Introduction

In the UK, the Criminal Justice System (CJS) is administered on a national level. People with autism spectrum disorders (ASD) accused of an offence will navigate the CJS like everyone else. At each stage there are safeguards within the CJS for those with a recognized mental disorder to be diverted for further assessment and treatment. A lack of routine screening and awareness of ASD, however, means that not all individuals are identified. This deficiency, both within the criminal justice system and public sector, has been identified as a problem by policy makers. This has led to development of a national autism strategy (Department of Health, 2010) to support the development of local services for adults with ASD.

There is no evidence to suggest that individuals with ASD offend at higher rates than people in the larger population; however, inherent factors such as social naiveté and the need for structure may increase the vulnerability of this group to unscrupulous people who cause them to become victims of crime or who exploit them to become offenders. A number of recent high-profile cases on both sides of the Atlantic—for example, the UK’s Gary McKinnon who hacked into Pentagon and NASA computers, and the USA’s Adam Lanza who murdered his mother and 26 others in Sandy Hook Elementary School in Connecticut—have increased interest in people with autism who may show offending behavior. The media publicity surrounding these and other high-profile cases, however, has often led to the reporting of misinformation about ASD, thereby fueling negative stereotyping.

This paper presents key findings on the experiences of people with ASD at different stages of the CJS from a recent special edition on ASD and offending as reported in the Journal of Intellectual Disability and Offending Behavior, published by Emerald Group Publishing Limited in 2013.

The Police Station

The police are the first point of contact in the CJS. Their powers and the protection for individuals are outlined in the ‘Codes of Practice.’ Individuals with ASD are classified as vulnerable adults and are entitled to assistance from an ‘appropriate adult.’ This role is independent of the police and designed to ensure the welfare and rights of the individual. The appropriate adult is required to be present during questioning and searching. With no routine screening for ASD, however, there are problems in identifying this group. This is being addressed for some groups—for example, for those with mental illness, by the introduction of mental health workers—but their role and expertise does not usually extend to ASD or to other neurodevelopmental disorders such as intellectual disability or Attention Deficit and Hyperactivity Disorder. Support for individuals with ASD and their families in police stations relies increasingly on contributions from charities such as the National Autistic Society (NAS) and Autism West Midlands (AWM). These groups also campaign at a national level. For example, AWM is currently campaigning on a number of fronts to raise police awareness of ASD. Their efforts are directed at improving identification through the introduction of an ASD police custody screening tool; developing low-level services to intervene on behalf of those at risk; and preventing unnecessary contact with the CJS for those committing minor offences (Archer, 2013).

The Court Stage and Diversion to Hospital Care

At the court stage, the credibility of witnesses in terms of reliability or ability to understand the evidence before them may be assessed. The Prosecution Service may arrange for the defendant to be assessed on their fitness to stand trial prior to the court case and recommend the use of ‘Special Measures.’ These can include screens in the courtroom, live video links, giving evidence in private, all designed to prevent the witness from...
seeing the defendant. The removal of wigs and gowns by judges and barristers and use of communication aids (e.g., alphabet boards and intermediaries to assist with communication difficulties) are other examples. However, it is more common for special measures to be granted to support ‘vulnerable or intimidated witnesses,’ including those with ASD.

People with ASD are subject to the same sentencing options as those in the larger population. For many, it is likely that a therapeutic disposition is more appropriate. Although community options are available for care and treatment, most will be detained within a hospital unit, which is categorized in England according to the level of security required—for example—high, medium, or low. The provision of specialized, secure in-patient units for offenders with ASD is still relatively uncommon; many of those committed to hospital will reside within secure services for those with mental illness or intellectual disability.

Specialized ASD secure in-patient services are a new concept. Haw and colleagues (Haw, 2013) compared 45 non-consecutive admissions from low-secure services specifically for men with ASD with 43 non-ASD cases residing in in-patient units for men with mental illness. Those in the ASD group had contact with mental health services at a lower age, were more likely to be younger, white, British, and single, and were more likely to come from Courts or Prison (15, 33.3%) compared to the control group of non-ASD patients (2, 4.7%). The group with ASD was complex in terms of comorbidity with a third (16, 35.6%) diagnosed with schizophrenia or related psychosis and six (13.3%) having a mild intellectual disability, although they were significantly less likely to have a personality disorder or history of drug abuse.

In terms of behavior, although over three quarters of the ASD group had a history of physical violence toward others, which was significantly lower than the study control group, the most common index offences reported from the ASD group were grievous bodily harm and homicide. A review of patients in a specialized medium-secure unit for men with ASD by Barkham, Gunasekaran, and Lovelock (2013) found a number of factors associated with offenders with ASD, including: deficient empathy, interpersonal naiveté, sexual frustration, and immediate confession. Behaviors such as stalking, arson, and sexual offences were over represented in this group. Barkham et al. (2013) hypothesized that the motivations for offending may have a different function (e.g., weak central coherence means the person is unaware of the wider context and potential consequences of his or her actions to both themselves and any victims).

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Risk Assessment of Offenders with ASD

Although there is little empirical evidence as to why people with ASD offend, there are a number of factors that are believed to independently increase the likelihood of offending by individuals with ASD. These include co-morbid or accompanying mental disorder, substance abuse, unemployment, being a young adult, male gender, and socioeconomic status. The use of traditional risk assessment tools for people with ASD has been criticised for not capturing their associated difficulties. Lack of empathy; over-reaction to disruptions in routine; lack of appreciation for the consequences of their behavior on others; and misinterpreting social cues have also been put forward as contributory factors. This lack of understanding of the factors that mitigate risk in this group is believed to contribute to individuals with ASD being detained for longer periods. Murphy (2013) reported considerable case variation using the HCR-20 [a violence risk-assessment and management tool based on the Structured Professional Judgment] in the clinical risk profiles on 20 offenders with ASD in high-secure hospitals. The risk items that scored high most frequently were: vulnerability to future stress (100%); history of relationship instability (90%); lack of insight into particular difficulties (85%); suspected or diagnosed personality disorder (80%); and early maladjustment in the home, school, or community (75%). The role of conventional risk predictors was less clear. Although all cases had a previous history of violence, many of them did not have a history of major mental illness or substance abuse. Murphy asks the question, if the risk items from the HCR-20 contribute little to the understanding of risk for the majority of individuals with ASD, then what should we be assessing? Although this study offers a fascinating insight, we don’t know if current risk assessment items effectively predict offending
in this group. The updated HCR-20 (v.3) (Douglas, Hart, Webster, & Belfrage, 2013) now emphasises the role of using information to help develop ‘meaningful formulations of violence risk, future risk scenarios, appropriate risk management plans, and informative communication of risk,’ in an attempt to forward our understanding of risk predictors for individuals with ASD.

Prison

ASD is currently not part of the prison screening process within the UK, so the number of prisoners with ASD is not known (Myers, 2004). There are 86,000 prisoners in the UK (Jordan 2012) and it is estimated that 1,000 of these may have ASD, applying the 1% rate in the general population. It has been suggested, however, that rates of ASD in prison may vary according to its type (e.g., remanded or sentenced, high-secure, local prisons, etc.) (Underwood, 2013). A lack of suitable assessment tools has been cited as a reason for the absence of screening which is a major issue at all stages of the CJS (Myers, 2004). With little evidence of the use of standardized assessment tools such as the ADOS-2 or ADI-R by prison mental health teams, there is skepticism regarding whether the perceived benefits of screening would lead to increased support, diagnostic assessment, and referral services. Diagnosis can also be difficult when there is a lack of corroborating evidence from an informant such as from a parent. It is generally accepted that individuals with ASD have difficulty engaging in current offender treatment programs. Unfortunately, failure to complete these is likely to affect decisions regarding parole or release.

Summary

The introduction of routine screening and assessment is essential to improve recognition of ASD across the CJS. The lack of screening and diagnostic services often means that high-risk individuals are not identified and targeted to receive appropriate education or interventions; therefore treatment goals can be unrealistic or the intervention, autism unfriendly.

The lack of understanding of ASD and what it entails is a problem for the larger society. Concomitant with this is a lack of expertise by staff that affects therapeutic service delivery. Moreover, it appears that the offenders with ASD are younger and have complex comorbidity. We have heard about some of the new secure hospital services specifically for this group, but as yet, these service models have not been fully evaluated in terms of therapeutic benefits.

References


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