IDENTIFYING INTELLECTUAL DISABILITY IN OFFENDER POPULATIONS – AND WHAT THEN?

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Defining intellectual disability

Intellectual disability (ID) is a term which refers to substantial limitations in a person's present functioning. It is characterised by

> *significantly sub-average intellectual functioning (that is, reasoning, memory, and other cognitive skills), existing concurrently with related limitations in two or more of the following applicable adaptive skill areas: communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics (basic literacy and numeracy), leisure, and work (American Association on Mental Retardation - AAMR, 2002).*

Usually a standard score or IQ score of less than 70 is the cut-off point for ID, whereas the **average** IQ in the community is 100, with people of above average intelligence having scores extending far above 100. Less than 3% of the population has an ID. Strictly speaking, the term "intellectual disability" is applied when the disability arises before the age of 18, but in practice with offenders, this may be difficult to determine, and may be confounded by other issues such as acquired brain injury from violence or motor vehicle accidents, or the long-term effects of substance abuse, which may have arisen during the developmental period or later.

Prevalence[1] - the facts about offenders with intellectual disability

People with intellectual disabilities are over-represented in the criminal justice system in every Western jurisdiction in which research has been conducted (Hayes & Craddock, 1992; Murphy, Harrold, Carey, & Mulrooney, 2000). In New South Wales (Australia), the most recent figures indicate that about 19-20% of the prison population has an ID, an increase of nearly 8% since the late 1980s when research was first conducted (Hayes, 2000). In the USA, the prevalence is estimated as being between 4-10% of the prison population (Petersilia, 1997), although direct assessment of prisoners is usually not undertaken when arriving at these figures, and in some instances, prison administrators have been asked indicate the number of inmates with ID in their institution.

A comprehensive study of prisons in Ireland (Murphy et al, 2000) found a prevalence rate of 28%. In the United Kingdom, low rates of ID amongst the prison population are reported, whereas rates of offenders with ID incarcerated in secure psychiatric hospitals and units are consistent with over-representation rates in other nations, at 16% (Taylor, Leese, Williams, Butwell, Daly & Larkin, 1998). Research indicates that 11% of a sample of offenders on probation in Kent were in the lowest 5% of the population on tests of cognitive functioning. Therefore, in the UK it appears that while there may an over-representation of people with intellectual disabilities in the criminal justice system, they are diverted into mental health services, or probation services (Mason & Murphy, 2002a).

Petersilia maintains that the prevalence appears to have doubled in the USA in a decade, and is likely to increase further, owing to

- increased prevalence of ID in low income populations,
- more young people (especially minority groups) coming under "correctional control",
- ongoing programmes for de-institutionalisation, without accompanying properly resourced community and mental health services, and

[1] **Prevalence** is defined as the proportion of cases in a defined population at a particular point in time, or over a specified period of time, whereas **incidence** is the rate of occurrence of new cases in a defined population over a period of time.

- inadequate diversionary programs, out of the criminal justice system into other services.

A further important issue in estimating prevalence is that the recidivism rate is between 40-70% for this group, and is especially high for sex offenders (Klimecki, Jenkinson & Wilson, 1994; Lindsay & Holland, 2000). Frequent re-offending can boost the incidence of people with intellectual disabilities in the criminal justice system, as they repeatedly appear in the system.

Is prevalence a red-herring?

There have been some fairly bitter arguments between researchers in various nations, and between researchers and corrective services, concerning whether or not the research accurately reflects the prevalence of people with ID in various sections of the criminal justice system. In some ways the issue of over-representation is a red-herring, because no matter how many offenders with ID are in the system, the important issue is to deliver effective services, to protect their safety and the safety of the community, and to try to achieve reductions in recidivism.

The prevalence figures do not alter the responsibility that corrective services have towards any person with an ID in the criminal justice system, in terms of

- duty of care
- delivery of appropriate programmes, e.g. literacy and numeracy, social skills training and specialist programmes to address substance abuse and sex offending
- therapeutic interventions, e.g. medical, dental and mental health care, and
- education for criminal justice professionals.

Identification of offenders with intellectual disability

A major difficulty in identifying offenders with an ID is the fact that the mean IQ of prisoners is lower than the average IQ in the community, and so the conundrum becomes one of making a fine differentiation between inmates who are functioning at below average levels in any case, and those with a diagnosable ID. Reflecting research performed elsewhere. the average IQ score for several hundred participants in NSW prisons has been shown to be 85, whereas the mean score is 81 on adaptive behaviour scales, well below the population mean of 100 (Hayes, 2000).

In addition, this population has other social and health issues that can confuse the ID issue, such as:

- half left school by age 14
- 1 in 20 have hearing impairment (higher for indigenous populations)
- 1 in 5 is visually impaired
- 1 in 12 is speech impaired

In order to address the difficulty of identifying offenders with an ID, the Hayes Ability Screening Index (HASI) has been developed, and is presently being used in a wide variety of service settings, including juvenile and adult offender services, as well as some mental health and community services. The HASI can also be used by police to identify when an interviewee requires the presence of an independent third party (an appropriate adult, under the terms of the *Police and Criminal Evidence Act)* while they are in police custody or being interviewed by police. (For full details about the HASI reliability, validity and development information, see the HASI *Manual*; Hayes, 2000).

The HASI requires about 5-10 minutes to administer, and consists of a number of subtests:

- several self-report questions
- reverse spelling
- a “join the dots” puzzle

- a clock drawing sub-test

Another screening instrument, Learning disabilities in the Probation Service (LIPS), has been utilised by Mason and Murphy in Kent probation offices (Mason and Murphy 2002b); LIPS consists of two tests, one verbal and one non-verbal, as well as some questions relating to daily living skills, and other background information. The limitations of the LIPS include the small study sample on which the instrument has been used, few women and no juveniles in the sample, reliance for some information on a third party who knows the offender well, and poor validity for one of the tests used. In comparison, the HASI was validated on 567 participants, including sizeable sub-groups of males and females, juveniles and adults, and indigenous and non-indigenous offenders, in both community and custodial settings. The rate of correct "diagnosis" of intellectually disabled versus non-disabled participants is known to be high, whilst the HASI effectively excludes non-disabled individuals from the need for further assessments.

The HASI does not make a diagnosis of ID, but rather, is designed to be used as a screening test, to indicate those offenders who need a full-scale diagnostic psychological assessment, and perhaps referral for psychiatric assessment or other health evaluations (for hearing or sight impairments, for example). The HASI is deliberately slightly over-inclusive, and will refer offenders who have little English, as well as those who have significant psychiatric symptoms that interfere with the ability to complete the HASI. These groups have been shown to have a high prevalence of ID, which is often masked by poor English language ability or by dual diagnosis, but in any case, these offenders should have a full-scale diagnostic assessment.

Characteristics of prisoners with ID

Holland, Clare and Mukhopadhyay's review of the evidence on the characteristics of offenders with an ID (2002) found that they tend to be young and male. Their backgrounds are characterised by:

- severe psychosocial disadvantage
- other offenders in the family
- behavioural problems dating back to early childhood
- high rates of unemployment, and
- likelihood of symptoms of mental disorder

Offenders with ID are not a homogeneous group, however. There are differences amongst the various sub-groups of offenders with ID (Hayes, 2002). For example, the variables that distinguish ID sex offenders from non-sex offenders are as follows:

- Communication skills – sex offenders are more likely than other offenders to have severe deficits in communication skills
- Daily living skills - sex offenders have greater deficits in daily living skills
- Adaptive behaviour – Vineland Adaptive Behavior Scales (VABS) show general deficits in all aspects of adaptive behaviour
- Place of residence – sex offenders are less likely to live at home with parents, or in their own home, and more likely to live in a boarding house or non-family situation
- History of inappropriate sexuality – sex offenders are more likely to have exhibited inappropriate sexual behaviours as a young person or child
- Family history of substance abuse – this is greater in sex offenders' families
- Uncertain sexual orientation - more sex offenders report that they are bisexual, or unsure of their sexual orientation
- Education - sex offenders tend to have higher levels of education than non-sex offenders, possibly enabling them to have the insight to groom their victims.

The little research that has been located on how offenders with an ID differ from non-offenders with an ID (Winter, Holland & Collins, 1997) shows that those who offend are more likely to have experienced psychosocial disadvantage, to lead chaotic lives which includes homelessness and substance abuse, to have a recent history of major life upheaval, and not to be receiving support from health or social care services.

Most noteworthy, however, are the many areas in which there is NO difference between ID and non-disabled offenders. In general, most of the offender population is young, male, and from very deprived and dysfunctional backgrounds. The average IQ of offender populations is lower than that of the general population, as mentioned above (Hayes, 2000). Illiteracy is the norm, as are problems with substance abuse, symptoms of mental disorder, and long-standing behavioural difficulties.

In a perverse way, this is good news, because this information implies that offenders with an ID are not in the criminal justice system predominantly because of factors that are specific to ID. Rather, they are similar to non-disabled offenders in exhibiting backgrounds of deprivation, alienation, and personal misery. It seems, therefore, that offenders with an ID may be over-represented in the criminal justice system because more people with ID possess these personal characteristics that are linked to offending behaviour, because they tend to be poor, unemployed, ill-educated, and not receiving family support. If this is the case, then the challenge ahead is to improve the lot of people with an ID generally in our society. Along with most of the offender population, people with intellectual disabilities need employment, social and recreational activities, stable and safe places of accommodation, assistance with financial management, literacy programmes, substance abuse programmes, and behavioural management interventions. Thus, rehabilitation programmes in prisons need to focus on these characteristics, whilst being tailored specifically for prisoners with ID.

Research in prisons

The design of research studies is important in determining an accurate rate of over-representation, which in turn is important in allocating resources for programmes. The Irish study (Murphy et al, 2000), an exceptionally well-designed research project, was fortunate in having full cooperation from corrective services. A random sample of 10% of the total prison population, from every prison in the country was included; the inmates individually participated in a comprehensive battery of cognitive assessments administered by psychologists expert in the field of ID. The results indicated that 28.8% of the sample scored below 70 on intelligence tests. This study avoided many of the usual pitfalls that be-devil research in this area, which are outlined below.

Pre-selection of inmates for assessment – inclusion of inmates who are pre-selected according to some criteria or "nominated" for participation by corrective services officers will certainly bias results of any research into prevalence. The precise nature of the bias is difficult to determine, and could result in over-representation or under-representation. On the one hand, if inmates are nominated for inclusion because officers think they have ID, the officers may be very perceptive and therefore the sample will be over-inclusive of inmates with ID. On the other hand, and the more likely scenario, officers are unlikely to recognise the presence of ID and instead may refer inmates who are floridly psychotic, or have behavioural problems, while the quiet and compliant inmate with ID is overlooked.

Non-random samples – sampling is sometimes done on the basis of convenience (all the inmates in one prison or wing, or the prisoners who are not working, for example). Any sample of convenience is bound to be biased, because the characteristics of prisoners in one section of the gaol may differ from those in another section, because of security classification, length of sentence or any other factors taken into account in classification decisions. We know that prisoners with ID are more likely to breach prison rules, and therefore probably will tend to be in maximum security sections, or punishment sections of a gaol. These are the types of areas

which are often avoided in research because of the difficulty in getting the researcher into protection areas, or alternatively moving the prisoners to the researcher. The best way of sampling a prison population is to decide on the percentage of inmates to be assessed, and if it is 10%, for example, randomly call a prisoner according to a table of random numbers. If that inmate declines to participate, then the next random number is called, until the sample is filled.

Volunteer samples – volunteer samples are similarly prone to bias. Whilst it is impossible to coerce inmates into participation, the random number method is really the only way of coping with non-participation without introducing bias. Asking for volunteers from a prison population will create unknown biases. Perhaps the non-disabled inmates will turn up because they do not fear having a weakness revealed, or because they like the novelty of the experience. Perhaps the ID prisoners will volunteer because they do not know any better than to volunteer, or because they think the experience will be helpful to them. The important issue is that the researchers simply do not know one way or the other.

Summoning the inmates for assessment – research shows that inmates with ID have a greater incidence of relevant physical problems such as hearing or eyesight impairments. More of this group are likely to be illiterate, compared with the rest of the prison population. Therefore, loudspeaker announcements are unlikely to be heard (or able to be interpreted, or instructions followed) by ID inmates, and they may not be able to read posters that are put up around the prison. It is unacceptable for officers to ask inmates whether they want to participate in the research, because officers may not know the aims of the research, or may portray the research in a different light from what is actually intended. The most reliable recruitment method is for officers to bring the inmates selected through the random number method to an area near where the research assessments will take place, and for the researchers then to ascertain whether each inmate chooses to participate. It should be noted that participation in psychological research poses somewhat different problems than physical health surveys, for example, as some degree of cooperation from the inmate is essential.

Group tests of intelligence - group tests of intelligence should be avoided because research indicates that individual tests usually yield a higher rate of ID, probably because individual tests are essentially more accurate.

Guesswork or the "eye-ball" method - un-normed and unvalidated assessments of intelligence (including estimates by prison officers, medical staff or administrators) must be avoided. The difficulty in recognising an offender with ID was highlighted by a court study (Hayes, 1993) where the research assistants (all psychologists) were asked to indicate whether they thought the participants had ID, before the test results were analysed – 58% of those with ID or borderline ID were not correctly identified by the researchers. Misclassification in the other direction occurred less frequently, with no participants of average intelligence being considered as ID. The findings reflect the difficulty encountered even by experts, when attempting to identify the presence of ID amongst people in the criminal justice system without comprehensive testing with reliable and valid tests.

Inadequate test batteries – the definition of ID is two-pronged, and incorporates both intelligence and adaptive behaviour. A common mistake is to omit a test of adaptive behaviour. The intelligence test that is administered should assess both verbal and non-verbal reasoning skills, especially when English is a second language. Any test that is administered must have norms and data about reliability and validity. "Homemade" questionnaires about drug usage or daily living skills can sometimes be useful in a clinical setting, mainly as a trigger for dialogue between the professional and the client, but are a waste of time in a research project.

Administration of tests by non-psychologists – most tests of intelligence and adaptive behaviour need to be administered by a psychologist trained in the specific test. Administration of tests by inadequately trained researchers can result in distortion of test results, lack of rapport between

tester and participant, and non-recognition of other medical/psychological/psychiatric conditions that might affect test responses, including depression, or poor eyesight, for example.

Non-inclusion of some inmate groups – for research to be as accurate as possible, inmates must be drawn from groups that are often considered to be too difficult to assess, including protection prisoners, non-English speakers, and psychiatrically disturbed prisoners. These groups can have high prevalence of ID, and their lack of English, or psychiatric illness can mask the presence of ID, because the difficulties with such prisoners can be attributed to their language or mental illness rather than to their intellectual impairments. Conversely, prisoners with ID have a high rate of psychiatric illness. Accurate research cannot leave out the difficult prisoners.

Only through well-planned and thorough research can an accurate picture of the real prevalence of ID in criminal justice populations be obtained, which in turn allows for planning of resources and services. Furthermore, information about the prevalence of ID needs to be collected not just in custodial settings, but also at various other points in the criminal justice system, to cast light on sentencing rates for this group, and whether they receive equitable treatment as they proceed through the system (Hayes, 1996), as well as the extent of resources needed for this group.

Prison programmes for prisoners with ID

Imprisonment in institutions administered by correctional services, or in some cases, police services (holding cells), is a very different experience from incarceration in hospitals, specialist institutions or small community-based units. The major differences lie in the fact that the facility is administered by correctional services, rather than by health or disability services, and that the aim of incarceration is primarily to punish the offender and remove him/her from society; a prison is a place to which no-one goes voluntarily, although the prison may have rehabilitation goals. Imprisonment is meant to have a deterrence function. Prisons are unique in that they must accept all comers – unlike community accommodation services, or even some hospitals, a prison cannot refuse a "client" because the client is violent or dangerous.

In an ideal world, many offenders with ID should possibly not be in prison, but in small secure units in the community for ID, not psychiatrically ill offenders. Realistically, this is unlikely to be an option for the majority of offenders with ID, especially repeat offenders – to begin with, the secure community units may not be available, or are not large enough to accommodate all referrals. Secondly, some offenders with ID commit such violent or serious offences that courts and the community consider that imprisonment is the only option for containment, and of course, punishment. Lastly, if the presence of ID is not recognised during the court process, then opportunities for diversion cannot be implemented.

In the same ideal world, prisons should offer inmates with ID the programmes and resources that they need if they are to avoid re-offending, and which will allow them to enhance their skills and abilities, for when they return to the community. Prisons certainly need to ensure that the safety of the prisoner with ID is protected and that he/she will not be "stood over" by other inmates, robbed of their belongings including food and cigarettes, sexually or physically assaulted, or placed in danger through becoming couriers for other inmates' trade in drugs and other substances. It must also be recognised that the ID inmate's behaviour may place them at risk of being assaulted by other prisoners, because they may behave in a manner that aggravates others.

No comprehensive study has been located that examines the health and rehabilitation needs of prisoners with ID, although it is likely that lack of identification on admission to gaol, the need for further training for correctional officers, and greater liaison between gaol and community service provision systems would probably be the recommendations to emerge from any study of inmates with ID.

Special units – to be or not to be?

The NSW (Australia) Department of Corrective Services is one of many world-wide that has established special units for a small number of prisoners with ID, usually those who would be most vulnerable in the prison mainstream owing to behavioural problems, dual diagnosis, immaturity or the nature of the offence (sexual offences against children, for example). This is a model which tends to occur elsewhere, for example Georgia (USA) where an Intensive Behavior Therapy Unit caters for female inmates with mental health or ID problems that result in the inmate having difficulty in the mainstream of the prison. An incentive program operates, and appears to improve prisoners' functioning as well as reducing the number of disciplinary reports (Daniel, Jackson & Watkins, 2003).

The disadvantages of special units within a prison are considerable. Prisoners with ID are segregated from the mainstream of the prison, with all the attendant limitations that can occur in a segregated environment. The ID prisoners may have less access to general prison programmes and health services, and if they have complaints, it may be difficult for them to access official prison visitors or others who can help them. Any reforms to the mainstream of the gaol may not filter down to special units. Because a number of individuals with very disruptive and possibly violent behaviours are incarcerated together, the unit may be dangerous, especially for the more vulnerable. Inmates may model on each other's dysfunctional behaviour, especially in the absence of non-disabled role models. Some lobby groups for people with ID oppose any form of segregation, maintaining that neither offenders in the mainstream of the prison nor the segregated unit benefit in the long run.

On the other hand, the benefits of special units can be considerable, both to the individual inmates and to the general smooth running of a prison. In my experience, a special unit, if appropriately staffed and resourced, can reduce levels of disruptive behaviour on the part of inmates, and also reduce the level of medication that some individuals are taking to control their behaviour. Prison officers can focus on the inmates with ID, and not have to cope with a range of abilities and behaviours. Some inmates with ID function at the level of pre-schoolers, albeit large and often violent pre-schoolers. Managing this type of inmates in mainstream becomes a difficult juggling act, and the difficult inmates may be transferred to a segregation or protection unit as a result of disciplinary breaches or for their own safety. In NSW prisons, segregation/protection units tend to have very limited out-of-cell hours, little access to education, training or employment opportunities, and to be dangerous and violent places. A special unit looks good by comparison.

Inmates with ID often spend more time than is necessary in maximum security, for a variety of reasons, including the fact that they are perceived as violent or unpredictable, but also because they may not be able to access educational programmes that will help them move along the security continuum (Glaser & Deane, 1999).

With imagination and good staff, special units can provide extra opportunities for education, including a more domestic environment, with kitchen and laundry facilities, and other minor inclusions that can more closely approximate a typical living environment. With thought, creative employment opportunities can be created even in limited space – in NSW prisons, a successful employment programme in special units has inmates assembling the headphone sets for Qantas and packing them into plastic bags.

What makes a special unit function well?

Staff selection – staff should volunteer to work in the units and to view the role in a positive manner. The NSW Department of Corrective services at one time had a special selection committee to consider applications from officers who wanted to work in the units. Most of the applicants expressed the view that they wanted their role to be more challenging than simply locking and unlocking gates. Some had prior experience that was relevant, such as having been a teacher, or a care worker.

Stability of staff – there should be as little turn-over in the staff as possible. Regular staff get to know the inmates and can usually tell when an episode of behavioural acting-out about to erupt. The inmates know that they cannot “put something over” regular staff, whereas someone who is posted to the unit for one or two shifts is unfamiliar with routines and protocols. Staff stability is important for the inmates, many of whom find it difficult to adapt to change. Sadly for many inmates in ID units, the placement is the most stable environment they have experienced in the course of their life.
*Expert support - s*upport needs to be available to unit staff from outside service agencies, including specialist ID organisations, as well as housing, welfare, education, mental health and employment services. Expert assistance to design behavioural programs is vital, but also to implement general programmes covering daily living skills and literacy, for example. Staff in the units cannot be expected to re-invent the wheel.
Behavioural management programmes - a programme designed for a particular inmate must be adhered to by everyone in the unit, whether nurse, officer or educator. When the inmate engages in a particular behaviour that is sanctioned, the response must be immediate, and consistent. If it is “in cell” time that forms the sanction, then that inmate must go to the cell for the specified period of time, no matter what activity they are engaged in. The “in cell” time must be the only punishment, however, and should not be accompanied by verbal scolding or interactions which may paradoxically meet an inmate’s desire for attention.
Unit meetings – unit meetings of the on-duty staff and the inmates is an effective way of disseminating information and establishing general rules for all inmates, especially when a new problem arises, or a new prisoner arrives. The meetings can be a good way of de-fusing problems, and developing fair and open responses to events in the unit.
Communication books – a system of communication books for each inmate is essential, so that staff who are on different shifts can communicate, and find out what happened with a particular inmate on the previous shift. Minor stressors, illness, medication changes, acting-out behaviour or friction between inmates can all be noted, as well as instances of positive behaviour change.
Records – detailed records related to the behavioural programmes must be kept, so that changes can be monitored (staff and inmates can forget quite how dreadful a prisoner’s behaviour may have been when they first arrived), and programmes can be altered if they seem not to be working.
Group therapy – in addition to the unit meetings, group therapy can be an effective tool in encouraging inmates to develop skills in interpersonal interaction, especially empathy.
Individual plans – a one-size-fits-all approach does not work. Each inmate has strengths and weaknesses in their abilities that need to be identified in order to be addressed appropriately. One prisoner may have major difficulties with substance abuse, whereas for another, the major problem may be interpersonal skills, or controlling aggression. An individual plan, and a baseline of abilities for each inmate also allows improvements to be carefully monitored, so that if an approach does not seem to be having any impact on the problem behaviour, another form of intervention can be considered. Built into the plan must be appropriate and consistent positive or negative reinforcement, that is, strategies designed to increase desirable behaviours, and decrease the incidence of problem behaviours. Everyone in the unit, including the inmate needs to be quite clear as to the goal of the plan, how changes are recorded, and the nature of the sanctions.
Evaluation – or put it another way, research – just as individual plans need to be evaluated, so too does the effectiveness of the special unit, in terms of outcomes for inmates (instances of behavioural problems or disciplinary breaches, use of medication, general improvements), outcomes for staff (satisfaction, and turnover, for example), and cost-benefit analyses for the correctional facility generally. The latter is difficult to estimate, because these units are expensive to run, and often the benefits lie in what does not occur, for example, deaths or injuries in custody.

Specialist rehabilitation programmes

Again, the issue of identification of offenders with ID is of major significance in recognising those prisoners who need targeted rehabilitation programmes, but may be unable to benefit from

programmes offered to non-disabled inmates. A second major issue is the importance of evaluating rehabilitation programmes, to determine whether or not they are working, which is another aspect of research in prisons.

Substance abuse

Whilst use of tobacco and alcohol may be less amongst the population of people with ID, compared with non-disabled people in the general population, substance abuse is prevalent amongst offenders with ID, and is related to recidivism (Winter et al, 1997). More than half of offenders with ID are alcohol dependent, and usually have been for over a decade (Hayes, 1994). The majority, as with non-disabled offenders, are intoxicated at the time of the offence (Hayes, 1994; Hayes, 1996). Whilst substance abuse is not confined to offenders with ID, specialist services and extra training for staff treating ID offenders is essential (Tyas and Rush, 1993). Offenders with ID lack insight into their problems, as well as the planning ability organise their attendance at substance abuse programmes, and the verbal skills to benefit from participation. On the other hand, staff find it almost impossible to achieve gains when clients are uncooperative or unwilling, or fail to present to the programme (Clarke and Wilson, 1999). In summary, offenders with ID cannot just be "plugged into" existing substance abuse programmes

Sex offenders

Sex offenders with ID typically have confused self-concepts, poor peer relations, a lack of sexual and socio-sexual knowledge, and a lack of personal power (Hudson, Nankervis, Smith & Phillips, 1999). Furthermore, they are likely to have been the victim of sexual or physical abuse, usually having being abused in institutions or by family members. Research indicates a higher prevalence of sex offences as a proportion of all offences committed by people with ID, compared with the rate of sex offending amongst non-disabled offenders; furthermore, recidivism rates are high (Law, Lindsay, Quinn & Smith, 2000). In a cognitive behavioural psychotherapy group for adolescent males with ID who had offended against children (Lindsay, Olley, Baillie & Smith, 1999), a primary issue was the participants' lack of motivation for change, requiring the therapists to expend great effort to build up the cohesion of the group and encourage insight into the offending behaviour. The researchers consider compulsory attendance, and accurate feedback to the participants about their level of involvement and use of denial, to be crucial, and usually any real impact on issues related to denial of intent or denial of responsibility takes about 6-9 months of treatment. Prison programmes must therefore be delivered, and assessed, over reasonably long periods of time, with two-year programmes being significantly better that one-year programmes . (Discussion of interventions with sex offenders with ID can be found elsewhere – Hayes, 2004; Sinclair & Murphy, 2000; Hordell, Hill, Forshaw, Bendall, Hipkins & Robinson, 2000).

"Peer abuse" by one inmate with ID against another is a widespread problem, and can be ongoing. Because this type of offence is often not recognised, there is a lack of appropriate intervention. Therefore, in any programme for sex offenders with learning disability, one of the major aims must be to protect participants against abuse from other participants (Brown & Stein, 1997).

Challenging behaviour

Challenging behaviour encompasses many aspects of problematical behaviour in people with learning disability, but in this context, the focus is upon behaviour that leads to contact with the criminal justice system, and threatens the individual's ability to continue to reside in the community and access community resources. One in five people with ID display challenging behaviour, and this is higher amongst black minority groups in the UK (Joyce, Ditchfield & Harris, 2001). Interpersonal aggression is clearly a major cause of charges of assault, manslaughter or murder. Aggressive behaviour can arise from a number of causes, ranging from effects of organic brain damage, to substance abuse, to modelling on familial violence and abuse, through to poor socialisation, and vulnerable sense of self (Jahoda, Pert, Squire & Trower, 1998). Those individuals who perceive that they are being treated as if they are stupid or intellectually disabled

are more likely to respond aggressively in interpersonal situations. Understanding the nature of the individual's self-perceptions may provide valuable insight into what may otherwise be regarded as unpredictable outbursts.

Medication, frequently used in mental hospitals and prisons to control behaviour, is frequently administered without adequate reason or follow-up, and research indicates that it appears to be of little use for offenders with ID. A review of research on the effectiveness of ant-psychotic medication for people with learning disability and challenging behaviour provides no evidence either way as to whether anti-psychotic medication does or does not help the behaviour of these individuals (Brylewski & Duggan, 1999). Further research is urgently needed in this area.

Detailed discussion and analysis of the design of programmes to address challenging behaviour in offenders with learning disability can be found elsewhere (see, for example, Xenitidis, Henry, Russell, Ward & Murphy, 1999). It is important, however, that these programmes be designed, implemented and monitored by specialist staff experienced in the area. As mentioned elsewhere, programmes need to be designed for each individual, after collection of appropriate baseline data, and be ongoing for as long as is necessary to address the behaviours, rather than be time limited because of cost constraints. The programme must be reinforced periodically, on a long-term basis, and all of the systems and services which assist the individual need to communicate and coordinate their efforts.

Psychiatric illness and treatment

The presence of psychiatric illness (dual diagnosis) can create extra problems for an offender with ID because the illness can affect behaviour, reasoning, memory, social and adaptive skills, and motivation, and of course the illness may increase the risk of recidivism. Studies on prevalence of psychiatric illness in this group have found rates between 13 - 37%, higher than in the general population (Deb & Weston, 2000; Hayes, 1994). Making an accurate diagnosis of psychiatric illness in a person with an ID is complex, partly owing to their communication impairments and lack of ability to recognise and articulate the nature of their symptoms. Very few professionals are expert in the combined fields of psychiatric illness and ID, and therefore one aspect of the diagnosis may often be overlooked. The difficulty in making an accurate diagnosis can be further confounded by substance abuse. Specialist diagnostic instruments have been developed to assist in recognising psychiatric symptoms in people with intellectual disabilities (Deb & Weston, 2000). In the prison population, women with ID have a higher rate of dual diagnosis than men (Hayes & McIlwain, 1988), possibly because of the fact that when a woman receives a custodial sentence there are often extra factors that the court takes into account, such as violent and unpredictable behaviour related to psychiatric symptoms.

Gunn (1998) comments on the apparent lack of major therapeutic activity for mentally ill offenders in the criminal justice system, a situation that is likely to be even more parlous for those with a dual diagnosis. Each part of the system, mental health, or ID services, or substance abuse agencies tend to foist the dually diagnosed offender off onto another part.

Release into the community

Release into the community after imprisonment must to be managed carefully, if individuals with ID are to avoid re-offending. A custodial sentence can provide an opportunity for the inmate to learn skills of daily living such as cooking, and budgeting, but acquiring these skills is a slow process, with the optimum time frame being two years (Lindsay, Smith & Michie, 2000). Offenders with ID who are released into the community or diverted from the criminal justice system into community resources without adequate support usually end up having transient living patterns, poor quality of life, no employment or educational programmes arranged for them, and turbulent life experiences (Chung, Cumella, Wensley & Easthope, 1999). Therefore, cooperation between correctional and community services and resources is vital.

Enrolment in pre-release programmes can be difficult for inmates with ID because they may not realise the strategic importance of such programmes, nor comprehend how to enrol. Many have little support outside prison, and few have a history of sustained employment, both factors that can affect the likelihood of day release. Ignorance about their condition may result in this group being regarded as dangerous and unpredictable by those making decisions about their release (Goninan & Walker, 2001).

Nevertheless, education about daily living skills is difficult to achieve when the inmate has no contact with the community and is not familiar with everyday objects such as automatic teller machines, or public transport ticket dispensers. Further, regular and intense reinforcement of learning is difficult – again, probably best achieved in a special unit where all the staff are aware of the general goals, and the specific objectives for each inmate, and these aims are then reinforced in specialist pre-release programmes.

Future directions

Research into the prevalence of inmates with ID in UK prisons, and into the characteristics of these inmates, has to date been fairly fraught with methodological problems, which result in uncertain findings that are of little assistance in planning resources. Research about the effectiveness of various programmes for this group is now yielding some useful signposts for the programme design, and just as importantly, for the evaluation of programmes. Administrators and clinicians are realising that the investment of large sums of money in clinical services and therapeutic interventions in prisons can be justified only if those services are demonstrated to be beneficial.

In practical terms, the questions that probably need to be addressed in prisons in the UK are as follows:

- What is the prevalence of prisoners with ID, and with dual diagnoses of ID plus psychiatric illness and/or substance abuse?
- What types of offences are being committed by this inmate group, and therefore, what are the likely needs for containment (level of security, vulnerability, and segregation) and therapeutic interventions?
- What services need to be provided for this group during incarceration? – education, work skills and experience, adaptive behaviour skills, literacy, numeracy?
- How can recidivism be reduced?
- How can prisons interact more effectively with community services in order to manage release back into the community in the most effective manner?

It is only through exploring the answers to these questions that a situation can be achieved where not only are the rights of inmates with ID respected, and their therapeutic needs met, but also better management of prisons and more satisfying and safer work environments for prison staff are achieved.

References

American Association on Mental Retardation. 2002. *Mental retardation: definition, classification and systems of supports*. Washington, DC: American Association on Mental Retardation

Brown H, Stein J. 1997. Sexual abuse perpetrated by men with intellectual disabilities: a comparative study. *Journal of Intellectual Disability Research* 41: 215-24

Brylewski J, Duggan L. 1999. Antipsychotic medication for challenging behaviour in people with intellectual disability; a systematic review of randomized controlled trials. *Journal of Intellectual Disability Research* 43: 360-71

Chung MC, Cumella S, Wensley J, Easthope Y. 1998. A description of a forensic diversion service in one city in the United Kingdom. *Medicine, Science and Law* 38: 242-50

Clarke JJ, Wilson DN. 1999. Alcohol problems and intellectual disability. *Journal of Intellectual Disability Research* 43: 135-9

Daniel C, Jackson J, Watkins J. 2003. Utility of an intensive behavior therapy unit in a maximum security female prison. *Behavior Therapist* 26: 211-2
Deb S, Weston SN. 2000. Psychiatric illness and mental retardation. *Current Opinion in Psychiatry* 13: 497-505
Glaser W, Deane K. 1999. Normalisation in an abnormal world: a study of prisoners with an intellectual disability. *International Journal of Offender Therapy and Comparative Criminology* 43: 338-56
Goninan M, Walker N. 2001. *Effective education for inmates with intellectual and/or psychiatric disabilities: a realistic option?* Presented at International Forum on Education in Correctional Systems, Bathurst, Australia
Gunn J. 1998. Forensic psychiatry at a crossroads. *Current Opinion in Psychiatry* 11: 661-2
Hayes SC. 1993. *People with an intellectual disability and the criminal justice system: appearances before local courts. Rep. 4*, New South Wales Law Reform Commission, Sydney
Hayes SC. 1994. *Intellectually disabled offenders - characteristics and psychological assessment*. Presented at First International Congress on Mental Retardation, Rome
Hayes SC. 1996. *People with an intellectual disability and the criminal justice system: two rural courts. Rep. 5*, New South Wales Law Reform Commission, Sydney
Hayes SC. 2000. *Hayes Ability Screening Index (HASI) manual*. Sydney: Behavioural Sciences in Medicine, University of Sydney
Hayes SC. 2002. Early intervention or early incarceration? *Journal of Applied Research in Intellectual Disabilities* 15: 1-9
Hayes SC. 2004. Alternative dispositions for offenders with developmental disabilities. In *Offenders with developmental disabilities*, ed. WR Lindsay, J Taylor, P Sturmey. UK: Wiley
Hayes SC, Craddock G. 1992. *Simply criminal*. Sydney: Federation Press
Hayes SC, McIlwain D. 1988. *The prevalence of intellectual disability in the New South Wales prison population: an empirical study*, Criminology Research Council, Canberra
Holland T, Clare ICH, Mukhopadhyay T. 2002. Prevalence of "criminal offending" by men and women with intellectual disability and the characteristics of "offenders": implications for research and service delivery. *Journal of Intellectual Disability Research* 46: 6-20
Hordell A, Hill J, Forshaw N, Bendall S, Hipkins R, Robinson D. 2000. Cognitive behavioural treatment of male sex offenders with intellectual disability. *Journal of Intellectual Disability Research* 44: 324
Hudson A, Nankervis K, Smith D, Phillips A. 1999. *Identifying the risks. Prevention of sexual offending amongst adolescents with an intellectual disability.*, Research Unit, DisAbility Services Division, Victorian Department of Human Services, Melbourne
Jahoda A, Pert C, Squire J, Trower P. 1998. Facing stress and conflict: a comparison of the predicted responses and self-concepts of aggressive and non-aggressive people with intellectual disability. *Journal of Intellectual Disability Research* 42: 360-9
Joyce T, Ditchfield H, Harris P. 2001. Challenging behaviour in community services. *Journal of Intellectual Disability Research* 45: 130-8
Klimecki MR, Jenkinson J, Wilson L. 1994. A study of recidivism among offenders with an intellectual disability. *Australia and New Zealand Journal of Developmental Disabilities* 19: 209-19
Law J, Lindsay WR, Quinn K, Smith AHW. 2000. Outcome evaluation of 161 people with mild intellectual disabilities who have offending or challenging behaviour. *Journal of Intellectual Disability Research* 44: 360-1
Lindsay W, Olley S, Baillie N, Smith A. 1999. Treatment of adolescent sex offenders with intellectual disabilities. *Mental Retardation* 37: 201-11
Lindsay WR, Holland A. 2000. Changing services for offenders with intellectual disability. *Journal of Intellectual Disability Research* 44: 367-8
Lindsay WR, Smith AHW, Michie A. 2000. Successful community integration following community living skills training: a controlled study. *Journal of Intellectual Disability Research* 44: 368
Mason J, Murphy G. 2002a. Intellectual disability amongst people on probation: prevalence and outcome. *Journal of Intellectual Disability Research* 46: 230-8
Mason J, Murphy G. 2002b. People with an intellectual disability in the criminal justice system: developing an assessment tool for measuring prevalence. *British Journal of Clinical Psychology* 41: 315-20
Murphy M, Harrold M, Carey S, Mulrooney M. 2000. *A survey of the level of learning disability among the prison population in Ireland*, Department of Justice, Equality and Law Reform, Dublin
Petersilia J. 1997. Unequal justice? Offenders with mental retardation in prison. *Corrections Management Quarterly* 1: 36-44
Sinclair N, Murphy G. 2000. Preliminary results from a treatment group for men with intellectual disability who sexually offend. *Journal of Intellectual Disability Research* 44: 466
Taylor PJ, Leese M, Williams D, Butwell M, Daly R, Larkin E. 1998. Mental disorder and violence. A special (high security) hospital study. *British Journal of Psychiatry* 172: 218-26
Tyas S, Rush B. 1993. The treatment of disabled persons with alcohol and drug problems: results of a survey of addiction services. *Journal of Studies on Alcohol* 54: 275-82
Winter N, Holland AJ, Collins S. 1997. Factors pre-disposing to suspected offending by adults with self-reported learning difficulties. *Psychological Medicine* 27: 59955-607
Xenitidis KI, Henry J, Russell AJ, Ward A, Murphy DGM. 1999. An inpatient treatment model for adults with mild intellectual disability and challenging behaviour. *Journal of Intellectual Disability Research* 43: 128-34