EVALUATING AUTISM SPECTRUM DISORDERS IN CORRECTIONAL AND FORENSIC PRACTICE

FMHAC- 2025

Robert Horon, Ph.D.

DISCLOSURES

The presenter works as an independent contractor, completing evaluations of intellectual disabilities and autism spectrum disorders referred by a California Regional Center.

The presentation of this workshop will not increase or impact the number of referrals or change renumeration for these referrals.

LEARNING OBJECTIVES

1) Attendees will be able to list symptoms of disorders that have overlap with autism spectrum disorders, as well as how these lead to common misunderstandings in patients and families.
2) Attendees will differentiate the course of development in autism spectrum disorder from other conditions, noting the importance of and ways to evaluate early course.
3) Attendees will analyze a case presentation in such a way as to differentiate disorders per a diagnostic formulation process, following a modeling of such a formulation by the presenter.

PRESENTATION OUTLINE

I. Overview of ASD rates, symptoms, diagnostic criteria, and prevalence in correctional and forensic settings

II. Symptoms common in ASD that are present in other disorders; differentiation between conditions; common misunderstandings

III. Processes for differential diagnosis and case formulation

IV. Review of a practice case (presenter led)

V. Group review and discussion of a case

VI. Q & A

OVERVIEW OF ASD RATES, SYMPTOMS, DIAGNOSTIC CRITERIA, AND PREVALENCE IN CORRECTIONAL AND FORENSIC SETTINGS

Section 1

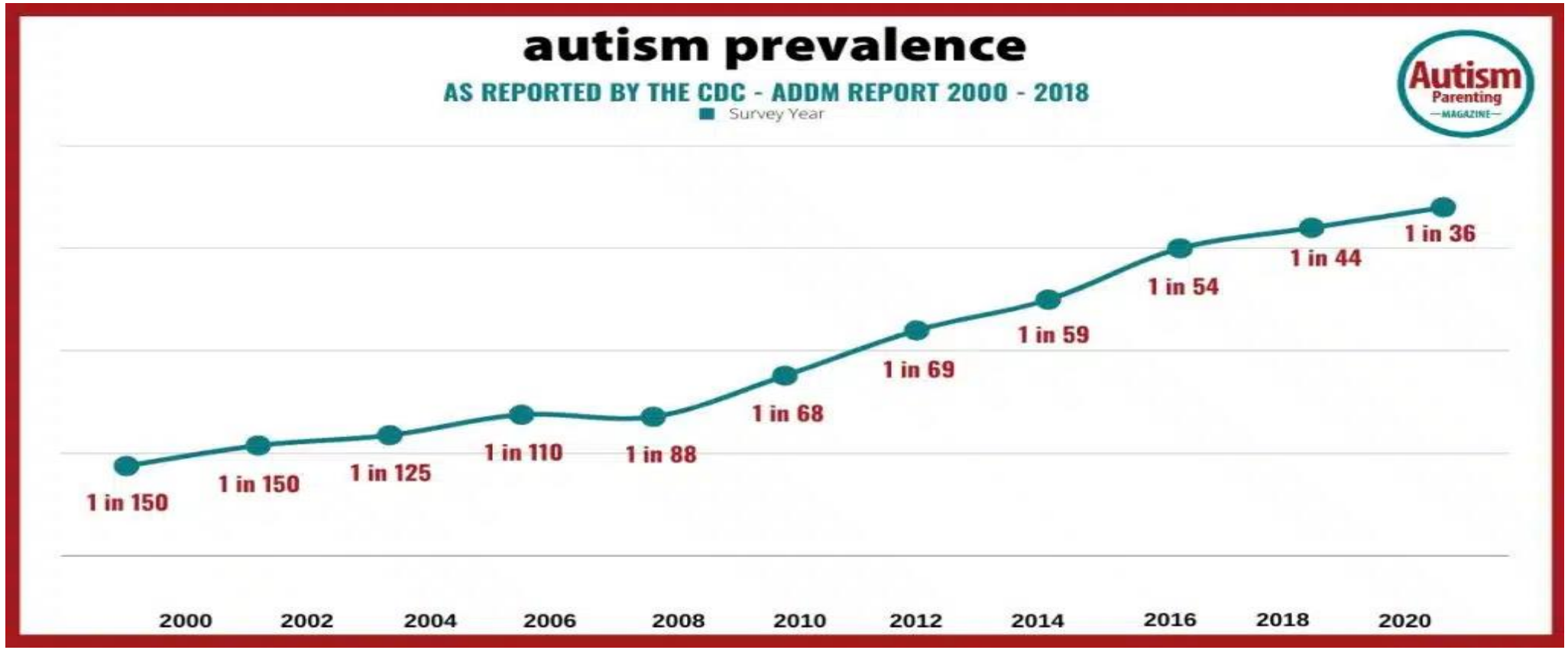
ASD PREVALENCE

CDC's ADDM Network 2000-2020: Combining data from all sites

Surveillance Year	Birth Year	Range in Sites	Combined Prevalence per 1,000 Children
2020	2012	27.6 (23.1-44.9)	1 in 36
2018	2010	23.0 (16.5-38.9)	1 in 44
2016	2008	18.5 (18.0-19.1)	1 in 54
2014	2006	16.8 (13.1-29.3)	1 in 59
2012	2004	14.5 (8.2-24.6)	1 in 69
2010	2002	14.7 (5.7-21.9)	1 in 68
2008	2000	11.3 (4.8-21.2)	1 in 88
2006	1998	9.0 (4.2-12.1)	1 in 110
2004	1996	8.0 (4.6-9.8)	1 in 125
2002	1994	6.6 (3.3-10.6)	1 in 150
2000	1992	6.7 (4.5-9.9)	1 in 150

***1980: (not ADDM): 1 in 1000**

ASD PREVALENCE



ASD PREVALENCE, NIMH (2023)

Prevalence of Autism Spectrum Disorder in 8-year-olds (2020)Data Courtesy of CDC1

		Prevalence[2]	Percent[2]
Overall		27.6 per 1,000	2.8%
Sex	**Boys**	43.0 per 1,000	4.3%
	Girls	11.4 per 1,000	1.1%
Race/Ethnicity	**White**	24.3 per 1,000	2.4%
	Black	29.3 per 1,000	2.9%
	Asian/Pacific Islander	33.4 per 1,000	3.3%
	Hispanic[3]	31.6 per 1,000	3.2%
	American Indian or Alaska Native (AI/AN)	26.5 per 1,000[4]	2.7%
	Two or more races	22.9 per 1,000	2.3%

DSM-5 CRITERIA FOR ASD

A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history. (all)

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.

DSM-5 CRITERIA FOR ASD

B. Restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following, currently or by history:

1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypies, lining up toys or flipping objects, echolalia, idiosyncratic phrases).
2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns or verbal nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat food every day).
3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interest).
4. Hyper- or hyporeactivity to sensory input or unusual interests in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement).

DSM-5 CRITERIA FOR ASD

C. Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities or may be masked by learned strategies in later life).

D. Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.

E. These disturbances are not better explained by intellectual disability (intellectual developmental disorder) or global developmental delay. Intellectual disability and autism spectrum disorder frequently co-occur; to make comorbid diagnoses of autism spectrum disorder and intellectual disability, social communication should be below that expected for general developmental level.

DSM-5 CRITERIA FOR ASD

The importance of developmental information…

1. To "fully manifest" suggests there has to be significant symptoms prior to increased social demands, MUST BE PRESENT
2. There has to be evidence of a developmental disability—delays in language not related to hearing, inability to play imaginatively, stereotypies, etc…
3. This issue is difficult to establish in correctional/forensic settings, but is absolutely vital to case formulation

How to gain information from schools, pediatricians, regional center…

1. Though there are exceptions, someone with ASD should have concerns raised or identified in pediatric treatment, preschool/childcare settings, or kindergarten
2. Ask about first concerns and at what age, early behavior at playgrounds or when visited at the home, etc.
3. ROI's for special education, any evaluations done…worth the wait!

ASD PREVALENCE IN CORRECTIONS

Cooper, D., Uppal, D., & Shea, L. (2022). Policy gaps and opportunities: A systematic review of autism spectrum disorder and criminal justice intersections. *National Autistic Society,* 26 (5). https://doi.org/10.1177/13623613211070341

-89 Studies reviewed with themes of increasing #s of individuals with ASD in the criminal justice system; no agreement on prevalence

Fazio, R., Pietz, C., & Denny, R. (2012). An estimate of the prevalence of ASD in the incarcerated Population, Journal of Forensic Psychology, 4: 69-80

-Prevalence rate of 4.4% in maximum security prison; assessment tool (Autism Quotient) an expedient but poor diagnostic marker

ASD PREVALENCE IN CORRECTIONS

"Studies of ASD in the offender population estimate that the prevalence rate is much higher than that of the general population, notably for individuals with ASD who are higher functioning…

In general, there is currently no routine, standardized screening, or assessment undertaken at any stage of the criminal justice process to determine the nature and extent of ASD. For adults, there are several screening tests… For example, the Ritvo Autism and Asperger Diagnostic Scale (RAADS)-14 is a 14-item questionnaire derived from an 80-item instrument with a sensitivity of 97 percent and **a specificity of *46 to 64* percent.**"

Michna, I., & Trestman, R. (2016). Correctional Management and Treatment of Autism Spectrum Disorder. *Journal of the American Academy of Psychiatry and Law*, 44:253-258.

ASD PREVALENCE: PRE-ADJUDICATED SETTINGS

"Past surveys have reported high rates of youth with disabilities in the juvenile justice system, however, little research has examined the frequency with which youth with Autism spectrum disorders (ASD) are in contact with law enforcement. Using records linkage with the Department of Juvenile Justice and the South Carolina Law Enforcement Division and the South Carolina Autism and Developmental Disabilities Monitoring Program (SC ADDM), this study compares the frequency, type, and outcome of criminal charges for youth with ASD and non-ASD youth. Youth with ASD had higher rates of crimes against persons and lower rates of crimes against property. Youth with ASD were more likely to be diverted into pre-trial interventions and less likely to be prosecuted than comparison youth. When compared to the overall SC ADDM sample, charged youth were less likely to have comorbid intellectual disability."

Cheely, C., Carpenter, L., Letourneau, E. (2012). The prevalence of youth with ASD in the criminal justice system, Jounral of Autism and Developmental Disorders, 42, 1856-1862.

ASD PREVALENCE: PRE-ADJUDICATED SETTINGS

Perlin, Michael L. and Cucolo, Heather and Dorfman, Deborah A., "I Saw Guns and Sharp Swords in the Hands of Young Children": Why Mental Health Courts for Juveniles with Autism Spectrum Disorder and Fetal Alcohol Spectrum/Disorder Are Needed (July 19, 2023). NYLS Legal Studies Research Paper No. 4515470

SSRN: https://ssrn.com/abstract=4515470 or http://dx.doi.org/10.2139/ssrn.4515470

Paper advocates for: "The creation of (separate sets of) problem-solving juvenile mental health courts specifically to deal with cases of juveniles in the criminal justice system with ASD, and with FAS/FASD… f such courts are created, we believe this will (1) make it less likely that sanism and other forms of bias affect legal decision making; (2) make it more likely that those aspects of the defendants' underlying conditions that may have precipitated (or contributed to) their criminal behavior be placed in a context that understands such conditions, and (3) best ensure that therapeutic jurisprudence principles be employed in the dispositions of all cases."

ASD PREVALENCE—FORENSIC SETTINGS

"A clinical case series consisting of 42 subjects with ASD, recruited from three well-characterized populations in forensic psychiatry and special youth care, was used to determine: 1) the prevalence of ASD in these institutions **(at least 13%),** 2) the distribution of diagnostic criteria in this special population (mostly social interaction and communication problems, few or atypical flexibility problems), 3) the degree of comorbidity (the rule rather than the exception), 4) neuropsychological test profiles (lowered IQ with uneven profiles), 5) types of crimes and offences (very heterogeneous, often stress-related), 6) mental health care needs (high), and 7) special clinical features (especially expressions of flexibility deficits…). This descriptive study indicates that ASD is a clinically relevant problem among forensic populations that has to be considered in diagnostics, assessments of needs and treatment planning."

Anckarsäter, H., Nilsson, T., Saury, J. M., Råstam, M., & Gillberg, C. (2008). Autism spectrum disorders in institutionalized subjects. Nordic Journal of Psychiatry, 62(2), 160–167. https://doi.org/10.1080/08039480801957269

ASD PREVALENCE—FORENSIC SETTINGS

Police: Professor Beaten to Death by Autistic Son

A mother's struggle to raise her autistic son ends after he allegedly kills her.

By ABC News February 10, 2009, 1:03 PM

*

Sky Walker couldn't tell his mother if he loved her. Or why he liked "The Price is Right.“ But Getrude Steuernagel was devoted to her son, nonetheless, even when their world shrank as Walker's severe autism seemingly cut them off from many aspects of a normal life.

Now, Walker, 18, is sitting in a jail cell, accused of beating his mother to death, while her friends and family members struggle to understand why -- an answer that may never come.

"There really weren't any clues in the house," Molly Merryman, a friend and Kent State University associate professor, told ABCNews.com. "I think it's always something we'll wonder about and never know.“

*photo: See: https://www.themarshallproject.org/2024/09/18/texas-autism-death-penalty-roberson

WILL WE BE SEEING MORE OF THIS…

ADD IN METRO DETROIT AREA…

Correctional Facility (Prison) Autism Assessment for Adults

Are You An Attorney or Guardian Interested In Our On-site Prison Autism Assessment Services?

As a independent 3rd party service provider we are able to travel on-site as well as accomodate the psychological

Table of Contents

1. Are You An Attorney or Guardian Interested In Our On-site Prison Autism Assessment Services?
2. Understanding Autism in Legal Proceedings: Importance of Autism Assessment and Implications with Title II of the ADA
3. The Unseen Challenge: Autism in Legal Proceedings
   - 3.1. Why Autism Diagnosis Matters in Legal Matters
   - Tailoring Communication for Individuals on

SYMPTOMS COMMON IN ASD THAT ARE PRESENT IN OTHER DISORDERS; DIFFERENTIATION BETWEEN CONDITIONS; COMMON MISUNDERSTANDINGS

Section 2

INTRODUCTORY COMMENTS *

An inmate in the Enhanced Outpatient Program (EOP) at CDCR approaches his clinician and says, “My mom always told me I have ASD and the school wouldn’t test it… I was referred by my doctor in high school and had an evaluation. They said it was likely I had ASD. I want to know and need to be in a special program for people like me. I never get along with people and don’t understand them.” The inmate has written an inmate appeal on the issue.

The clinician asks her supervisor and Chief Psychologist for help in the case. What would you do?

*https://weartv.com/news/local/florida-student-with-autism-sentenced-to-5-years-in-jail-after-beating-teacher-unconscious-brendan-depa-joan-naydich-matanzas-high-school-nintendo-switch-palm-coast-flagler-county

INTRODUCTORY COMMENTS

This is something we really don't want to get wrong.

1. If we miss the condition, then the individual will experience significant added difficulties…
   - Parent and family perspectives
   - Difficulties in incarcerated settings
2. If we misdiagnose ASD as present, then the additional burdens on systems is significant…

SO MANY REFERRALS IN THE COMMUNITY…

Why many referrals are “self-referrals”?

-One source: Websites providing self-assessments, such as:

https://embrace-autism.com/autism-tests/

https://www.additudemag.com/screener-autism-spectrum-disorder-symptoms-test-adults/

…and several others

SO MANY REFERRALS IN THE COMMUNITY…

Sources of confusion:

1. Seeing ASD as an answer to 'social failure' or shyness/social anxiety, disinterest in others, etc.
2. Seeing ASD as a way to receive services, accommodations, preferred housing…
3. Common misunderstandings, e.g., "if you have sensory issues, it must be ASD…"
4. The 'neurodivergent' movement, chat rooms, etc.

DISORDERS WITH OVERLAP…

ADHD:

What's in common? Sensory issues (up to 60% of those with ADHD have significant sensory processing issues*), interpersonal difficulties, aggression…

What differentiates? Developmental course, symptom presentation, type of interpersonal presentation, cause of social problems…

*Galiana-Simal, A., Vela-Romero, M., Romero-Vela, V. M., Oliver-Tercero, N., García-Olmo, V., Benito-Castellanos, P. J., … Beato-Fernandez, L. (2020). Sensory processing disorder: Key points of a frequent alteration in neurodevelopmental disorders. *Cogent Medicine*, *7*(1). https://doi.org/10.1080/2331205X.2020.1736829

DISORDERS WITH OVERLAP…

Disruptive Mood DMDD:

What's in common? Sensory issues, interpersonal difficulties, tantrumming

What differentiates? Cause of irritability, developmental course, interpersonal presentation, may not have functional difficulties in specific settings…

DISORDERS WITH OVERLAP…

Social Anxiety Disorder:

What's in common? Interpersonal difficulties or withdrawal, avoidance of social situations, poor eye contact (in some cases)

What differentiates? Developmental course, interpersonal presentation, type of reciprocal social deficits, type of communication deficits, absence of restricted interests or repetitive behaviors, lack of stereotypies…

DISORDERS WITH OVERLAP…

Avoidant Personality Disorder:

What's in common? Interpersonal difficulties, avoidance of social situations, poor eye contact (in some cases)

What differentiates? Developmental course, interpersonal presentation, type of reciprocal social deficits, type of communication deficits, absence of restricted interests or repetitive behaviors or stereotypies…

DISORDERS WITH OVERLAP…

Schizoid Personality Disorder:

What's in common? Interpersonal disinterest or difficulties, avoidance of social situations, lack of need of typical social relationships

What differentiates? Developmental course, interpersonal presentation, type of reciprocal social deficits, type of communication deficits, absence of restricted interests or repetitive behaviors or stereotypies…

DISORDERS WITH OVERLAP…

Schizophrenia:

What's in common? Interpersonal difficulties, difficulties in social situations, withdrawal, atypicality

What differentiates? Developmental course, interpersonal presentation, type of reciprocal social deficits, type of communication deficits, absence of restricted interests or repetitive behaviors, presence of thought disorder or positive symptoms…

DISORDERS WITH OVERLAP…

Early Trauma/PTSD/Attachment Disorders:

What's in common? Interpersonal difficulties, avoidance of social situations, can have atypical social relationships

What differentiates? Developmental course, interpersonal presentation, type of reciprocal social deficits, absence of restricted interests or repetitive behaviors or stereotypies…

PROCESSES FOR DIFFERENTIAL DIAGNOSIS AND CASE FORMULATION

Section 3

PROCESSES FOR DIFFERENTIAL DIAGNOSIS AND CASE FORMULATION

-Measures that help with differential diagnosis:

1. The ADOS-2 remains the 'gold standard'
2. ADI-R is very helpful in forensic and correctional settings; establishes Criteria C
3. Childhood Autism Rating Scale, Second Edition (CARS-2)

PROCESSES FOR DIFFERENTIAL DIAGNOSIS AND CASE FORMULATION

-Measures that 'muddy the waters':

-AQ: Developed by Simon Baron Cohen (2001) to tap "Asperger syndrome/ HFA…in scientists and mathematicians."

-AQ tested on Cambridge University students

Brief self-report scale readily available online

PROCESSES FOR DIFFERENTIAL DIAGNOSIS AND CASE FORMULATION

-Measures that 'muddy the waters':

-EQ: Empathy Quotient developed by S. Cohen (2004) to assess empathy in Asperger syndrome/ HFA…

-EQ results lower for AS/HFA subjects than controls tested on Cambridge University students

-Brief self-report scale readily available online

-Unclear relationship between Criterion A and EQ

PROCESSES FOR DIFFERENTIAL DIAGNOSIS AND CASE FORMULATION

-Measures that 'muddy the waters':

Social Responsiveness Scale-2nd Edition:

-Commonly used, including in schools; not readily available online

-Found to overlap significantly with social phobia/ social anxiety, selective mutism,* and PTSD**

*Cholemkery, H., Mojica, L., Rohrmann, S. *et al.* Can Autism Spectrum Disorders and Social Anxiety Disorders be Differentiated by the Social Responsiveness Scale in Children and Adolescents?. *J Autism Dev Disord* **44**, 1168–1182 (2014). https://doi.org/10.1007/s10803-013-1979-4
**https://doi.org/10.1016/j.chiabu.2015.04.010

PROCESSES FOR DIFFERENTIAL DIAGNOSIS AND CASE FORMULATION

Measures that 'muddy the waters:

"In this study, we tested the Ritvo Autism Asperger Diagnostic Scale–Revised and two short versions of the Autism-Spectrum Quotient, the AQ-28 and AQ-10, in 210 patients referred for autism spectrum disorder assessment and in 63 controls. Of the 210 patients, 139 received an autism spectrum disorder diagnosis and 71 received another psychiatric diagnosis. The positive predictive values indicate that these tests correctly identified autism spectrum disorder patients in almost 80% of the referred cases. However, the negative predictive values suggest that only half of the referred patients without autism spectrum disorder were correctly identified. The sensitivity and specificity of each of these instruments were much lower than the values reported in the literature. In this study, the sensitivity of the Ritvo Autism Asperger Diagnostic Scale–Revised was the highest (73%), and the Autism-Spectrum Quotient short forms had the highest specificity (70% and 72%). Based on the similar area under the curve values, there is no clear preference for any of the three instruments. **None of these instruments have sufficient validity to reliably predict a diagnosis of autism spectrum disorder in outpatient settings."**

https://doi.org/10.1177/1362361315589869

PROCESSES FOR DIFFERENTIAL DIAGNOSIS AND CASE FORMULATION

Understanding the full picture:

1. No self-report measure can replace a case formulation to indicate the presence or absence of ASD.
2. Careful history taken, observational ratings, and pointed interview is required
3. Case formulations that make sense vs. those that don't: Consideration of development, differential diagnostic consideration, consideration of cultural factors, impact of trauma…

PROCESSES FOR DIFFERENTIAL DIAGNOSIS AND CASE FORMULATION

-Case formulations that make sense vs. those that don't

1. Ensuring there is (or isn't) a developmental disability and understanding where adaptive deficits are coming from…
2. Developmental milestones in ASD and in other conditions
3. Key questions for parents/caregivers about ASD symptoms
4. Giving feedback re: ASD vs. other conditions

PROCESSES FOR DIFFERENTIAL DIAGNOSIS AND CASE FORMULATION

-Suggestions

1. The ADOS-2 can be ordered with only Module 4 (fluent adolescents and adults) for correctional/forensic settings, so as to not have infant/child toys that need to get through security!
2. The ADOS-2 needs a great deal of training…
3. The ADI-R needs training and available informants (parents or those knowing first hand about early development).
4. Online assessments may miss key communicative/interpersonal deficits or strengths; request evaluators come in person

REVIEW OF A PRACTICE CASE (PRESENTER LED)

Section 4

CASE PRESENTATION

Case mentioned in slide 20 was evaluated for ASD. The inmate, Case R., is age 45 and incarcerated for multiple counts of residential burglary. A history of methamphetamine dependence was noted.

-Developmental information: ROI signed by Case R. for his mother. Mother noted no developmental delays, onset of hyperactivity and behavioral problems around age 5 or 6. Case R. "drove away friends" with aggressiveness and demands to control play. Mother recalled, "A doctor told me he might have ASD." No communicative symptoms (eye contact, facial expressions, gestural use all fine). Sensory issues were noted to loud noise and food textures.

CASE PRESENTATION

Case R was never tested for ASD. School testing noted a low average IQ, issues with auditory processing, a specific learning disability, and likely ADHD. Case R was treated for ADHD beginning at age 7. His special education eligibility was based on Other Health Impairment (OHI) related to ADHD.

Current testing data: WAIS-IV: IQ in low average range; lowest in working memory. PAI validity questionable; high negative impression management score. ADI-R negative for ASD. ADOS-2 low; not indicative of ASD per ADOS-2 algorithm.

CASE PRESENTATION

Case R. had mixed reactions to the finding of no-ASD. He could understand his early problems "with having no friends" in the context of his impulsivity/hyperactivity and aggressiveness. He was interested in school reports and shared his learning disorder findings with his correctional counselor. He no longer demanded specialized treatment or housing and participated well in EOP.

GROUP REVIEW AND DISCUSSION OF A CASE

Section 5

WORKSHOP CASE

A 24-year-old male is referred for testing shortly after arrival to a forensic treatment unit as a Mentally Disordered Offender (MDO). The young man had served a 5-year prison sentence for an assault on a caregiver in a group home. The youth is aloof on the treatment unit and seems to interact very little with peers. He rarely makes eye contact. Letters written from a family member state the patient has ASD "and must be transferred to a developmental center."

Referral question: "Please assess for ASD vs. other diagnoses. The patient's current diagnosis is Major Depressive Disorder and Schizoid Personality Disorder."

Developmental information: See handouts

Prior evaluations: See handouts

WORKSHOP PRESENTATION

Current testing data: See handouts

Group Discussion: Tying together—case formulation

Group Discussion: Presenting results and recommendations

QUESTION AND ANSWER TIME

THANK YOU!

Contact:
rhoron@abpsychconsulting.com