

A GROWING TREND: DUAL DIAGNOSIS CLIENTS WITH FORENSIC INVOLVEMENT



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Centre de toxicomanie et de santé mentale

Poonam Raina & Anna Palucka
Centre for Addiction and Mental Health

Presentation Outline

- **The BIG Picture**
- **Smaller Picture**
- **An even smaller Picture**

Dual Diagnosis - Overview

- Dual diagnosis in Ontario (MHLTC & MCSS)
 - Developmental disability and co-occurring mental health problem (or significant challenging behaviour)
 - Developmental disability: ASD or intellectual disability
 - Expertise in both developmental disability and mental health is scarce, appropriate services are limited

Dual Diagnosis – Overview

- Approx. 125,400 individuals with intellectual disabilities (ID)
- 30% of ID population with dual diagnosis¹
- Higher rates of psychotic, mood, anxiety and personality disorders than general population²

Dual Diagnosis and the CJS – What do we know?

- Forensic clients *with DD* are younger, more likely to be single, come from minority backgrounds, and have suffered abuse/neglect (Glaser & Florio, 2004)
- Patients with DD more likely to be diagnosed with a personality disorder and are more likely to have committed a sexual offence (Puri et al., 2000)
- Forensic Clients *without ID* are older at time of conviction and hospital admission, more likely to have psychotic disorder and an index offence of homicide, attempted murder or manslaughter



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- Adults with ID are entering the criminal justice system at an increased rate (Hayes et al., 2007; Sondena, Ramussen, & Nottestad 2008)
- Many such individuals are suspected to have unrecognized psychiatric needs (Jones, 2007).

Where do DD Forensic Clients fit in?

- Categorized as one of the most stigmatized populations with a “**psychiatric**”, “**disability**” as well as “**offender**” label (Simpson & Hogg, 2001)
- CAPS Study (Lunsky et al., under review)

- Much of the research on the profile of individuals with intellectual disability and forensic issues has been based on those individuals in jail/corrections (Sondena et al., 2008 review).
- Less on individuals with forensic issues who have comorbid mental health difficulties and receive psychiatric services.

What's Missing?

- No studies have compared forensic psychiatric outpatients with intellectual disability to non-forensic psychiatric outpatients with intellectual disability
- Few studies have included a clinical population as a control group
- No known characteristics of forensic clients with ID and mental health concerns are attributable to the mental health concerns and which are unique to forensic profile

What's Missing?

- It is important to understand the needs of forensic DD clients because psychiatric services are not typically tailored to their unique needs.
- It is unknown when forensic DD clients should be placed in highly specialized services, and when they can be served in more general forensic psychiatry programs or more general mental health programs for people with intellectual disability

Profile- DD & legal involvement

- **Male**
- **Younger in age**
- **Higher functioning (Mild ID)**
- **Psychosocial deprivation**
- **History of abuse**
- **History of substance abuse**

Smaller Picture

- Our hospital/ clients we serve
- This is what we see in our hospital

A COMPARISON STUDY OF ADULTS WITH INTELLECTUAL DISABILITY AND PSYCHIATRIC DISORDER WITH AND WITHOUT FORENSIC INVOLVEMENT

Research Study



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Poonam Raina & Yona Lunsky (2009)
Centre for Addiction and Mental Health
University of Toronto

Dual Diagnosis Program (DDP)

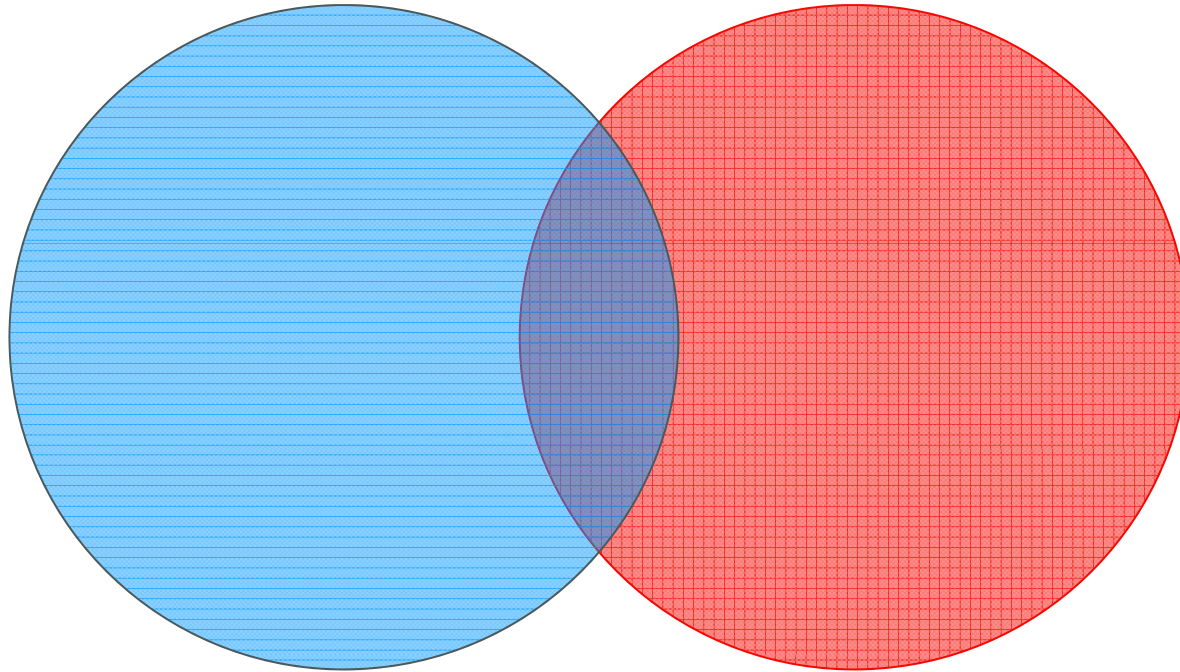
- Provides consultation, assessment, diagnosis, time limited treatment, education, training, and inpatient treatment
- Behaviour therapy
- Occupational therapy
- Social work
- Nursing
- Medication review (psychiatry)
- Psychological assessment



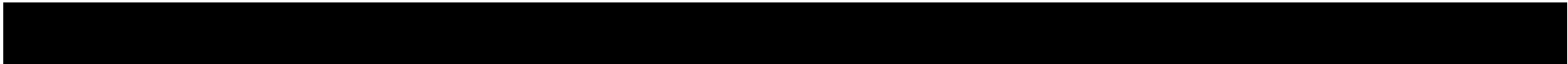
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Outpatient



Inpatient



Purpose (Raina & Lunsky, In press)

- Describe and compare profiles of individuals with intellectual disability and mental health issues, with and without forensic involvement using a hospital based inpatient and outpatient specialized mental health service.

Predictions

- Forensic inpatients and outpatients would more likely be **male**, and more likely to have a **mild disability**.
- Diagnostically, it was expected that **personality disorders and substance abuse** would be **more common** in the forensic group.

Method

- **Retrospective chart review**
- 78 adults were selected based on a review of 313 Referral Intake Forms.
 - captured and contained current as well as previous diagnostic, medical, social and psychological information, were completed by an intake worker at the time of each client's admission to the program

Method

- 313 RIFs between 2006-2008
- 279 clients in total (eliminated duplicate RIFs)
- 14% of sample forensic involvement
(30% of inpatients and 11% of outpatients)

Participants

- Forensic sample
 - N=39 (14 inpt and 25 outpt)
- Criteria
 - Hx of legal or forensic involvement in RIF and/or forensic referral sources
- Gender distribution
 - M:F - 20:19 (7:7 inpt and 13:12 outpt)



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Types of forensic involvement

- Inpatients
 - Type of offence: Fire setting; property destruction; assault; theft
 - ORB (5); Probation; Bail

- Outpatients
 - Type of Offence: Theft; public mischief; property destruction; assault; fire setting

Participants- Matched sample

- Non-Forensic sample
 - N=39 (14 inpt and 25 outpt)
- Gender distribution
 - M:F - 20:19 (7:7 inpt and 13:12 outpt)
- Matched on gender, inpt/outpt status, and age



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Demographics

	FORENSIC (N=39)	NON FORENSIC (N=39)
AGE	Avg. – 35.1 years Range: 24-47 years	Avg. – 38 years Range: 23-62 years
MARITAL STATUS	Single: 92% Separated: 8%	Single: 97% Separated: 3%
DAY TIME ACTIVITIES	Employed: 0% Student: 10% none: 56%	Employed: 3% Student: 8% none: 51%



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Key Findings: Residence (adm)

	FORENSIC	NON-FORENSIC
INDEPENDENT	18%	11%
SUPPORTED LIVING	66%	69%
FAMILY HOME	16%	19%

Key Findings: Diagnoses (D/C)

	FORENSIC	NON- FORENSIC
PSYCHOTIC Dx	39%**	14%
ANXIETY Dx	8%	14%
MOOD Dx	14%	26%
ASD Dx	14%	33%*
SUBSTANCE Dx	8%	0%
IMPULSE/ INTERMITTENT Dx	17%*	3%
NO AXIS I Dx	22%	31%
PERSONALITY Dx	19%	15%

****<0.05; *<0.10**



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Key Findings: PD Diagnoses (D/C)

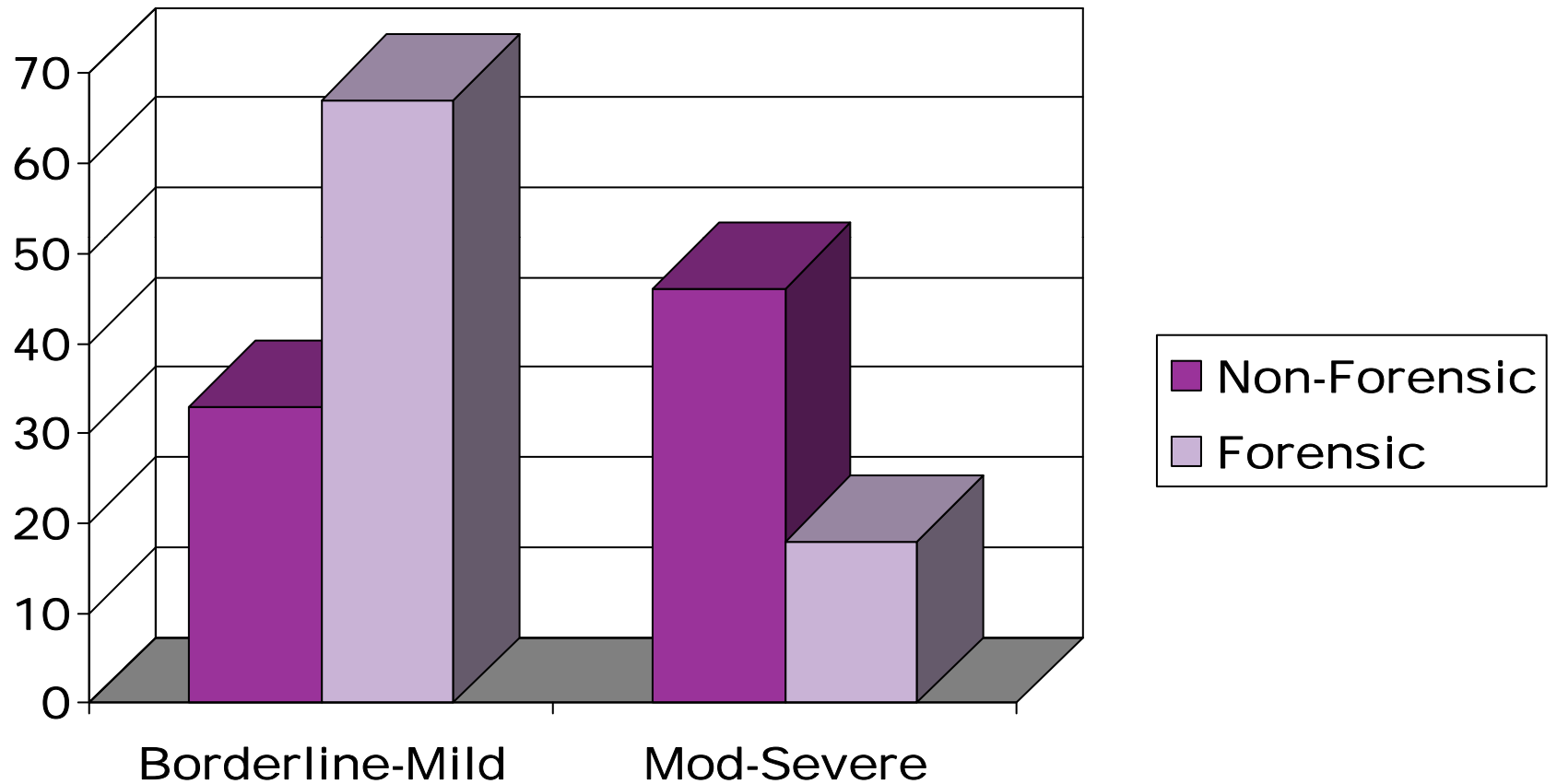
	FORENSIC	NON- FORENSIC
PERSONALITY	19 %	15 %
ANTISOCIAL	14 %	0 %
DEPENDENT	0 %	33 %
BORDERLINE	57 %	17 %
OTHER	29 %	50 %



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Key Findings: MR levels





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Key Findings: Meds

	FORENSIC	NON-FORENSIC
Anti Depressants	41%	40%
Anxiolytics	49%	57%
Anti Psychotics	75%	77%
Mood Stabilizers	20%	14%
Stimulants	0%	3%
Anti Convulsants	20%	34%
Beta Blockers	9%	0%



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Key Findings: Client History

	FORENSIC % (n) N=39	NON FORENSIC % (n) N=39
HISTORY OF SEXUAL ABUSE	39% (n=15)	26% (n=10)
HISTORY OF SUBSTANCE ABUSE	37%* (n=14)	3% (n=1)



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Key Findings: Inpatient Summary

	FORENSIC	NON FORENSIC
LENGTH OF STAY*	Avg. : 809 days Range: 22-4628 days	Avg. : 78 days Range: 14-184 day
CHANGE OF RESIDENCE AT D/C*	YES: 50% NO: 50%	YES: 14% NO: 86%

Key Findings: Inpatient Summary

- Global Assessment of Functioning (GAF) scores at the time of admission and discharge from the inpatient unit was compared using a two-way repeated measures ANOVA
- All individuals' GAF scores improved from admission to discharge ($F(1)=4.821, p=.041$)
- Inpatients in the forensic group were viewed as no more impaired clinically than those in the non-forensic group at admission or discharge.

Similarities between Forensic and non- Forensic

- medication profiles despite different diagnostic profiles
- residential placements at time of admission
- Hx of sexual abuse
- GAF Scores (Inpatients)

Unique issues for Forensic clients

More likely to have:

- Mild ID
- psychotic disorder
- Impulse control/Intermittent Explosive disorder
- Substance abuse history
- Longer LOS (Inpatients)
- More likely to change residence following discharge (Inpatient)

Things to consider

- Equal gender distribution amongst forensic clients
- History of Substance abuse
- Length of Stay/ GAF
- 18% Severe disability
 - Future research comparing patients by forensic status and severity of intellectual disability might help to elucidate clinical and systemic predictors of forensic involvement in the lower functioning group.

Summary

- This was the first study to compare both inpatients and outpatients with intellectual disability using a hospital based mental health service with and without forensic involvement.
- Results indicate that although there were many similarities between inpatients and outpatients with and without forensic issues there were also some important differences

An Even Smaller Picture

- Inpatient unit
- Single client

PUTTING PIECES TOGETHER: A COLLABORATIVE APPROACH TO TRANSITION TO COMMUNITY LIVING

Case Study



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Kim Mullens (OT), Lisa Orsi (BT), Anjali Holstein (SW), Anna M. Palucka (PhD), Teresa Wnukowska (RN)

**Dual Diagnosis Program,
Centre for Addiction and Mental Health**

Why this case?

- **This case illustrates**
 - **that even individuals with very complex needs and challenging behaviours can be supported in a community residence**
 - **what it takes to successfully discharge an individual with complex needs to a community residence**



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Overview

- **Case History**
- **Clinical & Diagnostic Challenges & formulation**
- **Communication Challenges & Interventions**
- **Behavioural Challenges & Interventions**
- **Discharge Challenges & Resolution**
- **Intensive Transition & Post discharge follow up**

Case History

- Female, early 30s, with congenital deafness. Level of Intellectual Disability (ID) not clear. Diagnosis of Pervasive Developmental Disorder (PDD) given in childhood, but not consistent over time. Past psychiatric diagnoses.
- Residing in a semi independent living setting for deaf persons. High expectation for independent functioning and lack of structure. Refusing to attend day program, and isolating herself to her apartment.

Case History

- FREQUENT episodes of very SERIOUS AGGRESSION in the home requiring 3 – 4 hour containments and repeated visits to the ER (ex. physically attacking others, threatening with knives)
- Eventually charged with physical assault with a deadly weapon after inflicting injury to a vulnerable peer. Admitted to hospital under ORB disposition

Diagnostic Challenges

- Level of Intellectual Disability ?
- Pervasive Developmental Disorder?
- Psychiatric diagnoses?

Outside psychological consultation:

- Mild ID & Pervasive Developmental Disorder
- No psychiatric disorder

Communication Challenges

- **Very significant communication difficulties due to deafness, ID and impairments associated with Pervasive Development Disorder**
- **Took time to understand her communication style & limitations**
 - Echolalic signing
 - Limited sign language abilities; only able to use & comprehend 1–3 words at a time
 - Not able to explain reasons or intentions (did not understand question WHY?)

Communication Challenges

- Idiosyncratic thinking (often no context or elaboration)
- Applied concrete, black & white dimensions to concepts
 - ***“Kick = good or bad? Go Heaven or hell?”***
 - ***“Heaven near or far?”***
 - ***“Where husband – BC, USA, or Alaska?”***
 - ***“Born when?”***
- Fixated on topics & needed answers - repeatedly going from staff to staff seeking information
- Anxious and tearful when provided contradictory or slightly different information

Behavioural Challenges

- **Environmental aggression:** banging on and tipping over furniture, throwing fire extinguisher
- **Physical aggression:** pinching, pulling hair/earrings, kicking, hitting, chocking
- **Eloping**

Behavioural Challenges: Physical Aggression

- Infrequent but on two occasions very serious
- Usually occurred “in spurts”, with repeated incidents over 1-2 weeks, then none observed for several weeks/ months
- Very difficult to determine triggers
- Very anxious post-aggression, asking staff what would happen (ex. “Police call?, No Group home?, Go hell?”)

Interventions: Communication as a process

- **Understanding her thinking & HOW to communicate concepts**
- **Using multimodal communication strategies**
 - ASL (ASL interpreter & staff), writing and pictures
- **Written Scripts/ Social Stories**
 - To ensure consistency of information across all staff
 - To describe unclear concepts in basic & concrete manner (ex. ORB process)

Interventions: Communication as a process

- **Redirection to Designated Staff (1:1 sessions)**
 - Consistency of information
 - Limiting going from staff to staff
 - Limiting perseveration by containing topics of fixation to specific times

- **Communication Book/ Folder for Topics for Discussion**
 - Place to write topics-to-be-discussed in next session
 - Concrete way of showing what would be discussed
 - Decreased anxiety/ provided reassurance

Behavioural Interventions

- **Mad/ Bored Card**– carried and used card to communicate when she was angry or bored and wanted staff help
- **Developing indicators of increased risk of aggressive acting out** – ex. facial expression, motivation level, isolation
- **Behavioural Reinforcement for NO AGGRESSION**
 - self-monitoring of SAFE behaviour - placed sticker on calendar after each aggression-free day
 - Off- ward privileges based on safe behaviour
- **Consistent Response Following Aggression to decrease anxiety**



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Discharge Challenges: What is the hold up?

- On waitlist for residential supports but never considered for a placement due to complex support & supervision needs (Deafness, PDD, aggression & risk)
- Residential services reluctant to accept individuals with legal involvement / serious aggression
- Significant risk of serious re-offence
- Lack of individualized funding

Navigating the System

- 1) Presented to a special committee of developmental sector agencies reviewing complex cases
- 2) Special working group formed with representatives from Developmental Sector agencies, Autism and Deaf specialized services across two regions, and Dual Diagnosis Program (CAMH)

Navigating the System

- 3) Unfunded vacancy identified within the developmental sector in a home for deaf persons
- 4) Funding granted following proposal for individualized annual funding to the Ministry of Community and Social Service

Resolution

- **Home for the Deaf in the developmental sector – with consultation from AUTISM and OUTPATIENT FORENSIC services**

Intensive Transition

One-month transition prior to discharge: Group Home Staff Education & Training

- A specially designated transitional staff
- Comprehensive information package prepared for group home staff – patient history, clinical & general support needs
- Visits by group home staff 3-5 x week to get to know patient, her daily routines & programming
- 1:1 education sessions with clinicians involved in her care (B.T., O.T., psychologist, Recreation Therapist, nursing)
- Two in-service sessions provided at the group home

Intensive Transition

Support to Patient

- Developing relationship with the transitional staff
- **Social story** about leaving hospital, including details of move and pictures of house
- **Counselling sessions** increased to 2 x week

Getting Resources Working Together

- Facilitating initial meetings between community resources (residential services and forensic outpatient support) to establish clarity of roles and processes for collaboration

Intensive Transition

- **Post Discharge Follow-Up**

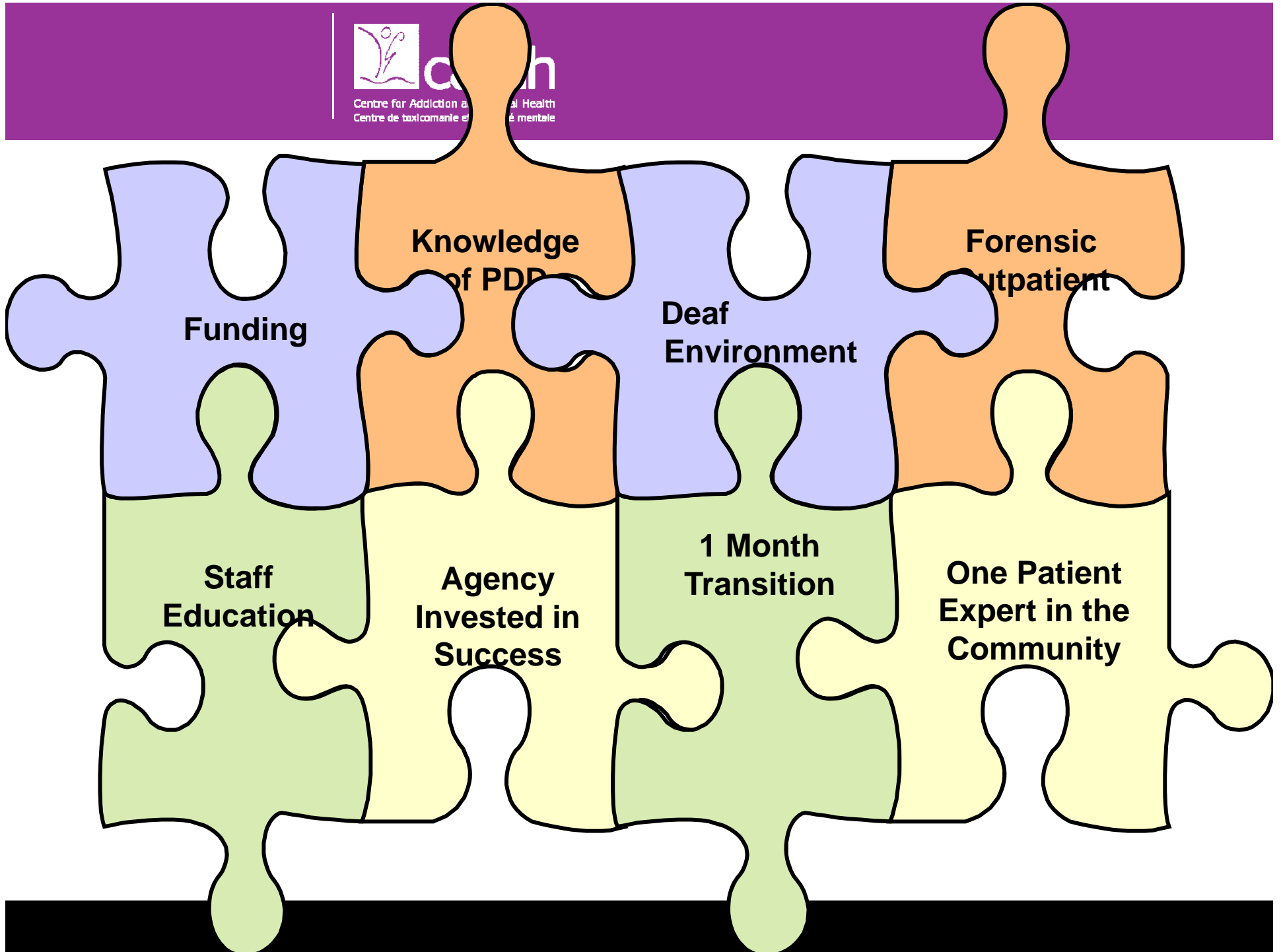
- 1 month outpatient support – behaviour programming, troubleshooting around instances of aggression

Ex. Aggression in home (threw chair down stairwell, chased peer x1, hit staff x1) related to inconsistencies in implementation of behaviour support plan



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Summary: essential pieces

- Good understanding of person's needs
- Collaboration across agencies and regions
- Investing time in transition
- One designated person from the agency/residence to take lead in supporting the transition
- Post discharge follow-up to address issues early

What have we learned?

- It is less about the crime and more about individual circumstances
- Most individuals are not adequately supported
- Takes longer to find appropriate community supports-takes longer to discharge from hospital

Contact Information

Poonam Raina, Poonam_Raina@camh.net

Anna Palucka, Anna_Palucka@camh.net

Dual Diagnosis Program

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