Offenders with Neuropsychiatric Conditions: Is the Right Treatment Available?

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Review of Evidence

- Prison Studies
- Population based studies
- Systematic reviews
- Relevant literature on offender rehabilitation
- Transferable lessons from schizophrenia research
- Effectiveness studies from Brain Injury Rehabilitation
Brain Injury & Offending

- Sampling bias and case definition problems have influenced reported prevalence of head injury in offender population - ranging from 3.3% to 82%

- Reports from secure psychiatric services identify that patients with history of head injury may be more difficult to discharge

- Community based studies report `cognitive damage` as significant risk factor for domestic violence
TBI increases the risk of mental disorder by two-folds

TBI is significantly related to mental disorder with co-existing criminality

Childhood conduct problems, loss of a parent, substance misuse, maternal drug use in pregnancy, impaired executive cognitive functioning, structural damage to orbito-frontal and ventromedial areas, amygdala, and hippocampus are reported as risk factors for violent offending in TBI-offending population group

Population-based studies and large scale military cohorts have reported a higher relative risk for criminal conviction in mild traumatic brain injury (TBI) group
Epilepsy and Aggression

- Increased prevalence of epilepsy amongst prisoners
- An association between epilepsy and violence is not established
- Significant discrepancies in prison-based health care provision for epilepsy, when compared with NICE guidelines
- Aggressive incidents during postictal psychosis are well-recognized
- Ictal aggression (though rare) has been reported and discussed (Medico-legal and clinical implications)
Indicators of brain dysfunction reported

Brain Dysfunction association with violent offending

In an elderly cohort: Most patients had history of psychotic or mood disorders, cognitive impairment, and a history of head trauma or neurological disorder
Reports of violent and sexual offending by people with AD

People with HD in Prisons or referred for secure psychiatric care

Reports of resident-resident aggression in care settings for people with progressive neurological conditions

Reports of altered fear response, deficient theory of mind, and deficits associated with social cognitions have been reported
Are there any well-recognized Treatment Models?

- Yes
- Limited evidence base
Model: Forensic Cognitive Rehabilitation

- Environment that compensates for cognitive deficits
- Working model actively avoiding negative interactions
- Antecedent Control (avoiding triggers for problematic behaviour)
- Compensatory aids (personal & environmental)
- Structured programme of activities
Post-acute rehabilitation
Community or hospital based
Transdisciplinary team approach
Structured environment
Learning theory and behavioural treatment central to this model
Improves social handicap arising from neurobehavioral disability
Social Problem Solving Skills
Enhanced thinking skills
Self awareness and insight oriented work
Judicial/ Legal Sanctions or Orders
Compliance Monitoring
Model: Social Inclusion Programmes-
(Deprivation, Chaotic Lifestyle, and Poor Life Skills Management)

- Changing Environment
- Skills enhancement
- Education and Vocational Training
- Substance Misuse Management
- Adaptive and healthy social networks
- Voluntary Sector Involvement
- Recidivism Prevention Work
Model: Therapeutic Uses of Security (Hospital based)

- Relational
- Physical
- Procedural
- Effective management of mental disorder or disabling symptoms.
- Offence Specific Work aimed at Relapse Prevention of Mental Disorder, Substance Misuse, and Recidivism Risk.
Other Models

- Risk-based Management
- Good Lives Model
- Recovery
Useful

Multiple overlapping constructs

Difficult to compare against each other

Whether useful for patients with complex healthcare needs?
Towards an Enhanced and Integrated Model of Care

- Multidisciplinary
- Advanced Skills
- Integrated Network of National, Regional, and Local Services and Expertise
Challenge 1: Co-morbidity & Treatment Resistance

- Effective treatment of mental disorders
- Enhance Functions
- Modify disabling symptoms
- Reduce Distress
Effective General Hospital Liaison
Specialist Centre Networking
Links with Neurosciences Centres
Healthy Lifestyle Education
Specialist Nutrition and Dietetics Advice
Primary Care and Dental Health Provision
Transferable lessons from Offender Rehabilitation Programmes
Learning from Social Cognition Research in Schizophrenia
Psychopharmacology Effectiveness Trials
Promoting Research in Psychological Interventions & Team Working Models
Challenge 4: Insufficient Management of Alcohol & Substance Misuse Problems

- Raise Awareness
- Collaborative Working with Alcohol & Substance Misuse Teams
- Specialist Nurse and/or Champion Consultant in every PCT, Commissioning body, and Provider Organization
- Interfaculty Working Party on Alcohol and Brain Damage
Education and training
Research
Guided use of Structured Professional Judgement Tools such as HCR-20
Checklist development to guide appropriate data gathering
Study and influence commissioning arrangements

Recruiting staff with Multiple Skill Sets

- e.g. SALT, Teachers working with Psychology to provide literacy assessments and identifying language and content of manual based therapy programmes as well as pace of programme delivery
- e.g. OT providing CBT for anger management, and running substance misuse relapse prevention programmes
- e.g. Psychiatrists providing robust physical health care provision as well as Brief Psychotherapeutic interventions in relation crisis management & victim empathy
Challenge 7: Lack of Enabling Therapeutic Environments

- Identify Standards of Provision
- Building audits
- Service Gap Analysis
- Network of hospital based, day-care, residential, outpatient provisions.
Service Structure Research
Systematic evaluation of referral routes, discharge destinations, and recidivism rates
Pathways based on low-high impact offending (secure care or locked rehabilitation)
Pathways based on functional independence and/or cognitive capabilities
Pathways based on life cycle (age groups) and/or gender segregation
End of life care
Challenge 9: Workforce Development

- Multi-agency partnerships
- Effective and low-cost training collaborations
- Inter-professional learning networks
- Professional leadership collaboration
Challenge 10: Effective Use of Assistive Technology & Computing

- Communication skills
- Executive function performance
- Video Feedback for learning
Stand-alone services or regional/national networks
Sleep labs
Epilepsy – Video Telemetry & EEG Diagnostic Service
Neuroimaging
Future of lie-detection methods
Assessment of suspected malingering
Challenge 11: Influencing Real-life Outcomes?

- Life expectancy
- Intact family units
- Supportive network of friends
- Re-employment
- Social acceptance by the community
- Happy life
Final Considerations

- Is the right treatment available?
- Do we need a national network to develop the agenda further?
Useful References:


