

OFFENDERS WITH DEVELOPMENTAL DISABILITIES

Edited by

William R. Lindsay

*The State Hospital; NHS Tayside and University of Abertay Dundee,
Dundee, UK*

John L. Taylor

*Northumbria University, Newcastle upon Tyne and Northgate & Prudhoe
NHS Trust, Northumberland, UK*

and

Peter Sturmey

Queens College and The Graduate Center, City University of New York, USA



John Wiley & Sons, Ltd

OFFENDERS WITH DEVELOPMENTAL DISABILITIES

WILEY SERIES IN FORENSIC CLINICAL PSYCHOLOGY

Edited by

Clive R. Hollin

Division of Forensic Mental Health, The University of Leicester, UK

and

Mary McMurran

School of Psychology, Cardiff University, UK

COGNITIVE BEHAVIOURAL TREATMENT OF SEXUAL OFFENDERS

William L. Marshall, Dana Anderson and Yolanda Fernandez

VIOLENCE, CRIME AND MENTALLY DISORDERED OFFENDERS:

Concepts and Methods for Effective Treatment and Prevention

Sheilagh Hodgins and Rüdiger Müller-Isberner (*Editors*)

OFFENDER REHABILITATION IN PRACTICE:

Implementing and Evaluating Effective Programs

Gary A. Bernfeld, David P. Farrington and Alan W. Leschied (*Editors*)

MOTIVATING OFFENDERS TO CHANGE:

A Guide to Enhancing Engagement in Therapy

Mary McMurran (*Editor*)

THE PSYCHOLOGY OF GROUP AGGRESSION

Arnold P. Goldstein

OFFENDER REHABILITATION AND TREATMENT:

Effective Programmes and Policies to Reduce Re-offending

James McGuire (*Editor*)

OFFENDERS WITH DEVELOPMENTAL DISABILITIES

William R. Lindsay, John L. Taylor and Peter Sturmey (*Editors*)

OFFENDERS WITH DEVELOPMENTAL DISABILITIES

Edited by

William R. Lindsay

*The State Hospital; NHS Tayside and University of Abertay Dundee,
Dundee, UK*

John L. Taylor

*Northumbria University, Newcastle upon Tyne and Northgate & Prudhoe
NHS Trust, Northumberland, UK*

and

Peter Sturmey

Queens College and The Graduate Center, City University of New York, USA



John Wiley & Sons, Ltd

Copyright © 2004 John Wiley & Sons Ltd, The Atrium, Southern Gate, Chichester,
West Sussex PO19 8SQ, England

Telephone (+44) 1243 779777

Email (for orders and customer service enquiries): cs-books@wiley.co.uk
Visit our Home Page on www.wileyeurope.com or www.wiley.com

All Rights Reserved. No part of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by any means, electronic, mechanical, photocopying, recording, scanning or otherwise, except under the terms of the Copyright, Designs and Patents Act 1988 or under the terms of a licence issued by the Copyright Licensing Agency Ltd, 90 Tottenham Court Road, London W1T 4LP, UK, without the permission in writing of the Publisher. Requests to the Publisher should be addressed to the Permissions Department, John Wiley & Sons Ltd, The Atrium, Southern Gate, Chichester, West Sussex PO19 8SQ, England, or emailed to permreq@wiley.co.uk, or faxed to (+44) 1243 770620.

This publication is designed to provide accurate and authoritative information in regard to the subject matter covered. It is sold on the understanding that the Publisher is not engaged in rendering professional services. If professional advice or other expert assistance is required, the services of a competent professional should be sought.

Other Wiley Editorial Offices

John Wiley & Sons Inc., 111 River Street, Hoboken, NJ 07030, USA

Jossey-Bass, 989 Market Street, San Francisco, CA 94103-1741, USA

Wiley-VCH Verlag GmbH, Boschstr. 12, D-69469 Weinheim, Germany

John Wiley & Sons Australia Ltd, 33 Park Road, Milton, Queensland 4064, Australia

John Wiley & Sons (Asia) Pte Ltd, 2 Clementi Loop #02-01, Jin Xing Distripark, Singapore 129809

John Wiley & Sons Canada Ltd, 22 Worcester Road, Etobicoke, Ontario, Canada M9W 1L1

Wiley also publishes its books in a variety of electronic formats. Some content that appears in print may not be available in electronic books.

Library of Congress Cataloging-in-Publication Data

Offenders with developmental disabilities / edited by William R.

Lindsay, John L. Taylor, and Peter Sturmey.

p. cm.—(Wiley series in forensic clinical psychology)

Includes bibliographical references and index.

ISBN 0-470-85410-3 (cloth : alk. paper)—ISBN 0-471-48635-3 (pbk. : alk. paper)

1. Offenders with mental disabilities. 2. Offenders with mental disabilities—Rehabilitation.

3. Developmentally disabled—Rehabilitation. 4. People with mental disabilities and crime.

5. Criminal psychology. I. Lindsay, William R. II. Taylor, John L. (John Lionel), 1961– III. Sturmey, Peter. IV. Series.

HV6080 .O46 2004

365'.66—dc22

2003021217

British Library Cataloguing in Publication Data

A catalogue record for this book is available from the British Library

ISBN 0-470-85410-3 (hbk)

ISBN 0-471-48635-3 (pbk)

Typeset in 10/12 pt Palatino by TechBooks Electronic Services, New Delhi, India

Printed and bound in Great Britain by Antony Rowe Ltd, Chippenham, Wiltshire

This book is printed on acid-free paper responsibly manufactured from sustainable forestry in which at least two trees are planted for each one used for paper production.

CONTENTS

<i>About the Editors</i>	page vii
<i>List of Contributors</i>	ix
<i>Series Editors' Preface</i>	xiii
<i>Preface</i>	xvii

PART I THEORETICAL ISSUES	1
---------------------------	---

1 Natural history and theories of offending in people with developmental disabilities	3
<i>William R. Lindsay, Peter Sturmey and John L. Taylor</i>	
2 Criminal behaviour and developmental disability: an epidemiological perspective	23
<i>Anthony J. Holland</i>	

PART II LEGAL AND SERVICE CONTEXTS	35
------------------------------------	----

3 Legal issues	37
<i>George S. Baroff, Michael Gunn and Susan Hayes</i>	
4 Pathways for offenders with intellectual disabilities	67
<i>Susan Hayes</i>	
5 How can services become more ethical?	91
<i>Jennifer Clegg</i>	

PART III ASSESSMENT AND EVALUATION	109
------------------------------------	-----

6 The assessment of individuals with developmental disabilities who commit criminal offenses	111
<i>Edwin J. Mikkelsen</i>	

7	Risk assessment and management in community settings <i>Vernon L. Quinsey</i>	131
8	Approaches to the evaluation of outcomes <i>Nigel Beail</i>	143
	PART IV TREATMENT AND PROGRAMME ISSUES	161
9	Sex offenders: conceptualisation of the issues, services, treatment and management <i>William R. Lindsay</i>	163
10	Treatment of sexually aggressive behaviours in community and secure settings <i>Michael C. Clark, Jay Rider, Frank Caparulo and Mark Steege</i>	187
11	Treatment of anger and aggression <i>John L. Taylor, Raymond W. Novaco, Bruce T. Gillmer and Alison Robertson</i>	201
12	Treatment of fire-setting behaviour <i>John L. Taylor, Ian Thorne and Michael L. Slavkin</i>	221
13	Offenders with dual diagnosis <i>Anne H.W. Smith and Gregory O'Brien</i>	241
14	Female offenders or alleged offenders with developmental disabilities: a critical overview <i>Kathleen Kendall</i>	265
15	The relationship of offending behaviour and personality disorder in people with developmental disabilities <i>Andrew H. Reid, William R. Lindsay, Jacqueline Law and Peter Sturmey</i>	289
	PART V SERVICE DEVELOPMENT, PROFESSIONAL AND RESEARCH ISSUES	305
16	Staff support and development <i>Anthony F. Perini</i>	307
17	Research and development <i>Peter Sturmey, John L. Taylor and William R. Lindsay</i>	327
	Index	351

ABOUT THE EDITORS

William R. Lindsay, PhD, *Consultant Forensic Clinical Psychologist, The State Hospital, Carstairs; Head of Clinical Psychology (Intellectual Disability) NHS Tayside & Chair of Learning Disabilities, University of Abertay Dundee, Dundee, UK*

Bill Lindsay is Consultant Forensic Clinical Psychologist at the State Hospital, Head of Clinical Psychology (Learning Disabilities) in Tayside and Professor of Learning Disabilities at the University of Abertay, Dundee, Scotland. He is a practicing clinician, has over 150 publications, and has directed several major research projects.

John L. Taylor, DPsychol, *Head of Psychological Therapies & Research and Consultant Clinical Psychologist, Northgate & Prudhoe NHS Trust, Northumberland & Principal Lecturer in Clinical Psychology, Northumbria University, Newcastle upon Tyne, UK*

Since qualifying as a clinical psychologist, John Taylor has worked mainly in developmental disability and forensic services in community, medium secure, special hospital and prison settings in the UK. In recent years he has published work related to his research interests in assessment and treatment of offenders with developmental disabilities in a range of research and professional journals.

Peter Sturmey, PhD, *Associate Professor of Psychology in the Department of Psychology, Queens College and The Graduate Center, City University of New York & Research Associate at the Institute for Basic Research, Staten Island, USA*

Peter Sturmey has published widely on intellectual disabilities, especially in the areas of challenging behaviours, functional assessment, dual diagnosis and staff training.

His current research interests include restraint reduction, client preferences for staff members, mood disorders and dissemination of behavioural technology.

LIST OF CONTRIBUTORS

George S. Baroff

Formerly Director of the Developmental Disabilities Training Institute, and Professor of Psychology, University of North Carolina at Chapel Hill, North Carolina, USA

Nigel Beail

Consultant Clinical Psychologist and Head of Psychology Services, Barnsley Learning Disability Service, and Professor of Psychology, University of Sheffield, Sheffield, UK

Frank Caparulo

Board Certified Forensic Examiner, Professional Specialist, Connecticut Department of Mental Retardation, Hartford, Connecticut, USA

Michael C. Clark

Director, Kern Regional Center, Bakersfield, California, USA

Jennifer Clegg

Senior Lecturer in Clinical Psychology, Division of Rehabilitation and Ageing, University of Nottingham, and Honorary Consultant Clinical Psychologist, Nottinghamshire Healthcare NHS Trust, Nottingham, UK

Bruce T. Gillmer

Consultant Clinical Psychologist, Northgate & Prudhoe NHS Trust, Northumberland, and Honorary Clinical Lecturer, University of Newcastle, Newcastle upon Tyne, UK

Michael Gunn

Professor and Associate Dean, Nottingham Law School, Nottingham Trent University, England, UK

Susan Hayes

Head of Behavioural Sciences in Medicine, Faculty of Medicine, University of Sydney, Sydney, Australia

Anthony J. Holland

The Health Foundation Chair in Learning Disabilities, University of Cambridge, Cambridge, UK

Kathleen Kendall

Lecturer in Medical Sociology, School of Medicine, University of Southampton, Southampton, Hampshire, UK

Jacqueline Law

HM Prison Service, Edinburgh, UK

William R. Lindsay

Consultant Forensic Clinical Psychologist, The State Hospital, Carstairs, Head of Clinical Psychology (Intellectual Disability) NHS Tayside, and Chair of Learning Disabilities, University of Abertay Dundee, Dundee, UK

Edwin J. Mikkelsen

Associate Professor of Psychiatry, Harvard Medical School, Medical Director for The MENTOR Network, and Consultant to the Massachusetts Department of Mental Retardation, Boston, Massachusetts, USA

Raymond W. Novaco

Professor, Department of Psychology and Social Behavior, University of California, Irvine, USA

Gregory O'Brien

Consultant Psychiatrist, Northgate & Prudhoe NHS Trust, Northumberland, and Chair in Developmental Psychiatry, University of Northumbria, Newcastle upon Tyne, UK

Anthony F. Perini

Medical Director and Consultant Psychiatrist, Northgate & Prudhoe NHS Trust, Northumberland, UK

Vernon L. Quinsey

Professor of Psychology and Psychiatry, Psychology Department, Queen's University, Kingston, Ontario, Canada

Andrew H. Reid

Formerly Consultant Psychiatrist and Medical Director, NHS Tayside, and Senior Lecturer, Department of Psychiatry, University of Dundee, Dundee, UK

Jay Rider

Director of Clinical and Wellness Services, Kern Regional Center, Bakersfield, California, USA

Alison Robertson

Consultant Clinical Psychologist, Northgate & Prudhoe NHS Trust, Northumberland, and Honorary Clinical Lecturer, University of Newcastle, Newcastle upon Tyne, UK

Michael L. Slavkin

Assistant Professor of Education, University of Southern Indiana, Evansville, USA

Anne H.W. Smith

Consultant Psychiatrist, NHS Tayside, Dundee, UK

Mark Steege

Steege and Associates, San Antonio, Texas, USA

Peter Sturmey

Associate Professor of Psychology in the Department of Psychology, Queens College and The Graduate Center, City University of New York, and Research Associate at the Institute for Basic Research, Staten Island, USA

John L. Taylor

Head of Psychological Therapies & Research and Consultant Clinical Psychologist, Northgate & Prudhoe NHS Trust, Northumberland, and Principal Lecturer in Clinical Psychology, University of Northumbria, Newcastle upon Tyne, UK

Ian Thorne

Forensic Psychologist, Northgate & Prudhoe NHS Trust, Northumberland, UK

SERIES EDITORS' PREFACE

ABOUT THE SERIES

At the time of writing it is clear that we live in a time, certainly in the UK and other parts of Europe, if perhaps less so in other parts of the world, when there is renewed enthusiasm for constructive approaches to working with offenders to prevent crime. What do we mean by this statement and what basis do we have for making it?

First, by "constructive approaches to working with offenders" we mean bringing the use of effective methods and techniques of behaviour change into work with offenders. Indeed, this might pass as a definition of forensic clinical psychology. Thus, this might pass as a definition of forensic clinical psychology. Thus, our focus is application of theory and research in order to develop practice aimed at bringing about a change in the offender's functioning. The word *constructive* is important and can be set against approaches to behaviour change that seek to operate by destructive means. Such destructive approaches are typically based on the principles of deterrence and punishment, seeking to suppress the offender's actions through fear and intimidation. A constructive approach, on the other hand, seeks to bring about changes in an offender's functioning, or increased awareness of the pain of victims.

A constructive approach faces the criticism of being a "soft" response to damage caused by offenders, neither inflicting pain and punishment nor delivering retribution. This point raises a serious question for those involved in working with offenders. Should advocates of constructive approaches oppose retribution as a goal of the criminal justice system as incompatible with treatment and rehabilitation? Alternatively, should constructive work with offenders take place within a system given to retribution? We believe that this issue merits serious debate.

However, to return to our starting point, history shows that criminal justice systems are littered with many attempts at constructive work with offenders, not all of which have been successful. In raising the spectre of success, the second part of our opening sentence now merits attention: that is, "constructive approaches to working with offenders to *prevent crime*". In order to achieve the goal of preventing crime, interventions must focus on the right targets for behaviour change. In addressing this crucial point, Andrews and Bonta (1994) have formulated the *need principle*:

Many offenders, especially high-risk offenders, have a variety of needs. They need places to live and work and/or they need to stop taking drugs. Some have poor self-esteem, chronic headaches or cavities in their teeth. These are all "needs". The need principle draws our attention to the distinction between *criminogenic* and *noncriminogenic* needs. Criminogenic needs are a subset of an offender's risk level. They are dynamic attributes of an offender that, when changed, are associated with changes in the probability of recidivism. Noncriminogenic needs are also dynamic and changeable, but these changes are not necessarily associated with the probability of recidivism. (p.176)

Thus, successful work with offenders can be judged in terms of bringing about change in noncriminogenic need *or* in terms of bringing about change in criminogenic need. While the former is important and, indeed, may be a necessary precursor to offence-focused work, it is changing criminogenic need that, we argue, should be the touchstone of working with offenders.

While, as noted above, the history of work with offenders is not replete with success, the research base developed since the early 1990s, particularly the meta-analyses (e.g. Lösel, 1995), now strongly supports the position that effective work with offenders to prevent further offending is possible. The parameters of such evidence-based practice have become well established and widely disseminated under the banner of *What Works* (McGuire, 1995). It is important to state that we are not advocating that there is only one approach to preventing crime. Clearly there are many approaches, with different theoretical underpinnings, that can be applied. Nonetheless, a tangible momentum has grown in the wake of the *What Works* movement as academics, practitioners and policy makers seek to capitalise on the possibilities that this research raises for preventing crime. The task now facing many service agencies lies in turning the research into effective practice.

Our aim in developing this Series in Forensic Clinical Psychology is to produce texts that review research and draw on clinical expertise to advance effective work with offenders. We are both committed to the ideal of evidence-based practice and we will encourage contributors to the Series to follow this approach. Thus, the books published in the Series will not be practice manuals or "cook books": they will offer readers authoritative and critical information through which forensic clinical practice can develop. We are both enthusiastic about the contribution to effective practice that this Series can make and look forward to it developing in the years to come.

ABOUT THIS BOOK

Developments in offender treatments over the past decade or so have, for the larger part, been aimed at white males with average intellectual abilities. The needs of people not in this category have been ignored to a great extent. Treatments designed to suit women, people with cultural backgrounds that are minority in our societies, and those with different abilities are few and far between. This text on the treatment of offenders with developmental disabilities takes us forward with at least one under-served group.

In working with people with developmental disabilities, some say that regular treatments may be adapted to suit and others say that altogether different treatments are needed. The answer to this matter lies in a comprehensive understanding of the prevalence, nature and development of offending by those with developmental disabilities. Basing treatment approaches upon theory and evidence is fundamental to good practice; anything else is simply taking a gamble on what might work. In this text, we are presented with an informed discussion of the knowledge base on which effective practice may be founded. Treatment cannot, of course, be planned effectively without attention to legal processes, treatment context and the professionals undertaking the treatment. Who is determined guilty by the criminal justice system and how do they go about this? How should services that offer treatment be configured? How do we ensure that treatment personnel are well trained, supported and supervised? Throughout all of these activities should run the thread of ethics; are our legal, clinical and management practices ethical? These issues are important in offender treatment in general, but take on an added dimension when working with people who may be less able to comprehend complex processes and assert their views in a domain that operates at a high intellectual level.

This book, admirably edited by Bill Lindsay, John Taylor and Peter Sturmey, addresses the issues raised. The editors have gathered scholarly contributions from eminent authors that undoubtedly place this text at the forefront of the field. We are delighted to include this important book in the Forensic Clinical Psychology Series.

August 2003

Mary McMurran and Clive Hollin

REFERENCES

- Andrews, D.A. & Bonta, J. (1994). *The Psychology of Criminal Conduct*. Cincinnati, OH: Anderson.
- Lösel, F. (1995). Increasing consensus in the evaluation of offender rehabilitation. Lessons from recent research synthesis. *Psychology, Crime and Law*, 2, 19–39.
- McGuire, J. (ed.) (1995). *What Works: Reducing Reoffending*. Chichester: John Wiley & Sons.

PREFACE

Research and practice developments concerning offenders with developmental disabilities have been growing apace over the past ten to fifteen years. Much of the published work in this field has involved descriptive and epidemiological studies, issues concerning individuals' competence to comprehend and participate in the criminal justice system, and treatment outcome case studies. While these types of studies have predominated, there has also been a steady, if gentle, flow of publications investigating the relationship between psychological variables and offending—such as work on the impact of mental illness, impulsiveness and other personality variables on offending, as well as studies on the assessment and evaluation of such behaviour. The impetus of this book has been to bring these developments together in one volume, not only to summarise and document these advances, but also to provide insightful and knowledgeable commentary from scientists and practitioners in the field. In the course of developing the book, contributors have also provided a wealth of new material for the interested clinician and researcher.

Those with developmental disabilities, and particularly those with lower intellectual functioning, have been overly identified with and blamed for disproportionate amounts of crime and delinquency in a most pejorative manner for more than a century. One only has to read of the outcry from suburban neighbourhoods when a group home for clients with intellectual disability is proposed in their vicinity to realise that these (mis)perceptions and prejudices are far from being historical phenomena. Yet generally these persons will be law abiding and peaceful neighbours. The thoughtful contributions in this book hopefully provide a counterbalance to some of society's persisting prejudiced views and attitudes concerning people with developmental disabilities and histories of offending.

As for the contributions themselves, they combine to provide a comprehensive overview of contemporary work in this field. The chapters begin by placing the topic in a historical and theoretical context and then go on to describe epidemiological, legal and ethical frameworks in which to consider later chapters on assessment, treatment and staffing issues. The reader will note that on occasions different contributors have differing, even opposing, views on particular issues, and sometimes incompatible interpretations of certain research findings. As editors we have decided to allow these differing perspectives, relying on each author to justify their position rather than insisting on uniformity of views. Consequently the reader is

exposed to a range of differing views about particular issues that they then need to make their own minds up about. However, this approach emphasises that there can indeed be different interpretations of particular sets of data and other types of evidence. In this way we hope that we have produced a lively volume that will not only be helpful in the development of treatment and management endeavours but will also stimulate future research and inquiry.

We need to explain to readers the reasons for the choice of terminology used by the editors in the title and text of this book to describe the client group with whom we are concerned. In the United Kingdom the term “learning disability” is commonly used to describe people characterised as having (a) significant sub-average general intellectual functioning as measured on standard individual intelligence test, (b) more difficulties in functioning in two or more specified areas of adaptive behaviour than would be expected taking into account age and cultural context, and (c) experienced the onset of this disability before the age of 18 years. These criteria are broadly those included in the International Classification of Diseases (ICD-10), Diagnostic Statistical Manual (DSM-IV) and American Association on Mental Retardation (AAMR) diagnostic classification systems. The terms “mental retardation” and “intellectual disability” are commonly used in North America and Australia, respectively, to refer to the same syndrome.

We have preferred the term “developmental disability” in this book. It refers to the definition given in the United States Developmental Disabilities Assistance and Bill of Rights Act (2000) and is a broad concept covering the equivalent terms of mental retardation, learning disability and intellectual disability. In general terms developmental disability means a severe, chronic disability of an individual that (a) is attributable to a mental or physical impairment (or combination of mental and physical impairments), (b) is manifested before the individual attains age 22, (c) is likely to continue indefinitely, (d) results in substantial functional limitations in three or more areas of major life activity, and (e) reflects the individual’s need for individualised and planned supports and assistance that may be of life-long duration.

In addition to mental retardation, the concept includes other conditions that do not necessarily involve significant sub-average intellectual functioning such as autism, epilepsy and some other neurological conditions. For these reasons we consider that the term “developmental disability” provides the best description of the population described in this volume. However, we have not insisted that individual contributors stick rigidly to this term, and some have preferred to use other terms with which they are more comfortable.

Inevitably in a volume comprising contributions from colleagues around the world, occasionally other minor cultural/language differences arise. For example, the word “disposal” has a particular meaning in the UK criminal justice system that relates to the type of sentence received following conviction for a crime. This does not translate in the same way in Australia or North America, where the word has connotations of getting rid of something, often something unpleasant.

A number of people at John Wiley have been helpful and patient while we produced this book. Notably Lesley Valerio and Dr Vivien Ward have all shown the patience of those who have the wisdom of experience. Dr Mary McMurran has

been helpful, supportive and constructive throughout the process. Most of all we are extremely grateful to Charlotte Quinn who prepared the finished manuscript, a task that was well beyond the call of duty.

August 2003

Bill Lindsay
John Taylor
Peter Sturmev

PART I

THEORETICAL ISSUES

Chapter 1

NATURAL HISTORY AND THEORIES OF OFFENDING IN PEOPLE WITH DEVELOPMENTAL DISABILITIES

WILLIAM R. LINDSAY,* PETER STURMEY[†] AND JOHN L. TAYLOR[‡]

**The State Hospital, Carstairs; NHS Tayside & University of Abertay Dundee, Dundee, UK*

[†]Queens College, City University of New York, USA

[‡]University of Northumbria, Newcastle upon Tyne and Northgate & Prudhoe NHS Trust, Northumberland, UK

This chapter reviews the natural history and theories about the development of offending behaviour in people with intellectual disabilities, and the extent to which current theories on the genesis of offending behaviour are relevant to this client group. If they are relevant, then what are the limits on this relevance and what other factors do we have to take into account because of intellectual disability itself? The first part of this chapter provides a summary of descriptive studies relating crime to intelligence and other potentially relevant factors. The second part investigates the various hypotheses about the development of offending behaviour such as genetic factors, familial influences, intelligence, environmental factors, peer group influences, the role of the media, developmental factors and the way in which criminal careers may develop in this client group. In the final section we provide an overview of this volume.

NATURAL HISTORY OF OFFENDING RELATED TO DEVELOPMENTAL DISABILITIES

Intelligence and Offending

History

There is little doubt that intellectual disability was seen as a prime factor in criminal behaviour in the late nineteenth century and the beginning of the twentieth century. Although the early and mid-nineteenth century were periods of relative optimism

about the educability of people with intellectual disability (Scheerenberger, 1983), Social Darwinism and the eugenics movement were major influences in the development of scientific and popular thought at the time as well as in the subsequent development of public policy.

In 1889 Kerlin put forward the view that vice was not the work of the devil, but “the result of physical infirmity” and that physical infirmity is inherited (Trent, 1994, p. 87). He went on to write that inability to perceive moral sense was like inability to perceive colour in the colour-blind and “the absence can not be supplied by education” (Trent, 1994, p. 87). Hence, Kerlin’s views directly challenged the optimism of earlier authorities that viewed people with developmental disabilities as full of potential and remediable by suitable education. For the next 50 years Kerlin’s views were dominant. Terman (1911), an author of one of the earliest IQ tests, wrote that “There is no investigator who denies the fearful role of mental deficiency in the production of vice, crime and delinquency . . . Not all criminals are feeble-minded but all feeble-minded are at least potential criminals” (p. 11). This quotation gives us an idea of the extent to which individuals who were lower functioning were considered a menace to society. Goddard (1921), author of *The Criminal Imbecile*, concluded that “probably from 25% to 50% of the people in our prisons are mentally defective and incapable of managing their affairs with ordinary prudence” (p. 7). Sutherland (1937) also concluded that the 50% of delinquents in prisons were feeble-minded.

Scheerenberger’s (1983) *History of Mental Retardation* is replete with the historical association between intelligence and crime in the late nineteenth and first half of the twentieth century. At that time intellectual disabilities came to be viewed as part of a broader degeneracy, which included moral degeneracy, child abuse and neglect, criminality, drunkenness and sexual promiscuity. In Gallagher’s (1999) cameo of race politics and eugenics in Vermont in the early part of the twentieth century, we see that part of the menace of the feeble-minded in Vermont was their menace to respectable, White property owners, whose property might be stolen. Family trees of degenerate families duly noted the criminals, sex offenders and those incarcerated in correctional institutions alongside the blind, alcoholic, still-born and feeble-minded (Gallagher, 1999, pp. 88–9, 181). Thus, in the late nineteenth and early twentieth centuries criminal behaviour and intellectual disability were firmly linked in the ideology of the menace of the feeble-minded (Trent, 1994). Whereas institutionalisation, segregation of the sexes and community placement contingent upon sterilisation could be effective in protecting the Anglo-Saxon gene pool, other strategies were also implemented. This was continued during the Nazi era, when Jews, Romanies, people with intellectual disabilities or psychiatric disorders, homosexuals and *persistent criminals* were gassed or taken out and shot, in order to preserve the Aryan gene pool (Burleigh & Wippermann, 1991).

Research findings

In a review of the role of intelligence in the development of delinquency, Hirschi and Hindelang (1977) concluded that the relationship between intelligence and delinquency was at least as strong as the relation of either class or race and delinquency.

- offending–DD link, 27–8, 266–7
- sampling bias, 328
- sex offending, 168–9
- substance misuse, 250, 334
- use of data from, 23–5, 32
- prevention of crime *see* crime prevention
- prison, 68, 75–6
 - alternatives to, 85–6
 - institutions, 74, 75–6
 - secure hospitals, 71–2, 73, 75
 - secure treatment centres, 194–200
 - see also* criminal justice system,
 - diversion from; disposition
 - (disposal) of incompetent defendants
 - Australian legal system, 62–3
 - England and Wales legal system, 53
 - ethnic minorities, 268–9
 - gender differences, 268–70, 271–4
 - health care facilities, 86
 - life sentences, 53
 - political attitudes to, 84–5
 - prevalence of people with DDs in, 30–1, 68
 - programmes for offenders in, 86, 279–80
 - release into community after, 84
 - sex offender treatment outcomes, 180–1
 - special units in, 74
 - treatment acceptability, 340
- probation
 - outcomes, 331
 - prevalence of offenders with DD on, 275, 328
- Special Offender Services, 78–9
- Problem Identification Checklist, 133–4
- problem solving
 - theories of offending, 14
 - training for sex offenders, 174–8
- process research, 156
- professional ethics
 - codes of conduct, 92–3
 - cultural narratives, 97–8
 - environments for, 100–3
- provocation, defence of, 51–2
- Provocation Inventory, 146, 208–9
- Proximal Risk Factor Scale, 133–4
- psychiatric facilities *see* mental health facilities
- psychiatric illness *see* mental illness
- psychiatrists
 - multi-disciplinary teams, 317–18
 - stress, 313
 - training, 310
 - see also* staff
- psychodynamic psychotherapy, 149–50, 152
- psychological factors in offending, 333–5
- psychologists
 - support for, 313
 - training, 310, 311
 - see also* staff
- Psychopathology Instrument for Mentally Retarded Adults (PIMRA), 147
- psychopathy, 289–90, 293, 295, 297, 298–300, 301
- Psychopathy Checklist (PCL-R), 138, 290, 293, 297, 298–300
- public safety
 - security–therapy conflict, 316–19
 - use of prevalence data and, 24–5, 32
- pyromania, definition, 222
 - see also* fire-setting behaviour
- quality assurance, 149–50
- race and ethnicity, 7–8
 - and eugenics movement, 4
 - gender differences in offending, 268–9
- randomised control trials (RCTs), 152–6, 179, 338
- reading ability, 6
- recidivism
 - after discharge from secure hospitals, 72–3
 - assessing risk of *see* assessment of offenders, future risk
 - programme outcome research, 144, 145, 148, 152, 180–1, 331–2, 336–7
 - sex offenders, 81
 - and treatability, 118–19
 - treatment outcome research, 152, 180–1
- regional forensic service, California, 188–94
- rehabilitation programmes *see* treatment
- Reiss Screen, 147
- relapse prevention, external, 121
- research and development, 327–45
 - crime prevention, 340–1
 - emancipatory research, 341–2
 - ethical issues, 153, 154, 179, 343–4
 - participatory, 341–3
 - prevalence of offending, 327–9
 - psychological factors, 333–5
 - qualitative research, 342
 - risk assessment, 330–2
 - risk management, 330–2
 - services, 329–30
 - theories of offending, 332–3
 - treatment outcomes *see* treatment outcome research
 - victims of crime, 340–1
- residential institutions, 73–4
 - California, 190–1
 - ethics *see* ethical issues

- residential institutions (*cont.*)
 - prison compared, 75–6
 - psychiatric treatment in, 83–4
 - US secure treatment centres, 194–200
 - see also* mental health facilities
- residential programmes, diversion schemes, 78
- residential services, California, 190–1
- risk assessment *see* assessment of offenders, future risk
- risk factors for offending, 70, 333
 - dynamic, 132, 134–6, 330
 - see also* natural history of offending
- risk management
 - community settings, 131, 136–7, 138–9
 - future research, 330–2
- Rosenberg Self-Esteem Questionnaire, 171
- schizophrenia, 243, 245, 247–9, 250, 251–3, 270–1
- schooling, theories of offending, 11, 12, 15, 16
- screening for DDs, 54, 60, 69
- seclusion
 - and service ethics, 91–2
 - use of in institutions, 73–4
- secure hospitals, 70–3
 - ethics *see* ethical issues
- secure treatment centres (STCs), 194–200
- security–therapy conflict, 316–19
- segregation policies, and prevalence studies, 23–5, 32
- self-esteem
 - fire-setters, 230, 231, 232, 234, 235, 236, 237
 - sex offenders, 171
- self-injury, 244
- self-paced learning, staff, 312
- self-reports
 - anger, 203, 209
 - fire-setters, 232, 237
 - sex offender assessment, 148, 170–1
 - treatment outcome research, 148, 337
- sentencing, gender differences, 269
- sentencing systems
 - Australia, 62–3
 - England and Wales, 53
 - USA, 45–7
 - see also* pathways for offenders
- service users
 - participatory research, 341–3
 - prevalence of offending by, 28, 31, 32
 - staff–offender relationship, 98–100, 106, 107
 - therapy–security conflict, 316–19
- services
 - audit of, 149
 - California, 188–94
 - deinstitutionalisation, 73–4, 83–4, 329
 - ethical issues, 91–107
 - future research and development, 329–30
 - importance of staff in, 308–9
 - internal markets, 329
 - offenders with dual diagnoses, 252–3
 - quality assurance, 149–50
 - secure treatment centres in USA, 194–200
 - staff in *see* staff
 - for women with DDs, 275–6
- sex education, sex offenders, 172–3, 174, 193
- Sex Offender Risk Appraisal Guide (SORAG), 138
- sex offenders/offending, 163–81
 - against children *see* child abusers
 - assessment, 169–72
 - aggression rating scales, 115–17, 133–4
 - cognitive distortions, 171–2
 - community settings, 121, 131, 132–4, 137–8
 - future research, 330
 - future risk, 131, 132–4, 137–8, 172, 330
 - personality, 298–9
 - self-report information, 148, 170–1
 - sexual attitudes, 148, 169, 171–2
 - sexual knowledge, 148, 169, 170
 - treatability, 118–20
 - see also* below treatment outcome research
 - community settings
 - assessment, 121, 131, 132–4, 137–8
 - California, 188–94
 - risk management, 131, 138–9
 - treatment in, 138–9
 - future research, 330, 334–5
 - hypotheses on causes, 163–8, 334
 - childhood sexual abuse, 166, 168
 - counterfeit deviance, 164–5
 - impulsivity, 167, 334–5
 - mental illness, 165
 - persistent tendencies, 166–7
 - mental illness, 165, 178–9, 243
 - mood disorders, 245, 246–7, 252–3
 - schizophrenia, 248, 249, 252–3
 - tolerance of, 251–2
 - prevalence, 168–9
 - substance misuse, 334–5
 - treatment, 80–2, 172–81, 187–8
 - behavioural, 172–4
 - cognitive, 174–8, 180
 - cognitive-behavioural, 81, 118–19, 120
 - community settings, 138–9, 193–4
 - group therapy, 81–2
 - length of, 81, 180–1

- mental illness, 178–9, 246–7, 249
- pharmacological, 118–19, 120, 178–9, 253
- in secure centres, 194–200
- treatability assessment, 118–20
- attitude assessment, 148
- empathy measurement, 148
- inventories for, 146
- knowledge assessment, 148
- open trials, 152
- randomised control trials, 153, 154, 179
- recidivism, 152, 180–1
- self-ratings, 148
- service audit, 149
- sexual abuse of offenders
 - in childhood, 166, 168
 - gender differences, 270, 277, 278
 - by peers, 82
 - prevention, 340–1
- sexual-suppressant medications, 118–19, 120, 178, 179
- shoplifting, 244
- Short Dynamic Risk Scale, 134–6
- single case studies, outcome research, 150–2, 337–8
- Social Comparison Scale, 171
- social contexts, cognitive-behavioural therapy, 279–80
- social learning, 11, 12
- social learning theory, 15
- social pressures, on prevalence studies, 23–5, 32
- social processes, DD patterns, 26, 32
- social skills
 - measures of, 147
 - theories of offending, 14–15
- social skills training
 - acceptability, 340
 - fire-setters, 225
 - offenders with autism, 256
 - sex offenders, 172–3, 174, 193
- socio-economic factors
 - crime desistance, 278–9
 - DD patterns, 26
 - gender differences in offending, 268–9
 - natural history of offending, 5, 7
 - theories of offending, 11, 333
 - see also* social contexts, cognitive-behavioural therapy
- Socio-Sexual Knowledge and Attitudes Test (SSKAT), 148, 169
- sociological theories of offending, 11–14, 332–3
- Special Offender Services (SOS), 78–9
- special units, 74–5, 174, 194–200
- staff, 307–21
 - aggression against
 - effects, 202, 314, 321
 - management, 319–21
 - assault by, 320
 - see also* staff, ethical issues
 - attitudes to client group, 98–100, 319
 - ethical issues, 91–107
 - job satisfaction, 309
 - multi-disciplinary working, 317–18
 - organisational culture, 309–10, 318–19, 321
 - retention, 309
 - selection, 308, 317
 - and service development, 329–30
 - supervision, 312–15
 - support for, 312–15, 317
 - service ethics, 99–100, 101–2, 106
 - when assaulted, 320
 - therapy–security conflict, 316–19
 - training and development, 308–12, 330
 - behaviour management, 314–15, 320–1
 - secure treatment centres, 196–7
 - stress management, 313
 - treatment outcome research, 148
 - violence towards, 319–21
 - and women in prison, 273
 - working hours, 315
- stalking, 245
- Standardised Assessment of Personality (SAP), 291
- State-Trait Anger Expression Inventory (STAXI), 146
- Static-99, 138
- stress, staff, 312–15
- subcultures, delinquent, 11, 333
- substance misuse, 250
 - future research, 334–5
 - offender assessment, 114, 123
 - rates of, 8, 250, 334
 - treatment, 79–80, 191, 250
- suggestibility by offenders, 113
- suicide, 244
- support for staff *see* staff, support for
- Symptom Checklist 90–Revised (SCL-90-R), 147
- systemic family therapy, 80, 102
- systemic handovers, 101–2, 106
- teacher–child attachments, 11, 12
- teams, multi-disciplinary, 317–18
- teleological theories, ethics, 93
- training, staff *see* staff, training and development
- treatability, offender assessment, 111, 117–20

- treatment, 79–84
 - acceptability, 339–40
 - aggression, 82–3, 203–16, 276
 - dual diagnoses, 246–7, 249, 250, 252–3, 256, 260
 - anger, 201–16, 276
 - ethical issues, 102–3
 - external relapse prevention, 121
 - fashions in, 344
 - fire-setting behaviour, 224–38, 276
 - gender-sensitive, 276–7
 - managing risk in the community
 - sex offenders, 138–9
 - violence, 136–7
 - multi-systemic therapy, 80
 - and neo-liberalism, 280–2
 - offenders with dual diagnoses, 83–4, 252–3
 - autism, 256
 - mood disorders, 246–7, 252–3
 - outcome research, 146–7, 154
 - schizophrenia, 248–9, 252–3
 - sex offenders, 178–9, 246–7, 249
 - substance misuse, 79–80, 191, 250
 - outcome research *see* treatment outcome research
 - in prisons, 86, 279–80
 - sex offenders, 80–2, 118–20, 138–9, 172–81, 193–200
 - with mental illness, 178–9, 246–7, 249
 - social contexts, 279–82
 - systemic family, 80, 102
 - therapy–security conflict, 316–19
- treatment outcome research
 - design of *see* treatment outcome research design
 - ethics, 344
 - generalisation of gains, 338–9
 - meta-analysis, 336
 - reviews of, 335–6
 - treatment acceptability, 339–40
- treatment outcome research design, 143–57, 336–8
 - anger assessment, 146, 208–9
 - attitude measurement, 148, 337
 - behaviour change measures, 337
 - behavioural interventions, 144–5
 - consent, 155
 - cost-benefit analysis, 156
 - cost-effectiveness studies, 156–7
 - cost-efficiency studies, 156
 - data collection, 144–8, 336–7
 - dependent measures, 336–7
 - empathy measures, 148
 - fire-setters, 231–8
 - group studies, 150, 152–6, 338
 - hourglass model, 150
 - index offence measures, 144–5
 - information from carers, 148
 - information from offenders, 148
 - interpersonal skill measures, 147
 - knowledge measurement, 148, 337
 - mental health measures, 146–7
 - non-index offence behaviours, 146
 - offence-specific inventories, 146
 - process research, 156
 - programmes for women, 277
 - quality assurance, 149–50
 - randomised control trials, 152–6, 338
 - recidivism rates, 144, 145, 148, 152, 331–2, 336–7
 - self-reports, 148, 209, 337
 - service audit, 149
 - single case studies, 150–2, 337–8
 - social skill measures, 147
 - statistical power, 154, 155
- trials (legal), competency (fitness) to stand assessment, 112–14
 - Australia, 54–7
 - England and Wales, 49, 112
 - training for, 193
 - USA, 39–40, 43, 112–13, 191–2, 193
- trials (research), 152–6, 179, 338
- twin studies, 9, 10
- USA
 - competency (fitness) to stand trial, 39–40, 43, 191–2
 - assessment, 112–13
 - training for, 193
 - criminal justice system, 37, 38–47, 112–13
 - California's forensic service, 187–94
 - secure treatment centres, 195–6
 - numbers classified with DD, 328
 - pathways for offenders
 - court diversion schemes, 78, 192, 331
 - identifying those with DDs, 69
 - intermediate sanction programmes, 76–7
 - parole, 78–9, 331
 - prison, 76
 - probation, 78–9, 331
 - regional forensic service, 187–94
 - secure treatment centres, 194–200
 - Special Offender Services, 78–9
 - treatment of sex offenders, 187–200
- Valuing People* strategy, 281
- Victim Empathy Scale, 148
- victims of crime
 - empathy with, 148
 - future research, 340–1