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Enabling the Disabled: A Proposed Framework to Reduce Discrimination Against Forensic Disability Clients Requiring Access to Programs in Prison

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**ENABLING THE DISABLED: A PROPOSED FRAMEWORK
TO REDUCE DISCRIMINATION AGAINST FORENSIC
DISABILITY CLIENTS REQUIRING ACCESS TO
PROGRAMS IN PRISON**

Astrid Birgden[†]

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I. INTRODUCTION

It is generally accepted that forensic disability clients experience discrimination and disadvantage when interacting with the criminal justice system (CJS) and, although overrepresented, are underserved regarding access to necessary programs.¹ The law can be a barrier to required programs and services upon contact with the court, within corrections and human services, and in the community upon reentry.

Prejudice against offenders with cognitive disabilities has been long-standing. Famously, in *Buck v. Bell*, Justice Oliver Wendell Holmes, Jr. noted that “three generations of imbeciles are enough.”² This chronic attitude was bolstered by the expert testimony of a eugenicist who proclaimed, “These people belong to the shiftless, ignorant, and worthless class of anti-social whites of the South.”³ When this view was later endorsed by a state trial court judge, it resulted in no community reaction.⁴ Between 1929 and 1974 North Carolina sterilized 7600 people deemed “socially or mentally unfit,” many of whom were sterilized “forcibly or with inadequate consent.”⁵

Persons with a mental disability are viewed by society as more deviant, “disproportionately dangerous,” and having less worth.⁶ It

1. Eileen Baldry et al., *Reducing Vulnerability to Harm in Adults with Cognitive Disabilities in the Australian Criminal Justice System*, 10 J. POL’Y & PRAC. INTELL. DISABILITIES 222, 222–23 (2013).

2. *Buck v. Bell*, 274 U.S. 200, 207 (1927).

3. Michael L. Perlin, “*They’re an Illusion to Me Now*”: *Forensic Ethics, Sanism and Pretextuality*, in *PSYCHOLOGY AND LAW: BRIDGING THE GAP* (David Canter & Rita Zukauskien eds., 2008).

4. See MICHAEL L. PERLIN, *THE HIDDEN PREJUDICE: MENTAL DISABILITY ON TRIAL* 21 (2000).

5. Valerie Bauerlein, *North Carolina Atones for Its Sterilizations—Surviving Victims of Eugenics Program to Split \$10 Million*, WALL ST. J., July 27, 2013, at A3, LEXIS.

6. Michael L. Perlin, *The ADA and Persons with Mental Disabilities: Can Sanist*

is expected that offenders with a mental disability would be viewed no differently. Joan Petersilia provided a typical example of what occurs when a person with an intellectual disability is sentenced to prison.⁷ If identified with a disability, the offender is placed separately with other offenders with special needs, including those with mental disability.⁸ This places the person in closer contact with inmates who are likely to victimize the person through physical and sexual abuse, theft, and ridicule.⁹ If not identified with a disability, the person is placed in the mainstream or general offender correctional system.¹⁰ Here, the person is more likely than higher-functioning inmates to be unable to follow the prison rules and is at risk of victimization from both staff and inmates.¹¹ In both settings, the person is unlikely to be able to participate in activities and programs, as the necessary accommodations are not made.¹²

This article will first define disability, focusing on the prevalence of forensic disability clients. Second, the dichotomous view of forensic disability clients that poses seemingly irreconcilable differences or conflicting values between the dual role of the person as an offender and a person with a disability is explored. This includes habilitation versus rehabilitation, duty of care versus dignity of risk, and social rights versus legal rights. Third, legal and psychological theories with principles that would support access to programs are considered in relation to a person with a disability and the person as an offender. These include international human rights law, U.S. human rights law (with an emphasis on program access), and psychological theories that include Positive Behavior Support, Risk-Need-Responsivity, the Good Lives Model, Desistance theory, and the Old Me-New Me model. Finally, a set of principles based on human rights and psychological theories are proposed to reduce the likelihood of discrimination against forensic disability clients, who should have rightful access to programs in correctional services.

Attitudes Be Undone?, 8 J.L. & HEALTH 15, 27 (1994).

7. See JOAN PETERSILIA, *DOING JUSTICE? CRIMINAL OFFENDERS WITH DEVELOPMENTAL DISABILITIES* 31 (2000).

8. *Id.*

9. *Id.*

10. *Id.*

11. *Id.*

12. *See id.*

A. *Disability Defined*

In the United States, the contemporary view is that disability is a social problem that comes about as a consequence of complex biopsychosocial interactions, “including physical, economic, and attitudinal barriers to participation at home, in education, at work, or in the community generally,” rather than a medical diagnosis.¹³ In Australia, a distinction has been made between *impairment*—a defect in the body’s functioning—and a *disability*, which is the disadvantage resulting from a social environment that does not cater to the impairment by providing appropriate support, accommodating those with impairments, or taking needs into account.¹⁴ In this instance, the environment that is generally required to adequately address the impairments is the CJS, particularly correctional and human services. In the United Kingdom, disability tends to be seen as a social construct that is created by the environment, rather than individual attributes, and it requires social change.¹⁵ Consequently, society inhibits individuals with impairments, which results in unnecessary isolation and exclusion from full participation in society.¹⁶

In 2001, the World Health Organization endorsed the International Classification of Functioning, Disability and Health (ICF).¹⁷ The ICF classifies health and health-related domains in terms of body functioning associated with the integrity of the person’s body structures and functions (including cognitive functioning);¹⁸ activities and participation known to effect health and well-being (including communication, learning, domestic

13. KEITH R. McVILLY & CHRISTOPHER NEWELL, INTELLECTUAL DISABILITY AUSTRALASIA, AUSTRALASIAN CODE OF ETHICS FOR DIRECT SUPPORT PROFESSIONALS, 10–11 (2007); *see also* HELEN SPANDLER ET AL., MADNESS, DISTRESS AND THE POLITICS OF DISABLEMENT 85 (2015) (“Disability is the consequence of an impairment that is physical, cognitive, sensory, emotional, and/or developmental.”); Sophie Mitra, *The Capability Approach and Disability*, 16 J. DISABILITY POL’Y STUD. 236, 237 (2006) (describing disability as the experience of “discrimination and segregation through sensory, attitudinal, cognitive, physical, and economic barriers”).

14. N.S.W. LAW REFORM COMM’N, PEOPLE WITH COGNITIVE AND MENTAL HEALTH IMPAIRMENTS IN THE CRIMINAL JUSTICE SYSTEM—DIVERSION 114 (2012).

15. Mitra, *supra* note 13, at 237.

16. *Id.* at 237.

17. *See generally* WORLD HEALTH ORG., INTERNATIONAL CLASSIFICATION OF FUNCTIONING, DISABILITY AND HEALTH (2001).

18. *Id.* at 10, 12.

activity, and social and community participation);¹⁹ and environmental factors that can facilitate or impede the person realizing their full potential (including physical, social, and political factors).²⁰ The emphasis is on function rather than the etiology of condition or disease, and the definition is relevant across cultures, age groups, and genders.²¹ The ICF, therefore, mainstreams the experience of disability as a universal human experience and in doing so integrates the medical and social models of disability.²² In 2006, the Convention on the Rights of Persons with Disability adopted a social model of disability that defined impairments as interactions with various social barriers that may hinder a person's "full and effective participation in society on an equal basis with others."²³

In U.S. legislation, the Americans with Disabilities Act of 1990 (ADA) defines disability as: "(a) a . . . mental impairment that substantially limits one or more major life activities of such individual; (b) a record of such an impairment; or (c) being regarded as having such an impairment."²⁴ The ADA Amendment Act of 2008 broadened the definition of disability.²⁵ The U.S. Equal Opportunity Commission provided a list of conditions that included intellectual disability and autism spectrum disorder, although specific conditions such as pedophilia, exhibitionism, and voyeurism were excluded to prevent abuse of the statute's purpose.²⁶

1. *Forensic Disability Clients*

In this article, forensic disability clients are defined as those with a cognitive disability who have engaged in behavior that leads to contact with the CJS. Determining the prevalence rate of forensic disability clients is compromised by the setting and the

19. *Id.* at 14.

20. *Id.* at 16–17.

21. *Id.* at 7.

22. *Id.* at 20.

23. Convention on the Rights of Persons with Disabilities pmbl., *opened for signature* Mar. 30, 2007, 2515 U.N.T.S. 3 (entered into force May 3, 2008).

24. Americans with Disabilities Act of 1990 § 101, 42 U.S.C. § 12102 (2012).

25. ADA Amendment Act of 2008, Pub. L. No. 110-325 (codified as amended at 42 U.S.C. § 12102 (2012)).

26. Agency Information Collection Activities, 78 Fed. Reg. 56,696, 56,698 (Sept. 13, 2013).

comparison of settings, variable screening processes, clinical assessment methods, and inclusion and exclusion criteria.²⁷ For example, the medical researchers in *Dual Diagnosis* listed several methodological flaws in the literature regarding the prevalence of offenders with disability in the U.S. correctional system related to assessment, definition, methodology, and regional differences.²⁸ Disability includes offenders with mental illness and offenders with cognitive disability.

2. *Cognitive Disability*

Disability entails the broad notion of a cognitive disability with more specific disabilities within the impairment. Persons with cognitive disabilities were previously viewed as a small but increasing portion of prisoners in the CJS in the United States. Joan Petersilia conducted a policy research study on California's CJS that was designed to explore the nature and extent of the problems that people with a disability experience.²⁹ She estimated that although persons with developmental disabilities comprised two to three percent of the general U.S. population, they comprised four to ten percent in prisons and were represented at a higher rate in jails.³⁰ Persons with learning disability comprised eleven percent of the incarcerated population.³¹ The researchers found higher rates of forty-two percent in a random sample of 765 males and females across three states in the United States who were functioning at a fifth-grade level or less.³² In the United Kingdom, it has been estimated that offenders more broadly defined with learning disabilities comprise twenty to thirty percent of the correctional population.³³ More recently, the findings of a research

27. Mitra, *supra* note 13, at 237; William R. Lindsay & John L. Taylor, *A Selective Review of Research on Offenders with Developmental Disabilities: Assessment and Treatment*, 12 *CLINICAL PSYCHOL.* 201, 202 (2005).

28. Charles L. Scott et al., *Dual Diagnosis Among Incarcerated Populations: Exception or Rule?*, 3 *J. DUAL DIAGNOSIS* 33, 47-48 (2006).

29. See PETERSILIA, *supra* note 7.

30. *Id.* at 25.

31. See *id.* at 1.

32. RAYMOND BELL ET AL., *NATURE & PREVALENCE OF LEARNING DEFICIENCIES AMONG ADULT INMATES* 122 (1983).

33. See Jenny Talbot & Chris Riley, *No One Knows: Offenders with Learning Disabilities and Learning Difficulties*, 35 *BRIT. J. LEARNING DISABILITIES* 154, 156 (2007).

project analyzing a cohort of Australian prisoners with cognitive disabilities found very low levels of education and high rates of homelessness, and only twenty-seven percent with intellectual disability/borderline intellectual disability were registered with disability services.³⁴

Offenders with cognitive disability have been found to be disadvantaged upon imprisonment. A report that merged linked data from numerous Australian human services and criminal justice agencies detailed that, in comparison to the mainstream, offenders with cognitive disability and intellectual disability were younger (nineteen to twenty-three years of age), had more days in custody (with dual cognitive disability/mental disability serving the most days), and had twice as many incarcerations but for shorter stays.³⁵ Offenders with cognitive disability experienced “dislocation, discontinuity, poverty, deprivation, ill health and violence.”³⁶ The authors concluded that such offenders are vulnerable to early, ongoing, and intense CJS contact, which is a “lifelong enmeshment.”³⁷

Within the umbrella term of cognitive impairment, the more specific disabilities of intellectual disability, dual diagnosis, acquired brain injury, fetal alcohol spectrum disorder, and autism spectrum disorder require consideration in their interaction with the CJS.

a. Intellectual Disability

Most literature focuses on offenders with intellectual disability. In the United States, persons with intellectual disability are often described as having “mental retardation” or a “developmental disability.” The Developmental Disabilities Assistance and Bill of Rights Act 2000 defined “developmental disability” as: (1) a physical and/or mental impairment; (2) manifested prior to twenty-two years; (3) likely to continue indefinitely; (4) resulting in functional limitations in three or more areas; and (5) requiring

34. See EILEEN BALDRY ET AL., PEOPLE WITH INTELLECTUAL AND OTHER COGNITIVE DISABILITY IN THE CRIMINAL JUSTICE SYSTEM 31 (2012).

35. See Eileen Baldry et al., *Reducing Vulnerability to Harm in Adults with Cognitive Disabilities in the Australian Criminal Justice System*, 10 J. POL'Y PRAC. INTELL. DISABILITIES 222, 225–26 (2013).

36. *Id.* at 227.

37. *Id.*

extended or life-long individualized support.³⁸ In 2010, President Obama signed “Rosa’s Law” requiring many federal statutes to refer to “intellectual disability.”³⁹

Intellectual disability results in impairment of skills related to intelligence, such as cognition, language, motor, and social abilities.⁴⁰ Intellectual disability can be defined in medical terms (IQ level) or social terms (the range of impairments and the support required).⁴¹ The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) defines intellectual developmental disorder as “a disorder with onset during the developmental period that includes both intellectual and adaptive functioning deficits in conceptual, social, and practical domains.”⁴² The DSM-5 requires three criteria be met:

(1) Deficits in intellectual functions, such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning, and learning from experience, and practical understanding confirmed by both clinical assessment and individualized, standardized intelligence testing; (2) deficits in adaptive functioning that result in failure to meet developmental and sociocultural standards for personal independence and social responsibility. Without ongoing support, the adaptive deficits limit functioning in one or more activities of daily life . . . ; (3) [o]nset of intellectual and adaptive deficits during the developmental period.⁴³

A mild impairment in an adult forensic disability client is captured in the

conceptual, social, and practical domains. In the conceptual domain, a mild impairment includes problems in abstract thinking, executive functioning (i.e., planning, strategizing, priority setting, and cognitive flexibility), short-term memory, academic skills, and concrete

38. Developmental Disabilities Assistance and Bill of Rights Act of 2000, Pub. L. No. 106-402, § 102, 114 Stat. 1677 (2000).

39. Rosa’s Law, Pub. L. No. 111-256, 124 Stat. 2643 (2010).

40. AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 31–33 (5th ed. 2013) [hereinafter DSM-5] (discussing the characteristics of, and delineating the diagnostic criteria for, intellectual disabilities).

41. *Id.* at 33–37.

42. *Id.*

43. *Id.* at 31.

approaches to problem solving and short-term memory, as well as functional use of academic skills (e.g., reading, money management) are impaired. There is a somewhat concrete approach to problems and solutions compared with age-mates.⁴⁴

In the social domain, a mild impairment renders the individual socially immature when

compared with typically developing age-mates. . . . Communication, conversation, and language are more concrete or immature than expected for age. There may be difficulty regulating emotion and behavior in age-appropriate fashion. . . . There is limited understanding of risk in social situations; social judgment is immature for age, and the person is at risk of being manipulated by others (gullibility).⁴⁵

In the practical domain, a mild impairment means that the individual may function age-appropriately in personal care. Individuals need some support with complex daily living tasks in comparison to peers. In adulthood, supports typically involve grocery shopping, transportation, home and child-care organizing, nutritious food preparation, and banking and money management. Recreational skills resemble those of age-mates although judgment related to well-being and organization around recreation require support. In adulthood, competitive employment is often seen in jobs that do not emphasize conceptual skills. Individuals generally need support to make health care decisions and legal decisions, and to learn to perform a skilled vocation competently. Support is typically needed to raise a family.⁴⁶

Importantly, the severity of impairment in DSM-5 is measured by adaptive functioning, not IQ score, as this determines the level of support required.⁴⁷ Therefore, identified deficits in adaptive behavior need to be included in designing prison treatment programs to accommodate offenders with intellectual disability.

A 2008 examination found that prevalence rates of offenders with intellectual disabilities ranged from the same rate as that of

44. *Id.* at 34.

45. *Id.*

46. *Id.*

47. *Id.* at 37.

the general population to around eight to twenty-seven percent.⁴⁸ In an international survey of 12,000 prisoners over ten surveys, typically 0.5 to 1.5 percent of prisoners were forensic disability clients.⁴⁹ Once in prison, offenders with intellectual disability are vulnerable; there is a lack of services to meet their needs; to prevent re-offending, they may have higher recidivism rates than mainstream offenders; and the cost to offenders and the broader community is high.⁵⁰ A study by New South Wales Corrective Services in Australia concluded that prisoners with intellectual disabilities are more likely to re-offend and return to prison (sixty-eight percent compared to the general population's rate of thirty-eight percent), for those with no prior convictions the rate of re-offending was over twice as great (sixty percent compared to twenty-five percent), and for those with prior convictions the rate was 1.48 times as great (seventy-two percent compared to forty-nine percent).⁵¹

In reviewing the literature, Petersilia made the following observations of persons with intellectual disability as they progress through the CJS.⁵² In court, they confessed more readily, provided incriminating evidence, were less likely to plea-bargain, were more likely to have been convicted, and received longer sentences.⁵³ In prison, they were more likely to have been abused or victimized and engaged in poorer institutional behavior.⁵⁴ Therefore, they became over-classified with a higher security level (failing parole eligibility because over-classification leads to a failure to earn good time credits or participate in early release programs), and they failed to obtain even menial prison work or vocational training.⁵⁵ As parolees, they were not placed on specialized supervision caseloads and were often excluded from rehabilitation programs, resulting in higher recidivism rates.⁵⁶

48. See Scott et al., *supra* note 28, at 48.

49. Seena Fazel et al., *The Prevalence of Intellectual Disabilities Among 12000 Prisoners—A Systematic Review*, 31 INT'L J.L. & PSYCHIATRY 1, 372 (2008).

50. See N.S.W. OMBUDSMAN, SUPPORTING PEOPLE WITH AN INTELLECTUAL DISABILITY IN THE CRIMINAL JUSTICE SYSTEM: PROGRESS REPORT 2 (2008).

51. N.S.W. LAW REFORM COMM'N, *supra* note 14, at 91–92.

52. PETERSILIA, *supra* note 7, at 13.

53. *Id.*

54. *Id.*

55. *Id.*

56. *Id.*

Based on the U.S. Supreme Court's decision in *Atkins v. Virginia*,⁵⁷ the following characteristics are considered specific to offenders with intellectual disability leading to specific problems: gullibility (talked into a confession); acquiescence (gives in under interrogation); suggestibility (accepts information without question); concrete thinking (does not understand abstract legal concepts); memory issues (does not recall details of the offense); communication problems (receptive and expressive language); seemingly inappropriate social behaviors (laughing seen as lack of remorse); and a "cloak of competence" (deny or hide limitations).⁵⁸ While these characteristics are described for the courtroom setting, they are also relevant to program delivery in corrections.

In terms of offense type, the most prevalent index behaviors in offenders with intellectual disabilities are aggression and violence, followed by sexual offenses and substance misuse.⁵⁹ Determining typical offense types is difficult, but they are more likely to be sexual offenses, arson, and property offenses that reflect impulsivity rather than premeditated offenses such as fraud and drug trafficking.⁶⁰

b. Dual Diagnosis

Dual diagnosis is a co-occurrence of an intellectual disability or cognitive disability with mental disability and/or substance abuse.⁶¹ Prisoners with dual diagnosis are also over-represented in U.S. jails and prisons.⁶² A systematic literature review found that high comorbidity rates, significant prevalence of mental disabilities (twelve to fifty percent), developmental disabilities, and substance abuse can be significant problems that exacerbate pre-existing

57. 536 U.S. 304 (2002).

58. James R. Patton & Denis W. Keyes, *Death Penalty Issues Following Atkins*, 14 EXCEPTIONALITY 237, 241 tbl.2 (2006).

59. William R. Lindsay et al., *Pathways into Services for Offenders with Intellectual Disabilities: Childhood Experiences, Diagnostic Information, and Offense Variables*, 37 CRIM. JUST. & BEHAV. 678, 686 (2010). Also, the prevalence of firesetting is unknown but it is recorded as an index offense between three and twenty-one percent of offenders with an intellectual disability. See William R. Lindsay et al., *Trends and Challenges in Forensic Research on Offenders with Intellectual Disability*, 32 J. INTELL. & DEVELOPMENTAL DISABILITY 55, 56 (2007).

60. See generally LESLEY HARDCASTLE ET AL., REVIEW OF THE CORRECTIONS VICTORIA DISABILITY PATHWAYS PROGRAM (2013) (on file with author).

61. Scott et al., *supra* note 28, at 35–36.

62. *Id.* at 36.

difficulties.⁶³ Offenders with cognitive disability are being increasingly incarcerated in the Australian correctional system, particularly those with dual diagnosis.⁶⁴

c. Acquired Brain Injury

The Toronto Acquired Brain Injury Network defined acquired brain injury (ABI) as “damage to the brain that occurs after birth and which is not related to congenital disorders, developmental disabilities, or processes that progressively damage the brain.”⁶⁵ ABI is the result of brain injury after birth caused by infections, accidents, strokes, substance abuse, or neurological disease that results in problems in cognitive, physical, emotional, or independent functioning.⁶⁶ “[ABI] is often referred to as the ‘hidden’ or ‘invisible’ disability”⁶⁷ and may also present with co-occurring mental health issues and substance abuse.⁶⁸ Brain Injury Australia argues that public awareness of ABI is “twenty to thirty years behind that of other disabilities.”⁶⁹

Information regarding ABI in U.S. prisoners could not be located, but research is being conducted in Australia. The first application of a set of national prisoner health outcomes to over 9000 prisoners public and private prisons found that prisoners upon reception reported having received a blow to the head resulting in loss of consciousness.⁷⁰

In 2011, Corrections Victoria commissioned the Acquired Brain Injury Service, Arbias Ltd., to conduct the only Australian study to examine the cause of ABI in a correctional population.⁷¹ A

63. *Id.* at 49.

64. Baldry et al., *supra* note 35, at 222.

65. Robert Teasell et al., *A Systematic Review of the Rehabilitation of Moderate to Severe Acquired Brain Injuries*, 21 *BRAIN INJ.* 107, 108 (2007).

66. *Id.*

67. NICK RUSHWORTH, *BRAIN INJ. AUSTR., POLICY PAPER: OUT OF SIGHT, OUT OF MIND: PEOPLE WITH AN ACQUIRED BRAIN INJURY AND THE CRIMINAL JUSTICE SYSTEM 4* (2011), <http://www.bia.net.au/docs/CJSpolicypaperFINAL.pdf>.

68. Jo Famularo, *Corrections Victoria: Ensuring Responsive Practices for Offenders with Complex Needs*, 2 *J. LEARNING DISABILITIES & OFFENDING BEHAV.* 136, 136 (2011).

69. RUSHWORTH, *supra* note 67, at 5.

70. AUSTRALIAN INST. OF HEALTH & WELFARE, *THE HEALTH OF AUSTRALIA'S PRISONERS 2009*, at 33 (2010), <http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=6442459982>.

71. VICTORIA DEP'T JUSTICE, *ACQUIRED BRAIN INJURY IN THE VICTORIAN PRISON SYSTEM* (2011).

detailed neuropsychological assessment was conducted on 117 prisoners; forty-two percent of males and thirty-three percent of females had an ABI due to substance abuse, including toxic overdoses and suicide attempts.⁷² In New South Wales, Australia, prisoners with an ABI more often sought protective custody (sixty percent) compared to those without (forty-five percent), and engaged in higher rates of self-injury (fifty-three percent) compared to those without (thirty-eight percent).⁷³

Between forty-three and seventy-three percent of offenders reported having received a head injury through loss of consciousness and substance abuse.⁷⁴ A New South Wales Inmate Health Survey recorded fractured skulls (fifteen percent males; twelve percent female), bleeding in the skull (twenty-five percent male; seventeen percent female), and surgery (sixteen percent males; twelve percent females).⁷⁵

In 2009, Corrective Services New South Wales introduced the Acquired Brain Injury Questionnaire.⁷⁶ The department found that of the 138 respondents, the injuries resulted from assaults (eighty-six percent), motor vehicle accidents (eighty percent), falls (sixty-two percent), alcoholic blackouts (sixty-one percent), overdoses (thirty-three percent), and suicide attempts (thirty percent).⁷⁷ Seventy-five percent of respondents reported “forty-one or less” head injuries and fifty percent reported “seventeen or less” head injuries.⁷⁸ There, outcomes of ABI included personality change (fifty-six percent), impulsivity (seventy-five percent), poor anger management (sixty-two percent), and problems understanding other people’s behavior (fifty percent).⁷⁹ In general, ABI resulted in dynamic risk factors in persons who were irritable and impulsive, had poor anger control, engaged in verbal and physical aggression, and exhibited behaviors of concern (e.g., inappropriate social

72. RUSHWORTH, *supra* note 67, at 8.

73. *Id.*

74. *Id.* at 7.

75. DEVON INDIG ET AL., 2009 NSW INMATE HEALTH SURVEY: KEY FINDINGS REPORT 65 (2010).

76. RUSHWORTH, *supra* note 67, at 26.

77. *Id.*

78. *Id.*

79. *Id.*

behavior, lack of initiation, perseveration, self-injury, and absconding/wandering).⁸⁰

Relevant to program needs, offenders with ABI have difficulty processing and understanding information, short attention span, poor understanding of abstract concepts, poor decision-making ability, inability to change tasks or follow multi-step instructions, poor concentration, memory loss or impairment, and language deficits.⁸¹ Recommendations made in 2011 to the Australian Federal Government included: providing offenders with ABIs equal access to offender rehabilitation programs, as required by the Convention on the Rights of Persons with Disabilities (CRPD); allowing access based on need rather than etiology of disability; and developing a nationally consistent definition of offense-related programs and disability-specific performance indicators.⁸²

d. Fetal Alcohol Spectrum Disorder

Canada is at the forefront of considering fetal alcohol spectrum disorder. Fetal alcohol spectrum disorder is the consequence of prenatal exposure to alcohol resulting in growth deficiency, facial anomalies (most identifiable in middle childhood), and central nervous system dysfunction.⁸³ Fetal alcohol spectrum disorder results in lifelong neurological impairments, including: learning disabilities, rash behavior, hyperactivity, substance abuse, social ineptness, lack of judgement, medical and mental health problems, violent behavior, lack of understanding of cause-effect, failure to learn from mistakes, propensity to perpetrate theft, memory deficiencies, and subsequent problems with daily living that lead to contact with the CJS.⁸⁴ More specifically, there is a view that individuals with fetal alcohol spectrum disorder are permanently hyper-responsive to stress, have deficits in social and executive functioning, may be impulsive and unable to foresee the consequences of their actions, which means

80. *Id.* at 13.

81. N.S.W. LAW REFORM COMM'N, *supra* note 14, at 125.

82. RUSHWORTH, *supra* note 67, at 3.

83. Larry Burd et al., *Fetal Alcohol Spectrum Disorder as a Marker for Increased Risk of Involvement with Correction Systems*, 38 J. PSYCHIATRY & L. 559, 561 (2010).

84. Jerrod Brown et al., *Fetal Alcohol Spectrum Disorders in the Criminal Justice System: A Review*, 3 J.L. ENFORCEMENT 1, 1 (2014); Diane K. Fast & Julianne Conry, *Fetal Alcohol Spectrum Disorders and the Criminal Justice System*, 15 DEVELOPMENTAL DISABILITIES RES. REV. 250, 251 (2009).

that they do not generalize past experiences to a new situation.⁸⁵ These deficits have been described as ALARM—Adaptive functioning, Language, Attention, Reasoning, and Memory.⁸⁶ These problem areas are equally applicable to other types of cognitive disability.⁸⁷ As with other cognitive disabilities, corrections workers and probation officers need to comprehend how fetal alcohol spectrum disorder affects offenders' abilities to understand and follow rules and probation orders.⁸⁸

Individuals with fetal alcohol spectrum disorder are estimated to be nineteen to forty times more likely to be engaged with the CJS, but identification is extremely poor.⁸⁹ For example, out of 3.08 million U.S. prisoners, only *one* prisoner was identified and diagnosed and nearly all affected people are therefore considered to be undiagnosed.⁹⁰ Sixty percent of adolescents and adults with fetal alcohol spectrum disorders came in contact with the CJS (most frequently due to crimes against persons at forty-five percent).⁹¹ Ten percent of offenders in a sample of ninety-one people in Canada were diagnosed with a fetal alcohol spectrum disorder, and with diagnosis through central nervous system or brain dysfunction but no confirmed alcohol history, it could be as high as eighteen percent.⁹²

[D]uration—treatment or interventions need to last longer; [m]ake it concrete—picture guides are helpful for teaching key concepts; [s]mall groups—allow more attention to topical material; [a]nxiety increases impairment—especially important in treatment of substance abuse, sexual abuse or PTSD; [o]ne problem at a time—allow participants to learn and apply solution before moving on to next topic; [a]ppreciate impairments—some problems cannot be treated and we need to learn how to adapt to them and minimize their effects; [a]ftercare is essential—improves generalization of learned behaviors; [s]hort directions—an essential key

85. Fast & Conry, *supra* note 84, at 252–53.

86. *Id.* at 252.

87. *Id.* at 254.

88. *Id.* at 256.

89. Brown et al., *supra* note 84, at 3.

90. Burd et al., *supra* note 83, at 565.

91. Fast & Conry, *supra* note 84, at 251.

92. *Id.*

for successful interventions; [and m]ental health concerns—need appropriate treatment.⁹³

e. Autism Spectrum Disorder

In DSM-5, autism spectrum disorder is viewed as a neurodevelopmental disorder with the triad of impairments:

(a) Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following . . . : (1) Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions; (2) Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication; (3) Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers.⁹⁴

Offenders with autism spectrum disorder are likely to require environmental support in social communication with difficulty initiating, or reduced interest in, social interactions.⁹⁵ Autism spectrum disorder may also result in difficulty switching between activities, and poor organizational and planning skills.⁹⁶

A review of twelve studies over the past thirty years indicates a lack of consensus on the prevalence of offenders with autism spectrum disorder.⁹⁷ A summary of two studies found that ten percent of females at Broadmoor Hospital in the United Kingdom met the diagnosis of autism spectrum disorder or had a “probable”

93. Burd et al., *supra* note 83, at 576.

94. See DSM-5, *supra* note 40, at 42.

95. *Id.* at 31.

96. *Id.* at 57.

97. Eddie Chaplin et al., *Autism Spectrum Conditions and Offending: An Introduction to the Special Edition*, 4 J. INTELL. DISABILITIES & OFFENDING BEHAV. 5, 5 (2013).

autism spectrum disorder.⁹⁸ Clinical case studies have concluded that “[s]exual offences, violent offences, and arson tend to be the most offence types described within these studies, while preoccupations and special obsessions, interpersonal naiveté, low empathy, self-centeredness, ‘logical’ explanations for offending and problems with sexual frustration are all described as contributory characteristics to offending.”⁹⁹ Offenders with autism spectrum disorder “tend disproportionately to commit certain categories of offences: (1) [a]rson; (2) [c]omputer offences; (3) [s]talking offences; (4) [s]exual offences; (5) [v]iolence and neglect offences; and (6) [d]ishonesty offences . . . marked by obsessionality, inability to apprehend verbal and nonverbal cues, rigidity, naiveté and a propensity to panic and behave impulsively and unpredictability in unfamiliar environments.”¹⁰⁰

A comprehensive review of ninety-eight services in the United Kingdom was conducted, including community mental health teams, local health boards, forensic practitioners, mental health practitioners, community learning disability teams, learning disability practitioners, specialist autism providers, and probation services and prisons.¹⁰¹ The results identified 126 persons with Asperger’s syndrome, of whom about twenty-five percent were offenders.¹⁰² In a more in-depth analysis of sixteen of the offenders with Asperger’s syndrome, forty-four percent had never been processed by the CJS, but the predominant offending behavior was violent conduct (eighty-one percent) followed by threatening behavior (seventy-five percent).¹⁰³ However, the results indicated that there was not a significant association between Asperger’s¹⁰⁴

98. Marc Woodbury-Smith & Kalpana Dein, *Autism Spectrum Disorder (ASD) and Unlawful Behavior: Where Do We Go From Here?*, 44 J. AUTISM & DEVELOPMENTAL DISORDERS 2734, 2739 (2014) (citing JULI CROCOMBE ET AL., *AUTISM SPECTRUM DISORDERS IN THE HIGH SECURITY HOSPITALS OF THE UNITED KINGDOM: A SUMMARY OF TWO STUDIES* (2006)).

99. David Allen et al., *Offending Behaviour in Adults with Asperger Syndrome*, 38 J. AUTISM & DEVELOPMENTAL DISORDERS 748, 748–49 (2008).

100. Ian Freckelton, *Autism Spectrum Disorder: Forensic Issues and Challenges for Mental Health Professionals and Courts*, 26 J. APPLIED RES. INTELL. DISABILITIES 420, 424–25, 426–30 (2013).

101. Allen et al., *supra* note 99, at 751.

102. *Id.*

103. *Id.* at 751–52.

104. Note that DSM-5 removed Asperger’s syndrome and replaced autism with autism spectrum disorder. AM. PSYCHIATRIC ASS’N, HIGHLIGHTS OF CHANGES FROM

and offending.¹⁰⁵ In this study, predisposing factors (e.g., lack of concern regarding outcome, obsessional interests, social naivety, and misinterpretation of rules) and precipitating factors (e.g., social rejection, bullying, family stress, relationship problems, and deterioration in psychological health) were noted.¹⁰⁶

A comparison of referrals to Forensic Intellectual Disability Services noted that, while individuals with autism spectrum disorder are considered to have a higher prevalence in both correctional and forensic disability settings, the authors concluded that they do not.¹⁰⁷ A review of 477 referrals to a forensic disability setting in the United Kingdom over a twelve-month period found that about ten percent of clients had autism spectrum disorder, but this was similar to the percentage in the general population of people with intellectual disability.¹⁰⁸ Clients with autism spectrum disorder showed similar patterns of offending, although they had lower prevalence of contact sexual offenses and fewer had previously been charged.¹⁰⁹ The comparison concluded that autism spectrum disorder was not a risk factor for re-offending or any particular type of offending.¹¹⁰ Likewise, a more recent review found that individuals with autism spectrum disorder are not overrepresented in the CJS, although they do commit a range of offenses and have some predisposing features. This includes having experienced high rates of physical abuse, neglect and adverse experiences, and demonstrates social naiveté. This social naiveté leaves them open to manipulation by others; results in reacting to disruption of routine or poor understanding of social situations with aggression; enables obsessionalism to lead to poor emotion regulation, reduced empathy, and limited ability to see from other perspectives; and ultimately increases likelihood of offending.¹¹¹

DSM-IV-TR TO DSM-5 1-2 (2013), <http://www.dsm5.org/Documents/changes%20from%20dsm-iv-tr%20to%20dsm-5.pdf>.

105. Allen et al., *supra* note 99, at 756.

106. *Id.* at 752.

107. William R. Lindsay et al., *A Comparison of Referrals with and Without Autism Spectrum Disorder to Forensic Intellectual Disability Services*, 21 *PSYCHIATRY PSYCHOL. & L.* 947, 947-48 (2014).

108. *Id.* at 949-50, 952.

109. *Id.* at 952-53.

110. *Id.* at 952.

111. Claire King & Glynnis H. Murphy, *A Systematic Review of People with Autism Spectrum Disorder and the Criminal Justice System*, 44 *J. AUTISM & DEVELOPMENTAL DISORDERS* 2717, 11-12 (2014).

Offenders with autism spectrum disorder tend to lack theory of mind (especially empathy and the ability to see from other perspectives), the ability to appreciate the whole context, executive functioning required for planning and organization, appreciation for the consequences of one's actions, and the ability to generalize learning from one situation to another.¹¹² These lacking behaviors also lead to contact with the CJS.¹¹³

B. Dichotomy in Forensic Disability Clients

The dual role of the person as an offender *and* a person with a disability poses seemingly irreconcilable differences or conflicting values. On the one hand, anti-social behavior should not be excused from the CJS as forensic disability clients expect equal rights and that would demand a double standard within the CJS; “[i]n a normalized world, one has to live within society’s rules and accept the consequences of one’s actions.”¹¹⁴ On the other hand, rather than being ostensible rights-violators, forensic disability clients may be viewed as “low functioning citizens who lack education on how to function responsibly in a complex society.”¹¹⁵ As a consequence,

forensic services for people with learning disabilities have an obligation to both reduce the risk posed by the service user and work with them in a person-centered way that enables them to live in the community and achieve their goals. This presents a challenge because these two goals may be in conflict with each other. This challenge is particularly evident in the correctional system where the obligation to ensure a person-centered approach is less clear.¹¹⁶

Michael Perlin has written of the prejudices, stereotypes, and myths that are held by the community toward persons with mental disabilities that lead to, and perpetuate, discrimination.¹¹⁷ Briefly,

112. David Murphy, *Risk Assessment of Offenders with an Autism Spectrum Disorder*, 4 J. INTELL. DISABILITIES & OFFENDING BEHAV. 33, 37–38 (2013).

113. *See id.*

114. PETERSILIA, *supra* note 7, at 5.

115. *Id.*

116. Sarah Aust, *Is the Good Lives Model of Offender Treatment Relevant to Sex Offenders with a Learning Disability?*, 1 J. LEARNING DISABILITIES & OFFENDING BEHAV. 33, 37 (2010).

117. *See, e.g.*, PERLIN, *supra* note 4.

mental disability law is influenced and controlled by three invisible concepts that he labels sanism, pretextuality, and distorted decision making.¹¹⁸ Sanism is an irrational prejudice that reflects prevailing stigmatizing and rejecting social attitudes toward disability sustained by stereotype, myth, and superstition (i.e., correctional staff treating the rights-violator as “the other”).¹¹⁹ Pretextuality means that the judiciary accepts distorted evidence from expert witnesses to achieve desired ends for the court that are ultimately perjurious or corrupt testimony (which can be extended to correctional administrators when making decisions about behavioral and disciplinary issues).¹²⁰ Distorted decision making may be considered “ordinary common sense,” but actually results in heuristic thinking, or “rules of thumb.”¹²¹ These rules of thumb are designed to “simplify complex, information-processing tasks” but instead result in “distorted and systematically erroneous decisions” (e.g., seeking evidence to support personal beliefs that all sexual offenders with intellectual disabilities are impulsive or “over-sexed”).¹²² Overall, these concepts reinforce the discriminatory attitude of correctional staff. Article 8 of the CRPD requires that stereotypes, prejudices, and harmful practices relating to persons with disabilities be combatted.¹²³

A key purpose of the ADA and section 504 of the Rehabilitation Act was to end discrimination that resulted from overprotective, paternalistic, and patronizing treatment of persons with disabilities based on irrational fears.¹²⁴ For forensic disability clients who ought to receive non-discriminatory and equal access to programs, there are a number of contradictory views that are applied to them, which may be influenced by sanism, pretextuality, and distorted decision-making. Below are some examples.

118. *Id.* at 4, 21, 59.

119. *Id.* at 22–23.

120. *Id.* at 59–60.

121. *Id.* at 4.

122. *Id.*

123. Convention on the Rights of Persons with Disabilities, *supra* note 23, art. 8.

124. See D. Aaron Lacy, *Am I My Brother's Keeper: Disabilities, Paternalism, and Threats to Self*, 44 SANTA CLARA L. REV. 55, 66–72 (2003) (providing a legislative history of the ADA).

1. *Habilitation Versus Rehabilitation*

The terms “habilitation” and “rehabilitation” are applied loosely in the literature and appear largely undefined in legislation, policy, and practice. The *Handbook on Prisoners with Special Needs* defines mental health treatment as “psychosocial support, counseling, speech and occupational therapy, physiotherapy, behavioural therapy, psychiatric and medical treatment, among other appropriate specialized health care services.”¹²⁵ The CRPD states that comprehensive habilitation and rehabilitation services and programs are required, but does not define what these terms mean.¹²⁶ The U.N. Standard Rules on the Equalization of Opportunities for Persons with Disabilities defines rehabilitation as

a process aimed at enabling persons with disabilities to reach and maintain their optimal physical, sensory, intellectual, psychiatric and/or social functional levels, thus providing them with the tools to change their lives towards a higher level of independence. Rehabilitation may include measures to provide and/or restore functions, or compensate for the loss or absence of a function or for a functional limitation. The rehabilitation process . . . includes a wide range of measures and activities from more basic and general rehabilitation to goal-oriented activities, for instance vocational rehabilitation.¹²⁷

In discussing offenders with a hearing disability habilitation is described as teaching basic skills and rehabilitation is described as restoring lost skills, differentiating between learning new skills and relearning old skills.¹²⁸ Petersilia, in arguing that policy development was meant to attend to developing good habilitation programs with in-custody and re-entry programs, noted that an earlier study could not locate one state-run program for offenders with intellectual disability in prison or jail or on probation

125. U.N. OFFICE ON DRUGS & CRIME, HANDBOOK ON PRISONERS WITH SPECIAL NEEDS, at 5, U.N. Sales No. E.09.IV.4 (2009), http://www.unodc.org/PDF/criminal_justice/Handbook_on_Prisoners_with_Special_Needs.pdf.

126. See Convention on the Rights of Persons with Disabilities, *supra* note 23, art. 25.

127. G.A. Res. 48/96, The Standard Rules on the Equalization of Opportunities for Persons with Disabilities, intro. (Dec. 20, 1993).

128. Neil S. Glickman et al., *Engaging Deaf Persons with Language and Learning Challenges and Sexual Offending Behaviors in Sex Offender-Oriented Mental Health Treatment*, 47 J. AM. DEAFNESS & REHABILITATION ASS'N 168, 185 (2013).

regarding rehabilitation or substance abuse.¹²⁹ In some parts of the United States, Petersilia described available programs as habilitation (e.g., advocacy, positive role modelling, use of leisure time, academic training and tutoring, obtaining employment, basic hygiene, learning about the law, socialization skills) and some as rehabilitation (e.g., weekly counseling group, eliminating substance use, and “rehabilitation”).¹³⁰ Likewise, Susan Hayes argued that the critical issues in prison for forensic disability clients are to: (1) protect client safety and the safety of the community (duty of care); (2) achieve reduction in recidivism through education, social skills training, welfare services, and offending behavior programs such as substance abuse and sexual offending (i.e., rehabilitation); and (3) address “personal, health, and psychological or psychiatric difficulties” through medical, dental, and mental health care (i.e., habilitation).¹³¹ In all of these instances, such programs could be viewed as offense-related programs (habilitation) and offense-specific programs (rehabilitation). Treatment provides supports for the offender to reconstruct the self (i.e., habilitation or learning new skills) or to re-establish a previously adaptive self (i.e., rehabilitation or re-learning old skills).¹³²

Regarding services to forensic disability clients in U.S. prisons, ninety-eight (sixty-nine percent) of the 141 prisons returned surveys as part of the National Criminal Justice Treatment Practices Survey (NCJTPTS), including prisons designated for those with “special needs.”¹³³ Delivery of rehabilitation programs (i.e., anger or stress management, cognitive skills development, mental health counseling, family therapy, co-occurring disorders counseling, and domestic violence intervention) and habilitation programs (i.e., life skills management, social skills training, and job placement) were provided to a relatively small proportion of offenders.¹³⁴ Researchers concluded, “Overall, the psychosocial and other

129. PETERSILIA, *supra* note 7, at 44.

130. *Id.* at 50–52.

131. Susan Hayes, *Missing Out: Offenders with Learning Disabilities and the Criminal Justice System*, 35 BRIT. J. LEARNING DISABILITIES 146, 147 (2007).

132. Svenja Göbbels et al., *An Integrative Theory of Desistance from Sex Offending*, 17 AGGRESSION & VIOLENT BEHAV. 453, 458 (2012).

133. See Karen L. Cropsey et al., *Specialized Prisons and Services: Results from a National Survey*, 87 PRISON J. 58, 67–68 (2007).

134. *Id.* at 74.

specialized facilities provided more services to at least half of the offender population compared to the generic prison—an average of 14 and 13 services, respectively, to an average of 9 for the nonspecialized prison.”¹³⁵

2. *Duty of Care Versus Dignity of Risk*

A balance between dignity of risk and duty of care needs to be found. Dignity of risk considers that most adults engage in risky behavior because of some perceived benefit.¹³⁶ As a result, persons with disabilities ought not to be subject to arbitrary restrictions on their right to choose; they should be able to experience “bad” decisions and allowed to take *some* risks in order to be afforded dignity and autonomy in decision-making:

Of course, we are talking about prudent risks. People should not be expected to blindly face challenges that, without a doubt, will explode in their faces. Knowing which chances are prudent and which are not—this is a new skill that needs to be acquired. . . . [A] risk is really only when it is not known beforehand whether a person can succeed.¹³⁷

Likewise, the Office of Senior Practitioner in Victoria, Australia supports dignity of risk related to life goals but warns that there is a difference between risk and *hazard* and provides a framework that allows clients to take risks in order to achieve their aims.¹³⁸ On the one hand, persons should be allowed some dignity of risk in decision-making, such as what planned activities they engage in, but on the other hand, they should not be allowed risks that will result in harm to themselves or others.¹³⁹

135. *Id.*

136. VICTORIAN LAW REFORM COMM’N, PEOPLE WITH INTELLECTUAL DISABILITIES AT RISK: A LEGAL FRAMEWORK FOR COMPULSORY CARE: REPORT 98 (2003).

137. Elspeth M. Slayter, *Identifying Substance Abuse Among Clients with Intellectual Disabilities*, NEW SOC. WORKER MAG., Oct. 3, 2015 (quoting ROBERT PERSKE, HOPE FOR FAMILIES 97–104 (1981)), http://www.socialworker.com/feature-articles/practice/Identifying_Substance_Abuse_Among_Clients_With_Intellectual_Disabilities/.

138. OFFICE OF THE SENIOR PRACTITIONER, ROADMAP RESOURCE FOR ACHIEVING DIGNITY WITHOUT RESTRAINT 17 (2012).

139. *See id.*

3. *Legal Rights Versus Social Rights*

Social scientists have considered the relationship between human rights and needs of persons with an intellectual disability in that legal rights have been utilized as a method to secure basic material needs (e.g., experiencing a supportive social context in order to develop as a person).¹⁴⁰ However, this approach ignores the social and material inequities that lead to a failure “to do justice” and more is required than “rights” to achieve the necessary social change.¹⁴¹ While a rights-based strategy diverts from a medical approach to a civil rights framework, it assumes equal legal status combined with negative rights and positive rights.¹⁴² In other words, “Quite simply, what is a ‘right’ when it means nothing legally?”¹⁴³ In addition, as a person with an intellectual disability may not clearly understand their rights (although they are a rights-holder), their agency may be removed and placed in the hands of a more “capable” agent, so decision-making autonomy is lost; in order to exercise rights, a person needs to be empowered to exercise those rights.¹⁴⁴ This reliance on rights to meet needs in persons with an intellectual disability has created conceptual confusion as human rights protect both interests and needs in ensuring two objects of human rights (freedom and well-being).¹⁴⁵ In other words, rights and needs should be considered allied, not dichotomous.

Tony Ward and Claire Stewart utilized a human rights framework to balance both the rights and needs for persons with an intellectual disability.¹⁴⁶ A model had previously been proposed in which “individuals hold human rights simply because they are members of the human race and, as such, are considered to be moral agents . . . capable of formulating their own personal

140. See generally Damon A. Young & Ruth Quibell, *Why Rights are Never Enough: Rights, Intellectual Disability and Understanding*, 15 *DISABILITY & SOC'Y* 747 (2000) (exploring inequities in rights of persons with an intellectual disability).

141. *Id.* at 747.

142. *Id.* at 747–48.

143. *Id.* at 752.

144. *Id.* at 753.

145. Tony Ward & Claire Stewart, *Putting Human Rights into Practice with People with an Intellectual Disability*, 20 *J. DEVELOPMENTAL PHYSICAL DISABILITIES* 297, 304 (2008).

146. See *id.*

projects and seeking ways of realizing them in day-to-day lives.”¹⁴⁷ Ward and Stewart emphasized “the importance of choice and empowerment for persons with intellectual disability and their families,” and that such persons should not be treated as eternal children unable to make their own decisions.¹⁴⁸ Instead, the community ought to work harder to ascertain the preferences and interests of persons with an intellectual disability and support them in making informed choices.¹⁴⁹ Supported autonomy can be explained in terms of intensity as a function of the severity of a disability and its pervasiveness across domains and support duration.¹⁵⁰ This framework can also be applied to forensic disability clients.

C. Summary

For forensic disability clients, the following potentially disparate views are expressed, which often reflect sanism. Table 1 provides those views that are primarily based on the person with a disability that aim to meet needs in the client’s interest, and those views that are primarily based on the person as an offender that aim to manage risk in the community’s interest.

147. Tony Ward & Astrid Birgden, *Human Rights and Correctional Clinical Practice*, 12 *AGGRESSION & VIOLENT BEHAV.* 628, 630 (2007).

148. Ward & Stewart, *supra* note 145, at 304.

149. *Id.* at 305–06.

150. *Id.* at 304.

| Table 1: Potentially Dichotomous Positions on Forensic Disability Clients | | | |
|---|---|---|--------------------|
| Client Interest | Person with a Disability | Person as an Offender | Community Interest |
| | Habilitation- teaching new skills, learning new skills, providing a function, re-establishing a previously adaptive self, offense-related programs, enhancing well-being. | Rehabilitation- restoring lost skills, re-learning old skills, restoring a function, reconstructing the self, engaging in offense-specific programs, reducing recidivism. | |
| | Dignity of risk- allowing to make some risky decisions in order to be afforded dignity and autonomy. | Duty of care- ensure that decisions do not result in likely harm to self or others. | |
| | Social rights- addressing social and material inequities will meet needs. | Legal rights- addressing positive and negative rights will meet needs. | |
| | <i>To "pull" the person forward to meet needs</i> | <i>To "push" the person forward to manage risk</i> | |

The emphasis in this article develops a set of principles that can guide both client and community interests regarding access to programs within the correctional system. Note that little research has been conducted on the efficacy of specialized services for forensic disability clients.¹⁵¹ These principles will be based on the following relevant theories.

II. SUPPORTIVE THEORIES

Legal and psychological theories that support program access for the person with a disability and/or the person as an offender are briefly summarized below.

A. *International Human Rights Law*

International human rights law provides guidance in developing principles to reduce discrimination and ought to be considered.¹⁵² For example, the CRPD is a legally binding instrument emphasizing the prevention of discrimination in article 8.¹⁵³ Forensic disability clients are rights-holders, as both persons

151. See Scott et al., *supra* note 28, at 51.

152. Convention on the Rights of Persons with Disabilities, *supra* note 23, art. 1.

153. *Id.*

with disabilities and as offenders. As stated in an amicus brief by Gold in 1997 in *Pennsylvania Department of Corrections v. Yeskey* 1998:

Eliminating discrimination against people with disabilities in prisons requires that disabled inmates be treated equally with nondisabled prisoners: their disabilities not be an excuse for segregating them from nondisabled prisoners; they have the same opportunities as nondisabled prisoners to work, recreation, education, sanitation, dining, and healthcare; and their lives not be perceived or treated as less valuable than nondisabled prisoners.¹⁵⁴

In its preamble, the U.N. General Assembly's Universal Declaration of Human Rights recognizes that the "inherent dignity and . . . the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world."¹⁵⁵ But with rights come responsibilities, and persons also have duties to the community that can be limited by the law in order to protect the rights of others and uphold the morality, public order, and welfare of a democratic society. This International Bill of Rights also includes the International Covenant on Economic, Social and Cultural Rights, emphasizing positive rights and demonstrating that the state has obligations to provide access to programs and services, and the International Covenant on Civil and Political Rights, emphasizing negative rights regarding freedom from state interference, such as the right to be free from unlawful restrictive practices.¹⁵⁶ An example provided by Damon Young and Ruth Quibell for persons with intellectual disability is equality of treatment (a negative right) together with equality that requires special treatment (a positive right).¹⁵⁷

The Australian Research Council Project argued that human rights law is applicable to prisons in Australia because fair and

154. Brief Amici Curiae of Adapt, Pennsylvania Coalition of Citizens with Disabilities & Disabled in Action of Pennsylvania in Support of Respondent, Pa. Dep't of Corr. v. Yeskey, 524 U.S. 206 (1998) (No. 97-634), 1998 WL 133762, at *6-7.

155. G.A. Res. 217 (III) A, Universal Declaration of Human Rights (Dec. 10, 1948).

156. International Covenant on Civil and Political Rights, *opened for signature* Dec. 16, 1966, 999 U.N.T.S. 171 (entered into force Mar. 23, 1976); International Covenant on Economic, Social, and Cultural Rights art. 9, *opened for signature* Dec. 19, 1966, 999 U.N.T.S. 4 (entered into force Jan. 3, 1976).

157. Young & Quibell, *supra* note 140, at 749.

respectful treatment has been shown to predict prisoner psychological well-being, human rights law operates as a shield for vulnerable individuals who are faced with a power imbalance within the hierarchical prison system, and correctional administrators are legally bound to abide by international human rights law.¹⁵⁸

Based on a review of international treaties, rules and principles, Australian national guidelines, and Australian State and Territory legislative requirements, four principles were established. These included an application to prisoners with cognitive disability (but narrowed to the context of medical treatment):

1. Consent to treatment—Do not forcibly subject people to treatment without their consent;
2. Provision of treatment—Do not deny people the medical care or treatment they require if they do consent (including within an appropriate environment);
3. Equivalence—Medical care or treatment should be of an equivalent standard to that provided to people in the general community; and
4. Staff treatment of people—Staff must treat all people deprived of liberty with humanity and respect for their human dignity.¹⁵⁹

B. Convention on the Rights of Persons with Disabilities

The Standard Rules on the Equalization of Opportunities for Persons with Disabilities endorsed disability rights but with merely binding norms.¹⁶⁰ In contrast, the CRPD is legally binding and authoritative; designed to promote, protect, and ensure the full and equal enjoyment of all human rights and fundamental freedoms of all persons with disabilities; and intended to promote respect for their inherent dignity.¹⁶¹ The United States signed the CRPD in 2009, but fell five votes short of ratification in the Senate.¹⁶²

The Standard Rules on the Equalization of Opportunities for Persons with Disabilities is relevant for prisoners with disabilities

158. Anita Mackaya, *Human Rights Protections for People with Mental Health and Cognitive Disability in Prisons*, 22 *PSYCHIATRY PSYCHOL. & L.* 842, 844 (2015).

159. *Id.* at 846.

160. *See* G.A. Res. 48/96, *supra* note 127.

161. *Convention on the Rights of Persons with Disabilities*, *supra* note 23, art. 1.

162. *See The Convention on the Rights of Persons with Disabilities*, USICD, <http://usid.org/index.cfm/crpd> (last visited Mar. 20, 2016).

and the CRPD provides guidelines relevant to prisoners with disabilities:

1. Equally recognize prisoners with disabilities as persons before the law with equal legal capacity.¹⁶³ In order to do so, provide safeguards to prevent abuse; ensure respect of the rights, will, and preferences of each person; keep persons free from conflict of interest; and minimize limitations on a person's ability to exercise her rights.¹⁶⁴ Establish "regular review by a competent, independent, and impartial authority or judicial body" for all limitations.¹⁶⁵
2. Do not subject anyone "to torture or to cruel, inhuman, or degrading treatment or punishment."¹⁶⁶
3. Protect the integrity of the individual as every person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others.¹⁶⁷
4. Ensure detainees have access to the highest attainable standard of health without discrimination, including gender-sensitive health-related rehabilitation (this is undefined). In particular, the CRPD provides a more contemporary approach to informed consent, with much stricter safeguards against treatment without consent, underlining the right of persons with disabilities to supported decision-making. This supports a person-centered approach in working with forensic disability clients.¹⁶⁸
5. "Organize, strengthen, and extend comprehensive habilitation and rehabilitation services and programs, particularly in the areas of health, employment, education, and social services" to enable persons to attain and maintain maximum independence; full physical, mental, social, and vocational ability; and full inclusion and participation in all aspects of life. A multidisciplinary assessment of individual needs and strengths should be made.¹⁶⁹

163. Convention on the Rights of Persons with Disabilities, *supra* note 23, art. 7.

164. *Id.*

165. *Id.*

166. *Id.* art. 15.

167. *Id.* art. 17.

168. *Id.* art. 25.

169. *Id.* art. 26.

6. Ensure the provision of effective medical care to persons with disabilities. Multidisciplinary teams of professionals should provide programs to detect, assess, and treat impairment, and states should ensure that regular treatment needed to preserve or improve level of functioning is required. This is medically oriented.¹⁷⁰
7. Provide rehabilitation services so persons can “reach and sustain their optimum level of independence and functioning.”¹⁷¹ National rehabilitation programs should be based on individual needs and on the principles of full participation and equality; programs should include basic skills training to improve or compensate for an affected function, counseling, developing self-reliance, and occasional services such as assessment and guidance; and all persons with disabilities who require rehabilitation should have access to them.¹⁷² This description appears to address habilitation and rehabilitation.¹⁷³

C. *Person as an Offender*

Several international instruments consider the person with a disability as an offender. Although, these instruments are more focused on the medical treatment of mental illness, rather than habilitation of forensic disability clients. For example, the *Handbook on Prisoners with Special Needs* emphasized that the high proportion of vulnerable prisoners worldwide meant that special needs cannot be considered marginally, but required attention to correctional legislation, policies, and practice.¹⁷⁴ But again, the promotion of mental health in prisons was the focus. Most recently, the 24th session of the U.N. Commission on Crime Prevention and Criminal Justice recommended draft resolutions to the U.N. Standard Minimum Rules for the Treatment of Prisoners, also now known as “the Mandela rules,” to be adopted by the General Assembly.¹⁷⁵ The

170. G.A. Res. 48/96, *supra* note 127, at 8–9.

171. *Id.* at 9.

172. *Id.*

173. *Id.*

174. U.N. OFFICE ON DRUGS & CRIME, *supra* note 125, at 5.

175. Commission on Crime Prevention and Criminal Justice, *Report of the Economic and Social Council on Its Twenty-Fourth Session*, U.N. Doc. E/CN.15/2015/19, at 17, 24–51 (May 18–22, 2015) [hereinafter *ESC Report*]; see also Commission on Crime Prevention and Criminal Justice, *United Nations*

changes sharpened the focus on rehabilitation somewhat; some rules were relocated in the document while others were new additions in recognition of progressive developments of international law regarding the treatment of prisoners since 1955.¹⁷⁶

The following principles are based on various U.N. instruments and provide a glimpse of the United Nations' efforts to improve adequate treatment of disabled prisoners:

1. Disabled prisoners have the right to have access to health care equivalent to that in the community, and perhaps even more intensive services, which requires adequate screening assessments.¹⁷⁷
2. "Disabled prisoners have the right to information about treatment options, risks, and expected outcomes and they should participate in treatment planning and decision-making" with free and informed consent (with lawful exceptions regarding imminent danger to self and others but violent behavior stemming from refusal of treatment should never justify involuntary treatment).¹⁷⁸
3. "Prisoners who suffer from . . . mental diseases or abnormalities shall be observed and treated in specialized institutions under medical management" during their stay in a prison, and "such prisoners shall be placed under the special supervision of a medical officer."¹⁷⁹ As stated above, this principle is focused on medical treatment rather than habilitation.
4. Prisons should respect fundamental freedoms and basic rights by noting that "all persons have the right to the best available mental health care;" to "be treated with humanity and respect;" and to be free from exploitation, physical abuse, and other degrading treatment.¹⁸⁰ There shall be no

Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules), U.N. Doc. E/CN.15/2015/L.6/Rev.1 (May 18–22, 2015).

176. Compare *ESC Report*, *supra* note 175, at 17, 24–57, with First U.N. Congress on the Prevention of Crime and the Treatment of Offenders, *Standard Minimum Rules for the Treatment of Prisoners*, U.N. Doc. E/RES/663(XXIV) (July, 31, 1957) [hereinafter *Standard Minimum Rules*].

177. U.N. OFFICE ON DRUGS & CRIME, *supra* note 125, at 12–14.

178. *Id.* at 29–30, 33–34.

179. *Standard Minimum Rules*, *supra* note 176, at 12–13.

180. G.A. Res. 46/119, The Protection of Persons with Mental Illness and the

discrimination, and detainees with mental disabilities “have the right to exercise all civil, political, economic, social, and cultural rights as recognized” by various U.N. instruments.¹⁸¹

5. In order for the principle of non-discrimination to be put into practice, prison administration shall take account of the individual needs of prisoners; particularly, the most vulnerable categories in prison settings with measures to protect and promote the rights of prisoners with special needs that are not regarded as discriminatory.¹⁸²
6. Criminal offenders as detainees should receive the best available mental health care with only limited modifications and exceptions when deemed necessary, which should not prejudice the person.¹⁸³
7. Every detainee has the right to be treated in the least restrictive environment to meet their health needs and protect others from harm; based on an individualized plan that is discussed with the detainee, regularly reviewed, and delivered by qualified professionals; mental health care should be in accordance with ethical standards; and treatment should be directed toward preserving and enhancing personal autonomy.¹⁸⁴
8. Disabled prisoners have the right to live in an environment that does not generate or exacerbate mental disability.¹⁸⁵ Prison administrators should be mindful that women are particularly susceptible to abuse and “deterioration of mental well-being.”¹⁸⁶
9. Every prison shall have in place a health care service tasked with evaluating, promoting, protecting, and improving the physical and mental health of prisoners, with particular attention paid to prisoners with special health care needs or with health issues that hamper their rehabilitation. The service shall consist of an interdisciplinary team with sufficient

Improvement of Mental Health Care (Dec. 17, 1991).

181. *Id.*

182. *Standard Minimum Rules*, *supra* note 176, at 10.

183. *See* G.A. Res. 46/119, *supra* note 180.

184. *Id.*

185. U.N. OFFICE ON DRUGS & CRIME, *supra* note 125, at 12–13.

186. *Id.* at 13.

- qualified personnel with expertise in dentistry, psychology, and psychiatry.¹⁸⁷
10. Disabled prisoners have the right to be protected against discrimination and stigmatization (including access to education and employment and not be subject to harsher disciplinary measures).¹⁸⁸
11. To encourage self-respect and self-responsibility, during an offender's time in prison, all appropriate means shall be used, including religious care in the countries where this is possible, education, vocational guidance and training, social casework, employment counseling, physical development and strengthening of moral character, in accordance with the individual needs of each prisoner, taking account of his social and criminal history, his physical and mental capacities and aptitudes, his personal temperament, the length of his sentence and his prospects after release.¹⁸⁹
"The institution should utilize all the remedial, educational, moral, spiritual and other forces and forms of assistance which are appropriate and available, and should seek to apply them according to the individual treatment needs of the prisoners."¹⁹⁰
12. Sentenced prisoners shall have the opportunity to work and actively participate in their rehabilitation, subject to a determination of physical and mental fitness by a physician or health care professional.¹⁹¹
13. "Imprisonment and other measures which result in cutting off [persons] from the outside world are afflictive by . . . taking from the[se] person[s] the right of self-determination by depriving [them] of [their] liberty. Therefore the prison system shall not, except as incidental to justifiable segregation or the maintenance of discipline, aggravate the suffering inherent in such a situation."¹⁹²

187. See *Standard Minimum Rules*, *supra* note 176, at 3–4.

188. U.N. OFFICE ON DRUGS & CRIME, *supra* note 125, at 15–16.

189. Economic and Social Council Res. 1957/10, U.N. Doc. E/RES/1957/26 (July 31, 1957).

190. *Id.*

191. *Standard Minimum Rules*, *supra* note 176, at 9.

192. *Id.*

14. Disabled prisoners have the right to safety and security in being protected from abuse, sexual assault, and violence from other prisoners (females and prisoners with intellectual disability are particularly vulnerable).¹⁹³
15. Disabled prisoners have the right to prevention of suicide and self-harm, which is exacerbated by long sentences, single cells, and combined mental disability and drug use.¹⁹⁴
16. Prison administrators must consider the prisoners' multiple needs to be met, particularly for female detainees, who are more vulnerable to mental disabilities and substance abuse (often as a result of family violence and physical/sexual abuse).¹⁹⁵ The "invisibility" of detainees with intellectual disability within corrections should also be noted, resulting in profound discrimination by systems in general and mental health professionals in particular.¹⁹⁶
17. Prison administrations shall make all reasonable accommodation and adjustments to ensure that prisoners with physical, mental, or other disabilities have full and effective access to prison life on an equitable basis.¹⁹⁷
18. Disabled prisoners should have access to a continuum of care upon release (presumably for medical or mental health care),¹⁹⁸ should be prepared for release, and have post-release support and the right to a continuum of care.¹⁹⁹ The twin goals of community protection and reduced recidivism can only be achieved if the period of imprisonment is used to reintegrate persons back into the community so they can "lead a law-abiding and self-supporting life."²⁰⁰
19. Social rehabilitation should include being allocated to a prison as close to home as possible,²⁰¹ community agencies should be enlisted to assist,²⁰² and governmental and private agencies

193. U.N. OFFICE ON DRUGS & CRIME, *supra* note 125, at 15–16.

194. *Id.* at 16–17.

195. *Id.* at 63.

196. *Id.* at 11.

197. Economic and Social Council Res. 1957/10, *supra* note 189, at 10.

198. *Id.* at 13.

199. U.N. OFFICE OF DRUGS & CRIME, *supra* note 125, at 18.

200. Economic and Social Council Res. 1957/10, *supra* note 189, at 9.

201. *See* U.N. OFFICE ON DRUGS & CRIME, *supra* note 125, at 93, 137.

202. Economic and Social Council Res. 1957/10, *supra* note 189, at 9.

should provide efficient after-care to lessen prejudice.²⁰³ Prisoners should be individually classified to facilitate their treatment and social rehabilitation,²⁰⁴ and should be encouraged and assisted to maintain or establish contact with persons or agencies outside the prison to promote the best interests of the family and social rehabilitation.²⁰⁵

D. United States Law and Human Rights

Conditions in U.S. prisons and jails for forensic disability clients are grim, and in practice, U.S. courts have afforded forensic disability clients little protection.²⁰⁶ Rights violations occur because forensic disability clients may not understand their rights, not realize the consequences of not exercising them, and lack the ability to advocate on their own behalf because the state does not ensure the required resources.²⁰⁷ There are two statutes that protect the rights of prisoners with a disability in the United States—Title II of the ADA and section 504 of the Rehabilitation Act.²⁰⁸ The ADA is a wide-ranging civil rights law that prevents discrimination based on disability, including cognitive disabilities. The ADA has the power to enforce the Fourteenth Amendment of the U.S. Constitution regarding equal protection, guaranteeing for the first time that this core constitutional protection is extended to disabled persons.²⁰⁹ Relevant to program delivery in prisons, Congress noted that persons with disabilities had no legal recourse to redress discrimination. They suffered “outright intentional exclusion,” including relegation to lesser services, programs, and activities; were subjected to purposeful unequal treatment; and were severely disadvantaged—socially, vocationally, educationally, and economically.²¹⁰ However, the ADA did not pay attention to persons with mental disabilities as the available commentary was

203. *Id.*

204. *Id.* at 10.

205. *Id.*

206. See JAMIE FELLNER, HUMAN RIGHTS WATCH, CALLOUS AND CRUEL: USE OF FORCE AGAINST INMATES WITH MENTAL DISABILITIES IN US JAILS AND PRISONS (2015).

207. PETERSILIA, *supra* note 7, at 5–7; see also Young & Quibell, *supra* note 140.

208. Rehabilitation Act of 1973, Pub. L. No. 93-112, § 504, 87 Stat. 394 (Sept. 26, 1973) (codified at 29 U.S.C. § 701 (2012)); 42 U.S.C. § 12132 (2012).

209. Perlin, *supra* note 6, at 16–17.

210. *Id.* at 27.

more focused on persons with intellectual disabilities.²¹¹ The most recent amendment to the Developmental Disabilities Assistance and Bill of Rights Act of 2000 emphasized that provision of care by developmental disability services (not prisons) was to be free of abuse, neglect, sexual and financial exploitation, and violations of legal and human rights; disability clients are to be subject to no greater risk of harm than others in the general population.²¹² Title II of the ADA regulates public entities run by state and local agencies, not just those that receive federal funding as in section 504 of the Rehabilitation Act.²¹³ In 2010, the U.S. Department of Justice issued prison and jail-specific ADA regulations requiring them to place prisoners with a disability in the most integrated setting appropriate to their needs.²¹⁴

Title II of the ADA indicates that a public entity must operate a service, program, or activity accessible to persons with a disability in the most appropriate integrated setting.²¹⁵ Some courts have interpreted the standard as requiring substantial effort,²¹⁶ while other courts have been more restrictive.²¹⁷ The problem has been that courts defer to safety, security, and other penological considerations in assessing whether the program access obligation has been met.²¹⁸ U.S. courts had differing views on whether Title II of the ADA applied to prison settings. Some courts refused to apply the ADA to correctional facilities in the absence of more specific language.²¹⁹ However, in *Pennsylvania Department of Corrections v. Yeskey*, the U.S. Supreme Court held that the ADA “unmistakably” applies to state prisoners (based on the refusal of the correctional

211. *Id.*

212. Developmental Disabilities Assistance and Bill of Rights Act of 2000, Pub. L. No. 106-402, 114 Stat. 1677 (Nov. 16, 2000).

213. Rehabilitation Act of 1973, § 504, 87 Stat. at 394.

214. 28 C.F.R. § 35.152 (2015).

215. Rehabilitation Act of 1973, § 504, 87 Stat. at 395.

216. *Armstrong v. Wilson*, 124 F.3d 1019 (9th Cir. 1997) (discussing emergency evacuation plans).

217. *Jones v. Smith*, 109 F. App'x 304, 309 (10th Cir. 2004) (finding that plaintiff had to allege that he was precluded from participating in a work service program simply because he was assigned a position he could not fulfill due to disability).

218. MICHAEL L. PERLIN & HENRY D. DLUGACZ, MENTAL HEALTH ISSUES IN JAILS AND PRISONS 822–31 (2008); Lawrence W. Paradis, Rights of Prisoners with Disabilities Under Title II of the Americans with Disabilities Act and Section 504 of the Rehabilitation Act at the ATLA Annual Convention (2006).

219. PETERSILIA, *supra* note 7, at 42.

system to allow a prisoner with hypertension to engage in a motivational boot camp program).²²⁰ In *Yeskey*, four claims were rejected by the Court.²²¹ First, in response to the petitioners contention that state prisons do not provide prisoners with benefits of programs, services, or activities as a public entity, Justice Scalia stated that “modern prisons provide inmates with many . . . educational and vocational ‘programs,’ all of which theoretically ‘benefit’ the prisoners (and any of which disabled prisoners could be ‘excluded from participation in’).”²²² Second, the petitioners argued that the term “qualified individual with a disability” was ambiguous when applied to state prisoners but the Court responded that this language meant “anyone with a disability,” including those receiving services from a public entity.²²³ Third, the petitioners argued that the words “eligibility” and “participation” implied voluntariness whereas prisoners were held against their will.²²⁴ The Court indicated that the words in legislation did not connote voluntariness and some services and activities in a prison are voluntary (e.g., using the prison library).²²⁵ Last, the petitioners indicated that prisons and prisoners were not mentioned in the findings and purpose of the statute.²²⁶ However, reference was made to discrimination within institutions (i.e., including penal institutions).²²⁷ These arguments by the petitioners portrayed persons with disability who are also prisoners as not deserving of equal rights.

In *Armstrong v. Schwarzenegger*, a class action had been brought fifteen years earlier arguing a violation of the ADA, the Rehabilitation Act and the Fourteenth Amendment in county jails.²²⁸ The Ninth Circuit affirmed that the California Department of Corrections and Rehabilitation was responsible under the ADA for ensuring that any disabled prisoners and parolees received accommodations, programs, services, or activities under Title II,

220. Pa. Dep’t of Corr. v. *Yeskey*, 524 U.S. 206, 209 (1998).

221. *Id.* at 208–11.

222. *Id.* at 210.

223. *Id.*

224. *Id.*

225. *Id.* at 211.

226. *Id.*

227. *Id.* at 211–12.

228. *Armstrong v. Schwarzenegger*, 622 F.3d 1058 (9th Cir. 2010).

including those with learning and developmental disabilities.²²⁹ Here the Court justifiably acknowledged the rights of disabled persons. Meanwhile, section 504 of the Rehabilitation Act states that no person with a disability should “be excluded from the participation in, denied the benefits of, or be subjected to discrimination under any program or activity” which includes federal agencies (e.g., Bureau of Prisons) and agencies that receive federal funding.²³⁰

The American Civil Liberties Union National Prison Project stated that courts analyze claims under both the ADA and the Rehabilitation Act in basically the same way and that prisoners with a disability can use cases under the Rehabilitation Act to interpret the ADA.²³¹ The ADA Amendments Act of 2008 was designed to focus courts on whether entities subject to the ADA had met their obligation to persons with a disability, rather than on whether a particular disability was an impairment, which has served to provide protection to more prisoners.²³² To bring a lawsuit under the ADA and/or the Rehabilitation Act, a prisoner needs to show that he or she: (1) meets the definition of disabled; (2) is qualified to participate in a program, with or without reasonable modifications; (3) is “excluded from, . . . not allowed to benefit from, or ha[s] been subjected to discrimination in the program;” and (4) under the Rehabilitation Act, prison officials or the governmental agency receives federal funding.²³³ There are limitations on these rights however: “[p]rison officials are not required to provide accommodations that impose undue financial and administrative burdens or require a fundamental alteration in the nature of the program.”²³⁴ Similarly, officials are “allowed to discriminate if the disabled prisoners’ participation would pose significant health and

229. *Id.* at 1063.

230. Rehabilitation Act of 1973, Pub. L. No. 93-112, § 504, 87 Stat. 355 (Sept. 26, 1973) (codified at 29 U.S.C. § 701 (2012)).

231. *Know Your Rights: Legal Rights of Disabled Prisoners: ACLU National Prison Project*, AM. C.L. UNION, https://www.aclu.org/files/assets/know_your_rights_-_disability_november_2012.pdf (last updated Nov. 2012) (citing *Frame v. City of Arlington*, 657 F.3d 215 (5th Cir. 2011) (applying the holding to both statutes)).

232. *See* Americans with Disabilities Act Amendments Act of 2008, Pub. L. No. 110-325, 122 Stat. 3553 (2008).

233. AM. C.L. UNION, *supra* note 231.

234. *Id.*

safety risks or a direct threat to others,” provided any discriminatory policies serve legitimate penological interests.²³⁵

The Prison Litigation Reform Act of 1995 (PLRA) requires prisoners to exhaust administrative remedies before bringing suit under section 1983 or any other federal law.²³⁶ However, in *Parkinson v. Goord*, the court found the exhaustion requirement did not apply to Title II claims as there is no exhaustion requirement within the ADA.²³⁷ In contrast, in *Jones v. Smith*, the court held that the exhaustion requirement applied to all federal law claims, including Title II.²³⁸

The Eighth Amendment prohibits any form of cruel or unusual punishment.²³⁹ Nonetheless, violations have occurred when federal or state prison officials are deliberately indifferent to the special requirements of a prisoner with mental illness regarding ongoing solitary confinement.²⁴⁰ Note that the United States is considered one of the only countries in the world that allows the execution of persons with intellectual disability.²⁴¹ The Fifth Amendment (regarding the federal government) and the Fourteenth Amendment (regarding state governments) prohibit government officials from depriving persons of life, liberty, or property without “due process” of law, and the Fourteenth Amendment requires that all citizens receive the “equal protection” of the law;²⁴² violations occur when prison officials discriminate against prisoners with disability because of their disability.²⁴³ However, demonstrating a violation is very difficult because courts generally give prison officials wide discretion in administering jails and prisons. For example, in *Overton v. Bazzetta*, the Court afforded substantial deference to the professional judgment of prison administrators, as they bore a “significant responsibility for defining the legitimate goals of a corrections system and the most

235. *Id.*

236. Prison Litigation Reform Act 1995, Pub. L. No. 103-134, § 803, 110 Stat. 1321, 1371 (1996) (codified at 42 U.S.C. § 1997e).

237. *Parkinson v. Goord*, 116 F. Supp. 2d 390, 398–99 (W.D.N.Y. 2000).

238. *Jones v. Smith*, 109 F. App'x 304, 307–08 (10th Cir. 2004).

239. U.S. CONST. amend. VIII.

240. *E.g.*, *Madrid v. Gomez*, 889 F. Supp. 1146, 1266–67 (N.D. Cal. 1995).

241. PETERSILIA, *supra* note 7, at 26.

242. U.S. CONST. amends. V, XIV.

243. Forensic disability clients “are routinely denied fundamental rights afforded to those” with cognitive capacity. PETERSILIA, *supra* note 7, at 26.

appropriate means to accomplish them.”²⁴⁴ However, it seems meeting legitimate prisoner interests may not be one of them. Additionally, the Eleventh Amendment provides state governments with sovereign immunity from being sued by citizens for many kinds of lawsuits.²⁴⁵ In *United States v. Georgia*, the Court ruled that the Eleventh Amendment does not bar monetary damage claims against state prisons under Title II where the discrimination is severe enough to violate the Fourteenth Amendment.²⁴⁶ However, the increasing rightward trend of the Court means that the success of such claims will likely be limited in the future.²⁴⁷ The Court is also likely to extend Eleventh Amendment protection to discriminatory practices in prisons that are prohibited by the ADA, which may not rise to the level of a constitutional violation.²⁴⁸

There appears to have been little legal interest regarding the right of forensic disability clients to access programs. Rehabilitation programs are not generally accessible to offenders with an IQ lower than eighty points. This author conducted an informal survey of program delivery in the United Kingdom and Australia that indicated very few programs were available to offenders in correctional or human services systems. Those that existed had been adapted rather than specifically designed to meet cognitive disability needs. This is despite programs with a focus on problem solving, behavior management, and social skills training to address anger and aggression, sexual offending, and firesetting receiving positive evaluations.²⁴⁹ In the United States, landmark cases regarding more fundamental rights have occurred in Texas and California. In *Ruiz v. Estelle*, a class action suit ended with a ruling that the conditions of imprisonment within the Texas Department of Corrections violated the Eighth Amendment, including lack of access to healthcare.²⁵⁰ Litigation continued for decades, ultimately resulting in the PLRA.²⁵¹ The judge found that ten to fifteen

244. *Overton v. Bazzetta*, 539 U.S. 126, 132 (2003).

245. U.S. CONST. amend. XI.

246. *United States v. Georgia*, 546 U.S. 151, 159 (2006).

247. *Paradis*, *supra* note 218.

248. *Id.*

249. John L. Taylor & William R. Lindsay, *Understanding and Treating Offenders with Learning Disabilities: A Review of Recent Developments*, 1 J. LEARNING DISABILITIES & OFFENDING BEHAV. 5, 5–16 (2010).

250. *Ruiz v. Estelle*, 679 F.2d 1115, 1166–67 (5th Cir. 1982).

251. *Id.*

percent of the prisoners had an intellectual disability and were abnormally prone to injuries, many of them job-related, and were disadvantaged when appearing before disciplinary committees.²⁵² As a result, the Texas Department of Corrections instituted staff training programs, policies of inmate assessment, specialized rehabilitation and housing, and the Texas Code of Criminal Procedure was amended to allow for the transfer of prisoners to the Texas Department of Mental Health and Mental Retardation.²⁵³

Armstrong, a class action lawsuit, was brought against Californian prison officials on behalf of all prisoners with developmental disabilities, and it ultimately settled.²⁵⁴ The lawsuit alleged that prisoners were being discriminated against through their experiences of inadequate emergency evacuation plans; having a more limited range of vocational programs; improper classification for work and educational assignments meaning they could not obtain good time credits; enduring assaults and taunts by other inmates and correctional staff; and being excluded from medical, work, and education programs.²⁵⁵ In *Clark v. California*, two intellectually disabled inmates in state prison sued on behalf of similarly situated individuals who had “suffered discrimination because of their disabilities.”²⁵⁶ Following the lower court’s denial of a motion to dismiss,²⁵⁷ the Ninth Circuit noted Congress’s “intent to abrogate the State’s immunity under both the ADA and the Rehabilitation Act,” as well as an “express waiver of Eleventh Amendment immunity which California accepted when it accepted Rehabilitation Act funds.”²⁵⁸ However, this lawsuit addressed prisons, not jails or probation, and access to rehabilitation programs was not mentioned.

Subsequently, the prisoner plaintiffs in *Coleman v. Schwarzenegger* alleged violations of the Eighth and Fourteenth Amendments and the Rehabilitation Act for unconstitutional conditions of mental health care.²⁵⁹ The court found violations of the Eighth Amendment and ordered injunctive relief that

252. *Id.*

253. *Id.*

254. *See* *Armstrong v. Wilson*, 124 F.3d 1019 (9th Cir. 1997).

255. *Id.* at 1021.

256. 123 F.3d 1267, 1269 (9th Cir. 1997).

257. *Id.*

258. *Id.* at 1269, 1271.

259. *Coleman v. Schwarzenegger*, 922 F. Supp. 2d 882, 898 (N.D. Cal. 2009).

ultimately required a special master who filed sixteen reports detailing the lack of progress.²⁶⁰ The plaintiffs in *Plata v. Schwarzenegger* then alleged violations of the Eighth Amendment and the ADA based on inadequate medical services.²⁶¹ By the time these cases reached the U.S. Supreme Court in *Brown v. Plata* on the issue of consistency with the PLRA, they had been merged.²⁶² California had been ordered by the three-judge panel, empowered under the PLRA, to reduce its prison population through deinstitutionalization because of inadequate medical services and an unnecessary death occurring at least once a week.²⁶³ However, this action is unlikely to ameliorate the systemic mental health care deficiencies for those who remain.

Access to programs is a fundamental right to forensic disability clients. In the United States, “[d]isabled prisoners have sued to get equal access to facilities, programs, and services.”²⁶⁴ However, these cases were brought by prisoners with physical disability or hearing impairments alleging inadequate medical care and deliberate indifference and challenging solitary confinement and segregation units.²⁶⁵ Surprisingly, there appears to have been very little response by the courts regarding access to programs, particularly if the programs are related to gain-time credits and parole. In the United Kingdom, forensic disability clients were discriminated against personally, systemically, and routinely throughout the CJS.²⁶⁶ In particular, exclusion from rehabilitation programs makes parole and release less likely and a return to prison more likely.²⁶⁷ In Europe, this problem was highlighted by the Joint Committee on Human Rights regarding the European Court of Human Rights and articles 5 and 14 (the right to liberty and enjoyment of rights without discrimination, respectively).²⁶⁸

260. *Id.* at 899–900, 907–08.

261. *Plata v. Schwarzenegger*, 603 F.3d 1088, 1090 (9th Cir. 2010).

262. *Brown v. Plata*, 563 U.S. 493, 500 (2011).

263. *Id.* at 509.

264. AM. C.L. UNION, *supra* note 231.

265. *Id.* (citing *Saunders v. Horn*, 960 F. Supp. 893 (E.D. Pa. 1997)) (alleging a failure to provide orthopedic shoes and cane); *see also Herndon v. Johnson*, 970 F. Supp. 703 (E.D. Ark. 1997).

266. *See* Jenny Talbot, *No One Knows: Offenders with Learning Disabilities and Learning Difficulties*, 5 INT’L J. PRISONER HEALTH 141, 160 (2007).

267. *Id.*

268. *Id.*

A United Kingdom case highlighted the difficulties a forensic disability client faces in prison: In *Gill, R. v. Secretary of State for Justice*, the High Court (an administrative court) found that the Secretary had breached the Disability Discrimination Act of 1995 in carrying out governmental functions.²⁶⁹ Mr. Gill was a person with a learning disability who was serving a life sentence, and although participation in offending behavior programs was not necessary to obtain parole, in this case it was “identified as an avenue.”²⁷⁰ The court used a six-step test for how a public authority must avoid indirectly discriminating²⁷¹ and found that the Secretary of State:

1. Had practices, policies, or procedures in place regarding access to the programs;²⁷²
2. Made it impossible for Mr. Gill to access the programs because of his intellectual capacity and despite the parole board recommending access;²⁷³
3. Had a duty to take reasonable steps to change practices to allow Mr. Gill to access the programs;²⁷⁴
4. Had not taken such steps to explore adjustments to the programs such as one-to-one support, a qualified person to assist, or a transfer to another setting;²⁷⁵
5. Made it unreasonably difficult for Mr. Gill to access the programs;²⁷⁶ and
6. Failed to provide a persuasive argument to justify the failure (the expense argument was dismissed as it entailed the treatment of one person).²⁷⁷

In addition, Justice Cranston found that the Secretary of State had breached public law duty by not prioritizing programs for Mr. Gill, not consulting specialized organizations or considering

269. *Gill, R. v. Secretary of State for Justice*, [2010] EWHC 364 (Admin) (Eng.); see also Isabel McArdle, *Learning Disabilities and Access to Offender Behaviour Programmes in Prison: A High Court Decision*, 1 J. LEARNING DISABILITIES & OFFENDING BEHAV. 27, 27 (2010) (noting that *Gill* set a precedent that will affect prisoners with learning disabilities).

270. *Gill, R.*, EWHC 364 (Admin) at [80].

271. *Id.* ¶ 58.

272. *Id.* ¶ 64.

273. *Id.* ¶¶ 65–68.

274. *Id.* ¶¶ 63, 68.

275. *Id.* ¶¶ 65–70.

276. *Id.* ¶¶ 65–68.

277. *Id.* ¶¶ 70–76.

alternative offending behavior work, not ensuring access to offending behavior work, and not assessing his suitability for offending behavior programs.²⁷⁸ The practice implication for prisoners with a learning disability was that prisons had to take greater steps to help prisoners participate in offending behavior programs included in sentencing, potentially including one-to-one support, assistance by a qualified person, or transfer to a prison that could more effectively serve the person's needs.²⁷⁹

III. PSYCHOLOGICAL THEORIES

Psychological theories have underpinned rehabilitation programs for mainstream offenders. However, only one model has been designed specifically for forensic disability clients. Here, a particular focus will be placed on the principles underpinning several relevant theories to support access of persons with a disability to programs, as persons with a disability and as forensic disability clients.

A. *Person with a Disability*

First, a person with a disability has rights, requiring protection by and from the state.

Behaviors of concern in forensic disability clients are generally managed by way of strength-based approaches that engage in prevention and early intervention to encourage more adaptive behaviors and replace maladaptive behaviors. Positive Behavior Support (PBS) is a philosophy of practice that captures a range of individual and multi-systemic interventions designed to effect change in people's behavior, and ultimately their quality of life (e.g., in the areas of improved social relationships, personal satisfaction, employment, self-determination, recreation and leisure options, community adjustment, and community integration).²⁸⁰ PBS is defined as "an applied science that uses educational methods to expand an individual's behavior repertoire and systems

278. *Id.* ¶¶ 77–79.

279. *Id.* ¶¶ 79–81; *see also* McArdle, *supra* note 269, at 27.

280. Andrea M. Cohn, *Positive Behavioral Supports: Information for Educators*, NAT'L ASSOC. SCH. PSYCHOL. (2001), http://www.nasponline.org/resources/factsheets/pbs_fs.aspx (“[PBS] is an empirically validated, function-based approach to eliminate changing behaviors and replace them with prosocial skills. Use of PBS decreases the need for more intrusive or aversive interventions. . .”).

change methods to redesign an individual's living environment to first enhance the individual's quality of life and, second, to minimize his or her problem behavior."²⁸¹ PBS has recognized that all people, regardless of their behavior, are endowed with certain basic human rights; any program delivery should be respectful of those basic rights and foster their exercise and experience.²⁸² PBS holds that all human behavior serves a purpose, a recognition equally applicable to offending behavior. In order to bring about adaptive change, it is important to first understand the purpose of existing behaviors, aspirations held, and the range of knowledge and skills already possessed. In order to develop effective behavior change strategies, it is important to understand the context in which offending occurs, the environments in which the person lives, and his or her needs to learn and use more adaptive behaviors. A key principle of PBS is that it is a non-categorical process (i.e., strategies, interventions, and decisions are not based on any particular category of behavior, impairment, or disability). This is aligned with the social model definition of disability.

PBS emphasizes a person-centered approach made up of values, strategies, and planning.²⁸³ Person-centered values include person-centered planning in supporting the perspective, specific needs, and goals of the person (rather than staff values); self-determination in supporting autonomy to make informed choices or best interest decision-making by those who know and love the person; and a wraparound process in developing behavioral support plans that are needs-driven and strengths-based, rather than service-driven and deficits-based.²⁸⁴ Person-centered strategies aim to place the person in the center of service design and decision-making; provide individualized supports to the person; and empower the person to achieve his or her own wishes,

281. Edward G. Carr et al., *Positive Behavior Support: Evolution of an Applied Science*, 4 J. POSITIVE BEHAV. INTERVENTIONS 4, 4 (2002) (citation omitted).

282. Peter Baker & David Allen, *Use of Positive Behaviour Support to Tackle Challenging Behaviour*, 15 LEARNING DISABILITY PRAC. 18, 18–20 (2011); Christina Doody, *Multi-element Behavior Support as a Model for the Delivery of a Human Rights Based Approach for Working with People with Intellectual Disabilities and Behaviors that Challenge*, 37 BRIT. J. LEARNING DISABILITIES 293, 293–99 (2009).

283. See KEITH R. MCVILLY, POSITIVE BEHAVIOR SUPPORT FOR PEOPLE WITH INTELLECTUAL DISABILITY: EVIDENCE-BASED PRACTICE, PROMOTING QUALITY OF LIFE (2002); Carr et al., *supra* note 281, at 4–16.

284. See Carr et al., *supra* note 281, at 6.

preferences, and aspirations.²⁸⁵ Person-centered planning procedures help the person work out what he or she wants in life; clarify the support needs for the person to pursue his or her aspirations; bring together people who have a part to play in supporting joint problem solving; energize and motivate the person; help direct and shape the contributions made from service agencies to ensure plans are based on what is important to people from their perspective, to more effectively help people meet their goals; and show service agencies how they can adjust their activities at both operational and strategic levels in order to better support people to achieve their goals.²⁸⁶

In Sydney, Australia researchers conducted sixty-one interviews with support network members and engaged in fifty-five participant observations of nine men and women with intellectual disabilities.²⁸⁷ The results of the study concluded that a “good life” was deemed to be experiencing happiness and safety; being listened to; being respected and having meaningful, reciprocal relationships; having as high a level of autonomy as possible; being a contributing member of the community; achieving a balanced life; and enjoying lifelong development.²⁸⁸ There, human rights violations included individual rights being over-ridden by service system regulations due to concerns about liability, occupational health and safety issues (the client-community interest dichotomy), and being vulnerable to having individual rights violated due to the perception of being compliant, lacking in confidence, or behaving in a manner considered socially inappropriate.²⁸⁹ The network members were committed to achieving an appropriate balance between risk, protection and autonomy, recognizing that they required well-informed judgments regarding decision-making capacity.²⁹⁰

285. *See id.*

286. *See id.* at 6–7.

287. Amy Hillman et al., *Experiencing Rights with Positive, Person-Centred Support Networks of People with Intellectual Disability in Australia*, 56 J. INTELL. DISABILITY RES. 1065, 1065 (2012).

288. *Id.* at 1068.

289. *Id.* at 1068–69.

290. *Id.* at 1069–70.

PBS is designed for human services settings but its principles can be applied in the correctional system. Ten principles have been adapted²⁹¹:

1. Comprehensive lifestyle change and quality of life: assisting people with disabilities and their supporters to improve quality of life is a focus of PBS;²⁹²
2. A lifespan perspective: In step with “the new standard,” PBS recognizes that achieving change can take years with different challenges at different stages of life;²⁹³
3. Ecological validity: PBS applies social science in real-life community settings;²⁹⁴
4. Stakeholder participation: under the PBS approach, professionals collaborate with stakeholders—parents, siblings, neighbors, teachers, job coaches, friends, roommates, and the person with disabilities—who function as active participants in defining quality of life and in planning assessment and intervention strategies;²⁹⁵
5. Social validity: PBS defines success not only by a program’s objective effectiveness, but also by its practicality, desirability, contextual fit, and subjective effectiveness (quality of life and behaviors of concern) as viewed by stakeholders;²⁹⁶
6. Systems change: PBS focuses on problem contexts through system change that enables sustained progress through a common vision, clear direction, adequate resources, and training and incentives to change;²⁹⁷
7. Multicomponent intervention: recognizing “that the multidimensional nature of quality of life requires . . . a multicomponent (plural) approach to intervention;” PBS reflects the modern reality that multiple functional and structural variables influence behaviors of concern and require multidimensional strategies;²⁹⁸

291. Carr et al., *supra* note 281, at 4–16.

292. *Id.* at 6.

293. *Id.* at 7.

294. *Id.*

295. *Id.* at 8.

296. *Id.*

297. *Id.* at 8–9.

298. *Id.* at 12–13.

8. Emphasis on prevention: PBS emphasizes proactive skills building and environmental design to produce desirable change;²⁹⁹
9. Flexibility in scientific practice: PBS emerged from the tradition of behavior analysis, and now also utilizes qualitative data, ratings, interviews, questionnaires, logs, self-reports, correlational analyses, naturalistic observations and case studies for data collection in uncontrolled settings;³⁰⁰
10. Multiple theoretical perspectives: one such perspective is that individuals in community settings are interdependent and multicultural and so change occurs in social systems, not just individuals; another is the notion that change requires reallocation of time, money and political power and behavior is a continuous process; a final perspective is that individual behavior is a result of environment adaptation.³⁰¹

PBS is applicable to forensic disability clients in prison and community settings.

B. Person as an Offender

Second, a person as an offender is a rights-violator from whom the community may require some level of protection.

1. Risk-Need-Responsivity

The Risk-Need-Responsivity model (RNR) is based on risk of re-offending, the treatment of identified dynamic risk factors or criminogenic needs, and being responsive to individual characteristics and the offender-staff interaction.³⁰² Through meta-analyses, RNR provides empirical evidence for effective interventions that reduce re-offending between thirty and fifty percent in mainstream offenders.³⁰³ Dose duration and frequency of sessions, as well as intensity and length of delivery over time, are all aspects of RNR, which requires higher risk offenders to receive

299. *Id.* at 9.

300. *Id.*

301. *Id.* at 10–11.

302. See DON A. ANDREWS & JAMES BONTA, *THE PSYCHOLOGY OF CRIMINAL CONDUCT* 45–78 (2010).

303. See Craig Dowden et al., *The Effectiveness of Relapse Prevention with Offenders: A Meta-analysis*, 47 *INT'L J. OFFENDER THERAPY & COMP. CRIMINOLOGY* 516, 516–18 (2003).

more intensive treatment that target dynamic (or treatable) risk factors.³⁰⁴ RNR treatment ultimately leads to a relapse prevention plan.³⁰⁵ However, relapse prevention has been criticized as a deficit-based model in which the offender is to avoid high-risk situations, thoughts, and behaviors and therefore, is an insufficiently motivating approach.³⁰⁶ No research has been conducted to date with offenders with cognitive disability within the RNR model (even among sexual offenders with an intellectual disability, who are the most researched group),³⁰⁷ although dynamic risk factors such as aggression and anger, social problem solving, offense-related thinking, cognitive distortions related to sexual offending, and motivation for firesetting are being explored.³⁰⁸

A low IQ alone is considered by RNR to be a minor risk/need factor with it being a less promising intermediate target to reduce re-offending, although the presence of low IQ may impact impulse control or self-regulation.³⁰⁹ Therefore, low IQ is considered a minor risk factor, as are personal or emotional distress, major mental disorder, physical illness, fear of punishment, socioeconomic status, and offense seriousness.³¹⁰ RNR declares that the assessed level of risk should drive the intensity and duration of treatment based on identified dynamic risk factors, not non-criminogenic needs such as basic life skills acquisition, communication, interpersonal skills, and self-esteem.³¹¹ However, a study described by Don Andrews and James Bonta “focused on a rather narrow continuum of social skills and on non-developmentally disabled offenders,” and found that attending to

304. Don A. Andrews et al., *Classification for Effective Psychology: Rediscovering Psychology*, 17 CRIM. J. & BEHAV. 19, 20 (1990).

305. Dowden et al., *supra* note 303, at 516–18.

306. Tony Ward & Mark Brown, *The Good Lives Model and Conceptual Issues in Offender Rehabilitation*, 10 PSYCHOL. CRIME & L. 243, 244 (2004).

307. *See, e.g.*, GERRY D. BLASINGAME ET AL., ASS’N FOR THE TREATMENT OF SEXUAL ABUSERS, ASSESSMENT, TREATMENT, AND SUPERVISION OF INDIVIDUALS WITH INTELLECTUAL DISABILITIES AND PROBLEMATIC SEXUAL BEHAVIORS 15 (2014), https://www.atsa.com/pdfs/ATSA_IDPSB_packet.pdf (noting no research has been done for this group).

308. *See, e.g.*, William R. Lindsay et al., *An Assessment for Attitudes Consistent with Sexual Offending for Use with Offenders with Intellectual Disabilities*, 12 LEGAL & CRIMINOLOGICAL PSYCHOL. 55, 56 (2007).

309. ANDREWS & BONTA, *supra* note 302, at 59, 262–64.

310. *Id.*

311. *Id.* at 47.

basic needs in offenders with disability *is* relevant to reducing reoffending.³¹² Further, those forensic disability clients who were internalizing emotional problems of anxiety, depression, and low self-esteem were at risk of re-offending.³¹³ Likewise, offenders with intellectual disability require attention to physical health, communication, and detailed past life experience in assessing intellectual and social ability, personality, and the nature of the offense.³¹⁴

RNR details eighteen principles for effective intervention, but only the eight principles will be presented here³¹⁵:

1. Assess risk and need;
2. Enhance internal motivation;
3. Target interventions:
 - a. Risk principle: prioritize supervision and treatment to high-risk offenders (the who);
 - b. Need principle: target interventions to dynamic risk factors (the what);
 - c. Responsivity principle: be responsive to temperament, learning style, motivation, culture, and gender when assigning programs (the how);
 - d. Dosage and intensity: high-risk offenders require 40-70% of their time over 3-9 months in intervention;
 - e. Treatment: integrate treatment into the full sentence;
4. Use cognitive behavioral treatment to provide skills training;
5. Increase positive reinforcement and enforce consequences in a firm, but fair, way;
6. Engage ongoing support in natural communities of support using advocacy and brokerage;

312. James Haaven, *The Evolution of the Old Me/New Me Model*, in PRACTICAL TREATMENT STRATEGIES FOR PERSONS WITH INTELLECTUAL DISABILITIES: WORKING WITH FORENSIC CLIENTS WITH SEVERE AND SEXUAL BEHAVIOR PROBLEMS 80, 86 (Gerty D. Blasingame ed., 2006).

313. William R. Lindsay et al., *Risk Assessment in Offenders with Intellectual Disability: A Comparison Across Three Levels of Security*, 52 INT'L J. OFFENDER THERAPY & COMP. CRIMINOLOGY 90, 107 (2008).

314. Susan J. Johnston, *Risk Assessment in Offenders with Intellectual Disability: The Evidence Base*, 46 J. INTELL. DISABILITY RES. 47, 48 (2002).

315. PEGGY B. BURKE, NAT'L INST. OF CORR., TPC REENTRY HANDBOOK: IMPLEMENTING THE NIC TRANSITION FROM PRISON TO THE COMMUNITY MODEL 27 (2008).

7. Measure relevant processes and practices, including intermediate targets (dynamic risk factors); and
8. Provide measurement feedback to offenders and staff.³¹⁶

RNR appears to be a less robust model of rehabilitation for forensic disability clients.

2. *Good Lives Model*

Imprisonment is distressing for most individuals, and forensic disability clients have been found, on psychometric measures, to suffer three times the depression and anxiety levels as general population prisoners.³¹⁷ The Good Lives Model (GLM) differs from RNR in that it also attends to the well-being of offenders.³¹⁸ The GLM is a psychological model that is based on the assumption that all offenders seek to meet their basic human needs (physical, social, and psychological) through maladaptive means.³¹⁹ If these maladaptive behaviors are replaced with adaptive behaviors, well-being will increase and offending will decrease.³²⁰ The GLM has been described as revolutionizing sexual offender treatment in that it formalized the role of positive goals and the development of a pro-social positive identity; it is strength-based rather than risk-based.³²¹ The GLM reflects the ICF as a biopsychosocial framework in general and the DSM-5 domains for cognitive disability, in particular regarding physical, social, and psychological human needs.

Unlike RNR, the GLM balances internal capacities with external supports. Therefore, the GLM is mindful of the role of non-criminogenic needs and external supports and opportunities in offending.³²² In disability terms, this would include adaptive behaviors such as communication and social skills as well as states of anxiety, depression, and low self-esteem. The GLM is also more

316. BURKE, *supra* note 315, at 27.

317. Talbot, *supra* note 266, at 146.

318. See Tony Ward & Claire Stewart, *Criminogenic Needs and Human Needs: A Theoretical Model*, 9 PSYCHOL. CRIME & L. 125, 136 (2003).

319. *Id.* at 138.

320. *Id.* at 133.

321. DOUGLAS P. BOER, ASSESSMENT, TREATMENT, AND SUPERVISION OF INDIVIDUALS WITH INTELLECTUAL DISABILITIES & PROBLEMATIC SEXUAL BEHAVIORS 16 (2014).

322. Ward & Stewart, *supra* note 318, at 136.

supportive of the principles in the CRPD.³²³ In contrast to relapse prevention, which avoids high-risk situations, places, and behaviors, the GLM is concerned with providing an offender with approach goals (actively approach situations that will meet life goals) in addition to avoidance goals (avoiding high-risk situations and behaviors).³²⁴ In addition, the GLM proposes that all individuals construct a narrative or personal identity that can provide offenders with the psychological and social capital to fashion ways of living that are personally endorsed and that result in reduced offending.³²⁵

To date, the GLM's applicability to sexual offenders with cognitive disabilities has been considered. In applying the GLM to sexual offenders with intellectual disabilities, it has been suggested that developing a Life Map would elicit the client's story from birth.³²⁶ Researchers indicated that they "have employed the method of a life map, which traces personal development from birth and which incorporates long-term future projections. This includes all actions, events, incidents and skills (whether positive or negative), which have led to a sense of self-esteem and the development of personal values."³²⁷ In this way, good and bad childhood experiences, pro-social and anti-social experiences, punishment for behavior problems, and exciting anti-social experiences that lead to offending are all considered.³²⁸ This information is then incorporated into a Good Lives Pathway.³²⁹ The GLM can address both person-centered planning (required in human services) and community protection (required in corrections) in offenders with learning disabilities.³³⁰

323. See Ward & Birgden, *supra* note 147, at 636.

324. *Id.* at 637.

325. Tony Ward & D. Richard Laws, *Desistance from Sex Offending: Motivating Change, Enriching Practice*, 9 INT'L J. FORENSIC MENTAL HEALTH 11, 12 (2010).

326. William R. Lindsay et al., *Self-Regulation of Sex Offending, Future Pathways and the Good Lives Model: Applications and Problems*, 13 J. SEXUAL AGGRESSION 37, 40 (2007).

327. *Id.* at 37.

328. *Id.*

329. *Id.*

330. Sarah Aust, *Is the Good Lives Model of Offender Treatment Relevant to Sex Offenders with a Learning Disability?*, 1 J. LEARNING DISABILITIES & OFFENDING BEHAV. 33, 37 (2010).

There are six GLM principles for mainstream sexual offender treatment programs, but these principles are applicable to all offense types and disabilities³³¹:

1. Due to adversarial developmental experiences as children, many offenders lack the capacities and supports to achieve a coherent good life plan;³³²
2. Offenders lack many of the capacities and supports necessary to achieve a fulfilling life;³³³
3. Offending is an attempt to achieve desired life goals but where the capacities and supports are lacking (direct route) or to relieve conflict arising from failing to reach life goals (indirect route);³³⁴
4. The absence of certain life goals—autonomy, inner peace, relatedness—are more strongly associated with interpersonal offending;³³⁵
5. Assisting offenders to develop capacities and social supports, and address autonomy, inner peace, and relatedness will reduce offending;³³⁶ and
6. Treatment should add to personal repertoire, not simply remove or manage a problem (i.e., to experience as normal a level of functioning as possible).³³⁷

In effect, the GLM is an extension of PBS to the correctional system, and so it is entirely applicable to forensic disability clients.

3. *Desistance Theory*

Desistance from offending is a change process that is initiated by decisive momentum, supported by intervention, and maintained through community reintegration resulting in a citizen with full rights and responsibilities.³³⁸ In conducting research on the life

331. Tony Ward et al., *The Good Lives Model of Offender Rehabilitation: Clinical Implications*, 12 *AGGRESSION & VIOLENT BEHAV.* 87, 93–94 (2007), <https://ccoso.org/sites/default/files/import/Ward-Mann-Gannon-2007.pdf>.

332. *Id.* at 93.

333. *Id.*

334. *Id.* at 94.

335. *Id.*

336. *Id.*

337. *Id.*

338. Astrid Birgden, *Maximizing Desistance: Adding Therapeutic Jurisprudence and Human Rights to the Mix*, 42 *CRIM. J. & BEHAV.* 19, 29 (2015).

narratives of male and female offenders in the United Kingdom, Maruna divided them into two groups.³³⁹ The first group was described as “persisters”—active offenders with a condemnation script (“I will never be able to get a straight job”; “I’m a loser”).³⁴⁰ Persisters experienced feelings of hopelessness.³⁴¹ The second group was the “desisters”—inactive offenders with a redemption script (“I’m a family man”; “I want to give back to society”).³⁴² Desisters made social contributions.³⁴³ The motivation for desisters to change was prompted by particular decision points, life events, or turning points such as reform school, employment, military service, or marriage and being believed by another.³⁴⁴ In particular, the desisters experienced human capital (the internal capacity to change) and social capital (the external opportunities to exercise those capacities to change).³⁴⁵ The notion of these internal and external capacities and supports are aligned with PBS and the GLM.

Desistance can be considered a phased process.³⁴⁶ An offender experiences a decisive moment (a positive or negative life event) that triggers readiness to change.³⁴⁷ Then, treatment provides formal and informal supports for the offender to reconstruct the self (i.e., habilitation) or re-establish a previously adaptive self (i.e., rehabilitation). Moreover, community reintegration can maintain desistance with an emphasis on approach goals (what the offender wants) rather than avoidance goals (what the community wants).³⁴⁸ “Normalcy,” or reintegration, is defined as successfully desisting

339. See SHADD MARUNA, MAKING GOOD: HOW EX-INMATES REFORM & REBUILD THEIR LIVES 38 (2001).

340. *Id.* at 73.

341. *Id.* at 74.

342. *Id.* at 85.

343. *Id.* at 87.

344. *Id.* at 95–96; see also David S. Kirk, *Residential Change as a Turning Point in the Life of Course of Crime: Desistance or Temporary Cessation?*, 50 CRIMINOLOGY 329, 330 (2012); Robert J. Sampson & John H. Laub, *A Life-Course View of the Development of Crime*, 602 ANNALS AM. ACAD. POL. & SOC. SCI. 12, 15 (2005).

345. MARUNA, *supra* note 339, at 95–96; see also FERGUS MCNEILL ET AL., 21ST CENTURY SOCIAL WORK: REDUCED RE-OFFENDING: KEY PRACTICE SKILLS 3 (2005).

346. Göbbels et al., *supra* note 132, at 454.

347. *Id.* at 454–57.

348. *Id.* at 457–58.

over a long period of time and ex-offenders defining themselves as non-offending citizens, which can be decades later.³⁴⁹

Desistance principles are³⁵⁰:

1. Be realistic about setbacks and relapses;³⁵¹
2. Individualize intervention by considering identity and diversity;³⁵²
3. Develop and maintain motivation and hope;³⁵³
4. Understand desistance in the context of relationships, the people who matter to the person, and ex-offenders who “make good”;³⁵⁴
5. Focus on strengths and resources for offenders to overcome obstacles to desistance, not just risk;³⁵⁵
6. Desistance is a process of discovering *autonomy*, which means working *with* offenders not *on* offenders;³⁵⁶
7. Base intervention on human capital (internal capacities) and social capital (external opportunities);³⁵⁷ and
8. Acknowledge and celebrate achievements and positive potential for development and redemption.³⁵⁸

Desistance theory is applicable to forensic disability clients.

C. *Forensic Disability Clients*

Third, a forensic disability framework needs to attend to the person as both a rights-violator and a rights-holder. One rehabilitation model explicitly considers the individual as both a person with a disability and as an offender.

The Old Me-New Me model has been designed for offenders with intellectual disability.³⁵⁹ The Old Me-New Me model has been

349. *Id.* at 460–61.

350. Iriss, *Supporting Desistance from Crime: Reconfiguring Penal Practice*, VIMEO (Sept. 14, 2011), <http://vimeo.com/29040198>.

351. *Id.*

352. *Id.*

353. *Id.*

354. *Id.*

355. *Id.*

356. *Id.*

357. *Id.*

358. *Id.*

359. Haaven, *supra* note 312, at 71; James L. Haaven & Emily M. Coleman, *Treatment of the Developmentally Disabled Sex Offender*, in REMAKING RELAPSE

applied since 1990 and is based on positive psychology in that clients identify their own anti-social characteristics and behaviors (Old Me) and develop new pro-social characteristics and behaviors (New Me).³⁶⁰ The Old Me-New Me dichotomy reflects the ongoing, simultaneous struggle that occurs within the sexual offender “when managing risk and life decisions.”³⁶¹ Old Me and New Me fit well with the self-identity narratives espoused by the GLM and desistance theory.

Old Me-New Me, like the GLM, is a humanistic and strength-based approach to addressing dynamic risk factors in offending, considering both internal capacities and external supports, and endorsing positive approach goals to live a healthy, fulfilling life without offending. Both the GLM and Old Me-New Me models assume that basic human needs should be met to reduce offending. The Old Me-New Me model lacks empirical evidence regarding efficacy, but nevertheless it is the central model utilized by HM Prison in the United Kingdom.³⁶²

The Old Me-New Me model has six principles³⁶³:

1. Develop a positive self-identity;³⁶⁴
2. Increase self-efficacy;³⁶⁵
3. Increase the capacity to meet basic needs;³⁶⁶
4. Manage dynamic risk factors;³⁶⁷
5. Focus on approach goals;³⁶⁸ and

PREVENTION WITH SEX OFFENDERS: A SOURCEBOOK 369, 380 (D. Richard Laws, et al. eds., 2000).

360. See REMAKING RELAPSE PREVENTION WITH SEX OFFENDERS: A SOURCEBOOK, *supra* note 359, at 380–84.

361. BLASINGAME ET AL., *supra* note 307, at 3, 16.

362. Douglas P. Boer, *Treatment of Persons with Intellectual Disabilities and Problematic Sexual Behaviors*, in TREATMENT OF PERSONS WITH INTELLECTUAL DISABILITIES AND PROBLEMATIC SEXUAL BEHAVIORS (L. Marshall & W.L. Marshall eds.) (forthcoming) (on file with author); Fionna Williams & Ruth E. Mann, *The Treatment of Intellectually Disabled Sexual Offenders in the National Offender Management Service: The Adapted Sex Offender Treatment Programmes*, in ASSESSMENT AND TREATMENT OF SEXUAL OFFENDERS WITH INTELLECTUAL DISABILITIES: A HANDBOOK 293, 293–94 (Leam A. Craig et al. eds., 2010).

363. REMAKING RELAPSE PREVENTION WITH SEX OFFENDERS: A SOURCEBOOK, *supra* note 359, at 380–86.

364. *Id.*

365. *Id.*

366. *Id.*

367. *Id.*

6. Develop the capacity to establish and maintain wraparound supports in the community.³⁶⁹

The Old Me-New Me model is designed for forensic disability clients.

D. Summary

Treatment (primarily for sexual offenders with intellectual disabilities) has been largely based on the adaptation of mainstream programs. Adaptation means simplifying concepts, using imagery, applying frequent repetition and rehearsal, and generalizing skills across settings.³⁷⁰ However, treatment should focus on identifying specific risk factors and developing specific interventions for forensic disability clients, rather than adapting mainstream programs.

The principles that underpin PBS, the GLM, Desistance Theory, and the Old Me-New Me model support those that underpin a social definition of disability as well as the habilitation and rehabilitation goals within the CRPD; they are all humanistic and support strength-based approaches designed to enhance well-being. In turn, these approaches support a human rights-approach to program delivery with rights violators, who are also acknowledged rights holders.

IV. CONCLUSION: FRAMEWORK PRINCIPLES

Practice principles guide service delivery. Some scholars have proposed a list of best practice principles for treatment interventions for sexual offenders with intellectual disabilities, later matched to underlying theories.³⁷¹ However, the principles are closely aligned with RNR, which is not considered the best model of support for forensic disability clients. Based on the supporting theories reviewed above, the following table proposes principles regarding program access to forensic disability clients to avoid discrimination with prisons.

368. *Id.*

369. *Id.*

370. Frank Lambrick & William Glaser, *Sex Offenders with an Intellectual Disability*, 16 *SEXUAL ABUSE* 381, 386 (2004).

371. BLASINGAME ET AL., *supra* note 307, at 16; TREATMENT OF PERSONS WITH INTELLECTUAL DISABILITIES AND PROBLEMATIC SEXUAL BEHAVIORS, *supra* note 362.

It is hoped that the proposed principles provide some guidance to correctional system administrators to enable forensic disability clients' access to available rehabilitation programs, which is their human right.

| Table 2: Principles to Reduce the Likelihood of Discrimination Against Forensic Disability Clients | | | |
|--|---|---|-----------------------------|
| Supporting Theories | Person with a Disability | Person as an Offender | Supporting Theories |
| Person-Centered Values | | | |
| Human Rights | Positive rights: access to programs, services, and activities. | Negative rights: freedom from unlawful restrictive practices. Any restrictions are proportional and tailored to the person's circumstances; apply for the shortest time possible; and are reviewable by a competent, independent, and impartial authority or judicial body. | Human Rights |
| Human Rights GLM | Consider the person as a rights-holder and a duty-bearer able to pursue his or her own goals. | Consider the person as a rights-violator and a duty-bearer with obligations toward others. | Human Rights RNR GLM |
| Human Rights PBS GLM | Support the person in exercising and experiencing his or her rights, wills, and preferences. | Support the person in exercising and experiencing responsibility for him/herself and toward others. | Human Rights PBS GLM |
| PBS GLM | Understand the context of the person's relationships, the people who matter to the person and the people who know and love the person. | Understand the context of the person's relationships, the people who matter to the person, and the role of ex-offenders who "make good" and assist the offender. | Desistance GLM |
| Human Rights PBS GLM | Provide full information about treatment options, risks, and expected outcomes; support participation in treatment planning and decision-making regarding program participation with free and informed consent. | | Human Rights PBS GLM |
| PBS GLM Old Me-New Me | Understand that change is a balance between the person and the broader social system and that behavior is a process of adaptation between the person and their environment. | | PBS GLM Old Me-New Me |

| Supporting Theories | Person with a Disability | Person as an Offender | Supporting Theories |
|---|---|--|---|
| Human Rights PBS GLM Old Me-New Me | Preserve and enhance personal autonomy and self-efficacy. | | Human Rights PBS GLM Old Me-New Me |
| Human Rights PBS | Establish practices, policies, and procedures that address discrimination in general and enhance access to programs in particular. | | Human Rights PBS |
| Person-Centered Assessment | | | |
| PBS GLM Old Me-New Me | Determine deficits and strengths in adaptive behavior and non-criminogenic needs. | Determine dynamic risk factors and protective factors linked to the offending behavior to be targeted for treatment. | RNR GLM Old Me-New Me |
| PBS GLM Old Me-New Me | With the person, determine his or her life goals and definition of a good life or an improved quality of life. | | PBS GLM Old Me-New Me |
| PBS GLM | Develop a clinical case formulation to determine the functions of the offending behavior and hypothesize what life goals the person is trying to meet through the offending behavior. | | PBS GLM |
| Person-Centered Treatment Planning | | | |
| PBS RNR GLM Desistance Old Me-New Me | Develop a treatment plan that guides adaptive behaviors to replace behaviors of concern (habilitation). | Develop a treatment plan that guides pro-social behaviors to replace dynamic risk factors (rehabilitation). | GLM Desistance Old Me-New Me |
| PBS GLM Desistance Old Me-New Me | Plan for human capital (internal capacity) and social capital (external supports). | | PBS GLM Desistance Old Me-New Me |
| Human Rights PBS GLM Desistance Old Me-New Me | Individualize the treatment plan, including positive self-identity narratives. | | Human Rights PBS GLM Desistance Old Me-New Me |
| RNR GLM Old Me-New Me | Include avoidance goals (community interest) in the treatment plan. | | RNR GLM Old Me-New Me |
| GLM Old Me-New Me | Include approach goals (client interest) in the treatment plan. | | GLM Old Me-New Me |
| Person-Centered Programs | | | |
| Human Rights PBS GLM | Provide programs in the least restrictive and most integrated environment. | | Human Rights PBS GLM |

| Supporting Theories | Person with a Disability | Person as an Offender | Supporting Theories |
|--|---|---|--------------------------|
| PBS GLM Desistance | Apply a therapeutic style that imparts motivation and hope, and acknowledges and celebrates achievements and positive potential for development and redemption. | | PBS GLM Desistance |
| Human Rights | Provide access to habilitation programs that are equivalent to those available to disability clients in the community. | Provide access to rehabilitation programs that are equivalent to those available to offenders in the community. | Human Rights |
| PBS | Provide habilitation programs that utilize task analysis of the individual to identify skill-building needs. | Provide rehabilitation programs that supply the correct dose and intensity to manage risk of re-offending. | RNR |
| Human Rights PBS | Consult specialized organizations. Provide one-to-one support, a qualified person to assist, or a transfer to an appropriate setting. | | Human Rights PBS |
| PBS GLM | Improve quality of life for person interest. | Reduce the likelihood of reoffending for community interest. | RNR GLM |
| <p>Work with, not on, forensic disability clients. Reintegrate a non-offending citizen with full rights and responsibilities who contributes to the community.</p> | | | |