# Individuals with Intellectual and Developmental Disabilities Who Become Involved in the Criminal Justice System: A Guide For Attorneys

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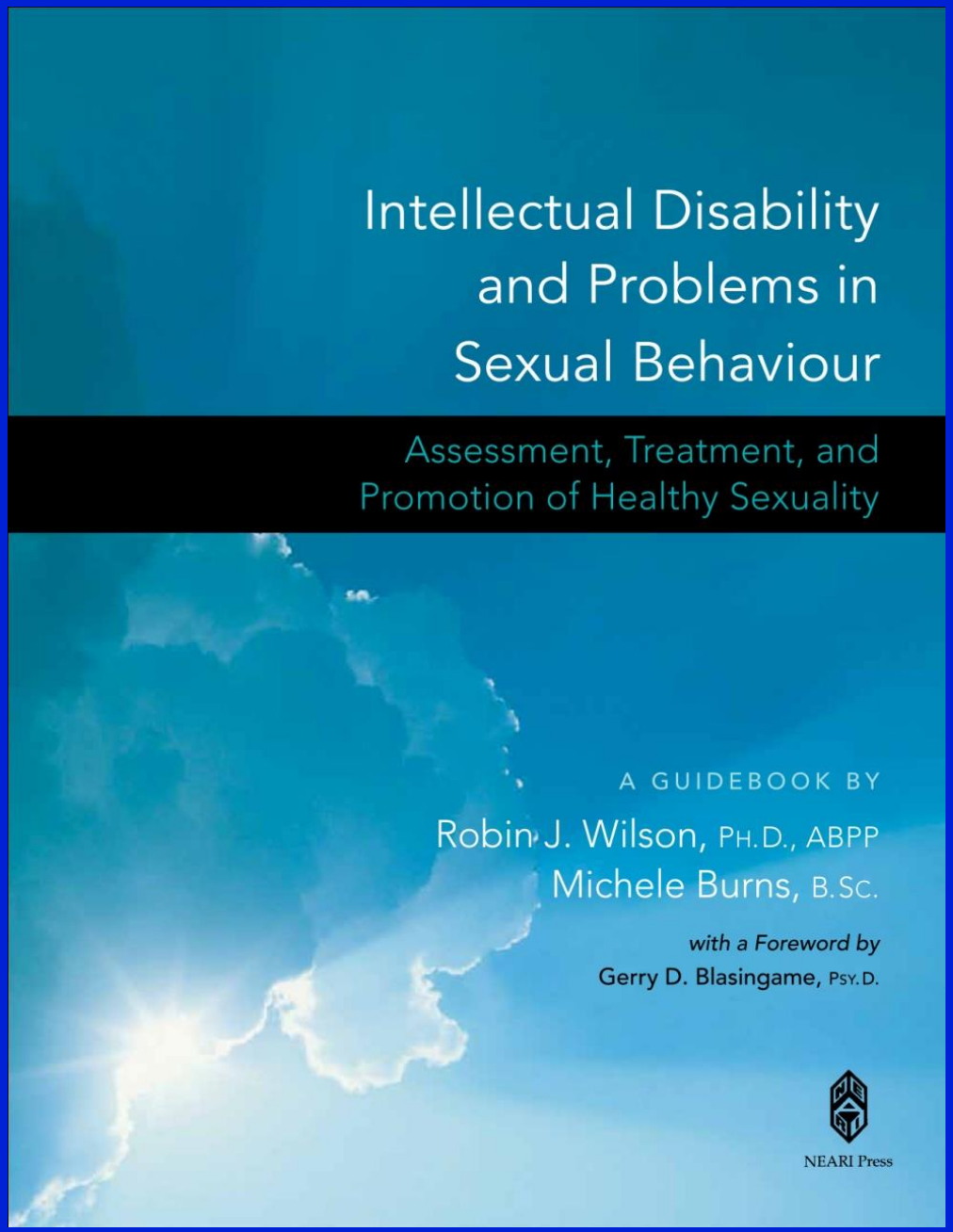


# Judge Trueman

*The cognitively challenged are before our courts in unknown numbers. We prosecute them again and again and again. We sentence them again and again and again. We imprison them again and again and again. They commit crimes again and again and again. We wonder why they do not change. The wonder of it all is that we do not change.*

# Who are we talking about?

# Who are we talking about?

For the purposes of this webinar, we'll be including anyone who experiences significant barriers to treatment and risk management success because of:

- Neurodevelopmental Disorders
- Other brain-based difficulties
- Severe mental illness
- Cognitive decline for other reasons

# Neurodevelopmental Disorders

- Intellectual Disability (Intellectual Development Disorder)
- Communication Disorders
- Autism Spectrum Disorder
- ADHD
- Neurodevelopmental Motor Disorders
- Specific Learning Disorder

# Brain-based Limitations

- Brain injuries
- Fetal Alcohol Syndrome / Spectrum
- Cognitive decline
  - Dementia
  - Parkinson's
  - Alzheimer's
  - Chronic lack of stimulation

# Cognitive Decline

An interesting phenomenon I've encountered is noticeable in clients who have been institutionalized for a very long time, including prison and civil commitment settings.

Sometimes, a prominent feature of their institutionalization is a kind of cognitive atrophy – likely caused by years of understimulation and lack of agency.

# Sexual Offending and Deviance

# Special Needs and Crime

- It is tragically well known that persons with special needs are increasingly found in criminal justice settings
- It is reasonable to assume that at least some of those with disabilities are not adequately identified by the courts
- Those who look different and/or have “problems” are more likely to be incarcerated and incarcerated for longer than average

# Special Needs and Sexual Offending

One judge in Canada had this thought:

> *Herein lies the problem relating to the commission of sexual offences. Having a mature body beyond his intellect, he has urges for sexual gratification which leads to impulsiveness and unpremeditated behavior without using caution and with risk taking. This is followed by non-comprehension that the behavior was inappropriate.*

# Sexual Offending

Over the past 30 years, there has been a significant increase in research about the nature and consequences of sexually abusive behavior.



# Inconsistency

However, a lack of clarity remains regarding definitions for sexual deviance and sexually abusive behaviors.

# DSM-5 Paraphilias

## Paraphilia

- Any intense and persistent (>/= 6 months) sexual interest other than sexual interest in genital stimulation or preparatory fondling with phenotypically normal, physically mature, consenting human partners.

## Paraphilic Disorder

- A paraphilia that is currently causing distress or impairment to the individual or a paraphilia whose satisfaction has entailed personal harm, or risk of harm, to others.

# Counterfeit Deviance

Describes sexual behavior in people with intellectual disabilities where the behavior looks deviant, but may not be when you consider the circumstances.

*– Dave Hingsburger*

# Consent

A particularly important concept to consider when looking at sexual offending is that of consent.

- What constitutes consent?
- Who can give it?
- Under what circumstances?
- Are there personal or situational variables that would impinge on consent?
  - Disability? Cognitive status?

# Inconsistency

In treatment, we tell people who have offended that it is not okay to fantasize about or have sexual relations with minors…

Yet we, as a society, appear to be okay with

- Young persons being sexually active
- Depicting minors in a sexually-charged manner
- Many of our special needs clients have a hard time with age discrimination

# Assessment

# Difficulties for these clients

People with special needs and sexual behavior problems often experience significant limitations leading to difficulties in many or all of the following domains:

- Communication
- Home living
- Community use
- Self-direction
- Functional academics
- Sexuality
- Self-care
- Social skills and relationships
- Health and safety
- Leisure and work

# Areas of Focus

**History of Abuse**

- Any history of physical, emotional or sexual abuse?

**Sexual Behavior**

- What kinds of sexual behavior (if any) have they engaged in other than the offense or referring problem?
- Is there any appropriate sexual behavior?

**Perpetual Arousal**

- Is client always aroused, masturbates all the time, never to completion?

# Areas of Focus

## Behavioral

- Sexual behavior to get attention?
- To avoid a task?
- Control?
- Communication?
- Learned?

## Socio-Sexual And Social Skills

- Inappropriate courtship skills, social skills, interactional skills?

## Partner Selection

- Do they have access to appropriate partners
  - (i.e. same age peers vs. staff or children)?

# Areas of Focus

## Sexual Knowledge

- What do they know about healthy sexuality?
- Where/How did they learn about sex?
- Who did they learn about sex from?
- What did they learn about sex?

## Sexual Learning History

- What consequences has sex had?
- Punishment, sterilization, aversive stimulus, etc.?
- Myths about sexuality.

# Inappropriate Sexual Behavior

**Partner Choice**
- male / female, adult / children, age

**Nature**
- touching, exposing, threats, use of force, sex, trickery, bribery, use of weapons

**Recency**
- When was last offense?

**Frequency**
- How many offenses/inappropriate behaviors?

**Seriousness**
- Harm to victim(s)

**Danger**
- To the community / self

# Areas of Focus

## Structure

- Does the client have privacy?
- Is appropriate sexual expression allowed/encouraged?
- Attitude of staff and parents/family?
- Policies around sexuality of supporting agency, group home or residence.

## Modeling

- Has the client learned about social distance, boundaries, private talk?

# Medical and Psychiatric Issues

## Medical

- Any medical or physical condition to explain behavior?
  - infection, allergies, clothing too tight, hypersensitivities

## Medication

- Side effects from meds?
  - decrease in sex drive, inability to get an erection

## Psychiatric

- Dual Diagnosis?
  - substance abuse, PTSD, re-enactment of behavior

## Hypersexuality

- Excessive sex drive

# Possible Problems

There are a number of possible problems inherent in doing sexual preference testing with special needs clients

- Procedures can be invasive and unpleasant, potentially triggering traumatic memories for clients with abuse histories
- Test protocols are often normed on non-disabled
- Presentation of explicit stimuli might spur anomalous fantasies or behavior

Other methods might be necessary

- Screening tests might eliminate need for costly, invasive measures

# Card Sort Test

A relatively quick screening procedure that sometimes reduces the need for PPG or VT.




# Risk Assessment

- Includes consideration of static (historical) and dynamic (day-to-day) variables
- Facilitated by use of actuarial instruments like Static-99R

# Dynamic Risk & ID

Clearly, many persons with special needs and sexual behavior problems are at a disadvantage in regard to many dynamic risk variables

- differential diagnosis and individualized case planning can be difficult

# ARMIDILO-S

**A**ssessment of **R**isk and **M**anageability of **I**ntellectually **D**isabled **I**ndividua**L**s who **O**ffend **S**exually

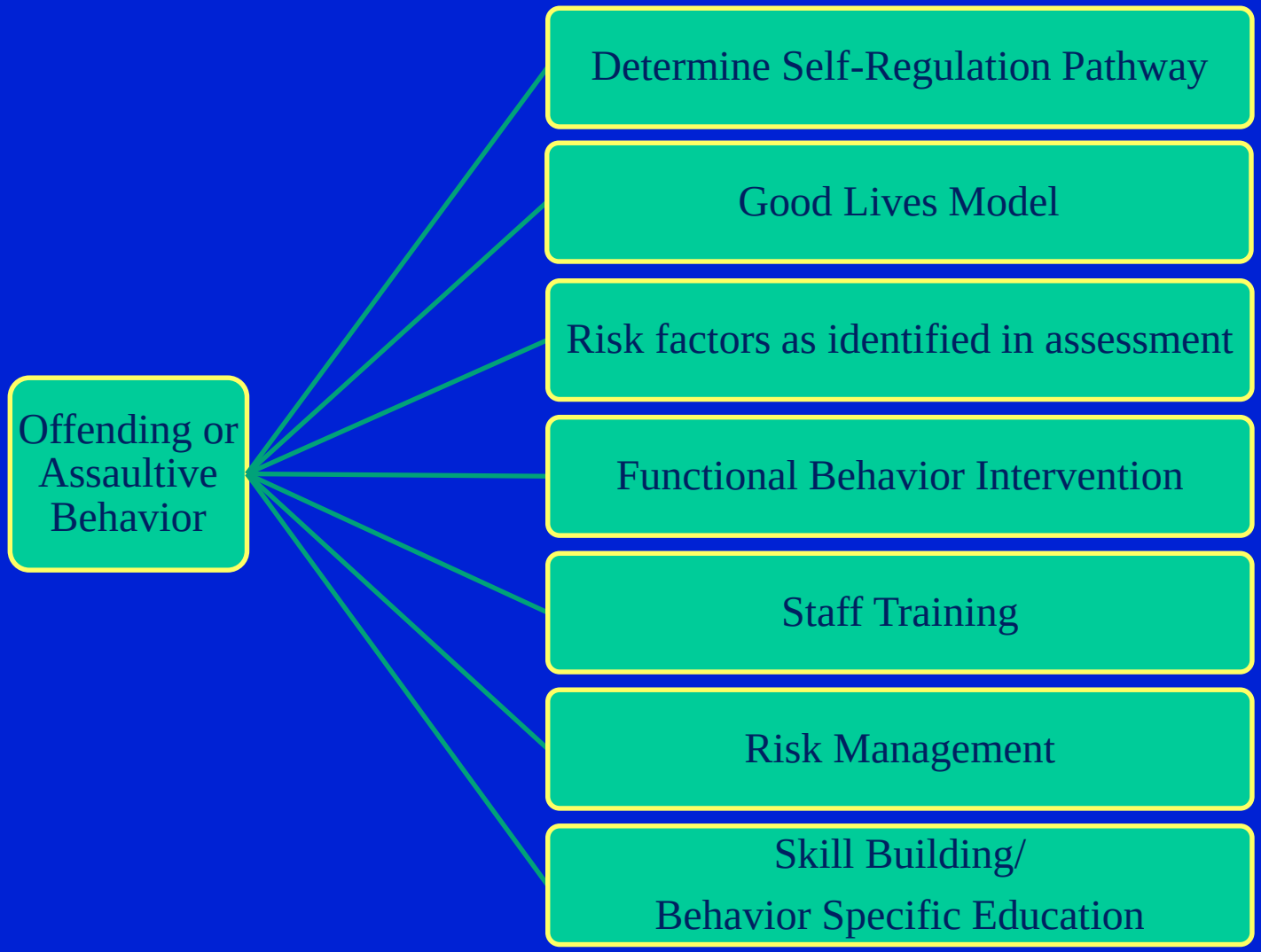
*www.armidilo.net*

# Who can we use this on?

- The ARMIDILO-S is designed for males ages 18 and older who have committed sexually offending behavior and are either in the borderline region of intellectual functioning or are intellectually disabled and have engaged in sexually offensive behavior.
- Sexually offensive behavior is defined as any sexual actions on the part of the individual that have been formally or informally sanctioned due to their inappropriate or illegal nature.

# Treatment & Supervision

# Treatment Programs



# The intent of treatment and supervision

First and foremost, we want to increase public safety. But, in order to do so, we are increasingly aware that we have to increase client quality of life and understanding:

- Treatment programs are created to reflect individual needs.
- Knowledge and skills are developed for domains such as social, leisure, and work.

# Treatment of Persons with Sexual Behavior Problems

- Historically, many types of treatment interventions applied to persons with sexual behavior problems
- Current effective practice requires…
  - Adherence to principles of risk, need, responsivity
  - Assessment of risk factors/criminogenic needs
  - Cognitive(?)-behavioral intervention
  - Treatment that targets identified risk factors/criminogenic needs
  - Post-treatment maintenance/follow-up programming

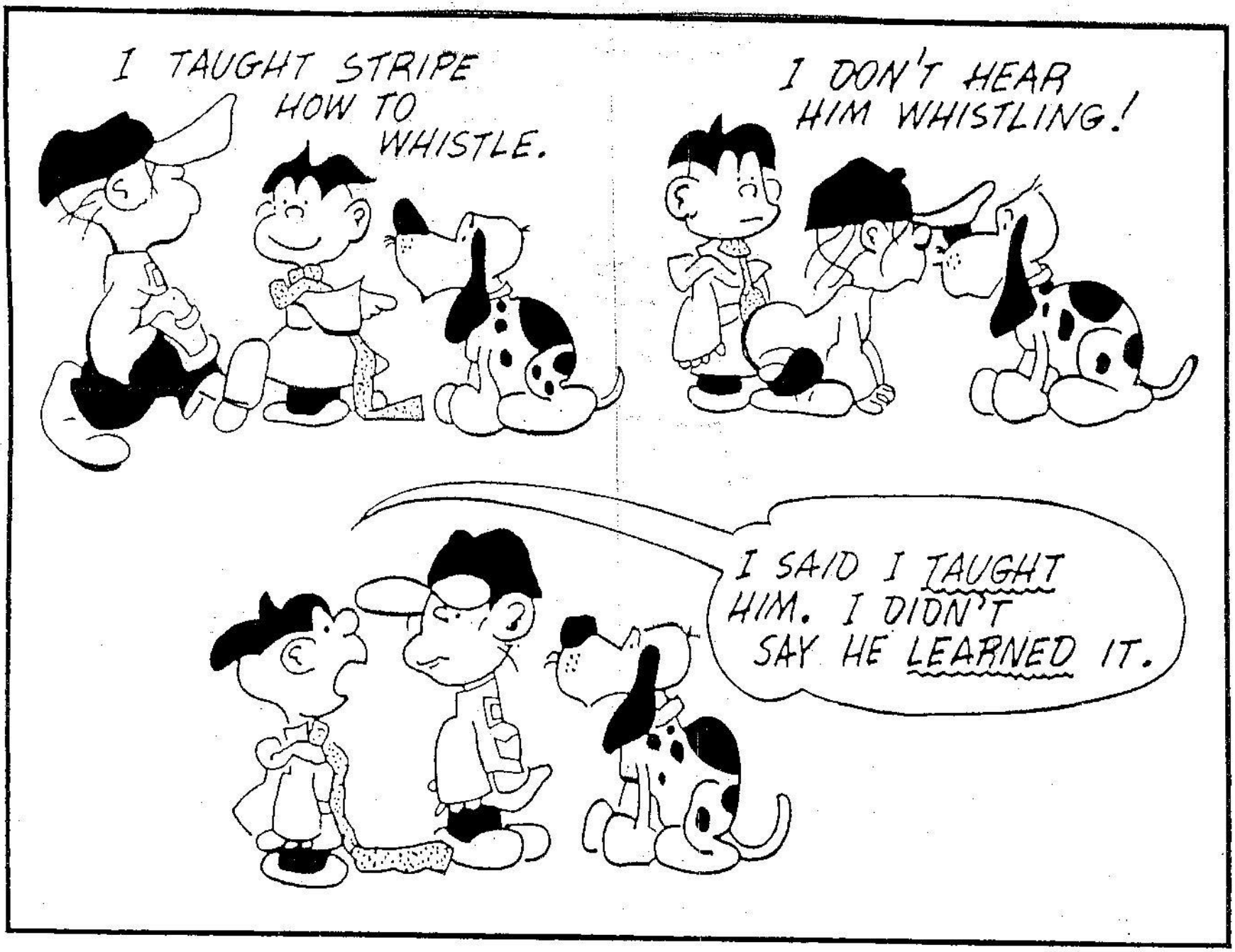
# RNR Principles


(Andrews & Bonta, 2010)

# Treatment & Supervision

**Responsivity**

- Program materials must be presented in a manner that is simplified, concrete, and redundant
- Frequent review of topics covered is important, as is sufficient time for practice and repetition
- Given the increasing ethnic diversity of our clientele, programs must be culturally relevant, holistic, and community-based


I TAUGHT STRIPE HOW TO WHISTLE.
I DON'T HEAR HIM WHISTLING!
I SAID I TAUGHT HIM. I DIDN'T SAY HE LEARNED IT.

# Program Delivery

## Treatment Components

- Sex Education
- Public vs. Private
- Social Skills
- Age Discrimination
- Relationship Training
- Social Responsibility
- Anger Management
- Problem Solving
- Self Regulation
- Risk Management Plans
- Supervision
- Community Access

# Modifying Interventions

Treatment modifications include:

- Reduced reliance on verbal materials
- Increased use of visuals and modeling
- Increased use of practice
- Sexual education
- Increased supervision and structure
- Emphasis on predictability, clarity
- Use active teaching/explicit instruction
- Medication may be necessary
- Focus on rules and consequences

# Treatment & Supervision

- For many clients with special needs and sexual behavior problems, a structured and supportive living environment will be required
- Group homes can be helpful, especially when 24/7 supervision is necessary
- Some clients may be able to function in assisted or semi-independent living environments, but proper assessments are required to identify appropriate clients

# Consequential Learning

Consequential learning is very important in people with poor problem-solving skills, or who are less able to develop appropriate means of assessing and responding to situations. Clearly, unless the consequence of engaging in a certain behavior is intolerable, it will not stop. But, this is not as easy as simple stimulus-response.

# Acting Out

We certainly don't want to "excuse" inappropriate behavior in a person with special needs, it is important that we consider that the causes and manifestations of sexual violence and other aggression in these clients require a different approach.

# A little more behavioral than cognitive?

- Often, we have to consider the extent to which the "special need" interferes with the clients ability to function in the cognitive realm
- Some clients will require a behavioral focus, including applied behavioral analysis
  - Requires development of a structured plan and collection of data
  - Attempt to gain better understanding of the function of the behavior

# Prevention - The other side

- We have focused on special needs clients who have become offenders
- We should not forget that an alarmingly high percentage of persons with special needs are also victims
- Many of the traits that increase risk for **victimizing** also increase risk for **victimization**
- These two positions will interact with one another, especially regarding modeling

# Prevention - The other side

- As we noted, many special needs clients are not just offenders, they are also victims
- Trauma is pervasive in this group
- Trauma causes people to “blunt” their lives
- Treatment of clients with ID and sexual behaviour issues will also require attention to that trauma
- Isolation – either social or geographic – is also something to be considered

# Challenges

## Promoting healthy sexuality while maintaining safety

# Meeting Sexual Needs

Individuals with intellectual disabilities may lack certain social and relationship skills; however, they all have the same desire for social comfort, personal relationships, and meeting of sexual needs in appropriate ways.

*– Gerry Blasingame*

# Rights

There has been much talk recently about "rights for persons with disabilities."

I agree…

…but would note that these rights include:

- A right to competent and individualized risk assessment
- A right to evidence-based treatment and risk management
- A right to safe and secure social interaction
- A right to live offense free

# Promoting Healthy Sexuality

- Attitudes of professionals can greatly influence clients
- This may lead to unhealthy ideas and beliefs about sexuality and their bodies
- Harsh words and consequences are common forms of overt pressures from staff
- Subtle expressions of disapproval such as facial expressions, body posture
- Clients pick up on these subtle gestures and begin to develop their own beliefs about sexuality

# Challenges

- Fewer opportunities for privacy or for finding a meaningful intimate relationship
- Few are taught the difference between appropriate and inappropriate sexual behavior
- Many agencies institute policies prohibiting any sexual expression within their program

# Challenges

What if your client's sexual practices are "abnormal" or "unusual"?

# Contact Information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