<0.001 from pre-group to f-u; none significantly worsened; SOSAS no significant changes
- 11 men showed further SAB since treatment began (32%); 8 since treatment ended (24%); 2 men reconvicted (6%)
- Almost all further SAB was non-contact
- ‘Chain’ behaviours – 17 men
- Only ASD and number ‘late chain’ behaviours predicted reoffending.
Physical and sexual needs
Feeling OK
Independence
Relationships
Feeling good at something
REFERENCES


- Langdon et al (2013) An evaluation of the EQUIP treatment etc. JARID, 26, 167-180
