

Offenders with Dual Diagnosis: Intellectual Disabilities/Autism Spectrum Disorders



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Division of Developmental Disabilities

Dual Diagnosis Program (DDCP)

- South Ontario regional inter-professional academic-service team of faculty from psychiatry, psychology and rehabilitation
 - Serve children/adults across the lifespan with dual diagnosis: intellectual disabilities and/or autism spectrum disorders with mental health problems
 - Offer consultation, assessment, intervention and therapy via uniprofessional & interdisciplinary clinics
 - Specialized clinics for TAY, ASD, Sensory, OT, Dual Diagnosis and Forensics (Offending/Sexuality)
 - www.ddcp.ca
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Outline

- Overview of the literature on offenders with intellectual disabilities and/or autism spectrum disorders
 - prevalence, characteristics and offence type
- Introduction to the prevalent issues for this population in the CJS
 - at arrest, interview and court
- Review of clinical issues for risk informed treatment and management in the community

DSM-5 Definition



319. INTELLECTUAL DISABILITY (Intellectual Developmental Disorder) is a disorder with onset during the *developmental* period that includes both *intellectual* and *adaptive* functioning deficits in conceptual, social, and practical domains.

* previously MR – DSM-IV

“Note: The diagnostic term Intellectual Disability is the equivalent term for the ICD-11 diagnosis of Intellectual Developmental Disorders. Although the term Intellectual Disability is used throughout this manual, both terms are used in the title to clarify relationships with other classification systems. Moreover, a federal statute in the United States (Public Law 111-256, Rosa’s law) replaces the term mental retardation with intellectual disability, and research journals use the term Intellectual Disability. Thus, Intellectual Disability is the term in common use by medical, educational, and other professions, and by the lay public and advocacy groups.”

DSM-5, p. 33, 2013



Diagnosis of ID/DD

- All definitions (DSM5, AAIDD) refer to three components:

1) Intellectual functioning significantly below average

- ✦ IQ below 70/ 2 standard deviations below the mean/below 2nd percentile

2) Deficits in adaptive behavior

- ✦ Impaired performance in daily living skills or independent functioning

3) Age of onset during the developmental period (<18)

Intellectual/Developmental Disability

- Lifelong impairments, 1-3 % of general population
- Categorized by severity
 - **Mild:** IQ 50-70, 85%
 - Independent, employable, Gr 3- 6 FA
 - **Moderate:** IQ 35-50, 10%
 - Semi-independent, supervised work, Gr 1-3 FA
 - **Severe:** IQ 20-35, 3-4%
 - Dependent, comprehensive care, KG–Gr 1 FA
 - **Profound:** IQ < 20, 1-2%
 - Fully dependent, total care, <KG FA

Why important to identify?

- Recognition that offenders with ID/DD should be dealt with differently in the CJS
 - due to vulnerabilities and risk of exploitation
 - high prevalence of comorbid psychiatric disorders (4x)
 - mitigating factors of cognitive deficits and sheltered experiences
- Specific challenges for police, courts and corrections
 - competing goals of treatment vs punishment
 - difficulty in assessing capacity and competence
 - complex support needs in minimizing recidivism

Why important now?

- Process of deinstitutionalization and social integration suggests resettlement is difficult
 - increased exposure to high risk situations & vulnerabilities
 - with increased choice there is increased risks
 - new legal pathways as facilities are closed
 - Presents service implications for caregivers/agencies
 - caregiver tolerance threshold
 - system culture change i.e. custody to community, inpatient
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Research Impact

- Policies of community inclusion and normalization impact future prevalence and incidence rates
 - Literature regarding offenders with developmental disabilities has evolved
 - Gradual change from prevalence to identifying subtypes
 - Focus on community risk assessment and management
 - Understanding 'pathways' to offending and legal outcomes
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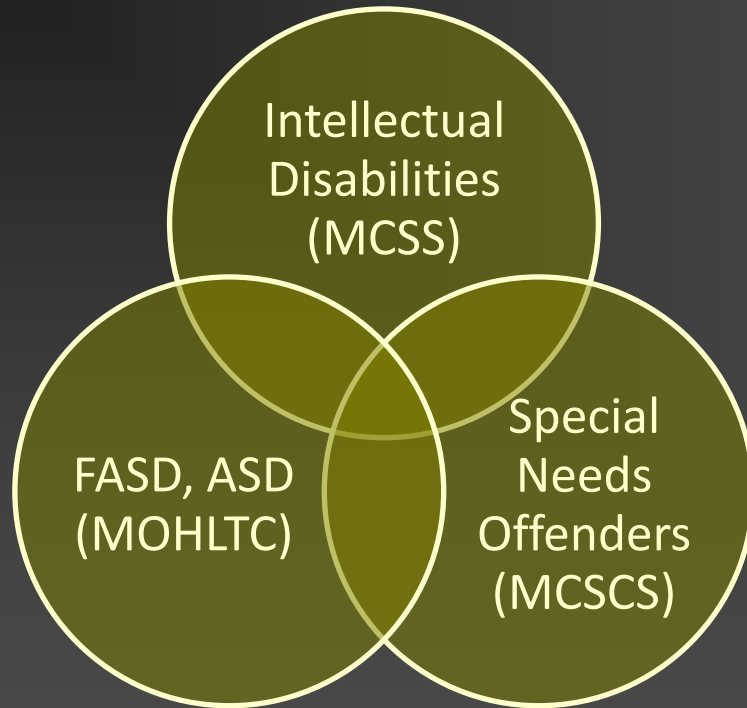
Prevalence

- Offending behaviour is much more common than is actually reported to police
 - Estimates in CJS vary (2-40%) due to setting, methodology and/or narrow or broad definitions of diagnosis and offending
 - Different study samples along CJS continuum
 - File review vs prospective studies
 - Historically custody/conviction rates rather than reoffending or recidivism rates
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Prevalence

- Estimates vary across settings ranging from community to prisons
 - Community services 2-5%
 - Police stations 5-10%
 - Courts 14-36%
 - Prisons 0.2-10%
- Individuals with cognitive impairments (BD, low avg IQ) are generally over-represented in the CJS
- 'special needs' offenders large group (<80 IQ)

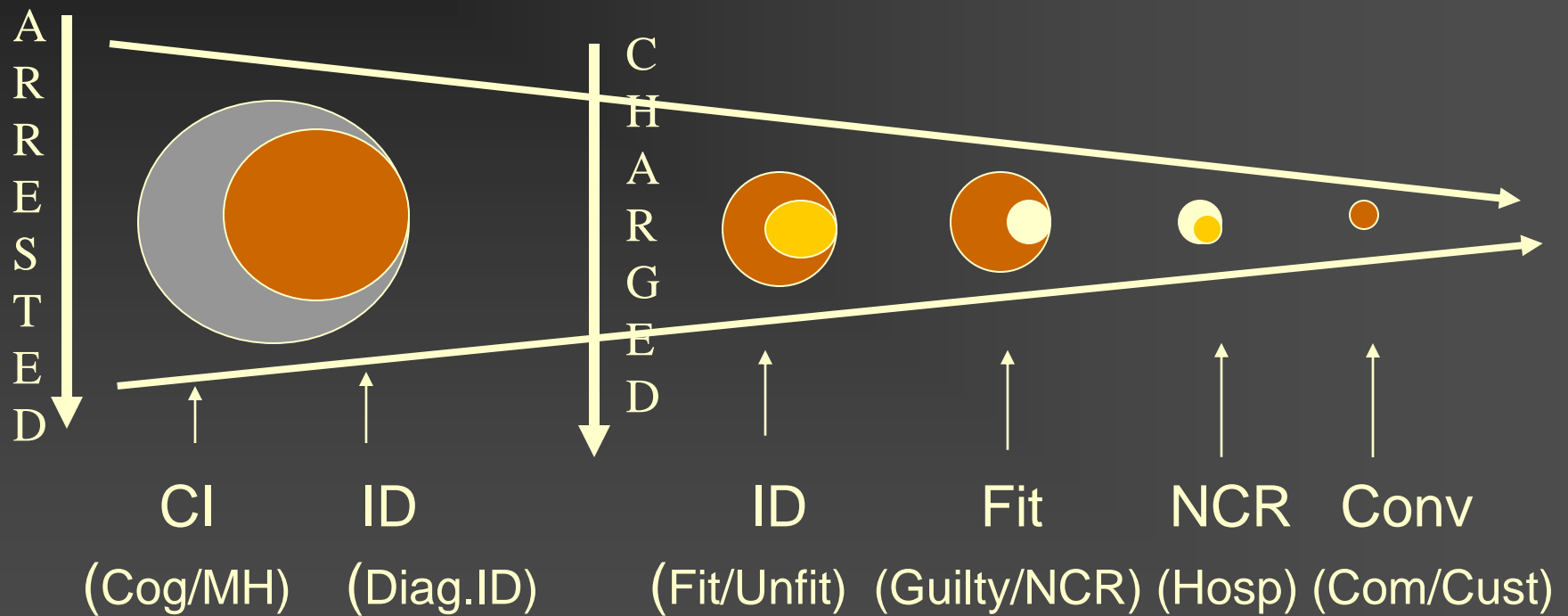
Persons with Intellectual/Developmental Disabilities and Offending Behaviour



**overlap with FASD and ASD (IQ>70, sig AB problems)*

**overlap with 'Special Needs Offenders' (IQ<80)*

Prevalence through the CJS

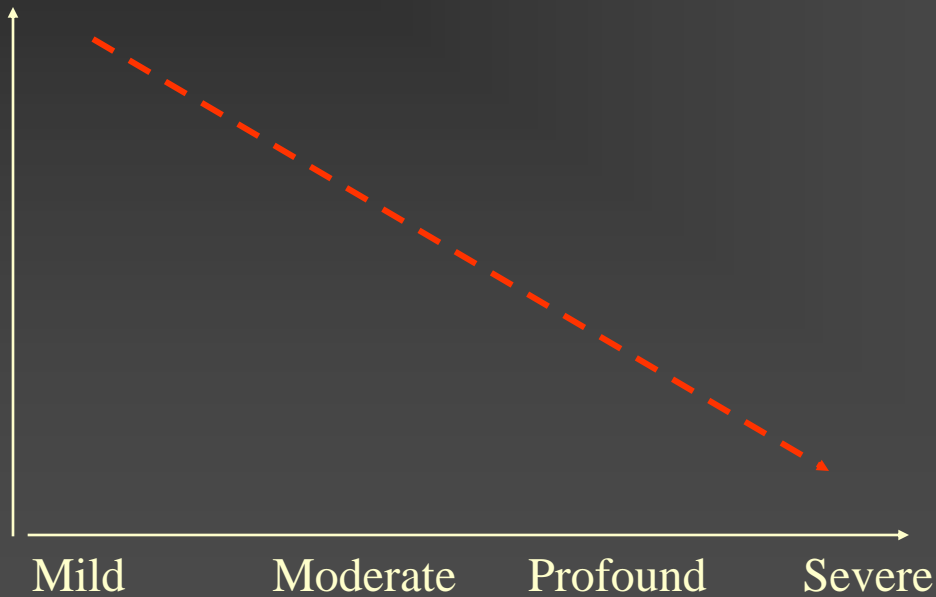


Offending Behaviour and ID

Likelihood of CJS Involvement

High

Low



Level of ID/DD

Independence Level

Autonomous



24 Support

Risk Factors

■ *Biomedical:*

- executive dysfunction and processing deficits
- co-morbid impulsivity and inattention (ADHD)
- increased risk of mental illness (40%)

■ *Psychological:*

- poor attachment, empathy and social inhibition
- limited consequential learning and poor insight
- increased risk of childhood sexual trauma (3 x)

■ *Socio-environmental:*

- Restrictive and/or repressive attitudes of others
 - punishment for normal behaviour e.g. anger, sexual curiosity
 - lack of knowledge of the law and societal norms
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Characteristics

- Very few individuals with Moderate/Severe ID
 - Less likely charged
 - Less likely found competent (mens rea)
 - Predominantly reactive aggression
 - Most offenders with ID are within the Mild range of intellectual impairment
 - Relationship between level of ID and offense type
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Characteristics

- General risk factors similar to non-disabled population (Lindsay et al 2011)
 - *young, male*
 - *psychosocially disadvantaged*
 - *familial offending/adversity*
 - *mental health/substance abuse*
 - *history of academic/emotional/behaviour difficulties*
 - *Anti-social peers/social network*
- Also less likely to be socially supported and more likely to have prior offences, ASD protective factor (Raina et al, 2012)

Characteristics

- More likely to have history of impulsivity, ADHD and conduct disorder
- More likely to have history of personality disorder and anti-social traits
- More likely to have a history of childhood environmental and emotional deprivation
- Age of index offence and gender predicts severity of legal consequence

Offence Type

- Majority are misdemeanors and public nuisance offences
 - Less likely to commit 'white collar' crime or traffic offence
 - High rates of verbal aggression and physical aggression
 - Secondary offences are property destruction, theft and fire setting
 - Sex offenders majority have sexual IO, Non-sex offenders have both sexual and violent IO
 - Victims more likely to be other individuals with disabilities or staff and family
 - Sex offenders more likely to have male victims
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Sexual Offences and ID/DD

- Risk similar to the general population given a ‘normative’ learning experience however high rates of childhood sexual abuse and neglect
 - People with ID are less likely to have healthy social sexual experiences and adequate knowledge
 - *higher risk of developing sexually inappropriate behaviour*
 - Sexual deviance or paraphilia is distinctly different, does exist but rare and often misdiagnosed
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Sexually Inappropriate Behaviour

- Offenders more likely to exhibit less violent but more sexually inappropriate behaviours (i.e. public masturbation, exhibitionism, voyeurism)
 - Essential to differentiate deviance from inappropriate behaviour that occurs in ID due to historical and developmental context i.e. 'counterfeit deviance'
- Result of external or medical factors
 - lack of privacy
 - poor sexual knowledge
 - Poor access or inappropriate partner selection
 - Polypharmacy

Aggression and ID

- Offenders more likely to have difficulties with anger dyscontrol and aggression management than premeditated violence
 - Highly associated with ADHD and impulsivity
 - Impact of high mental illness rates 38% i.e. poor self-regulation, ED
 - Associated behavioural phenotypes i.e. Fragile X
 - Compounded by external biases
 - Attitudes of others and ‘over-control’ e.g. power struggles
 - Punishment for ‘normal’ behaviours i.e. anger expression
 - Distorted social expectations based on false trust assumptions
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ASD Offenders

- Prevalence studies reflect around 1-3% of mentally disordered offenders in community (Siponmaa et al 2001)
- Higher rates of HFA and AS in secure hospitals
 - Hare et al. 1991, 3% ASD, 90% AS
- Current research divided about vulnerabilities to offending due to unique neuropsychiatric symptoms and behavioural phenotype of ASD

Phenotype of ASD and Risk

- Social impairment:
 - diffs in reading social cues and peer interactions
 - diffs in interpreting intent of others
- Verbal /Non-verbal communication:
 - Expressive diffs/ inflated perceived comprehension
 - Dysprosody and affect modulation diffs
- Routines and repetitive activities:
 - Rote pursuit of circumscribed interests/high risk beh
- Dexterity and motor clumsiness

Characteristics: ASD Offenders

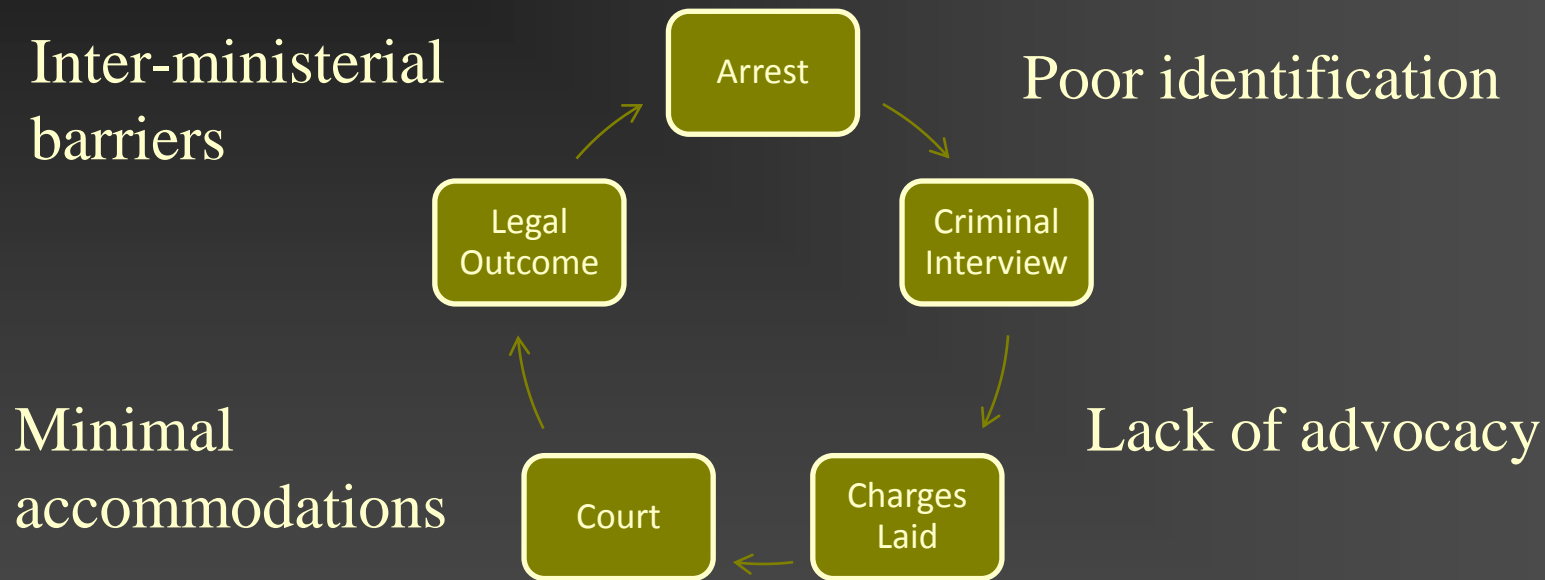
- More likely male due to gender bias
- Executive dysfunction problems
- Social naivety with interpersonal difficulties
- Impairment in social judgment of others
- Difficulty with empathy and remorse
- Acquiescent to others and situational exps
- Chronic anxiety and attachment problems

*Allen et al 2008

Offence Type: ASD

- Physical and Verbal Aggression
 - Low base rate of arson, theft & traffic offences
 - Sexualized Offences linked to:
 - Breaking societal norms
 - Impaired social perspective-taking i.e. harassment, stalking
 - Rule based world: Rote learners vs intuitive reactions
 - Lack of flexibility in social reciprocity
 - Persistence/rumination provokes situations
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CJS Inequities for ID/ASD



Limited understanding by police, lawyers and judges throughout the process; at best seen within a mental health court

CJS Junctures

- Specific issues for this population in navigating CJS
 - Arrest
 - poor identification
 - weighted legal outcomes for not identifying
 - Interview
 - Lack of representation e.g. PACE Act
 - Acquiesce and Suggestibility impacts confessions
 - Court
 - Limited accommodations in court e.g. language
 - Capacity/Culpability assumptions i.e. ID vs MH
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Interface between CJS & ID

- Wide range of variability *'when, why and what for'* CJS is accessed due to:
 - agency policies & philosophy of care (e.g. normalization)
 - risk tolerance & management approach
- No clear message of what to expect
 - authoritarian or paternalistic approach by agencies
- Most individuals have different experiences of contact with the law as most move around service system
- Fitness assessments are poor estimates of CJS capacity
- Faulty presumption of effective deterrent approach
 - requires insight, consequential learning and ability to generalize

Clinical Issues for Offenders with ID/ASD

- Risk assessment/management in community
 - Adapted mainstream tools: ARMADILLO-S (Boer, 2007)
 - Include environmental risk factors e.g. staffing impact
 - Support network dictates risk tolerance and expectation threshold
 - Agencies range from risk averse to active risk management (3 levels)
 - Oversight capacity (supervision, security, staff ratio, medication)
- Clear risk assessment and management protocols
 - Define risk
 - Define agency tolerance
 - Define expectation threshold
 - Define best interests for client i.e. custody may be preferred

Clinical Issues...

■ Treatment and Intervention

- Inter-ministerial cross-sectorial plan (dev, health, probation, education)
- Interdisciplinary care essential - multi-professional lens (psychiatry, psychology, OT, SW, BST)

■ Balance between public protection and individual vulnerabilities

- A. Direct treatment with *individual* to eliminate/reduce offending behaviour
 - B. Direct work with support *services* to enhance care and promote alternative behaviours
 - C. Direct work with *system* to minimize recidivism
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Thank you

- Questions or comments?
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