

Chapter 14

Prison based Programmes for people with IDD

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Introduction

The prevalence of people with intellectual and developmental disabilities (IDD) in the community is just over 1% according to a meta-analysis of 52 studies (Maulik, Mascarenhas, Mathers, Dua, & Saxena, 2011). Unfortunately, a significant number of these individuals will have some contact with the criminal justice system and a disproportionate amount of inmates in prisons may have IDD (Dowse, Baldry, & Snoyman, 2009; Hayes, 2007).

Despite a general consensus that people with IDD are overrepresented in prisons, relatively little research has been published relating to the assessment, risk, and treatment of these individuals. The existing research has also been naturally hampered by definitional and identification issues, methodological inconsistencies, small sample sizes, and specific to treatment, a lack of high quality rigorous approaches such as the use of controlled randomised studies.

Within this chapter, we explore these definitional and identification issues specific to prisons, consider what treatment for people with IDD in prison seeks to achieve, and carefully review the existing research specific to prison based programmes for people with IDD. We conclude with our considerations for future treatment programming and research.

Definitional and identification issues for people with IDD prison.

There is a lack of consensus as to who has IDD and who should be involved in treatment programs for people with IDD. The lack of strict *definitions* which include IQ range, levels of adaptive functioning and age of onset has resulted in publication of data which includes a heterogeneous group of people including those with IDD, autism spectrum disorder, borderline cognitive functioning, low literacy, acquired brain injury or other cognitive impairment. A view commonly held is that if a person is not suitable for a mainstream

program, that person should be placed in an ‘adapted’ program which may be more accessible (Keeling, Rose, & Beech, 2006). Alternatively, adapted treatments may be indicated for people who score low on a cognitive assessment yet high on some psychometric instruments indicating specific deficits or treatment needs (Newberry & Shuker, 2011). It is now accepted that people with intellectual disability may also have co-morbid disorders such as personality disorder (Alexander et al., 2010; Rayner, Wood, Beail, & Nagra, 2015; Taylor, 2014; Taylor & Morrissey, 2012) or substance abuse (Day, Lampraki, Ridings, & Currell, 2016; van Dooren, Young, Blackburn, & Claudio, 2015). The focus of treatment may then vary according to the complex interaction between the IDD and the comorbidity.

Identification of people with IDD is a difficult process within the criminal justice system (Snoyman, 2010). This said, the police often have brief interventions for offenders identified as having IDD that are directed at crime prevention or reduction (Eadens, Cranston-Gingras, Dupoux, & Eadens, 2016; Henshaw & Thomas, 2012). The judicial courts tend not to focus on disability aside from some considerations around mitigation or diversion (Astor, James, Sperling, Weisbrot, & Wood, 2012; Shaw, 2016). While jails and other correctional facilities have more time to work with prisoners, the main focus is on safe and humane treatment or treatment of high risk inmates rather than identification of a disability which is often not readily evident (Board, Ali, & Bartlett, 2015). There are small numbers of people with severe IDD, with most falling into the so called ‘mild’ range of intellectual disability (Bogart & Bruce, 2009). People with mild IDD frequently do not appear different from their peers, and by the time they reach adulthood have either become ‘street-smart’ or have learned to mask their limited abilities. Florio and Troller (2015) note that in a community sample of people with intellectual disability, only 18%-22% were diagnosed because of the presence of a comorbid mental illness. In prisons there is an overrepresentation of people with mental illness, particularly in females (Dean, 2016; Fazel, Hayes, Bartellas, Clerici, & Trestman, 2016). Indigenous people have been assessed as being overrepresented in prisons and are greatly overrepresented within cohorts of inmates with (McCausland, Baldry, & McEntyre, 2015; McEntyre, 2015). It is therefore likely that some people with IDD in custody are never identified particularly when they choose not to identify as having a disability.

What constitutes treatment for people with IDD?

More recent thinking, which moves from offence specific interventions to an analysis of pathways through the criminal justice system (Baldry, 2010; Lindsay et al., 2010a), indicates

that there is both: (1) a large group who commit less serious offences but are frequently incarcerated and (2) a smaller group of high risk high need offenders who commit serious violent or sexual offences. These two groups may require different treatment programs.

In prisons, it appears that the prevailing focus (for both of these groups) is on providing treatment specific to identified criminogenic needs rather than disability needs. Mainstream treatment programs tend to be 'adapted' or 'modified' so that people with IDD can not only attend but also benefit from the programs (Craig & Hutchinson, 2005; Eccleston, Ward, & Waterman, 2010; Keeling, Rose, & Beech, 2007b; Lindsay et al., 2013; Oakes, Murphy, Giraud-Saunders, & Akinshegun, 2016; Sakdalan & Collier, 2012; Taylor, 2013; Taylor, MacKenzie, Bowen, & Turner, 2012; West, 2007; Williams & Mann, 2010). People with IDD who offend have the same criminogenic needs as people without IDD who offend. However, they also have a number of compounding and intersecting disability related issues which cannot be separated from the individual in their treatment. There is a requirement for treatment programs designed to meet the unique needs of people with IDD who offend rather than adapting pre-existing programs.

Adapted programs or additional supports?

Treatment programs for people with IDD have been slower to develop than mainstream programs. Most of these have been adapted from adult mainstream programs (Wilcox, 2004) and modified for use with offenders with intellectual disabilities by simplifying the concepts and using visual imagery and other tools and interventions from the disability field to complement the offence-specific models (Lambrick & Glaser, 2004). However, there is a need to provide specific services for this client group opposed to simply modifying a mainstream treatment program which is unlikely to take into consideration the complexity and compounding nature of the needs of people who have both IDD and who offend.

Lambrick and Glaser (2004) suggest that the specific needs of people with IDD be taken into account. They advocate the simplification of concepts, use of visual imagery, emphasis on the generalisation of skills developed in treatment to the day-to-day and the use of assessments and intervention methods historically used in the field of intellectual disability. Thus, the literature in the field of the assessment and treatment of offenders with IDD demonstrates that this client group can be effectively treated if programs are specifically designed and delivered in a manner consistent with their level of functioning (Haaven & Coleman, 2000; Lambrick & Glaser, 2004; Lindsay, 2002; Lindsay, Steele, Smith, Quinn, & Allan, 2006). The key

differences in such programs compared with mainstream programs are the duration, level of external support, focus on behavioural application of treatment principles across contexts and level of post treatment follow-up or maintenance.

Within the prison setting in New South Wales, Australia, the need for additional programs to meet the specific needs of people with IDD was identified in response to offenders with IDD being excluded from mainstream programs, and high attrition rates of people with IDD in adapted programs. These additional programs should include interventions that are responsive to the cognitive, psychosocial capacities and learning style of the client group. The Self-Regulation Program (SRP) suite of programs, including programs for people with IDD who sexually offend (SRP-SO), who violently offend (SRP-VO) and those with general offending (SRP-GO) were developed in 2011. The programs sit beside mainstream programs and differ in terms of length of program, number of participants (8-10), utilising multiple modalities for learning, focus on experiential learning and generalisability, and maintaining structure yet providing a great deal of opportunity for process work.

People with IDD require additional supports when transitioning to, and residing within, the community. Bhandari, van Dooren, Eastgate, Lennox and Kinner (2015) note that there is a lack of an evidence base to inform transitional interventions for people with IDD. Bhandari, et al., note the complex presentation of many offenders with IDD including health and disability related needs, substance use, and poor social circumstances including lack of educational attainment, unemployment, and an offence history. The complexity around people with IDD is in stark contrast to the straightforwardness of risk and criminogenic need programs provided to mainstream offenders. Mainstream offender programs are more likely to be comprehensively evaluated.

There is currently a greater awareness of disability as a social construct (Snoyman, Aicken, & Malone, 2013), but many factors associated with risk of crime, those so called criminogenic needs (Andrews, 1995; Andrews & Bonta, 2010) are also prevalent in people with IDD not in contact with the criminal justice system. The overlap between criminogenic and disability needs also complicates decisions around treatment or support needs. This overlap includes factors on the Level of Service Inventory (Revised) (Andrews & Bonta, 1995; Hsu, Caputi, & Byrne, 2011) shown in Figure 1.

Criminogenic Needs	Disability Needs
<ul style="list-style-type: none"> • Poor educational attainment • Pre-incarceration unemployment • Increased likelihood of an institutional misconduct or charges laid while on probation • Reliance on social assistance • Poor attitudes towards sentence and supervision • History of mental health treatment • For those who offend, few anti-criminal acquaintances or friends and increased likelihood of drug or substance problems 	<ul style="list-style-type: none"> • Poor educational attainment • Unemployment • Reliance on social assistance • History of mental health treatment • Few peers

Figure 1: Overlap of criminogenic and disability needs

People with IDD receive a range of treatments in the community and secure hospital settings (Cohen & Harvey, 2016; Lindsay, Hastings, & Beech, 2011; Marotta, 2015). Most studies reporting treatment for people with IDD are located in the community (Lindsay, Michie, & Lambrick, 2010b) or high or medium security wards associated with mental health treatment (Alexander et al., 2011). Many of these studies report good outcomes along a range of dimensions including recidivism, or improved knowledge, attitudes and skills.

Range of treatment modalities used with people with IDD in prison

The range of treatment has also been reviewed in relation to people with IDD. A very early review examined the use of anti-libidinal drug treatment (Clarke, 1989) for people with IDD and aberrant sexual behaviour. More recently Marotta, (2015) reviewed programs in the USA, UK, Australia and New Zealand for people with IDD who offended sexually. Marotta reported most of the programs used cognitive behavioural therapy (CBT), but a few used dialectical behaviour therapy (DBT), mindfulness, problem solving therapy and relapse prevention, but as there were no randomised control trials and generally small samples, it is difficult to synthesise the qualitative data.

Authors have also presented a range of criminogenic treatment models developed from those established for people with IDD. These include the Good Lives Model (Ward & Brown, 2004; Ward, Mann, & Gannon, 2007; Ward, Yates, & Willis, 2012); self-regulation model (Keeling & Rose, 2012; Lindsay, Ward, Morgan, & Wilson, 2007) and various forms of psychotherapy (Cohen & Harvey, 2016). The reviews have consistently reported finding a lack of randomised control studies; a wide range of methods; a lack of consistently applied criteria for participation; an assortment of outcomes; a lack of control group or adequate control group; or a combination of these factors.

Finally, there has been a review of outcomes of individual versus group offence-focused therapy (O'Brien, Sullivan, & Daffern, 2016) which found only 13 evidence based studies (of which three were in prison and none were for people with IDD) of individual treatment, and only two studies comparing group and individual therapy for high risk high need offenders. While there are comparable outcomes in treatment, the authors discuss when individual therapy may be beneficial and assist in reducing treatment drop-out.

Evidence for effectiveness of prison based programmes for people with IDD

There have been a number of reviews, including two Cochrane reviews, around various aspects of treatment programs for people who offend (Dennis et al., 2012) and people with IDD who offend (Ashman & Duggan, 2009). While much has therefore been written about people with IDD who offend (Courtney & Rose, 2004; Endicott, 1991; Lindsay, 2002; Loucks, 2007; Marotta, 2015), there has not been a comprehensive review of their treatment in a prison setting.

Only five articles appear to provide adequate, albeit limited, evidence regarding the effectiveness of programs for people with IDD in prison. The program type, sample size, theoretical model of treatment, and evaluation method and outcome are presented in Table 1. The majority of the programs were for sex offenders, although a substance abuse and a thinking skills program were noted. No randomised controlled studies were found. The criteria applied for participation in the IDD groups in all but the McGillivray et. al., (2016) study, varied and commonly included people in the range of borderline to low average intellectual functioning (above 70 IQ points), or no adaptive functioning assessment was conducted to meet the criteria for a diagnosis of Intellectual Disability. All but the substance abuse program were noted to be 'adapted' from mainstream programs. Although there was a

theme across the studies suggesting that responsivity issues should be addressed for people with IDD as mainstream, programs are not entirely suitable and may lead to higher drop out rates.

The capacity to compare the 5 studies and draw conclusions from them is limited. Within the studies, the matching of participants was inexact; not all studies assessed the intervention itself but rather focused on changes in participants psychometric scores across time, or on participation rates. For this reason, identification of trends or consistent approaches with which to build an evidence base in the treatment of offenders with IDD is currently lacking.

Authors	Purpose	Sample size				Theoretical model / intervention		Evaluation method	Outcome
Keeling, Rose and Beech (2006)	Evaluating a program developed for offenders with specific need	18 men; Mean age 35.2; Mean IQ (WAIS-III) 71.78 (range – mild to low average); 18 Australian including 5 ATSI; 5 married, 13 single; 16 left school prior to age 15. Av. Sentence length 7.24 years; Moderate to high risk (Static-99)				CBT group for 12 months, 4 times per week. Adapted for IDD – session duration 2.5 hours from 3; only 4 days per week from 5; program length 12 months (from 8-10); used Old Me / New Me model; fewer written tasks and materials		Pre-post evaluation – no comparison group or follow-up	Program was successful in reducing supportive attitudes towards sexual offending; increasing victim empathy and self-control
Keeling, Rose and Beech (2007a)	Comparing self-regulation model for mainstream and ‘special needs’ sexual offenders	22 men in 2 groups – 11 mainstream and 11 ‘special needs’.				CBT group for 12 months, 4 times per week. Adapted for IDD – session duration 2.5 hours from 3; only 4 days per week from 5; program length 12 months (from 8-10); used Old Me / New Me model; fewer written tasks and materials		Participants matched: risk; victim sex; offence type; age)	Both groups showed lack of significant pre-post-test change. No ‘special need’ participant convicted for sexual offence after 16 months follow-up. No ‘mainstream’ data available
		<u>Mainstream</u> X age – 45.73 10 Australian Inc. 1 ATSI IQ - not assessed 73% high risk 0 married 6 divorced 5 single		<u>‘Special needs’</u> 37.82 11 Australian Incl. 4 ATSI 71 (63-83) 7 above IQ 70 73% high risk 2 married 4 divorced 5 single					
Williams, Wakeling, and Webster (2007)	Evaluating modified instruments for Adapted sex offender program	211 men; Sample from 8 prisons in England and Wales. Mean age 40.3; Mean IQ (WAIS-R) 71.9 (range 56-80); 191 born in UK; 156 no educational qualification; 123 single; 21 married; 41 divorced; 5 separated				CBT group treatment using Old Me / New Me model; Manualised standardised treatment delivery; multi-modal delivery strategies; link emotion and learning; longer time period for treatment. 89 treatment sessions – 200 hours		Pre-treatment and 6 weeks-post- treatment assessment on 6 self-report instruments across 8 prisons. No comparison group; self-report measures; missing data	Significant change found on 5 self-report measures with medium to large effect sizes for most. Higher risk offenders scored lower on risk following treatment
McGillivray, Gaskin, Newton, and Richardson (2016)	Evaluated substance use and participation in AOD treatment	449 prisoners in Victoria, Australia				<u>With ID treatment</u>		Prisoners with and without intellectual disabilities have many similarities relating to substance use	Completion rate of AOD treatment program by ID participants was substantially lower as was buprenorphine use. Treatment may not be addressing responsivity
		<u>With ID</u> 180 offenders 93% male Mean age 27 years ATSI 17% Higher proportion used ethanol Offence antecedent was drug 32%		<u>Non ID</u> 269 matched 90% male Mean age 28 years ATSI 13% Offence antecedent was drug 64%		Participate alcohol - .5 Complete alcohol - .59 Participate drug - .61 Complete drug - .57 Current methadone – 0 Current buprenorphine - .47			
Oakes, Murphy, Giraud-Saunders, and Akinshegun (2016)	Evaluation of an adapted thinking skills program	Across 3 prisons in England 8 male inmates				Realistic evaluation model used for the pilot of the Adapted Thinking Skills Program (ATSP) across 3 prisons with different security levels		Evaluation differences not described. Program consistent across sites. A more robust evaluation is required	Statistically significant improvements for locus of control as well as ability to create assertive social solutions.
		Prison number	# 1	# 2	# 3				
		Prison type	C - closed	C - closed	A - max				
		Prison size	800-900	700-800	1100-1200				
		No. participants	8	8	8				
		Average age	43.7	42.5	43.7				
		Age range	30-63	30-65	28-73				
		Average IQ	68.6	73.6	70.7				
		IQ range	63-73	60-95	64-76				

Table 1: Prison studies reporting treatment of people with IDD

Conclusions

So, what are the difficulties that people in prisons experience that impact on the creation of an evidence base? We will argue that some of the issues include identification and the consequential small numbers of people considered suitable for treatment programs; those small numbers impacting on the ability to randomly allocate to different treatment groups and being further reduced by individual choice around participating in various types of treatment; diagnostic overshadowing; the nature of prisons including the historical reluctance of governments to shine a spotlight on processes and programs that may impact negatively on public perceptions; and the focus on adapted treatments which are offence specific rather than dealing with the whole person across the span of sentence including reintegration into the community.

With reasonably small numbers of identified inmates for any treatment group, let alone one specifically for offenders with IDD, there is reduced opportunity for randomisation around interventions. The small numbers also impact on available locations for treatment with generally only a single location being available for a treatment group. Treatment suitability, readiness, and even sequencing of programs (i.e. generally sex offender treatment occurs towards the end of a custodial sentence while violent offender treatment can occur at any point of incarceration) further limits research design. There are also limitations around long-term research design in that the prison environment is not static across time, but is governed by changes in policies which impact staffing levels, inmate flows and inmate motivation to attend treatment. A further restriction is the inmate classification that limits in which prison an inmate may be held and may impact on treatment availability.

Each of the above factors affecting the development of an evidence base for mainstream programs in prison is true for programs for offenders with IDD. It is further impacted by the challenges of identification of the client group; the complexity and heterogeneity of people with IDD needing an individualised, flexible approach to group treatment, as well as the significant number of intersectional factors which further burden the person in their capacity to participate in a program and maintain attendance.

Future research

Despite all the limitations and restrictions described above, treatment in custody does occur and programs across Australia, including those targeting people with IDD, are detailed

(Heseltine, Sarre, & Day, 2011). There are programs that meet criminogenic need and / or disability need. Evaluation questions that still need to be addressed include the role of the therapeutic alliance in relation to the treatment approach i.e. do the results that are being obtained relate to the nature of the treatment (e.g. group based cognitive behaviour therapy (CBT) or dialectical behaviour therapy (DBT) or to the therapeutic relationship developed between group members and therapists, or a combination of these factors? What is the impact of different models e.g. Risk/Needs/ Responsivity and Good Lives (Netto, Carter, & Bonell, 2014) and how does the context of a prison impact on delivery of those models? Do other models such as mindfulness (Singh et al., 2011) and DBT (Frazier & Vela, 2014) work differently across various offence types (e.g. anger and violence; sex offending; or arson)? Is it good enough to demonstrate change on psychometric instruments e.g. better attitudes and knowledge, or must treatment extend to a reduction of harm in the community (e.g. future offending has less impact or recidivism is reduced)? We are not sure whether it is possible to answer some, or any, of these questions when considering treatment in custody because of the many limitations discussed above. So, how do we know whether treatment is effective and how can we build an evidence base in a prison context? We believe that for this to occur:

- There must be an overarching policy and strategic imperative to evaluate treatment for people with IDD in prison. This agenda comes with risk, but it is better than the current situation where we are unable to show the public there is an evidence base showing that treatment not only works, but that the public is safer when a person with IDD is released following treatment.
- For treatment to be effective there is also a requirement to identify people with IDD in custody. The identification process may be costly in terms of both financial and human resources, but at present the risk of not identifying this population includes providing treatment that does not meet responsivity principles. The risk of reoffending increases when offenders fail to complete treatment (McMurrin & Theodosi, 2007; Olver, Stockdale, & Wormith, 2011). If that drop-out is due to lack of identification, then the correctional system is inadvertently contributing to an increased risk of reoffending.
- People with IDD must be considered from a holistic perspective. It is not sufficient to conduct a well-constructed program that has been shown to work for people with IDD in the community or even in prison. The program that addresses criminogenic needs must be supplemented by one that addresses disability needs. A structure of

disability and offence related supports in the community is likely to have a greater impact than a treatment program alone. However, this hypothesis needs to be tested and an evidence base provided.

- There are many papers indicating that serious offenders can be treated in the community. For diversion from a custodial option to occur there needs to be a degree of public support (or even public apathy) as to not incarcerating people with IDD who offend. Diversionary options offer another way to build an evidence base and even the possibility of comparing treatment effectiveness with a community / prison sample using the same program.
- Finally, we need to address our current reality. As the population increases, so too do the numbers of people with IDD in custody. With better identification, the number of people with IDD becomes even larger. With more people in prison suitable for treatment programs, the opportunities for evidence based research become greater. Inmates can be randomly assigned to attend different programs in different locations providing there is consensus as to the scope of research and methodology prior to treatment. It may even be possible to do research across prison and community settings (notwithstanding individual differences allowing treatment in these various settings; or across states (even with varying legislative requirements) or internationally (despite different treatment settings). Without a coordinated effort to obtain an evidence base, we are likely to be reporting in reviews during the next decade the same words that have been reported in previous reviews i.e. there are promising trends in treatment approaches but no reported evidence based controlled studies around treatment of people with IDD in prison.

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Glossary of abbreviations

Abbreviation	Explanation
ASD	Autistic spectrum disorder
ATSI	Aboriginal or Torres Strait Islander
CBT	Cognitive Behavioural Therapy
GLM	Good Lives Model
IDD	Intellectual and developmental disabilities
IQ	Intelligence quotient (generally a full scale IQ score)
LSI-R	Level of Service Inventory (Revised) – a measure of risk of recidivism and criminogenic need
WAIS-III	Wechsler Adult Intelligence Scale – Third Edition (an IQ test)
WAIS-R	Wechsler Adult Intelligence Scale – Revised Edition (an IQ test)