AUTISM SPECTRUM DISORDERS AND OFFENDING BEHAVIOURS

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Content of Presentation

• Understanding Autism Spectrum Disorders (ASD)
• Offending & ASD
• National Strategy for Adults with Autism
• Presentation across Criminal Justice System
• Secure hospital care
• Conclusions
DSM-5 Criteria

• Persistent deficits in social communication and social interaction across multiple contexts

• Restricted, repetitive patterns of behavior, interests, or activities
Understanding ASD

- Social Communication – Problems using & understanding verbal & non-verbal language such as gestures, facial expression, tone of voice
- Social Interaction - Problems in recognising others feelings & managing their own
- Social Imagination - Problems predicting other people’s intentions and behaviours & imagining situations outside their routines.
Prevalence of Offending Behaviour

- More or less likely to commit a crime.
- More or less likely to be in the Criminal Justice System.
- More or less likely to be in Secure/Forensic Services.
Prevalence in Forensic Services

- All 3 High secure hospitals in England: 1.7% with ASD
- Scottish Prison Service: 0.93% with ASD
- Maximum secure Prison in United States: 4.4% (Fazio et al., 2012)
- Swedish Young Offenders Group referred for Forensic assessment: 15% had ASD
Types of Offending Behaviours

• Violent Behaviour – most common
• Sexual Offending
• Fire setting
• Obsessive harassment (stalking)
• Computer crimes.
Reasons for Offending Behaviour

• Lack of understanding of social cues & roles
• Impairments in empathy or lack of empathy
• Disruption to routine
• Obsession tendencies/morbid interests
• Sensory overload.
• Rarely a single responsible factor but an interaction with specific difficulties of autism and the environment (Murphy, 2010).
Reasons for Offending Behaviour

- Early social disadvantage, truancy, aggression
- Substance misuse
- Social Exclusion
- Psychopathy – share profile characteristics of lack of empathy, lack of guilt, failure to accept responsibility (Murphy, 2007)
- Co morbid psychiatric conditions- Psychosis (Haw et al., 2013)

All adults with autism are able to live fulfilling and rewarding lives within a society that accepts and understands them. They can get a diagnosis and access support if they need it, and they can depend on mainstream public services to treat them fairly as individuals, helping them make the most of their talents.'

www.dh.gov.uk/publications
Think Autism - National Strategy Update for Adults with Autism in England (2014)

• Cross Government Group to focus across CJS of Police, Prison, Probation
• Mandatory assessment of functioning and skills for all prisoners across from 2014

• Training & Awareness
• Screening
• Reasonable adjustments
• IT systems
Police Station

- First time the diagnosis of Autism is made
- Function poorly in unfamiliar environments
- Misjudge their relationship with Police
- Problems in interpreting theirs & others actions
- No difference in suggestibility (vulnerable to leading questions) but may be more compliant
Prison population

- At risk population for exploitation and abuse
- Complex Care & Psychiatric histories
- Staff not skilled to recognise, understand and address their needs
- How easy to identify in the prison system?
Diversion from Criminal Justice system

- Divert to hospital if have Mental Disorder under MHA or Unfit to Plead
- Other countries do not go to hospital but go to Secure Care or Mandatory Care (Norway, Finland & New Zealand).
- Enter Secure Hospital care via Courts, Prison or Community
- Specialist secure hospital care for adults with autism has expanded over past 5 years in England
Secure Hospital-Assessment

• Comprehensive Assessment
  ▫ Diagnostic assessments – NICE guidelines in 2012
  ▫ Social & Communication skills
  ▫ Cognitive Profile (executive functioning such as working memory, information processing e.g. local vs global perceptual functioning)
  ▫ Mental State
  ▫ Relationships
  ▫ Interests & preoccupations
Secure Hospital: Risk assessment

- Standard Risk assessment tools (HCR-20, RSVP)
- Autism-specific risk assessments
- Identify specific risk factors for the individual
- Frame risk in the context of any cognitive or sensory difficulties
- Identify known difficult situations e.g. interpersonal stress.
Secure Hospital: Interventions

- Psychological approaches—Cognitive Behaviour Treatment, Anxiety management, Music Therapy
- Adaptations with visual materials, more directive approach
- Social Empathy skills Training—Socialeyes
- Index Offence work—Adapted SOTP
- Education & Employment
- Medication.
Case Vignette A - Community History

- 22 year old man with moderate ID & ASD
- Known to local ID services but difficult to engage
- Twice under Section 136 for acting ‘strangely’
- Made threats to burn college down but never acted on these threats
- Preoccupation with attending film premieres in Leicester Square, seeing celebrities & obtaining autographs.
- Vulnerable: pick-pocketed & coerced into giving money.
Case vignette A - Events leading up to his offence

- Mother sacked support workers as did not understand autism
- Lack of structure and activities impacting on behaviours
- More anxious & self neglecting & worsening self-injurious behaviour
- 3 months later arrested outside Buckingham Place with possession of a bladed article
- Seen by Psychiatrist services in West London.
Case Vignette A – Outcome

- Spent a week in Prison which was unpleasant & then bail to his mother
- Decided not a danger to public as never acted on threats & carrying a knife is not reason for hospital admission
- Advised management under a Guardianship order to live with mother
- Knows never to carry a knife but still goes to Leicester Square.
Case Vignette B

- 20 year old
- Early diagnosis of Asperger syndrome and attended special schools
- 3 older siblings
- Parents separated when he was young & Mother was the main carer with alcohol dependence history in recent years
- Occasional evidence of aggression – threatened his brother with a knife when his brother didn’t allow him to do something (disproportionate threat)
- 16 to 20 years of age: Attended an autism day centre for, 5 days a week for 4 years
Case vignette B – Events leading up to offence

- Mother was the main carer with no previous history of violence towards her.
- On a few occasions the day centre noted, his mother was struggling to support him due to alcohol, i.e. self care needs, getting him ready for day centre.
- One night, he was home with his sister. His mother returned home after drinking.
- She was shouting (not at Y).
- Y killed his mother by stabbing her numerous times and called ambulance.
Case vignette B – Presentation in secure hospital

• Very meek individual

• Reduced eye contact

• Perceives that he communicates his needs and emotions to others perfectly well when the reality is he rarely ever says anything to others!

• Likes playing X Box, watching Japanese cartoons, SIMS game and watching films, somewhat violent ones
Case vignette B—Presentation in secure hospital

- Similar aggression on occasions
  - Another patient kept calling his name. Y responded by waiting and jumping on his back and punching him. No verbal warnings.
  - Threatened to stab another patient with knife when provoked
- No co morbid mental health problems
- Sees himself as a “tech guy”
Challenges in Risk Reduction

- Easy to formulate anxiety / stress link to violent behaviour
- Difficult to engage to him in sessions
- Difficult to actually demonstrate risk reduction and offence similar to index offence won’t happen again
Conclusions

- Early recognition & diagnosis
- Secure & Forensic Services with professionals skilled in diagnostic formulations, risk assessments and therapeutic interventions
- How to assess & influence the risk factors
Any Questions?

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