COMMUNITY FORENSIC SERVICES FOR ADULTS WITH INTELLECTUAL DISABILITY: AN INTRODUCTION

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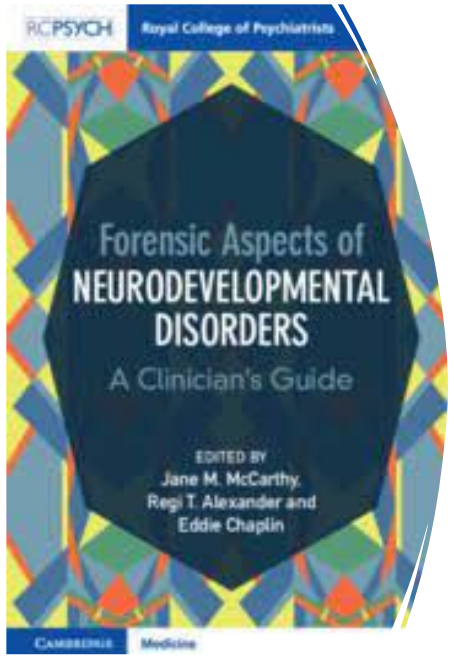
STRUCTURE

1. Who becomes ‘forensic’? Offending behaviour vs challenging behaviour
2. Prevalence of offending behaviour
3. Services and service models: an overview (1995-2020) and examples
4. Consultation with Experts by Experience: Service model + Outcomes framework



1. Who becomes ‘forensic’? Offending behaviour vs challenging behaviour

1. **Patient factors:** Degree of disability, visibility of the disability, presence of additional mental disorders and their visibility, personal support systems

2. **Offence factors:** type of offence, seriousness of the offence, visibility of the offence, age of the victim(s), pattern of offending

3. **System factors:** advocacy, nature of health and social care support, culture and value systems in the criminal justice, health and social care systems

Chester, V., Tharian, P., Slinger, M., Varughese, A. and Alexander, R. T. (2023) “Overview of Offenders with Intellectual Disability,” In McCarthy, J. M., Alexander, R. T., and Chaplin, E. (eds.), *Forensic Aspects of Neurodevelopmental Disorders: A Clinician's Guide*, chapter, Cambridge, Cambridge University Press, pp. 24–33.

2. Prevalence of Offending behaviour

- Warning: Issues with administrative vs real prevalence of LD
- Cambridgeshire (Lyall et al, 1995): 2%
- South London (McNulty et al, 1995): 9.4%
- Wales (Seaward & Rees, 2001): 1.24%
- Surveying an entire local authority area in Plymouth (McBrien et al, 2003): 26%

Offending and risky behaviour in community services for people with intellectual disabilities in one local authority

JUDITH McBRIEN, ALISON HODGETTS and JOHN GREGORY

ABSTRACT The total population of adults with intellectual disabilities known to health and social services in one local authority was surveyed to establish the extent of risky and offending behaviour. Face-to-face structured interviews established that of the 1,326 adults known to services, 348 (26%) showed risky behaviours that had been or might be construed as offences, 128 (9.7%) had a history of contact with the criminal justice system (CJS) and 38 (2.9%) had a history of criminal convictions, while 11 (0.83%) had a current conviction. Of the 84 settings surveyed, 48% had experienced caring for clients with a history of CJS contact, as had 93% of social services/health staff. There were some significant differences between private and voluntary sector residential homes and between day centres and residential settings. There were also significant differences between individuals with and without CJS contact and between those with CJS contact who had and had not been convicted. The

3. Services and service models: an overview (1995-2020)

1. In-patient services: high, medium, low secure, rehabilitation and other in-patient beds

2. Community based services:
   a. CLDT based (special interests, virtual teams, etc)
   b. A specialist forensic LD team (with/without ‘care co-ordination’)

3. Advantages and disadvantages for each, but the need is there.

Why the need?

- The assumption that all such behaviours were a consequence of institutional lifestyles, which would subsequently diminish once community care was introduced, may be flawed (Holland et al., 2002).
- Visibility of behaviours that were previously hidden or tolerated within institutions and an increased societal aversion to risk (Moss et al., 2002, Carroll et al., 2004).
- Issues with generic mental health services and specialist CLDTs: from expertise and skills to confidence (Moss et al., 1997, Cumella, 2009, Devapriam & Alexander 2012).
- Non-availability of short term admission beds and the risk of inappropriate‘‘forensicisation’’ of challenging behaviour (Jaydeokar and Piachaud, 2004, Hollins, 2000; Kingdon, 2005, Douds and Bantwal, 2011, Chester et al 2023)

- The Winterbourne scandal and the national response to it (DoH, 2012)

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3. Services and service models: some examples (1995-2020)

- Urban and rural centres in Scotland, Lindsay et al 2006
- 12 year follow up period.
- Impact in reducing the number of offences

Legal and Criminological Psychology (2006), 11, 113–130

The British Psychological Society
www.bpsjournals.co.uk

A community forensic intellectual disability service: Twelve year follow up of referrals, analysis of referral patterns and assessment of harm reduction

William R. Lindsay[1,2]*, Lynn Steele[2], Anne H. W. Smith[2], Kathleen Quinn[2] and Ronald Allan[2]
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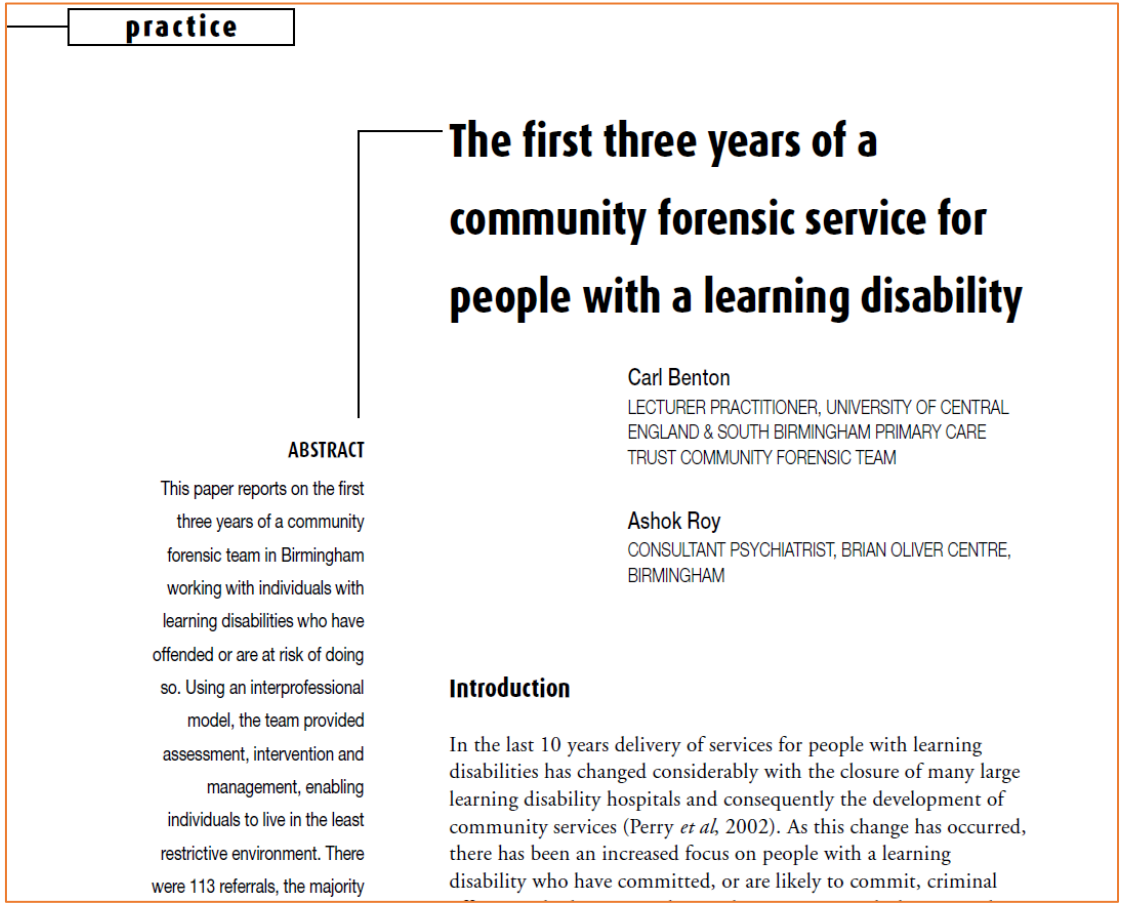
Background. Previous reports on the outcome of services for offenders with developmental disabilities have found recidivism rates of between 40% and 70% with an elevated prevalence of sex offending, fire-raising, and aggression. Studies have also reported that female offending rates in the intellectual disability population are broadly similar to those found in mainstream populations. All reports have been conducted on in-patient or prison samples. The present report is of a community forensic intellectual disability service.

Method. Two male cohorts of sex offenders ($N = 121$) and other types of offenders ($N = 105$) and female offenders ($N = 21$) are studied and compared. Data is reported on characteristics of the cohort, problems identified at referral, criminal justice disposal trends, index offences at time of referral, reoffending rates of up to 12 years after index offence, patterns of referral in the first 6 and second 6 years of the study period and the extent of harm reduction.

Results. There were no differences between the groups on IQ and the sex offender cohort tended to be older. Female offenders had higher rates of mental illness although

3. Services and service models: some examples (1995-2020)

- Birmingham, Benton & Roy 2008
- 3 year follow up
- Successful model



practice

The first three years of a community forensic service for people with a learning disability

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Ashok Roy
CONSULTANT PSYCHIATRIST, BRIAN OLIVER CENTRE, BIRMINGHAM

ABSTRACT

This paper reports on the first three years of a community forensic team in Birmingham working with individuals with learning disabilities who have offended or are at risk of doing so. Using an interprofessional model, the team provided assessment, intervention and management, enabling individuals to live in the least restrictive environment. There were 113 referrals, the majority

Introduction

In the last 10 years delivery of services for people with learning disabilities has changed considerably with the closure of many large learning disability hospitals and consequently the development of community services (Perry *et al*, 2002). As this change has occurred, there has been an increased focus on people with a learning disability who have committed, or are likely to commit, criminal

3. Services and service models: some examples (1995-2020)

- Bristol, Dinani et al 2010
- 6 year follow up
- Thoughtful discussion of achievements and frustrations

Service provision

Providing forensic community services for people with learning disabilities

Shamim Dinani
Consultant Psychiatrist in Learning Disabilities

Wendy Goodman
Forensic Senior Nurse

Charlotte Swift
Clinical Psychologist

Teresa Treasure
Forensic Community Nurse

Avon Forensic Community Learning Disability Team, UK

3. Services and service models: some examples (1995-2020)

- Fife, de Villiers & Doyle, 2015
- 10 years of referrals and outcomes
- Case management +
- Effectiveness +

Making a difference? Ten years of managing people with intellectual disability and forensic needs in the community

Jana de Villiers and Michael Doyle

Dr Jana de Villiers is Consultant Psychiatrist and
Dr Michael Doyle is Forensic Psychologist, both at Fife Forensic Learning Disability Service, Lynebank Hospital, Dunfermline, UK.

Abstract

Purpose – *Nationally community services for patients with intellectual disability and forensic needs are limited, and research to guide service development for this patient group with highly complex needs is sparse. The purpose of this paper is to provide an overview of referrals to and case management by the multi-agency Fife Forensic Learning Disability Service (FFLDS), including demographic data, treatment, risk assessments and outcomes.*

Design/methodology/approach – *All referrals received between 2004 and 2014 were reviewed to identify key demographic factors and to clarify the outcome of the referrals. Risks levels and presence of factors related to ongoing risk management were identified. For those accepted, final outcomes were noted.*

Findings – *In total, 145 referrals were received by FFLDS between 1 January 2004 and 31 December 2014. Of these 117 were accepted for ongoing case management. In total 106 patients were discharged from FFLDS over the review period, with the vast majority remaining in community settings. Patients were overwhelmingly male, with an age range of 16-79 (mean age of 30). Approximately half of referrals were from criminal justice agencies, and sexual and violent offences predominated. Alcohol and/or illicit substance use was problematic in 49 per cent of patients.*

Research limitations/implications – *FFLDS needs to consider building links with Drug and Alcohol Services, for assistance in developing expertise in managing problematic alcohol and/or illicit substance use. Links with professionals working with female offenders may increase the rate of referral of female patients.*

Originality/value – *Policy and legal frameworks emphasise the need to manage people with learning disabilities and forensic needs in the least restrictive environment possible. This paper provides information on a cohort of forensic patients over a ten-year period, including characteristics and outcomes, to inform the evaluation of these frameworks and the planning of both community and in-patient services for this*

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3. Services and service models: some examples (1995-2020)

- Leicestershire 2012
- NHS + independent sector collaboration
- Clinicians with a special interest within the CLDTs in a county
- Four tiers

Tiered model of learning disability forensic service provision

John Devapriam and Regi T. Alexander

John Devapriam is Consultant Psychiatrist at the Department of Psychiatry, Leicestershire Partnership NHS Trust, Leicester, UK.
Regi T. Alexander is Consultant Psychiatrist at St John's House, Partnerships in Care, Diss, UK and Honorary Senior Lecturer, Department of Psychiatry, University of East Anglia, Norwich, UK.

Abstract

Purpose – *Traditionally, services for people with learning disabilities (LD) and forensic needs are underdeveloped. This paper aims to describe the setting up of a tiered model of LD forensic service provision in Leicester, Leicestershire and Rutland, facilitated and driven by a core team of professionals who have the skills and expertise in this area.*

Design/methodology/approach – *With no dedicated funding, this team is virtual in nature and provides support for the community and in-patient teams in the assessment and management of offenders with LD. A care pathway including a process map is included to represent a visual idea of the referral, assessment, intervention and disposal strategies across the four tiers of service delivery. The service has a unique partnership arrangement with the independent sector that allows for staff training in order to deliver quality outcomes. The virtual team can support patients with learning disabilities and forensic needs in the community and in-patient settings, both by avoiding unnecessary in-patient admissions and by improving the treatment outcomes of those discharged from in-patient settings.*

Findings – *Further research is required to demonstrate the clinical and social outcomes for offenders with LD using the tiered model of care and care-pathway.*

Originality/value – *The virtual team and the LD forensic care pathway were developed because of a gap in service that was identified as part of a mapping exercise and stakeholder discussion. In the current economic climate, additional resources to address this gap in service may not be readily available; therefore, an innovative way of addressing this gap in service was by developing a care pathway for use by community LD teams based on lean principles and evidence-based medicine and the pooling of specialist skills to develop the virtual team to enable and support the implementation of the care pathway.*

Keywords *Offenders, Learning disability, Intellectual disability, Forensic, Service provision, Criminals, Disabilities, Learning disabilities*

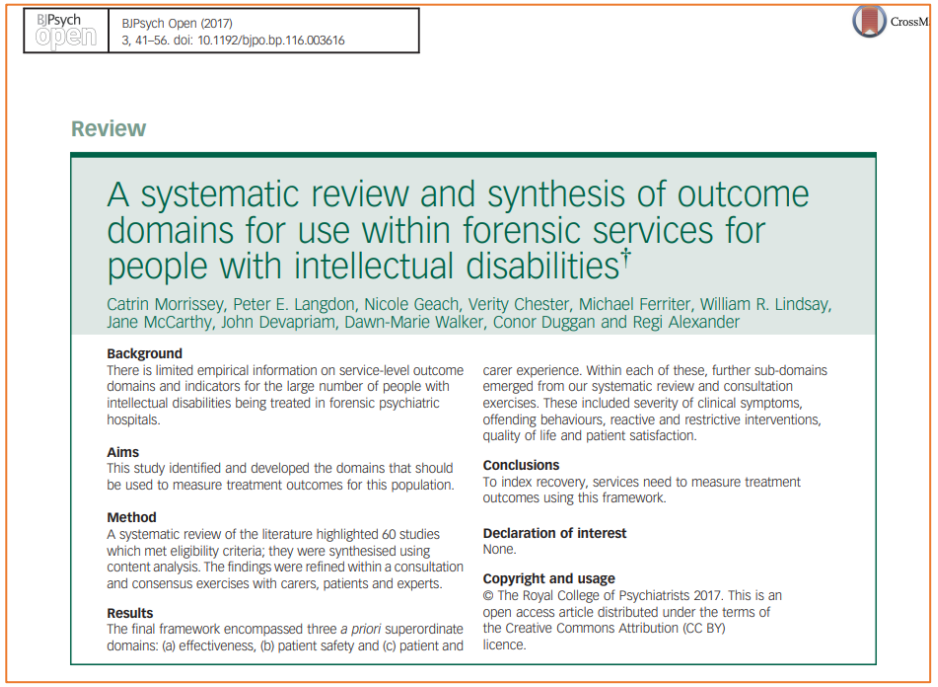
Paper type *Conceptual paper*

Services and service models: an overview (1995-2020) and examples

Table III	Tiered model of care for LD forensic service provision
Tier 1	Enabling other agencies (primary care and other mainstream services including criminal justice system) to support offenders with LD: provision of training, supervision and raising awareness of issues in relation to offenders with LD
Tier 2	Supporting CLDTs and other agencies to assess and manage offenders with LD: signposting and providing advice
Tier 3	Hands on assessment and management of offenders with LD: providing the specialist component of risk assessment and management of offenders with LD using structured professional judgement Access assessments for the EMSCG
Tier 4	Care and treatment of offenders with LD within in-patient facilities (category 2, 4/5 beds). Within the service, the main focus has currently been on category 4/5, i.e. rehabilitation beds of people who have already spent time in more secure settings Provide appropriate treatment programmes, interagency working with the police, probation and MAPPA to facilitate the step down from higher secure hospital placements and promote rehabilitation into the community

4. Consultation with Experts by Experience: Service model + Outcomes framework

- Background to the Norfolk FC-LD team
- Two systematic reviews, the first with experts by experience involvement



BJPsych Open (2017)
3, 41–56. doi: 10.1192/bjpo.bp.116.003616

Review

A systematic review and synthesis of outcome domains for use within forensic services for people with intellectual disabilities†

Catrin Morrissey, Peter E. Langdon, Nicole Geach, Verity Chester, Michael Ferriter, William R. Lindsay, Jane McCarthy, John Devapriam, Dawn-Marie Walker, Conor Duggan and Regi Alexander

Background
There is limited empirical information on service-level outcome domains and indicators for the large number of people with intellectual disabilities being treated in forensic psychiatric hospitals.

Aims
This study identified and developed the domains that should be used to measure treatment outcomes for this population.

Method
A systematic review of the literature highlighted 60 studies which met eligibility criteria; they were synthesised using content analysis. The findings were refined within a consultation and consensus exercises with carers, patients and experts.

Results
The final framework encompassed three *a priori* superordinate domains: (a) effectiveness, (b) patient safety and (c) patient and carer experience. Within each of these, further sub-domains emerged from our systematic review and consultation exercises. These included severity of clinical symptoms, offending behaviours, reactive and restrictive interventions, quality of life and patient satisfaction.

Conclusions
To index recovery, services need to measure treatment outcomes using this framework.

Declaration of interest
None.

BJPsych Open (2022)
8, e187, 1–18. doi: 10.1192/bjo.2022.571

Review

A systematic review of in-patient psychiatric care for people with intellectual disabilities and/or autism: effectiveness, patient safety and experience

Clare L. Melvin, Magali Barnoux, Regi Alexander, Ashok Roy, John Devapriam, Robert Blair, Samuel Tromans, Lee Shepstone and Peter E. Langdon

Background
An increasing number of children, adolescents and adults with intellectual disabilities and/or autism are being admitted to general psychiatric wards and cared for by general psychiatrists.

Aims
The aim of this systematic review was to consider the likely effectiveness of in-patient treatment for this population, and compare and contrast differing models of in-patient care.

Method
A systematic search was completed to identify papers where authors had reported data about the effectiveness of in-patient admissions with reference to one of three domains: treatment effect (e.g. length of stay, clinical outcome, readmission), patient safety (e.g. restrictive practices) and patient experience (e.g. patient or family satisfaction). Where possible, outcomes asso-

intellectual disability or general mental health in-patient service. Patients admitted to specialist intellectual disability in-patient services had greater complexity, but there were additional benefits, including fewer out-of-area discharges and lower seclusion rates.

Conclusions
There was evidence that admission to in-patient services was associated with improvements in mental health for this population. There was some evidence indicating better outcomes for those admitted to specialist services.

Keywords
Intellectual disability; neurodevelopmental disorders; autism spectrum disorders; psychiatric in-patient treatment; mental health; hospital.

4. Consultation with Experts by Experience: Service model + Outcomes framework

- An externally facilitated consultation exercise (Chester 2020)
- A scoping exercise for NHS East of England that involved (1) review of literature (2) focus groups with professionals, patients and family members
- The latter identified four key themes

4. Consultation with Experts by Experience: Service model + Outcomes framework

(i) ‘Fulfilling everyone’s exclusion criterion’

(ii) ‘You may be suitable, but not yet’

(iii) ‘We don’t know what we have to do to progress’

(iv) ‘So many delays’

- The second presentation will describe how the team was shaped to address these expert by experience concerns
- The final presentation will describe the outrcomes framework and the team’s 1 year evaluation.

TO RECAP….

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