PRISONERS WITH INTEL·LECTUAL DISABILITY

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People with DID are not different.

Sometimes they commit offences.

Delinquency and intel·lectual disability?

Fazel S, Xenitidis K, Powell J. The prevalence of intellectual disabilities among 12000 prisoners—A systematic review. Int J Law Psychiatry. 2008; 31 (4): 369–73.

Table 1

Studies of the prevalence of intellectual disabilities (ID) in prison populations (in order of sample size)

Study	Location	Total no.	Screening procedure	Final diagnosis	Interviewer	No. with ID	% ID	99% CI	Mean age	Gender	Status
Brandford (1997)	New Zealand (NZ)	3900	Functional questionnaire	WAIS-R & clinical	Psychologists	18*	0.5	0.3–0.8	NA	Male	Sentenced
Irion (1988)	USA	2156	CFIQ	WAIS-R	Psychologists	32	1.5	1.0–2.3	29	Male	Sentenced
Gunn (1990)	England & Wales	2052		Clinical	Psychiatrists	11	0.5	0.3–1.1	28	Male	Sentenced
Jones (1990)	Australia	968	Educational level and prison adaptation	WAIS-R, WJSIB & clinical	Psychologists	10*	1.0	0.5–2.2	28	Male	Sentenced
Maden (1996)	England & Wales	651	Quick test	Clinical	Psychiatrists	5	0.8	0.3–2.3	28	Male	Remand
Hayes (1988)	Australia	594	Functional questionnaire	WAIS-R	Psychologists	10	1.7	0.8–3.7	NA	Male	Mixed
Birmingham (1996)	England	441	Quick test	Clinical	Psychiatrists	6	1.4	0.5–3.7	28	Male	Remand
Maden (1994)	England & Wales	258		Clinical	Psychiatrists	6	2.3	0.9–6.2	29	Female	Sentenced
Irion (1988)	USA	178	CFIQ	WAIS-R	Psychologists	2	1.1	0.2–5.6	29	Female	Sentenced
Maden (1996)	England & Wales	169	Quick test	Clinical	Psychiatrists	4	2.4	0.7–7.6	31	Female	Remand
Brandford (1997)	NZ	164	Functional questionnaire	WAIS-R & clinical	Psychologists	0*	0	0–3.9	NA	Female	Sentenced
Murphy (1995)	England	157	Functional questionnaire	WAIS-R	Psychologists	0	0	0–4.1	30	Male	Remand
Ghubash (1997)	Dubai	142		Clinical	Psychiatrists	4	2.9	0.8–9.0	29	Male	Sentenced
Hayes (1988)	Australia	81	Functional questionnaire	WAIS-R	Psychologists	0	0	0–7.6	NA	Female	Mixed
Jones (1990)	Australia	58	Educational level and prison adaptation	WAIS-R, WJSIB & clinical	Psychologists	1*	1.9	0.2–13.4	28	Female	Sentenced

Note:.*=estimate based on final numbers with intellectual disabilities extrapolated to original study population (this figure used where insufficient information is reported).

NA=not available; CFIQ=Culture-fair intelligence quotient; WAIS-R=Wechsler adult intelligence scale — revised; WJSIB=Woodstock Johnson Scales of Independent Behaviour.

Table 2: Intelligence Quotient Scores (PRECA study).

Intelligence Quotient Score (TONI II)	Total	%
61–69	15	3.77
70–79	30	7.54
80–84	24	6.03
85–89	22	5.53
90–94	28	7.03
95–99	30	7.53
100–104	40	10.05
105–109	53	13.32
110–114	54	13.57
115–119	55	13.82
120–124	21	5.28
125–129	14	3.52
130–134	7	1.76
135–139	4	1
140	1	0.25
TOTAL	398	100

Research in Developmental Disabilities 53-54 (2016) 189–197

Contents lists available at ScienceDirect

Research in Developmental Disabilities

Prisoners with intellectual disabilities and detention status. Findings from a UK cross sectional study of prisons

Afia Ali [a,*], Sanjib Ghosh [b], Andre Strydom [a], Angela Hassiotis [a]

Of 3142 prisoners gave informed consent to be interwied ,170 (5,4%) were identified as having intellectual disabilities using Quick Test

Journal of Applied Research in Intellectual Disabilities 2017, **30**, 198–204

BRIEF REPORT

Screening Prisoners for Intellectual Disabilities in Three English Prisons

Glynis H. Murphy*, Jeff Gardner† and Mark J. Freeman†

Of 2429 prisoner that were screened , 169 were identified as being more likely to have Intellectual disbalities on the LDSQ (7%) .

11. Cooper SA , Smiley E, Morrison J, Williamson A, Allan L. Mental ill-health in adults with intellectual disabilities: prevalence and associated factors. Br J Psychiatry. 2007; 190: 27-35.

Table 3 Point prevalence rates of clinical diagnosis of mental ill-health at different ability levels and by gender

Diagnostic category	Mild intellectual disabilities (*n*=398)			Moderate to profound intellectual disabilities (*n*=625)			All ability levels (*n*=1023)		
	Men (*n*=204) %	Women (*n*=194) %	Total (*n*=398) %	Men (*n*=358) %	Women (*n*=267) %	Total (*n*=625) %	Men (*n*=562) %	Women (*n*=461) %	Total (*n*=1023) %
Psychotic disorder[1]	6.9	4.6	5.8	2.8	4.5	3.5	4.3	4.6	4.4
Affective disorder	5.9	7.2	6.5	5.3	8.6	6.7	5.5	8.0	6.6
Anxiety disorder[2]	5.4	6.7	6.0	2.2	2.6	2.4	3.4	4.3	3.8
OCD	0	1.5	0.8	0.6	0.7	0.6	0.4	1.1	0.7
Organic disorder	0.5	3.1	1.8	3.1	1.5	2.4	2.1	2.2	2.2
Alcohol/substance use disorder	2.5	1.0	1.8	0.8	0	0.5	1.4	0.4	1.0
Pica	0	0.5	0.3	3.9	1.9	3.0	2.5	1.3	2.0
Sleep disorder	1.0	0	0.5	0.6	0.7	0.6	0.7	0.4	0.6
ADHD	0	0	0	2.0	3.0	2.4	1.2	1.7	1.5
Autistic-spectrum disorder	5.4	1.5	3.5	13.4	5.6	10.1	10.5	3.9	7.5
Problem behaviour	11.3	14.9	13.1	24.3	34.1	28.5	19.6	26.0	22.5
Personality disorder	0.5	1.0	0.8	1.1	1.1	1.1	0.9	1.1	1.0
Other mental ill-health	1.0	1.0	1.0	0.6	3.0	1.6	0.7	2.2	1.4
Mental ill-health of any type, excluding problem behaviours and autistic-spectrum disorder[2]	22.1	22.7	22.4	20.7	24.7	22.4	21.2	23.9	22.4
Mental ill-health of any type, excluding autistic-spectrum disorder[2]	29.9	34.5	32.2	36.3	44.9	40.0	34.0	40.6	37.0
Mental ill-health of any type, excluding problem behaviours[2]	26.5	24.2	25.4	30.7	29.6	30.2	29.2	27.3	28.3
Mental ill-health of any type[2]	33.3	35.6	34.4	42.4	48.7	45.0	39.0	43.2	40.9

ADHD, attention-deficit hyperactivity disorder; OCD, obsessive–compulsive disorder.
1. Includes schizoaffective disorders.
2. Excludes specific phobias.

11. Cooper SA , Smiley E, Morrison J, Williamson A, Allan L. Mental ill-health in adults with intellectual disabilities: prevalence and associated factors. Br J Psychiatry. 2007; 190: 27-35.

Table 1 Point prevalence rates of mental ill-health as defined by clinical, DC–LD, ICD–10–DCR, and DSM–IV–TR diagnostic criteria

Diagnostic category	Clinical diagnosis (*n*=1023) %	DC–LD diagnosis (*n*=1023) %	ICD–10–DCR diagnosis (*n*=1023) %	DSM–IV–TR diagnos (*n*=1023) %
Psychotic disorder[1]	4.4	3.8	2.6	3.4
Affective disorder	6.6	5.7	4.8	3.6
Anxiety disorder[2]	3.8	3.1	2.8	2.4
OCD	0.7	0.5	0.2	0.2
Organic disorder	2.2	2.1	1.9	1.7
Alcohol/substance use disorder	1.0	0.8	0.8	0.8
Pica	2.0	2.0	0	0.9
Sleep disorder	0.6	0.4	0.2	0.2
ADHD	1.5	1.2	0.5	0.4
Autistic-spectrum disorder	7.5	4.4	2.2	2.0
Problem behaviour	22.5	18.7	0.1	0.1
Personality disorder	1.0	0.8	0.7	0.7
Other mental ill-health	1.4	0.8	0.7	0.4
Mental ill-health of any type, excluding problem behaviours and autistic-spectrum disorder[2]	22.4	19.1	14.5	13.9
Mental ill-health of any type, excluding autistic-spectrum disorder[2]	37.0	32.8	14.6	14.0
Mental ill-health of any type, excluding problem behaviours[2]	28.3	22.4	16.5	15.6
Mental ill-health of any type[2]	40.9	35.2	16.6	15.7

ADHD, attention-deficit hyperactivity disorder; OCD, obsessive–compulsive disorder.
1. Includes schizoaffective disorders.

The 6,5% of inmates have ID
In the **69,7%**, their ID was undetected prior to admission in prison.

(FEAPS, 2014).

INMATES WITH ID

- Basic unmeet needs are covered (food, accommodation, etc)
- High structured environment.
- Routines.

Daily living Difficulties.

- Rules and norm understanding.
- Administrative procedure.
- Abuse victims
  - Inmates (extortion, violence, sexual abuse).
  - Security personnel (informers, abuse , etc)
  - incomprehension)
- Conflict resolution
- Loneliness
- Access to treatment professionals .
- Every day living management.
- **Invisibility**
- Violence/sanctions
- Isolation
- Lack of healthy peers.
- Risk factors learning (drugs, use of violence).
- Management of external (outside prison) issues/ bussines.
- Economical problems.

INMATES WITH ID

- Easily manipulated.
- Low capacity to planning.
- Difficulties to adapt to new situations.
- Few coping strategies .
- Low tolerance to frustration .
- Low level of motivation .
- Frequent demanding attention
- Low self esteem.
- Low self control
- Low insight of disability.
- Difficulties to have satisfactory relationships.
- Behavioral problems.
- Communication problems .

Ramón
«Sueño con el campo»

Trabajaba como agricultor en Vilobí, en el Penedès. Lleva siete meses preso, en el módulo de enfermería, por un delito que no quiere explicar. Sueña con volver al campo cuando salga, el año que viene. «Sin las chicas del programa de ayuda me aburriría, siempre estoy esperando a que vengan a buscarme, nos llevamos todos muy bien en el grupo».

INMATES WITH ID

The have some **psychological limitations** in

- Intellectual functioning
- Thinking
- Planning
- Ability to solving-problems
- Abstract thinking
- Understanding of complex ideas
- Experience learning

And this limitations determine ability of solving problems and adaptation to penal settings.

INMATES WITH ID

CONSEQUENCES

- Drug abuse.
- Worsening of mental disorder or disruptive behavior
- Medical problems HIV/HCV infections...
- Debts.
- Inclusion in mobs.
- New offences (drug trafficking).
- No attachment to rehab programs.
- Dificulties to adapat to community.

Profile

- ✓ Men - @33 y.o.
- ✓ Limited or intermittent needs support.
- ✓ Drug problems
- ✓ Mental, personality and behavioral problems
- ✓ Poor education .
- ✓ Low Socioeconomic Status.
- ✓ Dysfunctional family.

INVISIBLE–VULNERABLE
EXCLUDED

ACCEPTA program

- Support people with ID in the criminal justice pathway.
- Support rehab, reinsertion and social inclusion.
- In any moment of legal (penal) pathway and once finish and the person come back to the regular community setting.

PROGRAM ACCEPTA (WHY)

- The network of ID resources produce exclusion.
- The criminal pathway produce harm to people with ID.
- Users and families generate problems that should be attended .
- The prison system has not an specific procedure for people with ID and criminal procedure.
- Sometimes the ID could undetected during this proceedings (invisibility).

WHAT ACCEPTA DOES? SUPPORT

- Support during **detention**
  - To highlight the disability.
  - Give support user and family.

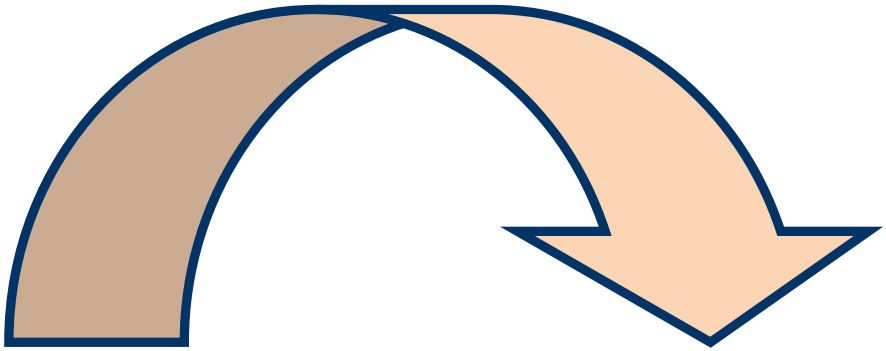
Support **legal proceedings**
- To highlight the disability
- Avoid imprisonment / facilitate alternative measures.
- Give support user and family.

- Support to **Alternative Penal Measures**
  - User
  - Delegate.(Justice officer)
  - Setting (Prison) .

- Support **execution of sentence (inside prison)**
  - Program Marc
  - DAE-DID.

- Support to **come back to community.**
  - Community worker (Job seeker)
  - Social educator /worker.

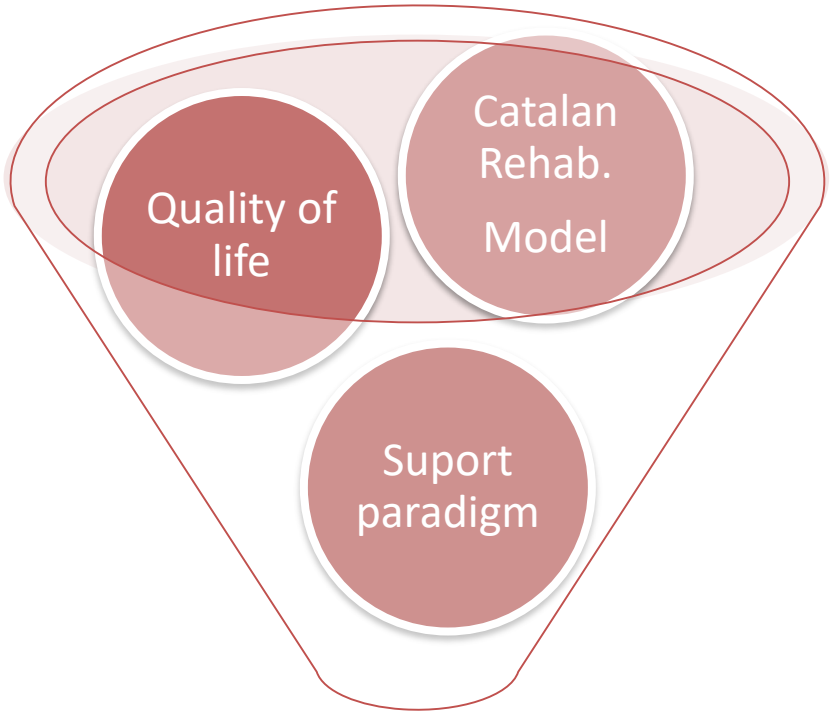
Change of paradigm in the understanding of disability



From SERVICE to SUPPORT

Change of paradigm in the needs care of people with ID

- ✓ Improve de quality of life, care and intervention given the necessary supports
- ✓ Provide strategies to minimize the recidivism and increase the resocialization
- ✓ Promote the release from prison in those that have a wide community support.



PROGRAMA MARC

INTERVENTION in INMATES with ID

Ambulatory intervention

In all Centers and Services of Penitentiary Department

- **Specialized supervision**
- Offer unmeet services
- Advice to Prison professionals
- Advice families and social referent

Residential Intervention

Departament d'Atenció Especialitzada per a interns amb DID (DAE-DID), del Centre Penitenciari Quatre Camins

- Intervention program focused in ID inmates
- Based in quality of life and rehab model (Catalan prisons).
- Coordination between Penal Social Services, DAE-DID professionals and Program Accepta.

BACK TO COMMUNITY – Critical situation

- Frequently they do not have basic needs
- Also they do no have the suitable suport for the disability
- Often the have no entailment with social resources.
- Multiple problems that prevent their social insertion

Programa ACCEPTA	Suport inmates in theit community environment (family, friends, neighbours , social services ,...)
	Help to find basic needs (accomodation, economical benefits,etc) or another importants issues (health assistance, census register,....)
	To ensure especific treatment (drug , menatl health , rehab services)
	Familiy suport to facilitate return to family setting or to have an independent life.

IMPACT of the PROGRAMA MARC

Improvement of detection and assessment of people with ID.

More inmates have specialized support

More knowledge in prison of aims of the Program ACCEPTA

Review of the care and intervention from Quality of Life and needs supportt

Quality of life review suggest an positive impact in their lives.

Areas of improvement

- Improve coordination with mental health services/prison services.
- Improve training of professionals.
- Improve risk assessment /management.
- Increase of forensic community resources.
- Better screening in admission to prison.
- Early detection of ID in the initial contact with Criminal Justice.
- Other (Research , education, etc)

- Assesment and management tool in prison settings

DATA COLLECTION TOOL

RisCanvi

Multiple protocol for geenral risk assesement (penitentiary setting)

Computarized protocol 2 types (screening and full)

Look 4 types of different risk 4 t

- Self-directed violence risk
- Intra –instituional violence risk
- Violent recidivism risk
- Senten ce breaking risk

15 offence and penitentiary
14 personal o socio-familia
8 clínical
6 personality

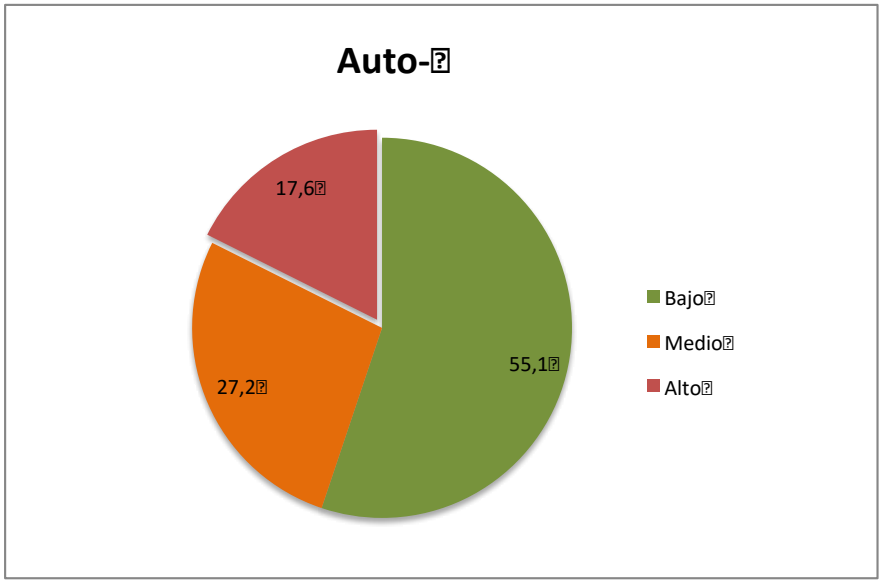
43 factors

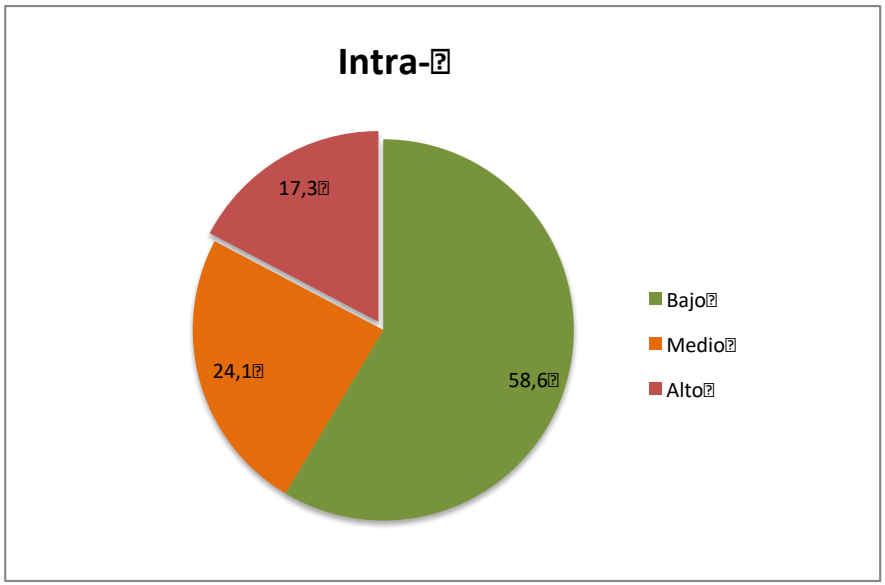
RisCanvi Aims

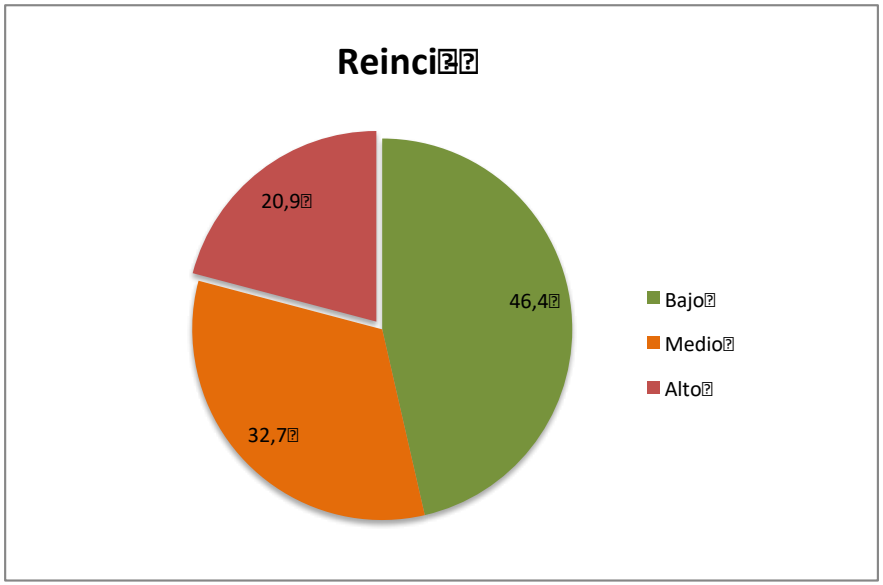
- **1.- Risk Assesment of:**
  - Self –directed violence(auto-)
  - Intra-institutional violence (intra-)
  - Violent Recidivisme (Reinci-)
  - Quebrantamiento (Breaking?) (Quebran-)

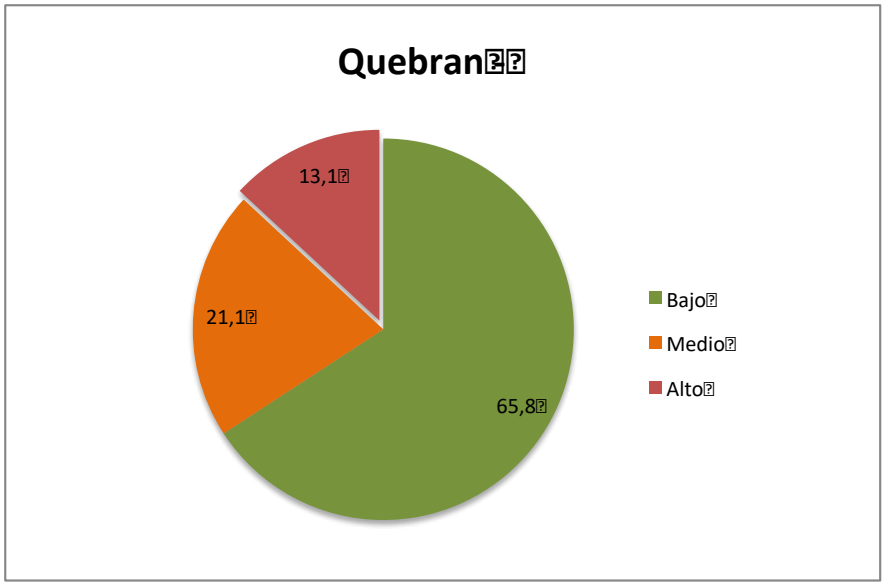
- **2.- Risk assesment:**
  - Aproach
  - Treatments (*****)

Overall RisCanvi-C rates





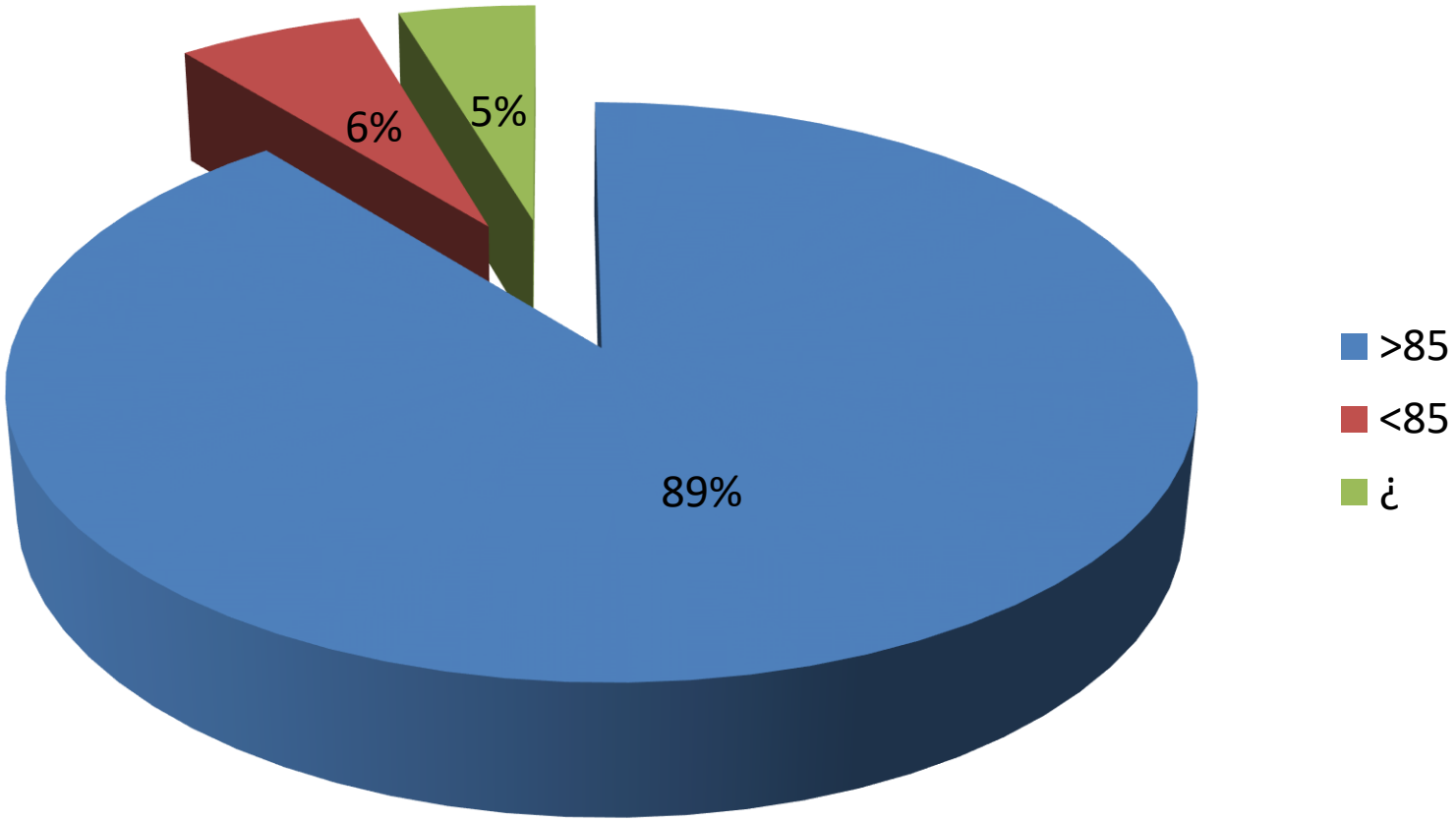




Limitations

- Only target a limited number of inmates with ID.
- Immigrants with not official recognized certificate of ID.
- Inmates with Measures of Security (not guilty for reasons of insanity) with a ID and are placed in Penitentiary Psychiatric Units
- Other vulnerable groups (Juveniles/Women)

Prevalence Januray 2017



Type of offence

TIPO DE DELITO

	Altres	Contra la llibertat sexual	Contra la propietat	Contra les persones	Drogues	Trànsit
?	11	12	34	41	11	6
No	347	148	582	823	202	147
Sí	21	13	45	61	8	8

Table 1: Frecuencias

	Altres	Contra la llibertat sexual	Contra la propietat	Contra les persones	Drogues	Trànsit
?	0.10	0.10	0.30	0.36	0.10	0.05
No	0.15	0.07	0.26	0.37	0.09	0.06
Sí	0.14	0.08	0.29	0.39	0.05	0.05

Table 2: Proporciones

Pearson's Chi-squared test

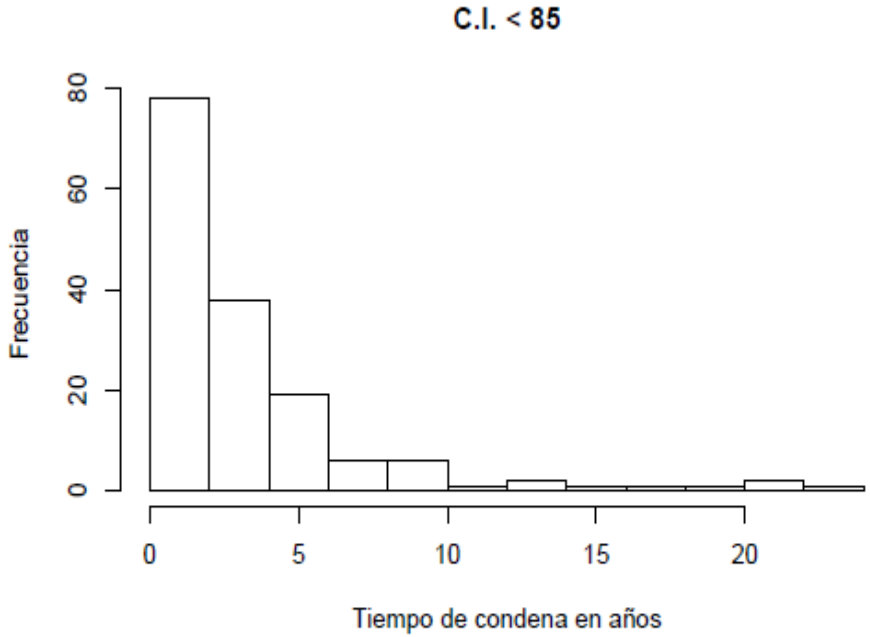
data: mytable X-squared = 10.222, df = 10, p-value = 0.4212

No hay diferencias significativas en cuanto a tipo de delito entre las dos poblaciones

No significant differences were found by type of offence

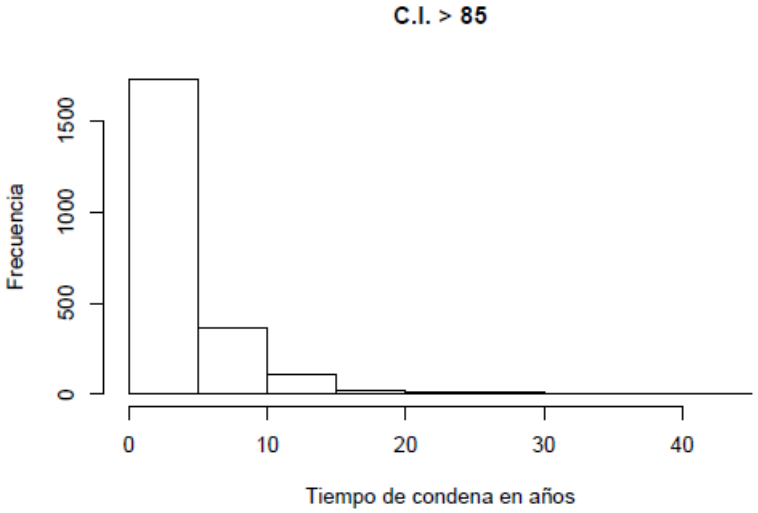
Length of sentence

TIEMPO DE CONDENA



	min	max	media	desv.tipica	num.sujetos
1	0.04	23.00	3.46	4.18	156

Table 3: Descriptivos C.I. < 85, anhos



	min	max	media	desv.tipica	num.sujetos
1	0.01	42.95	3.66	4.50	2249

Table 4: Descriptivos C.I. > 85, anhos

Welch Two Sample t-test

data: exdata$TEMPSCONDEMNA and mydata$TEMPSCONDEMNA t = 0.57507, df = 180.84, p-value = 0.566 alternative hypothesis: true difference in means is not equal to 0 95 percent confidence interval: -177.3640 323.2715 sample estimates: mean of x mean of y 1335.108 1262.154

No hay diferencias significativas en cuanto a tiempo de condena

No significant differences were found for length of sentence

Data

- Were found significatives differences in
  - Limited effect of treatment ,
  - drugs,
  - recidivisme ,
  - violent offending ,
  - alternative mesures of imprisonment
- No significants differences with
  - alcohol ,
  - belonging to a risk social group,
  - mental disorder

Take-home messages

- In Spain ,ID Prevalence is around 6-7 %
- Change from Service to Suport paradigm
- We should have to break the invisibility of people with ID in prison settings
- Improve current services
- More ID community resources
- Vulnerable group (inmigration , youth people, elderly people, women, etc). Special attention

Thanks to :

- ✓ Inmates with ID
- ✓ Program Accepta team (Dincat),
- ✓ DAE-DID team,
- ✓ Psychatry Rehab Team

Thank you for your attention
Any Questions?

vtort@pssjd.org

Parc Sanitari Sant Joan de Déu