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COMPARATIVE STUDY OF THE QUALITY OF LIFE OF PEOPLE WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES IN PRISONS IN CATALONIA

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1. Introduction

Research on the prevalence of people with intellectual and developmental disabilities (IDDs) in the criminal justice system has yielded variable results. This diversity in results is due to a number of factors ranging from differences in the definition of disability to differences in the methodology and tools used.

Several studies indicate that criminal conduct may occur more frequently among people who have mild learning disabilities (IQ less than 85) than in the rest of the population. People with very severe learning disability (IQ less than 50) tend not to be sentenced because they are considered legally incompetent given the lack of intentionality resulting from their inability to plan sufficiently in order to have committed the offence deliberately.

Historically the prison environment has been sensitive to this group, which is particularly vulnerable and difficult to address in terms of identification, evaluation and diagnosis (Myers, 2004), and also to the living conditions and specialised care these inmates require as part of their rehabilitation process. The European Council at its meeting in Nice in December 2000 acknowledged that people with disabilities are a highly vulnerable social group given the multiplicity of risk factors for exclusion that they may face. Thus in Catalonia since 1995 the Catalan Federation for Persons with Intellectual Disabilities, APPS (now DINCAT) has been running the Accepta programme in partnership with the Ministry of Justice to provide care for people with intellectual disabilities subjected to penal measures.

Since then a total of 297 users have received direct care. Furthermore, the Federation has also provided assessment and diagnosis at one time or another for 1,435 people both in the preliminary stage and when serving their sentences, since in many cases they are inmates who have not been identified beforehand by social, community or health care networks.

Recently, in June 2013, the Department of Specialised Care for Persons with Intellectual and/or Developmental Disabilities (DAE-DID in the Catalan acronym) was set up in Quatre Camins Prison as a unit for intervention with people with special dysfunctions. This unit covers inmates in second degree of treatment with intellectual disabilities who are thought to need an environment that facilitates their care and serving their sentence and in which rehabilitation treatment is tailored to their specific features. Hence the purpose of the DAE-DID is to improve the intervention and quality of life of these inmates.

The concept of *quality of life*, as defined by Robert Schalock, reflects "a person's desired conditions of living related to eight core dimensions of one's life: emotional well-being, interpersonal relationships, material well-being, personal development, physical well-being, self-determination, social inclusion, and rights." Each of these dimensions was defined by Schalock and Verdugo in 2003.

1. DINCAT, Discapacitat intel·lectual Catalunya.

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In Catalonia, the Government of Catalonia's Catalan Institute of Social Services (ICASS) and the Institute for Community Integration (INICO) at the University of Salamanca have developed the GENCAT multidimensional quality of life evaluation scale as part of the Plan to Improve Quality of Life in Catalonia.
Based on this referential construct and given the specific care provided to this group confined to prisons, in this paper we seek to examine the reality of inmates with intellectual and/or developmental disabilities serving a sentence in prisons in Catalonia.

2. Research objectives

Consequently the purpose of this paper is to **learn about** the quality of life of people with intellectual and developmental disabilities who are serving sentences in prisons in Catalonia.
This general objective can be broken down into more specific objectives. The first is to **explore and describe** the criminological characteristics of inmates with IDDs who are in the various prisons and residential units.
Secondly, we seek to **compare** the quality of life of inmates who are in the recently founded (June 2013) Department of Specialised Care for Persons with Intellectual and/or Developmental Disabilities at Quatre Camins Prison (hereafter DAE-DID) with that of other inmates with IDDs who are serving sentences in other prisons in Catalonia and where intervention is less intensive. We also **analyse** the differences in quality of life between persons with IDDs who are in prison and persons with IDDs and behavioural disorders who are admitted to a closed residential facility in the community environment.
Finally, in this paper we seek to **identify** the distinguishing quality of life dimensions between inmates with IDDs and inmates with no disabilities who are in the same residential units.

3. Methodology

3.1 Subjects

A total of 185 subjects took part in this research. Of the 144 that made up the prison sample, 112 were people with IDDs or suspected of having them. The sample of subjects in a social services residential facility came to 41.
The subjects in the different groups were in Brians 1, Brians 2, Quatre Camins, Barcelona Men's and Young Offenders' prisons. We designed a total of 5 non-probabilistic samples grouped as follows:

Group 1. Inmates in the DAE-DID.
This consists of 39 inmates who at the time of data collection using the GENCAT scale were resident in the DAE-DID at Quatre Camins Prison. These inmates had a disability certificate.

Group 2. Inmates with IDDs being monitored by the Accepta Programme.
Composed of 39 inmates with IDDs who were living in ordinary units and receiving specialised outpatient care from Dincat's Accepta programme. These inmates had a disability certificate.

Group 3. Inmates presenting IDDs but who were not being monitored by the Accepta Programme.
Consisting of 34 inmates with no IDDs certificate but suspected of having them, living in ordinary units and not receiving specialised care from Dincat's Accepta programme.

Group 4. People with IDDs living in a community network institution.
This group is made up of 41 subjects who were living in specialised care facilities in the Catalan Institute of Social Services (ICASS) social services network in Catalonia belonging to the Pere Mitjans Foundation. The data from this group were obtained indirectly from a study on quality of life which was evaluated using the same scale as the one employed in this study and was carried out in 2011 in community environment residential facilities.

Group 5. Inmates without IDD.
This control group includes a total of 32 inmates without IDD or suspected of suffering it, living in ordinary prison modules.

3.2. Evaluation tools

The study was conducted using an adaptation to the prison environment of the GENCAT scale[2] that enabled objective evaluation of the quality of life of social services users. Based on the multidimensional quality of life model proposed by Schalock and Verdugo, the scale includes eight dimensions: emotional well-being, physical well-being, material well-being, self-determination, personal development, social inclusion, interpersonal relations and rights. Its 69 items are to be completed by a

2. http://dincatpcp.blogspot.com.es/p/qdv.html

professional, preferably in the social field and with direct knowledge of the subject (as the latter relates to the environment) and the service being evaluated, using a frequency scale of 1 to 4 (1 being "always or almost always" and 4 "never or almost never") based on the observation of the person.

4. Results

4.1 Description of the sample

Concerning socio-demographic variables, 100% of the sample from prisons were men, their average age was 33.41, 51% of them were Spanish and in most cases they did not have a partner (85%).
With respect to criminological variables, one third of the sample were serving their sentences for crimes of robbery with violence or intimidation, followed by other types of violent crimes (battery, assault, etc.) at 9.1% and sexual assault and burglary with forced entry at 8.9% each. 92.3% of subjects were repeat offenders with an average total sentence length of 6 years and 5 months. The average age on committing the first offence was 19 and they were mostly prisoners (92.3%) in the ordinary regime (95.6%). 39.3% of the sample were in the closed regime in their then current sentence and had an average of 8.8 disciplinary offences. 44% of the sample had presented self-harm behaviour at some point in their lives.
As for other prison variables, the subjects studied had been in an average of four prisons, with an average of 22.18 different units throughout their lives.
Finally, in relation to treatment variables, 85% of the sample had a Certificate of Disability with an average disability percentage of 49.65% and in 44.4% of cases were receiving a pension. The level of education of most of them (36.3%) was Basic Skills I, 71% lacked work habits, 57.1% had family support and there was a high level of substance abuse history (84.4%).

4.2 Variable criterion: quality of life

The quality of life scores (total direct score) have a theoretical range between 69 and 340, with the empirical range for the whole sample being from 102 to 258. The highest average total quality of life score was obtained by the control group (group 5) at 209.94, followed by the group of inmates who were in the DAE-DID (group 1) with a score of 186.54 and the group of inmates who were suspected to be disabled but were not monitored by the Accepta programme (group 3) on 182.44. In the bottom positions were the inmates with disabilities who were monitored by the Accepta programme (group 2) at 157.82 points and finally the group formed by people who were in a community network residential facility (group 4) who had the lowest average total quality of life score at 106.12.

4.3. Differences between groups

Applying the Kruskal-Wallis test, H_1 is accepted and it is concluded that the group which inmates belong to influences quality of life (sig. 0.000 <0.05). Groups 5, 1 and 3 have higher quality of life than groups 2 and 4.
To test whether the differences between groups are significant we performed pairwise comparisons of means with the Mann-Whitney U test. Table 1 below presents the mean difference between groups, indicating in the usual way (with an asterisk) if these differences are statistically significant.

Table 1. Mean differences (rows – columns) between groups in quality of life

Groups	DAE-DID	IDDs Accepta monitoring	Suspected IDDs W/o Accepta monitoring	IDDs Community Residential Facility	Control Group
DAE-DID		28.72*	4.1	80.42*	-23.4*
IDDs Accepta monitoring	-28.72*		-24.62*	51.70*	-52.12*
Suspected IDDs W/o Accepta monitoring	-4.1	24.62*		76.32*	-27.5*
IDDs Community Residential Facility	-80.42*	-51.70*	-76.32*		-103.82*
Control Group	23.4*	52.12*	27.5*	103.82*	

* Statistical significance at level .05

As can be seen, all the quality of life differences between the means of the groups are significant except those between the group of inmates who are in the DAE-DID (group 1) and the group of inmates with suspected disability but not monitored by the Accepta programme (group 3).
The greatest differences in quality of life are between the inmates in the control group (group 5) and those who have disabilities and are in a community network residential facility (group 4) with a difference of -103.82 points, followed by the difference between the group of DAE-DID inmates (group 1) and the community network group (group 4) at 80.42. Finally, the third significant difference is again between the community network group (group 4) and the group of inmates pending confirmed diagnosis of IDDs and not yet being monitored by the Accepta programme (76.32).

5. Conclusions

In terms of quality of life, the results indicate significant differences between the various groups of inmates assessed. As expected the results vary depending on the characteristics of the place where they were and according to the intensity of the intervention. Thus inmates with IDDs in the Department of Specialised Care had higher quality of life than inmates who had IDDs and were monitored by the Accepta programme. However, the results also indicate that, despite being in this specialised department, their quality of life was not significantly higher than that of inmates who were suspected to have a disability but were not certified and therefore not monitored by the Accepta programme. One possible explanation for these data could reside in the fact that the inmates who do not have a Disabled Centre certificate probably have a milder form of disability and therefore have more personal resources to live independently in ordinary residential units. They would in some way be less vulnerable than inmates diagnosed with observed IDDs. Another explanation has to do with the stigma that being identified as an inmate with IDDs may entail; in this case, because they belong to a group that has yet to be diagnosed and are therefore not identified by others, they may be less vulnerable to possible coercion or harassment by other inmates. By contrast, those who are being monitored by the Accepta programme could be more easily identified in the residential facility unit. These data would bear out the need to set up specialised units to handle this type of person as we have found that the quality of life of Department of Specialised Care inmates is closer to the prison average.
The comparison of the results for inmates with IDDs who were in prison (groups 1, 2 and 3) with data from other persons with IDDs who were in community network residential facilities (group 4) shows that there are statistically significant differences between the various groups. Specifically, this latter group (group 4) presents a level of quality of life consistently lower than other groups of disabled inmates. This important difference may be attributed to several factors. One possible explanation could be that the people who collected the data in the *Research into Quality of Life Profiles in ICASS Social Services* (the results that we used for conducting our research) were better trained in using the GENCAT scale and therefore evaluated some aspects differently. Another explanation for this difference in scores would be related to the specific features of people with disabilities in community network residential facilities. Most likely these people, who are older (the most common age of the participants was 85) than our prison sample (average age 33.41), are in a more burdensome situation of social isolation compared to those who are incarcerated, who despite being in prison may have a better external situation in terms of social and family support and greater life expectations. It might also be that they have a higher degree of disability and are much less self-sufficient and more dependent, factors which would directly impinge on their quality of life.
Finally, within the prison environment there are also significant differences in the quality of life of inmates who have an intellectual disability compared to those without disabilities. The group of inmates who did not present any disability and make up the control group (group 5) had a significantly higher quality of life than the sample as a whole. This finding is relevant because it shows that inmates with disabilities who are in the Department of Specialised Care still do not have a quality of life similar to non-disabled inmates. It might be that their condition as persons with disabilities means their quality of life as evaluated by the instrument used could never reach the levels of non-disabled people, but at least this fact should make us reflect on what new approaches need to be considered in the intervention carried out in the Department of Specialised Care to further increase the quality of life of the users who live there.

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