Breaking the Cycle

Better help for people with learning disabilities at risk of committing offences:

A framework for the NW

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Executive Summary

1. People with learning disabilities who are at risk of offending have benefited relatively little from recent policy initiatives. They frequently receive too little support in the community, or are admitted into hospitals or secure settings, often for years. They need better support.
2. The key principles for such support are: legal and civil rights, the right to support and treatment, and the right as much independence, choice and inclusion as possible, and the least restrictive environment. These rights also have to be balanced against risks to others.
3. Local services are struggling to meet the needs of people with learning disabilities who are at risk of offending, due to problems with commissioning strategies, inadequate or poorly targeted resources, variable staff competence (with these service users) in ordinary learning disabilities services, insufficient cross-agency coordination (eg. between the CJS, mental health services and CLDTs), insufficient community-based specialist services and a shortage of staff training.
4. People with learning disabilities at risk of offending usually have moderate, mild or borderline disabilities. They frequently have challenging behaviour, additional physical or mental health needs and/or autism. Often their family background is one of chaos, deprivation, abuse and neglect. Usually they have been known to services during childhood but some may lose touch with services for a while when they leave school.
5. Community-based studies have shown that around 10-13% of people in touch with learning disabilities services have engaged in behaviour that has brought them into contact with the CJS. About 3% of the people in touch with learning disability services have actually had a conviction of some kind in the past, while less than 1% are serving a sentence or detained in secure accommodation at any one time.
6. Partnership boards and commissioners need to know how many people they have who are at risk of offending, in their area, and what services are available. They need to plan for improved services.
7. Opportunities for early intervention occur in childhood, as most people at risk of offending were known to children's services and/or Youth Offending Teams. Adult services need good coordination with these teams and with Connexions services or transitions workers.
8. People need good support in the community, either from community-based Learning Disability teams (CLDTs) or from specialist intensive support teams. These should provide a central referral service; specialist advice and assessment for police, courts and probation; a wide range of clinical assessments and interventions; risk assessment and management; on-call back-up; small specialist registered homes, able to take people under section when needed (with proper psychiatric, psychological and nursing support); flexible support from community support workers for people (and their families) when they need it; staff training. Where there is no specialist intensive support team, CLDTs need to be prepared to provide these services.
9. In addition, like anyone with learning disabilities, people need access to person-centred planning and individual service design, a range of different

types of accommodation, day activity and employment services, active care management and advocacy. They may need specialist advice to access some of these services, so as to balance risks and opportunities.

10. Police, probation, courts, prisons and MAPPPs (Multi-Agency Public Protection Panels) need good contacts with local CLDTs and/or specialist intensive support services. There needs to be regular two-way contact across these agencies, to consult regarding individuals and how to meet their needs. There also needs to be joint staff training.
11. Police services need to ensure their staff have some knowledge and understanding of learning disabilities and know how to interview people with learning disabilities.
12. Police custody sergeants should have the means to screen people who are coming in for questioning, to check whether they may have learning disabilities
13. The police need to call Appropriate Adults for those who require them and to ensure people understand their rights and the procedure (governed by PACE) in the police station
14. There needs to be an Appropriate Adult training scheme that does not just train approved social workers and provides sufficient AAs, so that people do not have long waits for them in police stations.
15. Probation services need to screen people for learning disabilities and adjust their procedures and programmes to fit their needs
16. Courts need to know who has learning disabilities and to make their procedures comprehensible for people with learning disabilities
17. There should be court diversion schemes able to divert people with learning disabilities to specialist services, as appropriate.
18. Prisons should screen people so that they know who has learning disabilities.
19. Prison staff should have training in how to work with people with learning disabilities and prison rehabilitation programmes should be adapted accordingly, with help from learning disability specialists as necessary
20. There need to be some available secure services. Medium secure services are highly specialist and will need to be shared across areas. They are likely to have 15-places or more. Low secure services need to be small and local, as far as this is possible, with a policy of least restrictive care, active assessment and treatment, and planning for discharge
21. There need to be good, local, step-down facilities for people as they leave secure services (for example, properly staffed community homes, with a clear understanding and remit to meet the needs of people at risk of offending)
22. Commissioners need to ensure that they collect data across their area on the need for services for people at risk of offending, so that they can use evidence-based planning.
23. They need to commission services that provide a range of support for people at risk of offending, including good step-down facilities. This may include cross-borough commissioning.
24. They need to be alert to the use of out-of area placements and plan with local services so that these are not required
25. Workforce training is crucial and there need to be training courses, that are accessible at different levels, for staff in learning disability services to learn about CJS issues and offending, and for staff in CJS services to learn about people with learning disabilities.

The term ‘at risk of offending’

This term is used deliberately. It is intended to refer to those people with learning disabilities whose challenging behaviour can be construed as offending (for example, people who engage in property destruction, stealing, violent behaviour, arson, sexually abusive behaviour). This behaviour may have brought them into contact with the Criminal Justice System and some people will have been convicted of crimes. However, the police are often reluctant to charge people with learning disabilities, so not all of them will have convictions (and therefore they cannot all be termed ‘offenders’).

What to aim for: a model for each area

This strategy document argues in detail for a whole series of actions to improve support for people with learning disabilities who are at risk of offending. This section summarises much of the document in describing what each area needs to have in place. This is only intended as a guide: services really need to be individual and therefore each area can only really know what is needed by knowing well each person for whom it provides support. (The following assumes the area has a general population of about 200,000; of these up to about 1500-2000 people will be known to learning disability services; research suggests that about 30-40 of these will have had some kind of criminal conviction at some time in the past)

Police, probation and prison services

These services need to have systems in place for screening people who come to their service for learning disabilities (for example, between 5-9% of those people who come to police stations for questioning and about 6% of people seen by probation have learning disabilities). Good links with the local community support team (see below) will be needed, so that they can get advice, assessment, treatment, court reports, and joint work for individuals in their services, and also more general advice and training in learning disabilities.

Community support service

A community support service is an essential arm of a good overall service. It could be provided by a named small group of members of a CLDT or by a small specialist team, such as an intensive support team (if the former, then there is likely to be a need for regular advice/supervision from more specialist forensic practitioners; if the latter, then it is likely to include staff with forensic training and will probably cover two districts with an overall population of 400,000). The group needs to include one or two support workers, one or two community nurses, a psychologist, a part-time psychiatrist, a care manager. What needs to be provided is:

- A referral system, that can take and deal with emergency referrals including from the police, courts, prisons and probation
- Good links with police, prisons, probation, MAPPS and the ability to provide training and advice to these services

- Access to person-centred planning and individual service design
- Access to leisure and employment services (with the possibility of support worker help)
- Advocacy services
- Appropriate assessment and treatment (e.g. anger management training, sex offender treatment)
- Risk assessment and risk management
- On call service
- A good information system on who has behaviour that puts them at risk of offending and, of these, who is placed out-of-area (in order to plan for them to return)
- Good links with children's and adolescent services, as well as Youth Offending Teams (in order to plan for transitions into adult services)

Leisure, college and employment services
Many people at risk of offending will be able to use integrated leisure facilities and college placements in the community, with support (this support will need to be planned as part of their risk management strategy). They are unlikely to want to use large congregate day centres and are often unsafe in such circumstances because of the vulnerability of others there. Most people will also be keen to gain employment of some kind and again this will need careful risk management and may need a support worker to assist, at least initially.

Community-based residential services and supported living
Some people who are at risk of offending may only need some support (e.g. from the community support team) to continue living in independent flats, or in their family home, or they may be able to live in supported tenancies, group homes or other supported living arrangements. Care is needed to ensure they have risk management strategies in place, which are regularly reviewed and that they do not victimise more disabled or vulnerable people who may share their day/residential service.

Intermediate residential services

These services are intermediate between secure services and ordinary community services: they can be considered to be 'step-up' services for people who need more support than is available in ordinary community facilities or 'step-down' services for people moving on from secure services. There are very few services of this kind at present in most areas, so they will need a concerted effort for development. They are likely to consist of a mixture of one-person, two-person and three-person houses/flats that can provide 1:1 staffing for all/most of the day for the person at risk of offending. The staff will be mostly needed for emotional support, risk management and help with high levels skills like budgeting (rather than help with basic self care skills). Some people may need waking night staff, some sleep-in night staff; some may not need night staff. Approximately 5 -10 people per area are likely to need this kind of provision at any one time (this will depend in part on the skills of the staff in the ordinary community-based service – the more skilled staff are there, the fewer 'intermediate' places will be needed)..

Secure services

- Access to low secure services, preferably local house(s) adapted as necessary for the purpose, and registered as nursing homes/hospitals, where people at risk of offending can be detained under sections of the Mental Health Act. The likely level of need is for **3 - 4 places in low secure services** at any one time. Senior staff need to be trained in learning disabilities (including in autism and mental health needs) and need some training in forensic work.
- Access to medium secure services. Each area is likely to need about **3 places in medium secure facilities**. Currently these services usually each take up to 15 people who have committed serious offences (Mary Dendy unit and Auden Unit; Calderstones is larger and has 30 places which are medium secure). They are for people who need specific facilities and staff. They will probably be shared by several areas, so these services may not be in the immediate area but should be within one hour of travel. Staff need to be trained in learning disabilities and forensic work.
- Access to a high secure service if necessary (for most areas there will be no need for this, as there are only 4 people with learning disabilities from the NW currently in high secure services - for a population of 4.4 million - and two of these are considered ready to move on)

Commissioning

Joint Commissioning Boards (partnerships between PCTs and Local Authorities) have a responsibility to ensure that services are properly planned for people at risk of offending. They need to ensure that large sums are not simply spent on expensive out-of-area placements; rather they should plan how to use those funds better in providing good services in the area, of the type described above. They need to be pro-active in developing plans with local providers for individuals in their area and may occasionally need to share services across borough boundaries.

Training

Training needs to be available at several levels: the NW is extremely lucky to have easy access to good forensic courses in St Martins College, where a BSc, diploma and certificate level courses are provided. Staff who will work in secure services and/or specialist intensive support teams will benefit from these, while staff in less specialist services, such as the intermediate residential services, could be trained by the specialist intensive team members.

Why is this so important?

In *Valuing People* (2001), the government set out how services and supports for people with learning disabilities should be transformed to promote legal and civil rights, choice, independence and inclusion. The Cabinet Office has recently published new government policy called *Improving the Life Chances for Disabled People* which sets out a radical agenda to achieve true citizenship for all, through shifting power to people with disabilities and designing service supports around individuals.

These policies apply to all people with learning disabilities. People who have learning disabilities and are at risk of offending, however, are often the most marginalised group and they do not always benefit from the new policies, because of difficulties that services and society have, in including them and serving them well.

People with learning disabilities 'at risk of offending' are those who show challenging behaviour which is likely to harm others and/or to constitute a criminal offence (behaviour such as aggression, sexual offending, arson, property destruction, theft). As a result of their behaviour, they may be arrested by the police, they may be remanded in custody, and if convicted they may be fined, or sentenced to prison or hospital, or supervised by probation services. The lack of comprehensive and competent service support, especially in the community, as well as the problems in service system co-ordination, is damaging, both to the people themselves and often to those with whom they come into contact, as the following example shows.

S was a young Asian man with autism. His family found it hard to cope with him when he was aggressive. There were several other brothers and sisters too and the family could not manage with S at home, so he went into residential provision locally. The local services were poorly staffed and the management had not ensured that staff were trained in autism or "challenging behaviour". The staff found it difficult to set limits for S because of his "rages" and they tended to leave him to his own devices. He chose to wander the neighbourhood. Often he would sleep outside his parents' house (unknown to them). He was frequently in contact with the police and was finally arrested after stealing 3 CDs and some milk in two local shops. He hit the policemen who tried to arrest him and was eventually convicted and sent to a private secure hospital 100 miles from home (a very expensive provision, funded from the local health budget). His family could only visit once a year. When they visited, they were appalled to find that the staff knew nothing of S's religion, that S had not been observing his religious festivals or eating appropriate food. His local services had no plans to bring him back nearer his family and he continued to live a long way away for over 15 years (costing the local health budget over £1,000,000, which could have been used to design a better more local service).

S's experiences are not unusual, as, as Margaret Flynn and Jennifer Bernard made clear in their study *Deep Trouble (1999),* a report of first hand accounts from people with learning disabilities who were in prison, or in high secure or medium secure services or on probation. It is certainly not always easy for local services to effectively meet the needs of people at risk of offending and many workers and professionals are doing their best in very difficult circumstances. However, people like S and his family, as well as the staff and workers themselves, must be able to

expect improvements that will break the cycle of inappropriate placement and insufficient support, with its damaging consequences for people with learning disabilities and for others.

This framework document is intended as a guide for service commissioners and providers in the North West to build on existing good work and drive further forward. It summarises what is known from international research and from national experience and describes the elements of an effective strategy.

Key Principles

All people with learning disabilities want the same opportunities in life as everyone else. The key principles of Valuing People apply equally to people at risk of offending, even if they are harder to apply:

- **Legal and civil rights**
  People with learning disabilities should have the **same legal and civil rights as other people,** to have a decent education and good health services, to be able to vote, to form relationships, to express their opinions and to receive support tailored to their needs. Those people with learning disabilities who are at risk of offending should enjoy these rights too. They also have **a right to be held accountable for intentional actions, to have fair boundaries set and to have the full range of sentencing options available to them**, if convicted. They are particularly likely to **need support when they enter the criminal justice system, as they are vulnerable to not understanding and not exercising their rights in this situation**.

- **Independence**
  Promoting independence is a key principle. The starting assumption should be one of independence, not dependence and support must be carefully tailored to people's needs. People with learning disabilities at risk of offending often have many skills and only mild or moderate learning disabilities. However, some of their behaviour may result in them living in restrictive settings, such as prisons or hospitals, where they may be less able to exercise what skills they have and where they may sometimes not be able to learn new skills. People with learning disabilities who are at risk of offending need **good person centred risk assessment and service design to help them to be as independent as possible**. They **need to learn new skills**, while not putting themselves or others at high risk.

- **Choice**
  People with learning disabilities, like other people, should be able to choose where they live, what work they should do and who supports them. Much of this should be achieved through good Person Centred Planning (*Valuing People, 2001*). People with learning disabilities who are at risk of offending also need **Person-Centred Plans** and they need **accessible information** on what is available. **Their views need to be heard**. It is important that commissioners and providers should ensure that they have a range of local services available, that people are offered the **least restrictive services**

possible and that people with learning disabilities at risk of offending are given **as many choices as possible, and equal access to services. A**t the same time, action may need to be taken (by a variety of agencies) to limit the risk posed by people with learning disabilities to themselves and others.

People who are at risk of offending, or have offended, are not all the same. Some people will be able to live alone (or with a few other people who they choose), with staff support; others will need more intensive support and some people will need to be in secure settings, at least for a while. All of these options should be available to people with learning disabilities at risk of offending, and agencies should recognise that people's needs may change over time.

- **Inclusion**
  People with learning disabilities want to be socially included, in ordinary, community life (*Valuing People, 2001*). People with learning disabilities who are at risk of offending also want to be included. However, some are admitted into secure services, frequently as a result of a lack of good local support, rather than because this is really necessary. **Good risk assessment, service design, and treatment and support services** will ensure that people at risk of offending can be included in ordinary life, to a much greater degree that at present, without putting themselves or others at high risk.

  A few people may really need secure services for part of their lives. These services should be as **close to home as possible, provided that this does not put victims at risk**. In the past, secure provision has often involved large, distant services with little active treatment. People should not be admitted to secure services unless it is absolutely necessary because of the level of risk that they pose. If they do need such levels of security, there must be **good monitoring (including by commissioners), reviews and active planning for their move back to the community** as soon as this is possible, and continued support towards full social inclusion. This will require good local services, sometimes including some very **specific service planning and some intensive support**, at least initially. Crucial components for such resettlement in the community, as reported by current support providers, are: adequate funding and acknowledgement of the need for 24 hour on call management support, relief budgets that recognise the needs of staff, good staff supervision, regular team meetings, backing from the CLDT and emergency/crisis support services (which may include admission to a short-term emergency service).

Relevant policy

There have been a number of government documents issued recently that are relevant to people with learning disabilities, including:

- The white paper *Valuing People (2001)* which set out the plans for improving the opportunities for choice, legal and civil rights, independence, inclusion and other life chances for people with learning disabilities.
- The recent green paper for social care *Independence, Well-being and Choice (2005*) which emphasised the need for service users to have more control over their support and services
- The cabinet office paper *Improving Life Chances for Disabled People (2005),* which examined ways of reducing disadvantage (poverty, poor education, poor employment prospects, poor housing, poor access to transport, vulnerability to crime) for people with disabilities

Two previous reports also have direct relevance to people at risk of offending, the Mansell report (1992) on improving services for people with learning disabilities and challenging behaviour and the Reed report (1993) on forensic services. Both of these reports emphasised the need for community placements wherever this was possible, close to families and friends. The Reed report recommended that if secure provision was necessary it should have the maximum rehabilitation potential possible and no greater security than was absolutely necessary. In the Mansell report, one of the important points made was about the competency of local services: these often determine the numbers of out-of-area specialist placements, with least competent areas needing the most expensive placements. This remains the case for people with learning disabilities at risk of offending. Nevertheless, *Facing the Facts (1999)*, a Government survey of 24 local authorities, conducted some years after The Mansell and Reed reports, found only half of the Local Authorities surveyed felt they had adequate community-based forensic learning disability services and only a third felt that in-patient forensic and mental health services were adequate. The report *Green Light for Mental Health (2005)* provides guidance on how to meet the mental health needs of people with learning disabilities.

The increase in independent sector hospital places for people with learning disabilities and 'forensic' needs (reported by the Healthcare Commission in 2004) caused the Department of Health to issue a policy clarification note called *Commissioning Close to Home (2004)* which restated policy expectations for commissioners and emphasised the need to ensure people with 'forensic' needs or challenging behaviour are not placed many miles from home when they need specialist help.

Why is this becoming urgent?

Valuing People(2001) has helped to give people with learning disabilities more of a voice in the way their services are designed. The green paper on social care *Independence, Well-being and Choice (2005)* has also reinforced the idea that people should have more control of their services. However, people with learning disabilities who are at risk of offending often have the worst services. Their voice tends not to be heard. They need to be listened to and they need flexible specialist services that support them when they need help.

For example, George's service did not meet his needs, with disastrous consequences:

George had mild learning disabilities and autism. He was extremely large and well-built and tended to force people (including his mother) to do what he wanted. He did not understand other people's feelings and very much wanted a girlfriend. In group homes he tended to harass the female residents and he was found several times in their rooms in a state of undress. His social worker argued that because he had good self-care skills he would do better living in an independent flat on a local council estate. However, George was not properly supported there. His odd social behaviour meant that he was bullied by local gangs of youths. Also, George was not good at budgeting and often ran short of food, meaning that he had to steal from local shops. He became increasingly stressed. His desperation for a girlfriend led him to stalk a young woman he saw on the bus and he was arrested when he was hammering on her door shouting for her to let him in. He had never met her before but, when arrested, he seemed surprised because he said he 'only wanted to be friends'. He was convicted and detained under section 37 of the MHA 1983. He lived over 150 miles from his place of origin for the next 10 years and cost his placing authority over £1,000,000, which could have been better spent on local provision.

Where community services fail for people at risk of offending, they are often too unsupportive, as in George's case above. However, once such community services do fail, the person often transfers straight into over-supportive provision, usually secure services, which may be over-restrictive (as indeed happened to George). In most parts of the country, NHS long stay hospitals have already closed. Yet as they close, it seems that new independent sector long-stay hospitals spring up. Most of the people referred there are people with learning disabilities who are at risk of offending. Recent figures from a Healthcare Commission survey of independent sector hospitals showed that there are about 1000 places for people with learning disabilities in these hospitals nationally. Many of them are large facilities, a long way from people's homes and many of the people admitted there, according to the recent survey, were not formally detained. What this tells us is that local services are really struggling to meet the needs of people with learning disabilities at risk of offending and are often resorting to purchasing expensive places in independent out-of-area hospitals. The likely cost of 1000 places is conservatively estimated at over £150 million per year, nationally (assuming each place costs £150,000 per year – some cost much more than this).

Why are local services struggling to meet the needs of people with learning disabilities at risk of offending? There are the following difficulties:

- Insufficient knowledge and analysis at Strategic Commissioning levels of both what is required to successfully support people more locally and what is achievable. There is insufficient awareness of the benefits, in both outcome and value for money, from developing responsible and responsive local provision available at the time of need.
- Insufficient knowledge and confidence of staff in day/employment, residential and other services and in CLDTs in dealing with this very complex group, leading sometimes to very high anxieties about the risks involved and at other times to naïve approaches to services

- Lack of coordination between all the agencies involved (including the police, probation, forensic services, mental health services, young offender teams, CLDTS). For example, this lack of good inter-agency working sometimes results in long waits for Appropriate Adults at the police station and in difficulty engaging an RMO for someone who is ready to leave hospital and live in the community
- Lack of investment in crisis/early intervention and longer term outreach services to support families, and local providers
- Insufficient range of supported accommodation in local areas (including intensive support services and low/medium secure services), leading to distant placements in out-of borough services
- Perception that local solutions are too difficult and too time consuming or are not within the stated priorities for purchasing authorities
- Insufficient training available in "forensic" work, at all levels
- Workforce shortages within specialist learning disability multi-disciplinary teams

It is possible to make improvements to services, though as this example of good practice shows:

In one area (population 400,000 approximately), health commissioners were worried that large parts of their budget were being spent at times of crisis on expensive out-of area placements for people with challenging behaviour. Independent consultants (from a local university) looked at what was happening and found that local services for people with severe learning disability and challenging behaviour were adequate but that the people with mild or borderline learning disabilities who were at risk of offending were often not receiving a service. This was frequently because of arguments about eligibility criteria between various services, so that people were being 'bounced' from service to service (mental health, forensic and learning disability services were all saying they were not responsible for them), often falling through service gaps. As a result, people were ending up in crisis, and frequently being sent out-of-borough to expensive placements.

A new community-based intensive support team was funded to bridge the gap. The team included a part-time psychiatrist, two social workers, a clinical psychologist, a psychologist in learning disabilities, an OT, and two support workers (some of these professionals came from Learning Disability services, some from forensic services and some from mental health services, providing a good mix of knowledge and skills). Over the next two years no one who was at risk of offending went to out-of –borough expensive placements as a result of challenging behaviour or offending. Service users and carers were very positive about the service. Many of them felt they had never had proper help before.

What are the problems we need to solve?

- As we have said, people with learning disabilities who are at risk of offending deserve the same rights as other people but at the same time public safety cannot be ignored. There is sometimes **a clash between the social model of disability and the so-called medical model,** in considering people's needs. However, most people would agree that what needs to be achieved is **a**

balance between the rights of people with learning disabilities who are at risk of offending and the right of the public to be safe.

- We need a **range of services and supports, individually designed as far as possible,** so that people can remain in the community when they are safe to live there, but also can be well supported in more secure environments when this is unavoidably necessary. The specialist environments should be as **local as possible** (provided victims are not at risk) and should not be a long way from people's homes because that dislocates family relationships. The different services involved need **good cross-agency coordination** and **access to staff training in the relevant forensic issues, as well as in person-centred approaches and individual service design**.
- People with learning disabilities who end up in the police station are not always known to local teams. They need **rapid access to assessment and other services,** which will require **good cross-agency collaboration**. Moreover, people with learning disabilities in police stations and those in prison and in secure environments tend not to understand their rights and are often abused and/or wrongly convicted. We need to ensure **good information, advocacy and support for people in the Criminal Justice System**.
- In hospitals, people with learning disabilities at risk of offending are frequently kept admitted for extremely long periods of time, without active treatment, and often end up staying far beyond the length of time that an alternative sentence in prison would have lasted. Often this is the result of a lack of suitable step-down provision in the community. People's **stays in restrictive environments must be time-limited so they can move out when they are ready**. In the community, some people will need **local, skilled, targeted and carefully designed support,** so they do not harm others or themselves in the community.

Despite these difficulties, there are examples of good practice in local services which show what can be done, with good inter-agency working, even without special resources, as the following example shows.

Brian lived with his father, but when he was in his 20s, his father died (his mother had died when he was a child). For a while, Brian carried on living alone but a group of men (including a friend of Brian's father) took advantage of him, taking money from him and getting him drunk. The local learning disability service helped Brian move into a house, which he shared with a co-tenant, supported by a local agency. Later, the co-tenant moved out, leaving Brian living in the house on his own. One day Brian met one of his "friends" and went drinking. When he got back to his house, in a confused, anxious and intoxicated state, he set fire to the house. He was arrested, spent a night in a police cell then was released on bail to his service provider. Prior to his trial there was good liaison between all the professionals involved with Brian; his service provider, probation officer, social worker, psychologist, psychiatrist and solicitor met to discuss the support Brian would need at the trial and the possible outcomes.

The outcome of the trial was that Brian was given a three-year probation sentence and a stipulated "care package" by the service provider with support from local professionals. His probation officer saw Brian every two weeks and linked closely

with the service provider to monitor Brian's progress. Regular multi-disciplinary meetings were held, attended by the probation officer, service provider, social worker and psychologist to discuss risk factors and monitor progress. The probation officer also liaised individually with the other members of Brian's support team. Times when Brian felt low and generally anxious were identified as possible risk factors and good liaison between agencies meant that Brian would see his probation officer once a week at such times, but only once a month at low risk times. When his period of probation ended in 2004, Brian's probation officer was happy that any risk factors were minimised by a continuation of the support service which was in place. Brian has since participated in a day programme of vocational activities and has been referred to a supported employment service to help him look for suitable work.

Who needs better help?

Research tells us that people with learning disabilities who are labelled as 'at risk of offending' tend to be people with mild or moderate learning disabilities and challenging behaviour which causes harm to others (such as aggression, sexually abusive behaviour, property destruction, arson)[1]. They have frequently come from very disturbed, deprived and abusive backgrounds and have usually been known to services in the past (see also *Deep Trouble, 1999).*

Degree of disability

In practice, very few people described as having severe or profound learning disabilities are ever seen as 'at risk of offending'. They are very rarely arrested or charged for showing challenging behaviour, even where this behaviour is harmful and could, in theory, fall within the purview of the criminal justice system. This is because the law requires both '**actus reus'** and '**mens rea'** to be proved in prosecuting criminal offences, i.e. that the act was done and that the person intended to do it. Even where people described as having severe or profound learning disabilities show behaviour which is seriously dangerous and harmful to others, such as extreme physical aggression, they are very unlikely to be charged by the police because, while proving 'actus reus' may be possible, proving 'mens rea' may be impossible. In addition, where someone with severe or profound disabilities is charged with an offence, it is likely that they would be unable to understand the charge against them, unable to instruct a solicitor in their defence, and unable to understand court proceedings, so that they could be found unfit to plead. Consequently for people with severe/profound disabilities who display dangerous behaviour, the need is usually for support and treatment to help them reduce these behaviours, not for the intervention of the criminal justice system.

For people with less significant learning disabilities where there was an **intention to engage in dangerous or criminal behaviour**, recourse to criminal law and its sanctions may help in the establishment of clear boundaries. These

[1] Some kinds of challenging behaviours, especially those which do not cause harm to others, such as stereotyped behaviours and self-injurious behaviours, are very unlikely to be regarded as offending and tend not to fall within the purview of the criminal justice system.

are the people who are at risk of prosecution for offending. Many also have additional mental health needs and/or autism.

Arbitrary nature of consequences

People with learning disabilities are considered 'at risk of offending' when their behaviour is likely to result in contact with the Criminal Justice System. As a result of their behaviour, they may be arrested by the police, they may be remanded in custody, and if convicted they may be fined, or sentenced to prison or hospital, or supervised by probation services.

Technically, though, no one is an 'offender' until they have been convicted of a criminal offence – hence the phrase 'at risk of offending' and we know from research that:

- Not all of the behaviour that could be called 'offending' comes to the attention of the police (this is also true for non-disabled offenders of course)
- The police may be reluctant to arrest, interview and/or charge people with learning disabilities with crimes
- The Crown Prosecution Service (CPS) may be reluctant to proceed with a case against a person with learning disabilities
- Government policy requires, wherever possible, that people with learning disabilities are diverted from custody.

Quite often, the decision to prosecute some people with learning disabilities and not to prosecute others seems **arbitrary**. Sometimes when people with learning disabilities engage in behaviour that could be construed as against the law, their behaviour is ignored or 'brushed under the carpet'. Often this is because service providers are unsure what to do about the behaviour or are worried about adverse publicity. Frequently, people with quite dangerous behaviour, like sexually abusive behaviour, are simply moved to a new placement. It is not unusual for staff in new placements to assume that, with a better 'ordinary life' approach, the person's challenging behaviour will disappear, though this is rarely the case. Where people do repeat their challenging behaviour, it often escalates in frequency or intensity until one day the person's behaviour is so dangerous that it just cannot be ignored. Then the CJS may be brought in and the person with learning disabilities may be shocked at the consequences of his or her own behaviour, which until then may have seemed harmless (at least to him or her).

Who are the people at risk of offending?

From research we know that people with learning disabilities at risk of offending:

- Are most often male (around 20-30% are female)
- Usually have good basic self-care skills and reasonably good communication skills (i.e. can engage in a conversation)
- Commonly have additional health needs, such as mental health needs or autism
- Have often grown up in socially deprived, abusive and chaotic homes
- Have normally experienced little consistent emotional support in their early lives

- Frequently have a very long history of ‘failed’ placements, including residential placements as children, often a long way from home, making rocky family relationships even more tenuous.
- Are often ‘bounced’ from learning disability services to mental health services, to forensic services, and back, with each one saying that they are ‘not responsible’

Service commissioners and providers do not always understand the needs of people with learning disabilities at risk of offending, for emotional and practical support. They may underestimate the needs for support partly because of people’s relatively good basic self-care and communication skills. It is very common to find that people with learning disabilities at risk of offending are living relatively unsupported, in poor conditions, engaging in minor criminal behaviour, that escalates over time until the Criminal Justice System becomes involved, as in the two examples below. Had the CJS been brought in at an earlier stage for Mark (see below), less damage would have been done, both to himself and to others; likewise, in Susan’s case (see below) it seemed that her behaviour was so out of control that she needed a secure service at least for a while, in order to receive proper assessment and treatment.

1. Mark was one of five children, born to a poor and struggling family. He was badly sexually abused by a ‘friend’ of the family as a child. He told no one, because the perpetrator threatened that Mark’s siblings would suffer if he did. When his parents died, Mark went to live in a series of group homes. He sexually assaulted both the male and female residents with severe disabilities in the homes but no one did anything about it, apart from moving him to yet another home. One day he attempted to rape a young girl in a respite care home, adjacent to his own group home. He was arrested, convicted and sentenced to hospital. Had action been taken earlier on, a number of people would not have been abused and Mark could have probably have been charged with lesser offences and been able to receive treatment in the community.

2. Susan was a young woman with mild learning disabilities, who was referred to a secure hospital service for people with learning disabilities, at 17 years of age. Prior to this she had had a very difficult childhood, during which her mother had died and her father had been accused of abuse. So Susan had lived in care from the age of 12 years. She had a history of aggressive challenging behaviour but, at the time she was 15 years old, this consisted mainly of verbal abuse. However, her behaviour escalated after she was 15 and by the time she was 17 years old she had 32 convictions (for hoax calls, attempted arson, arson, assault and assault on a police officer). During this period Social Services placed Susan in a series of foster homes and residential units, but all placements failed due to her escalating behaviour. Finally she was placed in Bed and Breakfast hotels, with supervision from a Youth Offending Team worker, but her behaviour continued and resulted eventually in her being convicted and sent to prison. Only when she was in prison was she finally referred to the secure service. Had she been referred to more specialist services earlier,

or even a secure service for adolescents, she would not have had so many convictions and might have been spared some damaging experiences.

How many people need better help?

Planning

One of the very important factors for good services for people at risk of offending is **inter-agency coordination and planning**. A very large number of services may need to be involved, including the learning disability services (both social services and health teams), mental health services, forensic services, police, probation, youth offending teams, prisons, and the multi-agency panels (MAPPPs).

In planning services, reliable prevalence figures are needed, so that we know how many people we are planning for. Such figures are difficult to obtain (see below for a discussion of this issue).

How many people?

National figures

The prevalence of offending amongst people with learning disabilities is very difficult to establish with certainty. Most studies have asked: **how many offenders have learning disabilities?** They have then examined services for offenders (such as prisons or probation) to find this out. In contrast, some studies have asked a rather different question: **how many people with learning disabilities have offended?** They then look at all the people known to learning disability services to find this out.

There follows a summary of what we know of the prevalence of people with learning disabilities at risk of offending (the detailed information can be found in Appendix A):

- About 5-9% of the people arrested for questioning at the police station have a suspected learning disability
- Most of these are not charged or convicted: many are released without any charge at all; some may be sent to hospital under civil sections (part II of the Mental Health Act 1983) – see below
- Of those who are charged and convicted, recent studies have shown that very few go to prison (less than 1% of prisoners have learning disabilities according to a number of studies in England)[2]
- Some of those who are convicted are sent to hospital, under part III of the Mental Health Act 1983 – see below for figures

[2] Some agencies feel the numbers in prison may now be rising, as hospitals close, and there is a current study investigating this possibility (by Phil Shackell and colleagues)

- Many of the people with learning disabilities who are convicted are given Community Rehabilitation Orders and are supervised by the probation service (one English study found 6% of people seen by probation services have a learning disability)

National Government figures show that during the course of the year 2003/4, overall there were 45,700 detentions under the various sections of the Mental Health Act 1983, amounting to 88 per 100,000 population[3]. These figures break down as follows:

- Of the 45,700 detentions, 26,200 were formal admissions to hospitals under the MHA 1983; 18,200 were detentions after admission.
- The majority of these 26,200 admissions, 89%, were under part II of the MHA (i.e. were civil sections)
- Most admissions were on grounds of serious mental illness.
- People admitted during the year under mental impairment or severe mental impairment into NHS hospitals amounted to only 147; only 43 of these admissions were under part III of the MHA.

These figures on admissions do not make clear the number of people detained in hospital at any one time (since some admissions, especially under the category of mental illness, may be short). The Government does give figures for the total number of people detained on one census date, however: **On March 31st 2004, there were a total of 14,000 people detained in hospital** – 11,700 in NHS hospitals and 2,300 in independent hospitals. Most of these people were detained under mental illness or psychopathic disorder (11,383), **only 1092 were being detained under mental impairment or severe mental impairment (408 of these were in independent hospitals).**

It is also known from the recent Healthcare Commission survey[4] that on 31/3/04, over 900 places in private psychiatric hospitals were being used by people with learning disabilities, mostly for people who were at risk of offending. One third of these people were informal patients (i.e. not detained), while 41% were detained under section 3 and 25% under section 37 or 37/41 of the MHA 1983. The average distance from the person's place of origin was over 70 miles (maximum over 380 miles).

A recent survey of the use of medium secure provision for people with learning disabilities in the London region (including NE, NW, SE and SW London, with a population of 7.2 million people) found 104 people detained in medium secure placements[5]. For an average borough with a population of 220,000 this would equate to just 3 medium secure places. A similar survey of low secure provision in SE London, Kent, Surrey and Sussex[6] showed there were about 60 places for people with learning disabilities, i.e. approximately 4 places for an average borough of 220,000.

[3] Regions varied in their use of detention. London region had the highest use at 140 per 100,000 population; East of England the lowest at 70 per 100,000. The figure for the NW was 95 per 100,000 (second highest)

[4] We are grateful to Debra Moore for these figures

[5] We are grateful to Karen Ahmed for these figures.

[6] See Beer & McGovern (2003)

Community-based studies that look at the numbers of people, known to learning disability services, in any one area, who have had contact with the CJS are rare. The best and largest of these is a study by McBrien et al (2003). They found that **of all the 1326 people with learning disabilities known to health and social services** and living in a city with a general adult population of 195,000 approximately:

- 11 people (0.8% of the 1326) had a current conviction (i.e. were serving a sentence at the time)
- In addition, 27 people (2% of the 1326) had had a criminal conviction of some kind in the past
- A further 90 people (7% of the 1326) had a history of contact with the criminal justice system as a suspect, at some time in their lives but had no convictions
- Another 220 people (17% of the 1326) had 'risky behaviours' that could have been construed as criminal offences but they had not had CJS contact.

The figures in the McBrien study exclude people not known to the Learning Disability services (who may at some point in the future be arrested as suspects by the police and turn out to have learning disabilities). Only 10 of the people in the survey (0.75%) were in secure accommodation at the time of the survey.

A somewhat similar but broader study by Vaughan et al (2000) of community psychiatry teams' caseloads of mentally disordered offenders in the area covered by Wessex consortium (population 1.8 million) found that 13% of the people supported by CLDTs were at risk of offending.

Regional figures

The NW covers Cumbria, Lancashire, Cheshire, Merseyside and Greater Manchester. The area has a population of 4.4 million adults of working age and is covered by three Strategic Health Authorities (Cheshire and Merseyside; Cumbria and Lancashire; Greater Manchester). Each SHA area includes over 10 Primary Care Trusts and over 10 NHS Trusts. Learning disabilities health services are sometimes based in PCTs and sometimes in mental health NHS Trusts, so the region has a complicated pattern of health services. In addition, there are 22 Local Authorities with Social Services departments and these are normally where the Joint Commissioning Boards for learning disabilities are sited.

For planning purposes it is important to know how many people with learning disabilities in the North West are at risk of offending. There was a study in the early 1990s by Professor Chris Kiernan and colleagues from the Hester Adrian Research Centre, conducted in a Community NHS Trust in the NW (the Trust covered a population of 270,000), which found that 8 people were currently detained under the MHA 1983. They also recorded the numbers of people considered at risk of offending and the numbers of people whose behaviour was classified as challenging but not 'at risk of offending'. However, the survey was undertaken some time ago and needs may have changed.

The current provision of secure facilities for people with learning disabilities from the NW is as follows:

- the NW has 4 people with learning disabilities whose behaviour presents 'a grave and immediate danger' placed in Rampton high security hospital (2 of these are being assessed for a possible return)
- The Auden unit in Warrington has 15 places for people with learning disability needing medium/low security
- The Mary Dendy unit in Macclesfield has 15 places for people with learning disability needing medium/low security
- Calderstones hospital has 188 places for people with learning disability at risk of offending (178 of these places were occupied on 31/12/04). Of these 188 places available, there are 30 places which are medium secure and 40 which are low secure, while the remaining 118 are low secure/rehabilitation places (some are off-site in Rochdale)
- There are thus a total of about 218 medium/low secure/rehabilitation places, in Calderstones, the Auden unit and Mary Dendy unit altogether. Many of these people (about 50) are considered ready to leave their specialist placement however (they are mainly in the rehabilitation section). If these 50 are removed from the total, then it appears that there are 168 medium/low secure places for a population of 4.4 million adults. This equates to 8 medium/low secure places for a notional average borough of 220,000. (This is very similar to the figures in McBrien's study, in Kiernan's study and in the South East studies).
- In addition to the above medium/low secure services for people with learning disabilities in the NW, there is some other specialist accommodation for people at risk of offending in various locations in the NW. However, these are in very short supply. For example, some of this kind of provision is in the Morecambe Bay area, where there are 3 single person flats, one 3-person house and one 2-person house which can support people detained under the MHA (i.e. 8 low secure places). Many areas of the NW do not have such provision.

It is important to note that even in Calderstones, the largest secure hospital in the NW for people with learning disabilities at risk of offending, many of the people placed there are not detained (those in Mary Dendy and the Auden unit are all detained though). According to Calderstones' figures (31/12/04), around 20% of those 178 people currently resident are not detained[7]. Of the remainder, over 30% are detained under civil sections (part 2) of the MHA, while the rest (over 40%) are detained under criminal sections (part 3) of the MHA (i.e. section 35, 37, 37/41, 47/49). Many people have lived in Calderstones for years: 36% of those in the secure services have been there for 0-3 years; 18% for 3-5 years; 28% for 5-10 years and 18% for more than 10 years.

Some localities in the NW have done considerable work to identify and monitor the placements for people at risk of offending. They know how many people, originating from their area, use secure and specialist services – see Table 1. We were unable to obtain figures from many areas however. This was partly

[7] These figures exclude the 23 people with severe learning disabilities and challenging behaviour in Calderstones (i.e. those who do not have forensic needs)

because staff had difficulty disentangling those people placed out of area due to 'forensic' needs from those placed out of area for other reasons.

Table 1: People with learning disabilities using low/medium secure services in NW

Area (population given in brackets)	Medium/low secure places out of borough	Low secure places in borough (small homes in borough)	Other
Bolton *Information from John Baulcombe & Miranda Washington (pct)*	20 in Calderstones 2 in indep. sector (Castlebeck, co. Durham & Care Principles, Shropshire) (Plan to move 8 of these back to local service by June 05)		Intensive support team provides support to: 10 people who moved out of hospital (2 living with support in family home, 5 in supported tenancies, 2 in group homes, 2 out of borough); plus 9 other people in supported tenancies, and 4 in a group home
City of Manchester *Info from Bernard Natale*	1 in Prudhoe, 1 in Leeds, 25 in Calderstones, 1 in Atherton, 1 in David Lewis Centre		
Oldham *Info from Terry Hevicon-Holland & Ken Stapleton*	17 in Calderstones, 1 in Northgate, 1 in Blackburn		Plan for a local 6-place service, with 2 of these 6 places registered as secure provision
Salford *Info from Anita Hardman*	8 in Calderstones 4 in Castlebeck, co. Durham		2 places commissioned in general psychiatry hosp; plus 3 people in St James, Manchester (specialist residential setting)
Stockport *Info from Gina Evans (pct)*	1 in Calderstones		
South Cumbria & Lancaster (ie Morecambe Bay pct) *Info from Paul Thomas*	11 in Calderstones; 6 or 7 in Northgate; 1 in Norwich	8 places in small homes/flats (see above) in Morecambe Bay area and 6 places in a low secure house in Barrow	

There is a project currently underway, funded by the Dept of Health, called *Tough Times*. The project[8] aims to help Partnership Boards to devise local services that can support people with learning disabilities at risk of offending, so that those who are placed in secure services out of area, can return to their communities. The first part of this project involves identifying stakeholders involved with people in secure care. Information gathered from them will be used to produce a 'learning sheet' relating to the processes involved in proposing or maintaining people in secure provision~~collecting information on secure placements, so we may have a more complete picture of the use of secure provision by each locality shortly~~.

Elements of effective strategy

Key principles for services

There are some principles which are key to providing effective services:

- The emphasis must be on prevention, social inclusion and least restrictive practices, within a positive, person-centred, individually-designed and risk managed framework
- Support should be provided as close as possible to home (unless specific victim issues mitigate against this)
- If secure care is required, there needs to be a treatment and rehabilitation emphasis, with active planning for discharge to the community, as soon as possible after admission
- Positive partnership approaches are needed between the Criminal Justice System, Mental Health and Learning Disability services. Some services may be provided through local partnerships; some may require cross-borough cooperation and joint planning; some may need regional level planning
- A sense of shared responsibility across the system is necessary, with careful consideration of funding. Potential for offending is not just a specialist Learning Disability health or social care issue; it is an issue where specialist services can also support mainstream services, through individually tailored support
- There needs to be a shared understanding and hence a concerted effort to provide training about people with learning disabilities at risk of offending, for a broad workforce, including a variety of staff, at a variety of levels, in a number of services (this is considered further in the section on workforce development and training later).

Agencies involved

Early years

Many of the people with learning disabilities who are later considered to be at risk of offending, have been known to children and families services years before (see *Deep Trouble, 1999*). According to a long-term research project in Aberdeen, children who come from families that are struggling to cope, where

[8] We are grateful to Wendy Silberman, who leads this project, for this information

there are also mental health needs, issues of alcohol abuse and/or disrupted care or imprisonment amongst the parents, as well as abuse and domestic violence within the family, are more likely to commit offences as adults. They may come into contact with Sure Start services as young children and may become known to education and CAMHS services later. According to research (mainly from USA), early intervention at this stage may reduce the need for specialist services related to challenging behaviour later on and make it less likely that people's behaviour will escalate to the point where they are sent to secure care or out-of-borough placements. The services most likely to be important in this regard are:

- Educational psychology services. Many young children with mild/moderate learning disabilities and challenging behaviour are referred to educational psychology services during their school years. Educational psychologists may see the children individually for assessment and may suggest alternative school placements and/or they may assist schools in preparing behavioural support plans for children who are challenging.

- Child & Adolescent Mental Health Services (CAMHS): Children with mild/moderate learning disabilities and challenging behaviour are likely to be seen, often with their families, at CAMHS teams. Psychiatrists and psychologists, as well as social workers and other health professionals, provide assessment and treatment services to help children (and families) who are distressed and challenging. Community Learning Disability Teams for adults need to have good links with CAMHS, so as to provide support, advice and joint working for teenagers with learning disabilities, who are at risk of offending

- Youth Offending Teams (YOTs): Young offenders with and without learning disabilities are likely to be referred to their local YOT. There is a YOT in every local authority in England and Wales, overseen by the Youth Justice Board (see www.youth-justice-board.gov.uk). The teams are made up of representatives from the police, probation, social services, health, education, drug and alcohol misuse and housing officers. All those referred are assessed using a national assessment of needs and risks, and YOTs are able to respond to young offenders in a comprehensive way because of their inter-agency representation. They also engage in preventative work with potential young offenders.

  A number of new provisions are available for dealing with young offenders, outside the court system. These include Acceptable Behaviour Contracts, Anti-social Behaviour Orders, Local Child Curfews, Child Safety Orders, Formal Reprimands and Final Warnings. These may be useful adjuncts to other services for people with learning disabilities at risk of offending.

  Specialist learning disability services need to work closely with Youth Offending Teams to ensure that teenagers with learning disabilities have access to early intervention and prevention of behaviour that is likely to

escalate into serious offending

- Transitions workers for people with disabilities. Transitions services for people with disabilities, work with children who are leaving school to assist them in making successful transitions into adult life. These transitions services often 'miss' people with mild learning disabilities, who may lose contact with all services when they finish school. Transitions workers need to link up with Youth Offending Teams and draw into transitions planning young people who are deemed challenging, vulnerable and may be relatively difficult to engage.

At the time of transition, many people with mild learning disabilities 'disappear' from service settings. They may remain out of touch with services for the remainder of their lives but, if they have challenging behaviour, they may periodically come to the notice of Community Learning Disability Teams. Sometimes CLDTs will then argue that they cannot offer ongoing support because of the Team's eligibility criteria (prioritising people with severe disabilities) or because of 'Fair Access to Care' criteria. However, these issues seem to vary geographically, with some teams providing services for people with mild learning disabilities and others not.

The Government Green paper on social care *Independence, Well-being and Choice* (2005) recommends shifting the balance of care from major support in traditional ways at later points, to more individually targeted support early on. This may assist those people who are unable to access care now because of a rigid adherence to Fair Access to Care criteria and may help to ensure that people with mild/moderate learning disabilities who are at risk of offending can access services. Without services when they are in need, people's offending is likely to escalate. (People with severe learning disabilities are much less likely to lose touch with sources of support and are normally considered eligible for services by CLDTs).

Adulthood

Community-based learning disabilities services are important to the well-being of many people with learning disabilities at risk of offending. The following services may considerably reduce their risk of offending, even though they **may not relate directly to their offending:**

- Community support teams, such as Community Learning Disability Teams (CLDTs)
- Employment and day activity Learning Disabilities services
- Residential and domicilary Learning Disabilities services
- Care managers
- Self Advocacy groups

In addition, people with learning disabilities at risk of offending may access some mainstream services that are not specifically for people with learning disabilities and that do not directly relate to their learning disabilities or their offending, such as:

- Generic health services (e.g. GPs)

- Mental health services (sometimes there are designated places for people with learning disabilities and mental health needs; sometimes these are integrated with mainstream provision)

Some learning disability services and mainstream health services may feel unused to dealing with offending behaviour and may feel unconfident about how to handle people at risk of offending.

People with learning disabilities at risk of offending also come into contact with a huge variety of services **directly related to their offending**, such as:

- Police
- Courts
- Probation services
- Prisons
- Secure hospital services
- Multi-agency Public Protection Panels

These services may know what to do with offenders but may not feel confident about dealing with people with learning disabilities, and they may therefore not offer the same opportunities for interventions as are available to people without an intellectual impairment, including recognised offender treatment programmes.

In addition there are important organisations involved in planning services for people with learning disabilities who are at risk of offending. These organisations are responsible for a large range of service users and activities. People with learning disabilities at risk of offending may not be one of their priorities:

- Partnership Boards
- PCTs
- Joint commissioning teams
- Secure commissioners
- MDO groups and NOMS (the Home Office's National Offender Management System)

All of these adult services, some of which have a provider role and some a commissioner role, are discussed in more detail below.

Supports and services that are not directly offence-related

Community Support Teams & Specialist Intensive Support Teams

Increasingly, community learning disability teams (CLDTs) are integrated into a single base, including both Health professionals and Care Management, and providing access for people with learning disabilities to a range of therapies and support. The majority of teams will have access to community nurses, OT, physiotherapists, speech and language therapists, psychologists, social workers, and psychiatrists. The application of 'Fair Access to Care' can lead local authorities to prioritise people with moderate/severe learning disabilities and make it very difficult for people with mild/moderate learning disabilities to access help, even where they do have dangerous behaviour and are at risk of offending. In part this may be due to assumptions that more preventative

interventions are not a statutory responsibility, or that they may appear unaffordable. As a result, people may get ‘bounced’ from service to service, with everyone claiming that they are not responsible for them.

People with learning disabilities who are at risk of offending, and their families, often feel the need for some provision of crisis/emergency support and/or community outreach services. Such resources can increase the likelihood of people being able to remain within their own home and local community, and may assist in preventing people becoming entrenched in patterns of offending. Further, they may need to access any of the therapists on CLDTs, but are most likely to need the support of community nurses, psychologists and psychiatrists. For those with relatively low risk of offending, the **CLDT should be able to provide or to ensure access to the following kinds of help**:

- Good person-centred planning and individual service design
- Risk assessments (that specify the levels of risk and the conditions likely to increase risk of offending or re-offending)
- Risk management (positive strategies that enable people to keep control over their behaviour and retain their quality of life and community identity)
- Clinical assessments (for example, of depression or anxiety)
- Positive interventions (both those specifically related to their offending, such as anger management training, cognitive-behavioural treatment for sexual offending, and those less directly related to their offending, such as such as training in life skills, like cooking, budgeting, social skills)
- Care managers will be able to advise people upon their eligibility for statutory funding, direct payments or self directed supports, and/or will help them access other community amenities.

Where people’s risk of offending is high and/or their difficulties are complex, CLDT professionals sometimes feel out of their depth or in need of assistance. They may find the person at risk of offending needs more support than they can offer. They may feel insufficiently informed about the particular type of offending (for example, stalking or hoax calls or arson or serious sexual offending) and ‘what works’ in such circumstances. In some areas (such as in Lancaster and in North Cumbria), a small number of people on the CLDT have developed a specialist expertise in forensic work (often this includes a psychologist and community nurses). They may call on more specialist forensic services for advice from time to time but otherwise deal with any forensic issues themselves.

In other areas, **Specialist Intensive Support Services** are set up, to provide intensive help for people with learning disabilities at risk of offending (see example on page 10). Ideally, Intensive Support Services should provide:

- A central referral service for people with learning disabilities at risk of offending
- A small team of specialists, including psychologists, nurses, an RMO, social workers and others (eg specialist support workers), to take these referrals
- An advice and assessment service to police, probation and the courts for people with learning disabilities

- Access to person-centred planning and individual service design
- Help to access employment services or day activities
- Assessment and treatment services in the community (for example, risk assessment, risk management, anger management training, sex offender treatment, etc)
- A crisis/on call service for families and residential services
- Additional support systems (eg. flexible support from a community support worker) when a person most needs it
- Some registered home(s) for short-term intensive support for people who are in crisis (under MHA section if necessary)
- Access to flexible long-term support in flats, alone or with one/two co-residents
- Training for staff and ability to promote the development of local teams skills/knowledge base
- Good links with mental health teams, forensic services, probation, police, courts, Youth Offending Teams, prisons
- Knowledge of how many local people are placed out-of-area because of forensic needs
- Active plans to develop community services for people placed out-of-area.

Further, there could be real opportunities for joint initiatives between Criminal Justice agencies and specialist learning disability services in the development of adapted programmes, and supported community sentencing options.

In addition, cross-borough co-operation needs to be considered, where necessary, in order to commission local services, including supported living schemes, which better match people with similar needs and interests.

<u>Employment and day activity learning disability services</u>.
People with learning disabilities at risk of offending were until recently offered little choice about what they did during the day. Although there is now much constructive work underway to modernise day opportunities, for many people with more complex behaviours, building-based Day Centres are still often the only option available. However, people often dislike such settings as they are stigmatising and do not teach new skills of the kind they wish to learn, nor do they provide the kind of positive role models they may wish to emulate. Moreover, such congregate settings are likely to be risky environments for those liable to offend, as it may be easy to take advantage of other people's high degree of vulnerability, low levels of staff supervision, low levels of engagement with activities, and large buildings with many unsupervised areas. More inclusive and less segregated services may help to reduce people's risk of offending, as in the example below, **provided care is taken to ensure the inclusive setting is not a high risk one**:

Gerry had Down Syndrome. He was a popular man in his local day service, which he had attended for years. He had good basic skills and enjoyed

kitchen work so he spent most of his time assisting in the kitchen. Every so often though, he would disappear from the kitchen. Several times he had been found sexually assaulting much more disabled people, who he usually claimed were his girlfriends, in a quiet part of the building.

Gerry never offended outside the day service (at home, when out in the community or on the way to the service). He lived in a house, with three other men, where he was doing well. He himself said he was bored at the day service and that he would like similar work but in the community.

Gerry was referred to a Men's Group with regard to his sexual behaviour (a cognitive-behavioural treatment group) and he attended there every week for a year.

He was considered too high risk to remain in his previous day service and he had said he did not enjoy attending. Instead, he began to help at the local 'pop-in parlour' for older people, cleaning tables, stacking and washing dishes. He was very popular there with the older people and with staff and never re-offended.

There are now greater opportunities for people to receive more individualised day opportunities based upon person centred plans, frequently supported by staff of their own choosing with whom they are more compatible. Some former Day Centres are reconfiguring their range of provision in order to offer a wider range of employment, volunteering, training, social and leisure options, but with the security of some 'bolt holes' or private spaces for people at times when they may need these.

Some people at risk of offending may prefer to attend drop-in services designed for people with mental health needs. These tend to vary a great deal, but the better ones are small and often have a more relaxed ethos than big day centres, which may suit them well. Again, care has to be exercised as people with mild learning disabilities at risk of offending may be at high risk if the other service users are very vulnerable.

Other options for whole or part time can include further education courses in the local FE college. Similar issues in relation to relationships with other students may apply, and the size of buildings and low staff ratios can create problems. In practice, some students with very complex needs may need 1:1 classroom support (which may not be funded through Education resources).

Usually people at risk of offending have considerable skills and they may be able to work, given the right environment. Often people really appreciate the confidence and skill development provided by employment. Disability Employment advisors, Connexions Special Needs staff and supported employment schemes may all be able to support the actions of local provider teams in securing meaningful work for people with more complex needs. In all cases, thought has to be given with regard to confidentiality and the agency's 'need to know'. In addition, great care is needed to ensure that members of the public are not put at risk by the employment of someone at

risk of offending. This needs to be considered in relation to the person's risk management guidelines, as in the two examples below.

1. *Roger was a man with mild learning disabilities, who lived with an older man, Jack (who did not have learning disabilities). Roger had a history of losing his temper and being violent to those who upset him, and consequently lost a number of jobs he held in the community. He found other people very difficult to get on with (and was thought to have an autistic spectrum disorder).*

Eventually, Roger and his partner, Jack, fell out. Roger attacked Jack very seriously and he was convicted of GBH and sentenced to hospital (where he was detained under section 37 of the MHA 1983). There, it transpired that Jack had abused Roger over many years and Roger received help in relation to the abuse he suffered, as well as some anger management training. On leaving hospital, Roger went to live in a group home but he found the other people difficult to live with. He was re-settled into an individual flat with daily support.

Meanwhile, one of Roger's enduring interests was in buses and one of his ambitions was to go back to work again. Eventually, Roger was employed as a messenger between a number of offices/settings of a large learning disability organisation. Roger's job was to deliver messages and post to and from the various settings, using public transport to travel between them. This suited Roger's needs extremely well and used his enormous skills on bus routes and bus timetables.

2. *Harry was a man with mild learning disabilities who very much wanted to work. He had relatively good literacy skills and was physically fit. However, he also had a history of making obscene phone calls to women.*

Harry's local disability employment officer helped him to obtain a job in a printing agency. Harry enjoyed the job and was happy there. But one day Harry rang the secretary from home and left an obscene message on her phone. The secretary knew who had made the call since the telephone number of the caller was displayed on her equipment. The police were informed and the employer told Harry that he ought to resign. Harry did so. He was mortified at losing his job but showed little empathy for the woman he telephoned. The police interviewed Harry but did not proceed with the case.

A few years before, Harry had attended a cognitive-behavioural treatment group for men at risk of sexual offending. He had not re-offended for several years after the group. Harry felt he needed further help so he rang the psychologist at the CLDT who had run the group. As a result, Harry joined a further treatment group. Meanwhile, his employment officer helped him to obtain a job in a very male environment (a bike and car shop), where he was responsible for working in the warehouse, rather than with customers, and where he was considered at very low risk of re-offending.

Residential learning disability services and supported living
People with learning disabilities at risk of offending often live in inappropriate circumstances, such as:

- In hospitals, where they were admitted often years before, with little contact with their previous friends and family, sometimes with little active treatment and no realistic plans for discharge back to the community[9]
- Group homes with more vulnerable people who have severe learning disabilities, and a staff team that is not well-informed about how to support them
- In supported living or specialist schemes, where they may well not have chosen and/or been chosen by co-tenants, and where incompatibility of tenants exacerbates any problems they may have
- With families, who feel very stressed and worried about the person's risky behaviour, but do not know how to prevent it
- In independent flats but with insufficient staff support and no job, making them feel lonely and anxious and bored

When offered a choice, most people would want to live independently from their families. Some may want to share their home, often with people who they have known for some time or who have similar interests, but many will want to live alone. In either case, staff support will be necessary and it is important for people at risk of offending to be able to choose who supports them. Frequently they will choose people with good social skills, who do not have a confrontational attitude. The amount of support time needs to be carefully calculated to fall at the times the person has most difficulty (detailed risk assessments should be helpful in this planning) and there needs to be a facility for **on-call back up, good arrangements for relief cover for staff, proper staff supervision, team meetings and other supports** (which reduce the scope for burnout and out-of-hours assistance at times of crisis). People need to be supported by staff who understand their behaviour, the likely causes of it, the best way to avoid it and who are also able to set limits with the person in a fair manner. At times, people may need to be restrained and support services need to be able to discuss this with the person in question and use any agreed techniques in as respectful a manner as they can, maintaining good records of its use. Similarly, when very distressed, people may find medication helpful (or additional medication) and this needs to be agreed in advance with the person, with clear guidelines on who should provide the medication and when.

Many areas have now developed select lists of providers of support for people with more complex needs, in order to attract staff and managers who positively choose to work with people with more complex needs, and who can demonstrate a strong values base, appropriate knowledge, and 'stickability' with people who can present significant challenge. Staff often find working with people at risk of offending very difficult and need training and support to be able to do so.

[9] Some people do genuinely need a short period of hospital treatment. However, this needs to be carefully monitored and the person should be discharged to the community as soon as possible.

Residential services do not always need to be specialist but they do need **good support from specialist services**, as in the example below.

George (see case example on page 4) had mild learning disabilities and autism. He had had challenging behaviour from an early age and found getting on with other people very difficult. When he was living unsupported in a flat alone he was at times very aggressive to members of the public. He was also very lonely and tended to follow women he liked the look of. Eventually he was convicted of a number of offences of stalking and sexual assault. He was sent to hospital and had been living in this out-of-borough placement for many years.

His local NHS Trust recognised that it was failing service users with these kinds of needs. It set up a local Intensive Support Service, consisting of a (low secure) residential house with 5 places and a community team for people with learning disabilities at risk of offending (see page 5). After living in the specialist low secure house for several years and attending a cognitive-behavioural group treatment programme for men with learning disabilities who had committed sex offences, George was able to move out into the community, into a house he chose. When unsupervised for brief periods, it was found that George was still at high risk of following people he found attractive, often late at night. After consultations with the local psychiatrist, psychologist and community nurse, it was agreed that George would only survive in the community if his risk management guidelines included 1:1 supervision whenever he was out. He began a job in a sheltered workshop with staff supervision. It was hoped that he would be able to manage with lower levels of staffing as he became more able to cope with life in the community. One of the major tasks for support staff was to assist George in making friends.

Sometimes, where people have been unable to cope in the community and have offended or engaged in dangerous behaviour, they may need a period of intensive support or secure care (see below, under offence-related services).

<u>Advocacy and Self Advocacy groups</u>

Advocacy and/or self-advocacy groups should always be involved in supporting people with learning disabilities at risk of offending. This is particularly important for people at risk of offending as they are often not listened to, especially in restrictive environments.

Where independent self advocacy groups have emerged, they have generally demonstrated a strong sense of justice, and commitment to enabling the inclusion of others who have often been more excluded than themselves. There are a number of self-advocacy organisations in the NW. For example, Manchester People First was set up in 1992 and by 2000 it had over 200 members with learning disabilities. As an organisation, Manchester People First can provide support to people with learning disabilities to speak up for

themselves and can also provide training for people with learning disability and for health/social services/other agencies on rights and self-advocacy. A national organisation, the National Forum for People with Learning Disabilities (see www.nationalforum.co.uk) was set up following *Valuing People*, to provide a route for people with learning disabilities to influence policy and services. It includes regional representatives from the NW.

The eventual aim of advocacy groups is to help people to become self-advocates. Where people are not yet ready to be self-advocates, the advocate's role is to provide information to people about their choices, to take instruction from people about their wishes and to channel their comments and views through to the appropriate professionals. Advocates/self-advocates should be involved at client review meetings, where they should receive information and share information with the client and support the client to make their own views known.

Generic health services

People with learning disabilities at risk of offending often have additional health needs, including mental health needs or autistic spectrum disorders, as well as physical health needs. If they live relatively independently, with some support from staff and/or family members, they may be able to access some help to organise appointments with GPs, but may well attend the GPs alone. When it comes to explaining to the GP what the problem is, their communication difficulties may produce problems and they may not always understand the GPs advice.

Meanwhile, people with learning disabilities at risk of offending who are living in secure services, even though they may be living in a health service provision, often have unmet health needs. According to a recent survey, of 170 people in Calderstones hospital[10]:

- 95% had not been able to access 'well person' health screening
- About 50% were overweight
- Over 60% smoked cigarettes
- 20% had a history of alcohol misuse
- 13% were asthmatics
- 12% had a history of substance misuse
- Nearly 80% had shown self-harming behaviours
- Many had a diagnosed syndrome or condition that indicated an associated health need

Often these were long-standing health needs, present when the person lived in the community (where many were not registered with GPs). They may have been overlooked in the hospital because resources were being concentrated more on people's offending behaviour than their health (very similar findings were reported in a recent study from Rampton high security hospital). Nevertheless, it demonstrates an enormous unmet health need. Calderstones now ensures health screening occurs and there is a group to tackle weight issues to try to address unmet health need.

[10] We are grateful to Janet Cobb for these figures and to Christine Whalley for the up-date

The more general implications are that people with learning disabilities at risk of offending are very likely to have unmet health needs and they will require regular health screening and may need support in accessing the GPs (and other health services) to ensure their needs are met.

Support and services that are directly offence-related

Detailed accounts of these services and of research about people with learning disabilities in these services can be found in Appendix C.

Police

Overall, in England and Wales, the police recorded just under 6 million crimes in 2002-2003 (according to the Home Office website – www.crimestatistics.org.uk). We also know many crimes are not reported to the police.

When a person with a learning disability commits a crime, it is not always reported to the police, especially if it occurs in a service setting (see Appendix C for details). When it is reported, though, the police have a duty to investigate. Many police officers are unclear what precisely a 'learning disability' means and relatively few have good training in how to interview people with learning disabilities.

When someone is arrested and taken to the police station for questioning, the police have to proceed according to the regulations of the Police and Criminal Evidence Act 1984 (PACE, Code C, revised July 2004). This means that the suspect must be informed of:

- their right to have someone told of their whereabouts
- their right to a solicitor (for free legal advice)
- their right to consult the Codes of Practice.

They must also be provided with written information about their rights and given the caution (see below):

> *You do not have to say anything. But it may harm your defence if you do not mention when questioned something which you later rely on in court. Anything you do say may be given in evidence.*

The custody officer must also decide if the person needs medical attention or needs an *Appropriate Adult* to:

- advise the person being interviewed
- ensure the interview is conducted fairly
- facilitate communication with the person being interviewed.

We know from research that people with learning disabilities often:

- Do not fully understand the meaning of the caution
- Do not fully understand the written information in the Notice to Detained Persons, even when it is read out to them
- Are very likely to be suggestible and to be led by the police when being interviewed (and may therefore admit to something they did not do)
- Do not always make wise decisions during police interviews (for example, they may admit to crimes, in order to be allowed to go home, thinking they can correct any errors later)

The *Appropriate Adult* is intended to provide people with learning disabilities (and other vulnerable people) some protection against these difficulties. But we know AAs are not always called and do not always do a good job when present.

Examples of good practice

1. *Research from a variety of studies in police stations has shown that AAs are not provided for all those suspects who need them, often because it is difficult to tell when a suspect has a learning disability or other special needs (such as mental health needs). In one study in London, a series of screening questions was introduced for custody sergeants to ask suspects. It transpired that the questions were very successful in helping custody sergeants decide who needed an AA (and, despite some officers' fears, the AA system was not swamped with too much extra demand). Following the study, the questions were incorporated into a special screening form (see Appendix D), which is now used by custody sergeants in the Metropolitan police to screen all suspects*[11].
2. *In Eastern Cheshire, community-based staff have worked over a period of some years, with the police (especially the community and school liaison officers and the police family protection unit, which has responsibility for people with learning disabilities), to develop a shared understanding of roles and ways of working. This collaborative approach to people with learning disabilities has led to police presence and input at risk assessment and management meetings, as well as case-specific advice over the phone between police and CLDT members. Joint training days have also been run between learning disabilities services and the police, and there is joint working in relation to individuals with learning disabilities who come into contact with the police.*

Consequently, there are a number of actions which staff in learning disability services and the police need to take:

- Staff in Learning Disability services need to ensure their organisation has a clear policy about when to report possible criminal offences to the police, and how to support service users in the police station
- The police need to ensure that custody officers have a method that is quick and reliable for screening suspects, so as to detect whether or not suspects have possible learning disabilities.
- When suspects are identified as possibly having learning disabilities, the police need to ensure that people understand their rights, and obtain an AA.
- There need to be AA training schemes to help ensure that AAs are able to fulfil their role. In many parts of the NW there is a shortage of AAs and it is mainly approved social workers who are trained for the role. It is likely that the training net needs to be cast more widely, as AAs do not need to be social workers.

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[11] We are grateful to Isabel Clare for this information. See Clare, I.C.H. and Gudjonsson, G. H. (1992) and Clare, I.C.H. (2003)

- The police need to be trained in how to recognise and how to interview people with learning disabilities. This especially true for custody officers and for police officers regularly working with vulnerable people.
- The police need to make links with social services and CLDTs, so they know who to contact when a suspect has a learning disability
- Staff inlearning disabilities services and police officers need to have copies of the guidance written for people with learning disabilities about what happens in the police station. This is available in a book which is largely pictorial: '*You're Under Arrest*' (Hollins, Clare, Murphy & Webb, 1996).

Probation

The National Probation Service for England and Wales is overseen by NOMS, the Home Office's National Offender Management System. The Probation Service itself is divided into 42 areas (including, in the NW, the areas of Cumbria, Lancashire, Cheshire, Merseyside, Greater Manchester). Nationally, the probation service supervises over 200,000 offenders at any one time (mostly young men) and provides over 245,000 reports to the court annually, as well as doing other work (see below). Details about their work are included in Appendix C.

Research has shown that about 6% of the people on community orders, supervised by probation staff, have a learning disability. Yet probation staff often feel unsure about which of their clients have learning disabilities and they often do not have good contact with the local CLDT. Probation staff frequently say they feel uncertain how to help people with learning disabilities and they realise that many of their procedures need adapting for people with learning disabilities. Many of their excellent accredited treatment programmes, designed for mainstream offenders, are not suitable for people with learning disabilities and few adapted programmes are available in the Probation Service (though the Sex Offender Treatment Programme is now being adapted for men with learning disabilities).

Example of good practice

Treatment for people with learning disabilities who have sexually abusive behaviour has not been easily available in the community, even though cognitive-behavioural treatment seems to be widely available for mainstream offenders. One CLDT decided to start up a cognitive-behavioural treatment group for men with learning disabilities and sexually abusive behaviour and they approached the local probation service for help. A treatment group was then set up with a number of facilitators from health (clinical psychologists) and a probation officer. The health professionals all worked in learning disabilities but knew little about sex offender treatment; the probation officer, on the other hand, knew little about learning disabilities but had run numerous treatment groups for mainstream sex offenders. Co-working between the health professionals and probation made a treatment group possible for men with learning disabilities living in the community. The group was a prototype for the SOTSEC-ID service (Sex Offender Treatment Services

Collaborative - Intellectual Disabilities) that now runs treatment groups nationally for men with learning disabilities and sexually abusive behaviour.

In order to provide good services for people with learning disabilities, the Probation service needs to:

- Have a system of screening for finding out which of their clients have possible learning disabilities (many clients cover up their difficulties)
- Adapt their procedures (for example, make their letters and information leaflets accessible) for people with learning disabilities
- Adapt their accredited programmes of treatment for people with learning disabilities
- Have good contact with CLDTs so that referrals for assessment or other help with particular clients is possible
- Be prepared to co-work with learning disability practitioners for some clients
- Consider developing contractual partnerships with specialist learning disability services where this will support them in offering equal treatment options, more suited to the specific needs of people with an intellectual impairment.

Courts

There are few English research studies of the numbers of people with learning disabilities who come to magistrates or crown court. Studies in other countries, such as Australia, suggest that people with learning disabilities are over-represented in courts but that may be a result of limited options for diversion from the Criminal Justice System. In England, the one study that was undertaken of an unselected series of people coming to court in Berkshire showed no over-representation of people with learning disabilities (2-3% of people coming to court as suspects had learning disabilities).

Provided police stations have good systems in place for determining when people have learning disabilities, no one should come to court unidentified. Most courts now have court diversion schemes as well, usually staffed by Community Nurses. These allow people who may have learning disabilities (or mental health needs) to be assessed by specialist nurses or health teams and to be diverted out of the Criminal Justice System, if this is appropriate. In some areas these schemes also operate at the police station stage (and are able to intervene earlier, as they pick up people before they get as far as court).

Everyone (including the general public) finds courts confusing and alarming. When people with learning disabilities go through court they may find the whole process completely incomprehensible. Research has shown that solicitors and judges often do not tailor their language to the level of understanding of the people they are questioning. Some support is now allowed for victims with learning disabilities (such as introductory visits to the court, support in the witness box, the possibility of giving evidence by video link, etc) but there is little provision for suspects with learning disabilities. There are some materials available to help suspects, such as the book with

pictorial aids 'You're On Trial', designed for people with learning disabilities, which explains the court process (Hollins, Murphy & Clare, 1996).

Example of good practice
The Wessex Consortium is a multi-agency group with representatives from mental health and social services, probation, police and magistrates. In Wessex, about 250 requests were made for psychiatric reports each year in courts (these figures include people with mental health needs and/or learning disabilities). The Consortium recognised the unnecessary delays that sometimes occurred when courts asked for psychiatric reports on suspects and set up a protocol to deliver rapid information to courts (within 7 days), mainly through court diversion schemes. The protocol includes descriptions of the process and example forms for court and health service staff.

In order to provide good services for people with learning disabilities at risk of offending, courts need to:

- Have a system for finding out which suspects have learning disabilities (many clients cover up their difficulties)
- Make information accessible to people with learning disabilities
- Adapt their procedures for people with learning disabilities, for example, using questioning styles that people can understand and offering communication aids and support for suspects, equivalent to that for witnesses with learning disabilities
- Have diversion schemes with trained mental health & learning disability service staff on site and good contact with CLDTs for help with suspects with learning disabilities.

Prisons

There are over 130 prisons in England and Wales, of which 17 are women's prisons and 10 are contracted-out prisons. In the North West, there are 16 prisons, two of these are for women and three for young offenders (see Appendix C for details).

Overall, in England and Wales, the prisons are currently holding over 75,000 prisoners (2005 figures) and the numbers are rising. The prisons are generally over-crowded and prisoners often have high rates of mental health needs and substance misuse, with poor literacy and numeracy skills. The rates of assault, suicide and self-harm are also high amongst prisoners.

Health services in prisons are recognised by the Government as in need of improvement (see *Changing the Outlook*, 2001). In 2002, it was announced that the funding for health services in prisons would in future be transferred to PCTs. These changes are on target and will be achieved during 2005/6. The new services are described in the draft document *Prison Mental Health Care Pathway* (2004), which proposes how the services will operate, at the pre-prison stage, at prison reception (including screening), and thereafter (see www.hsmc.bham.ac.uk/prisonhealth). The document refers mainly to people with mental health needs but would also apply to people with learning disabilities.

It is known that people with learning disabilities are very vulnerable in prisons and there have been some reports of bullying, abuse and even rape by other prisoners,

against people with learning disabilities (see for example, *Deep Trouble* by Flynn & Bernard, 1999; Davidson & Clare, 199?). UK Government policy is that prison sentences should only be used when absolutely necessary for people with learning disabilities and that they should be diverted from custody where possible.

Most prisons now run rehabilitation and education programmes for prisoners. One of the best known is SOTP, the sex offender treatment programme. There is an adapted version of this programme (ASOTP) for people with learning disabilities but it does not run in all prisons.

Example of good practice
Thorn Cross Young Offenders institution, near Warrington, is a recognised centre of excellence. Participation in vocational and educational activities is an integral part of the rehabilitation programme there. Staff in the Education unit have developed a themed educational programme, which focuses on personal and social responsibility. This theme runs through even the literacy work, so that young offenders have to consider issues around offending and anti-social behaviour while developing basic skills. It is likely that some of the young people at Thorn Cross have learning disabilities, though it is not clear exactly how many.

In general, prisons need to have:

- A way of screening prisoners, so that they know when a prisoner has a learning disability
- Prison staff need training in how to work with people who have learning disabilities (including how to spot when they are distressed)
- Prison staff need good contact with CLDTs, so that the CLDTs can be alerted if a prisoner has a learning disability
- CLDT staff should help prison staff to plan services to meet the needs of prisoners with learning disabilities and, if necessary, help plan for the person to move to a more suitable place. In some prisons, Learning Disability nurses are based in the prison
- Prisons needs to provide services that meet the needs of people with learning disabilities, such as adapted rehabilitation and education programmes

Secure services

Secure services in England and Wales are designed to care for people with mental health needs, learning disabilities and /or psychopathic disorder who present such risks to others that community services or other health service provision is inadequate for their needs. Normally, people living in secure services are detained under part III of the Mental Health Act 1983, following appearances in court, or they are detained under civil sections of the MHA 1983; occasionally they may be informally admitted. Interviews with people detained in secure services indicate that they think these are a much better option than prison but still leave a great deal to be desired at times (see *Deep Trouble, 1999* and Murphy et al, 1996).

Calculations by Phil Shackell (June 03) have suggested that for the North West, which has a population of 4.4 million people (of working age, 16yrs-64yrs), there is a need

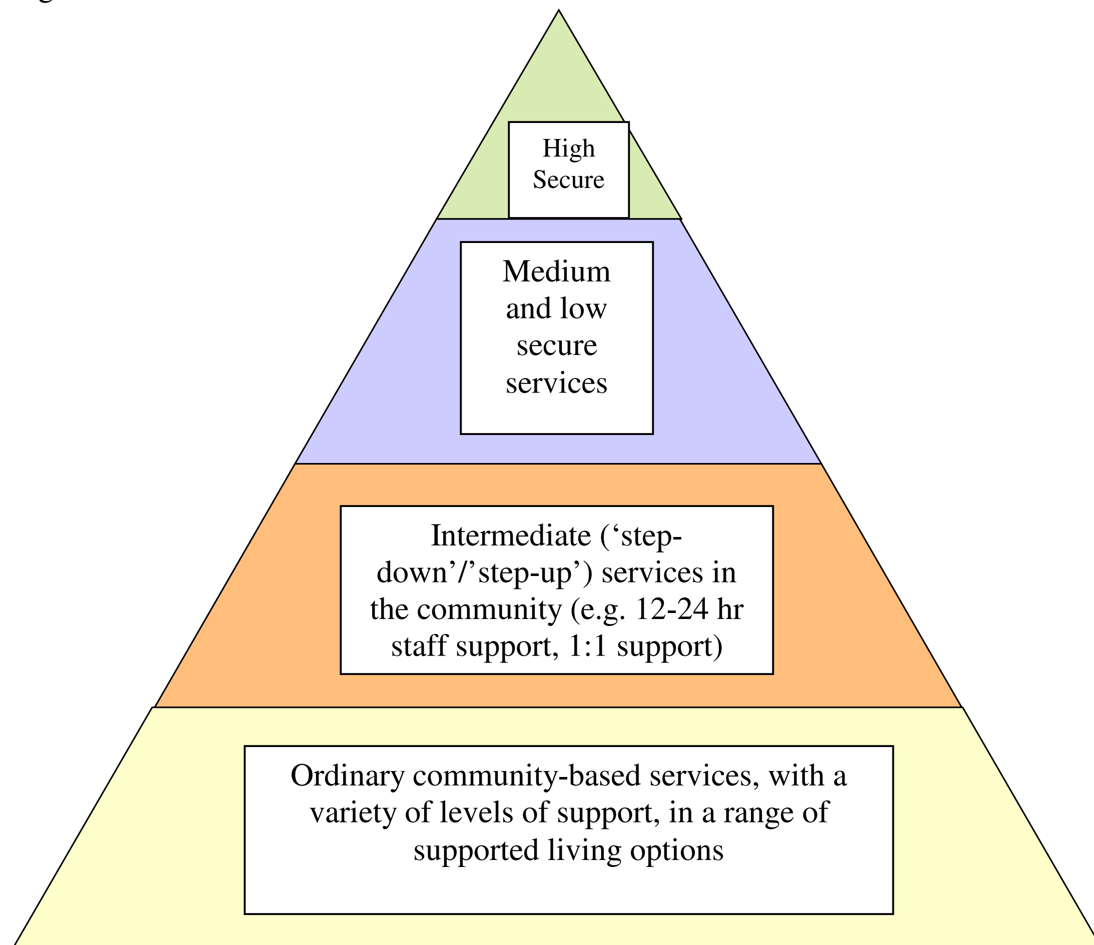
for the following services:

- 0.06 per 100,000 high secure places – 3 places in all

- 2.04 per 100,000 medium secure places – 89 places in all
- 1.02 per 100,000 long term secure places – 45 places in all
- 0.86 per 100,000 low secure places – 38 places in all
- 1.59 per 100,000 intensive support unit places (community based) – 70 places in all

These figures have been gathered and estimated, partly from current usage and partly from estimated need. The figures may overestimate the need for secure facilities, since there are so few step-down facilities currently available (meaning that people will tend to be referred up from community-based services, to a higher level of security than may be necessary).

One useful model of forensic service provision, developed for the Wessex Consortium by Philip Vaughan (1999), suggested that the need for secure places and intensive support services could be represented as a triangle (see below), in which the base was formed by ordinary community services, including various kinds of supported living arrangements, suitable for people with learning disabilities. Higher up the triangle, services became more intensive, and eventually secure. Fewer places were needed at the more intensive/secure levels. In many places, Vaughan argued, there were too few services at one level, causing difficulties above and below that level. Most commonly, in the NW, there seem to be too few 'step-down' services (the orange bar in the triangle), so that people whose needs cannot be met in ordinary community-based facilities will be sent to more secure facilities (the blue bar in the triangle) than they might otherwise need.



High Secure Services
High secure services in England and Wales are for people who present a grave and immediate danger to others and they are provided in Ashworth, Rampton and Broadmoor hospitals, with most people with learning disabilities (mental impairment) being in Rampton. In 2000[12], there were 447 places in Rampton, of which 90 were for people with mental impairment (with and without additional disorders). In 2004, there were somewhat fewer mental impairment places: 68, of whom 4 came from the NW region (see also page 17).

Medium/low secure services
There are three services in the North West offering medium/low security for people with learning disabilities (Calderstones hospital in Lancashire, the Auden Unit in Warrington and the Mary Dendy Unit in Macclesfield, South Cheshire. The places in these services are described in more detail on page 17. They basically provide a maximum of 218 medium/low secure/rehabilitation places in the NHS across the NW. In addition, some areas have small specialist services that provide low secure services (such as in Morecambe Bay PCT) – see also page 18.

In addition, as discussed on page 16, there are about 1000 places for people with a learning disability nationally in private secure facilities. Many of these hospitals are large and distant from people's families. Many service users are not formally detained there.

The fact that there are a considerable number of people in Calderstones hospital, who are ready and waiting for discharge, suggests that one of the blocks to discharge is the lack of skilled 'step-down' services in the community. Figures on the discharge of individuals from Mary Dendy and Auden unit supports this view[13]. There are also sometimes disagreements between agencies on the risks a person would pose in the community and this is a difficult issue to tackle when there is a large gap (in terms of freedom and responsibility) between 'ordinary' and 'secure' services.

Secure services summary
Secure services are certainly necessary for some people with learning disabilities, where they have very dangerous behaviours, at least for short periods. Some countries, such as Ireland, Australia, New Zealand, have no provision for secure care for people with learning disabilities within their hospital system and have had major difficulties placing people who show very dangerous behaviour (they tend to end up in prison). New Zealand has recently had to set up a new system of 'secure care' for precisely this purpose.

The reason why some countries have wanted to avoid the use of secure care is that there are some well-known problems associated with it (see also *Deep Trouble*, 1999):

- Large secure services tend to suffer from many of the same problems as the old institutions (such as abusive practices, isolation from other services, low levels of rehabilitation for service users). They may do active discharge planning but there is often a difficulty, with the district of origin, finding

[12] These figures are from the Tilt report 'Review of Security at the High Security Hospitals', Dept of Health, 2000.
[13] Figures collected by Anne-Marie Kingdon

appropriate 'step-down' facilities for people, so that people are unable to move out into the community

- Large secure services are often a long way away from the families (and the local origins) of many of the people they serve. This makes family contact and re-settlement difficult (there are also a small number of occasions where victims do not wish the person to return to live locally). Where services are distant from families, it is likely people will lose contact with local professionals, who may adopt an 'out-of-sight, out-of-mind' attitude or feel too deskilled to provide support more locally.
- Some secure services have low levels of active treatment for service users, so that service users may feel abandoned and forgotten. In addition, where people get 'stuck' in secure services, they may have active treatment at the beginning of their stay but then remain for long periods after treatment ceases.
- Many secure services are not good at ensuring that they adopt 'least restrictive' practices for each service user
- Service user views are not always sought in secure services and service users are not always aware of their rights and properly informed of the conditions under which they are detained.
- Commonly the smaller units have 'bed-blocking' problems, due to difficulty re-settling service users (this is not just the fault of the secure services, since step-down facilities are often lacking)
- Secure services are not set up to respond to emergencies and service users may have to go to very distant places as a result
- Staffing is a common problem for secure services. Ideally staff should be selected to work in secure services if they have a positive, but firm and professional, attitude, with good negotiation skills. Sometimes, however, staff have punitive and confrontational attitudes, that are not helpful to service users. In addition, staff shortages are common in such settings and in the face of staff shortages, over-stretched staff are likely to resort to more restrictive practices and to provide a lower quality of care

Consequently there are a number of tasks for secure services:

- To keep secure services across the NW to a minimum and to plan services so that they are within easy reach of families and their local services
- To ensure services have good quality of care, active treatment and proper discharge planning
- To ensure that service users have a voice in secure services
- To ensure that the 'least restrictive' practice is adhered to for each service user
- To help plan for sufficient 'step-down' local facilities, so that people do not stay in secure services longer than they need
- To gear supports towards enabling people's rehabilitation
- To examine the need for staff selection, staff training and methods of staff retention, to avoid over-stretched staff and abusive practices

<u>MAPPA</u>

The Multi-Agency Public Protection Arrangements were set up in each of the prison and probation areas in England and Wales, following the *Criminal Justice and Court Services Act* in 2000. In the North West, these areas include Cumbria, Lancashire, Cheshire, Merseyside and Greater Manchester.

Each areas has Multi-Agency Public Protection Panels (MAPPPs) which are led by probation and police services and are required to make joint arrangements for the assessment and management of sexual, violent and other dangerous offenders in their areas. MAPPPs work by assigning levels of risk to offenders: level 1 (lowest risk), level 2 (medium) or level 3 (high risk) and structuring the levels of monitoring and multi-agency working accordingly (see Appendix C for details).

MAPPPs provide annual reports with summary statistics. They can be accessed on www.probation.homeoffice.gov.uk. No details are given in MAPP reports as to the number of these offenders who may have had learning disabilities; it is likely to be relatively few.

MAPPPS need to:

- Ensure they are well-informed about learning disability services
- Provide training and information about their role and ways of working for CLDT and other learning disability staff
- Have good links with CLDTS, so that they can work together to ensure proper management and monitoring of individuals who pose risks to the community

Commissioning: SHAs, Specialist commissioners, PCTs and Joint Commissioning of Services

Some of the changes that are necessary to improve services for people with learning disabilities at risk of offending can only be brought about at commissioning level.

Strategic Health Authorities (SHAs) were set up in October 2002 as part of government policy in *Shifting the Balance of Power*. This policy was designed to give the 28 national SHAs a strategic planning role, while devolving most of the NHS decision-making down to 302 local Primary Care Trusts (PCTs), where health professionals and local people could take more part in deciding local priorities and policies. SHAs have the job of coordinating services across a large area, managing hospital and PCT performance, and improving the quality and quantity of services. For learning disability services, Joint Commissioning Boards involving partnerships between PCTs and Local Authorities, have been established to ensure that health and social services work together in commissioning services. Joint Commissioning Boards have to agree priorities and timetables, and have a responsibility to make sure local organisations and service users have a voice (for example, through Partnership Boards).

SHAs, health commissioners (such as PCTs and specialist secure commissioners) and local joint commissioning boards have a series of tasks to ensure that good services are available for people with learning disabilities at risk of offending:-

- To collect good data from all relevant agencies and all areas in the NW, regarding the need for services, so that the places available are planned from an evidence-base
- To ensure good in-borough services, so that out-of-borough placements are a rarity

- To plan for sufficient 'step-down' facilities, so that people do not enter or stay in secure services longer than they need
- To work towards a series of small secure services across the NW and to plan to disaggregate large services, so that all services are within easy reach of families of service users and their local services
- To develop proactive resettlement plans around people currently placed within secure settings and specialist hospital settings.
- To explore the potential of constructive and responsive local services designed to reduce breakdown of family living and community connections. These will include early intervention/crisis supports and longer term outreach services
- To commission a range of accommodation and support, day opportunity and short term break arrangements that are geared to welcome and include people who may challenge services, who may be returning from secure settings, or at risk of offending.
- To explore cross-borough, area and regional Commissioning arrangements where these may better help to 'match' tenants with complex needs whilst enabling them to live as close to home as possible
- To plan for and develop local health infrastructures, such as Intensive Support Services, geared to supporting people to stay within their own community, or to return with appropriate, flexible and responsive supports
- To support and attend reviews and be proactive in working towards people's resettlement

In practice, whilst many people can be supported within their own local community, there are some people with more specialist needs for whom there may not be a sufficient level of demand within a single borough to attract the health and social care infrastructures that may be required to provide high quality support. Such services should be planned and shared across boroughs.

Workforce issues

In order to provide good services for people with learning disabilities at risk of offending, staff at a variety of levels need to be trained.

In Mental Health services, there has been considerable work undertaken to identify 10 core competencies for staff, including being competent in:

- Working in Partnership
- Practising ethically
- Challenging inequality
- Respecting diversity
- Promoting recovery
- Identifying people's needs and strengths
- Providing user centred care
- Making a difference
- Promoting safety
- Engaging in personal development and learning

The same core competencies are needed by staff working with people with learning disabilities who are at risk of offending.

In terms of the specific knowledge required for work in this area, staff in Criminal Justice Services may know a great deal about crime and the CJS, but they may need training in learning disabilities, whereas staff in learning disabilities services may know a great deal about learning disabilities but may need training in crime, risk and CJS issues. Some of the training for the CJS staff could be provided by people with learning disabilities themselves. In addition, with good partnership working, CJS agencies should be able to provide training forlearning disabilities staff andlearning disabilities staff should be able to provide training for CJS staff.

The topics that such training might cover are listed below.

Training needed for CJS staff

- What is a learning disability (LD) and how might one screen for learning disabilities?
- What is the range of abilities and disabilities in people with learning disabilities?
- How does learning disabilities differ from mental health needs?
- How does learning disabilities differ from literacy difficulties?
- What other health problems might people with learning disabilities have?
- Institutions in the past; normalisation and empowerment; advocacy and self-advocacy; *Valuing People* and Person-Centred Planning
- Challenging behaviour and offending behaviour by people with learning disabilities; the role of the CJS in responding to ‘offending-type’ behaviours
- How to interview someone with an learning disabilities
- How to get help for people with an learning disabilities (health and social services roles, CLDTs, Intensive Support Services, employment and residential services (including the independent sector’s roles).

Training needed for learning disabilities staff

- The Criminal Justice System and how it works (police, probation, courts, diversion, Youth Offending Teams, RAMPS, MAPPA)
- Relevant legislation (eg the Mental Health Act 1983; fitness to plead legislation; Sexual Offences Act 2003, etc)
- Offending-type behaviour by people with learning disabilities (prevalence, characteristics, family background, etc)
- Risk assessment and risk management
- Social inclusion & circles of support for people at risk of offending
- Ethical issues in forensic work
- Assessment and treatment for specific types of offending (eg sexual offending; arson; anger management)
- Assessment and treatment for mental health needs
- Management of violence (and non-aversive restraint)
- Staff support and supervision needs

There are very few specialist University or Further Education courses focussing on learning disabilities and forensic issues. However, a number of Universities run Forensic Masters courses, which will include some information on learning disabilities, though the focus is likely to be on people with mental health needs (for example, University of Leicester, University of Kent run such masters courses). Some

of these can be completed by distance learning and may suit staff working in learning disabilities services with an interest in the area.

In St Martin's College, Lancaster, there are three forensic courses (covering topics like crime and mental disorder, legal contexts, values in forensic systems, risk assessment and management, interventions, professional responsibilities, research and evidence in forensic services) – see www.ucsm.ac.uk/courses/health. Some parts of the courses can be completed by distance learning. The courses build on one another and consist of:

- a certificate course (2 years, part-time, for those with A levels or other entry qualifications)
- a diploma course (2 years part-time, intended for those who have completed the certificate level or equivalent)
- a BSc course (2 years, part-time, intended for those who have completed the Diploma or equivalent)

These courses would particularly suit staff, such as those in secure settings or on Intensive Support Teams, who are going to work full-time with people with learning disabilities at risk of offending and who need an in-depth knowledge.

7.0 Checklists for good practice & specific recommendations for key organisations

The checklists that follow are self-assessments checklists and are designed to help services examine what they have in place and to plan how to improve their services.

Commissioners

	Yes	**No**	**Plan for improvement**
Do you collect good data from all relevant agencies, regarding the need for forensic learning disabilities services, so that the places available are planned from an evidence-base? (expect 9-13% of people known to learning disability services to be at risk of offending)			
Do you know exactly how many people from your area are in medium secure places? (and how many are out-of-area?)			
Do you know exactly how many people from your area are in low secure places? (and how many are out of area?)			
Have you sufficient 'step-down' facilities, so that people do not enter or stay in secure services longer than they need?			
Are you working towards a network of small secure services across the NW and are their plans to disaggregate large services, so that all services are within easy reach of families of service users and their local services?			
Have you got proactive resettlement plans for people currently placed within secure settings and specialist hospital settings?			
Do you have local services designed to reduce breakdown of family living and community connections, including			

early intervention/crisis supports and longer term outreach services?			
Are you commissioning a range of accommodation and support, day opportunity and short term break arrangements that are geared to welcome and include people who may challenge services, who may be returning from secure settings, or at risk of offending?			
Are you exploring cross-borough, area and regional Commissioning arrangements where these may better help to 'match' tenants with complex needs whilst enabling them to live as close to home as possible ?			
Are you planning and developing local health infrastructures, such as Intensive Support Services? (geared to supporting people to stay within their own community, or to return from out of borough with appropriate, flexible and responsive supports)?			

CLDTS

	Yes	No	Plan for improvement
Do you (or your ISS) know how many people are placed in medium secure and low secure places and how many are out-of-borough?			
Do you (or your ISS) actively work to develop community-based plans for out-of-borough people?			
Do your eligibility criteria bar people with learning disabilities who are at risk of offending?			
Do you arrange training for your staff so that they can support people at risk of offending?			
Are at least some of your staff confident in using risk assessment, risk management and CPA procedures			
Do you have to resort to out-of-borough placements in crises for people at risk of offending?			
Do you have Intensive Support Services available for those who need them ?			
Do you (or your ISS) have good links with local police, probation, courts and prison services, as well as Youth Justice Teams, and regularly co-work with such organisations?			

Do you (or your ISS) provide assessments and interventions (such as anger management training, sex offender treatment, etc) suitable for people at risk of offending – including programmes devised and run in partnership with Criminal Justice organisations?			
Do you have good links with mental health and forensic services locally and do you have access to an RMO?			
Do you have cross-borough co-operation, where necessary, in order to commission local services, including supported living schemes, which better match people with similar needs and interests?			

Intensive Support Services

	Yes	No	Plan for improvement
Do you have a central referral system for people with learning disabilities at risk of offending?			
Do you know how many people are placed in medium or low secure services and how many are out-of-borough?			
Do you actively work to develop community-based plans for out-of-borough people?			
Are your staff are trained to support people at risk of offending?			
Are your staff confident in using risk assessment, risk management and CPA procedures			
Do you have to resort to out-of-borough placements in crises for people at risk of offending?			
Do you have good links with local police, probation, courts and prison services, as well as Youth Justice Teams, and regularly co-work with such organisations?			
Do you provide assessments and interventions (such as anger management training, sex offender treatment, etc) suitable for people at risk of offending – including programmes devised and run in partnership with Criminal			

Justice organisations?			
Do you have medium/low secure places for people with learning disabilities at risk of offending in borough?			
Do you provide training in learning disabilities and offending for other agencies?			
Do you have suitable long term provision for people at risk of offending?			
Do you have good links with mental health and forensic services and access to an RMO?			
Do you have cross-borough co-operation, where necessary, in order to commission local services, including supported living schemes, which better match people with similar needs and interests?			

Probation

	Yes	No	Plan for improvement
Do you have a system of screening to find out which of your clients have learning disabilities?			
Have you adapted your procedures (for example, made letters and information leaflets accessible) for people with learning disabilities?			
Do you have adapted accredited programmes of treatment for people with learning disabilities?			
Do you have good contact with CLDTs for help with particular clients with learning disabilities?			
Do you co-work with learning disability practitioners for some clients?			
Have you considered developing contractual partnerships with specialist learning disability services (to extend treatment options)?			

Police

	Yes	No	Plan for improvement
Do you have a way of screening people who are brought in for questioning, with respect possible learning disabilities?			
When suspects are identified as possibly having learning disabilities, do you ensure that people understand their rights, and obtain an Appropriate Adult?			
Is there an AA training scheme in your area and are AAs easy to get in relatively a short time?			
Are you trained in how to recognise and how to interview people with learning disabilities?			
Do you have good links with social services and CLDTs, so you know who to contact when a suspect has a learning disability?			
Do you have copies of the guidance written for people with learning disabilities, about what happens in the police station (e.g. '*You're Under Arrest'*)?			

Courts

	Yes	**No**	**Plan for improvement**
Do you have a system of screening to find out which suspects have learning disabilities?			
Do you make information accessible to people with learning disabilities? (for example, '*You're On Trial*')			
Do you adapt your procedures for people with learning disabilities, for example, using questioning styles that people can understand; offering communication aids and support for suspects, equivalent to that for witnesses with learning disabilities?			
Do you have diversion schemes with trained mental health & learning disability service staff on site?			
Do you have good contact with CLDTs for help with suspects with learning disabilities?			

Prisons

	Yes	**No**	**Plan for improvement**
Do you have a way of screening prisoners, so that you know when a prisoner has a learning disability?			
Do your prison staff have training in how to work with people who have learning disabilities?			
Do you have good contact with CLDTs, so that they can be alerted if a prisoner has a learning disability?			
Do CLDT staff help prison staff to plan services to meet the needs of prisoners with learning disabilities?			
Do CLDT staff help plan for people with learning disabilities to move to a more suitable place where necessary?			
Do you have Learning Disability nurses based in the prison?			
Do you provide services that meet the needs of people with learning disabilities, such as adapted rehabilitation and education programmes?			

Secure Services

	Yes	No	Plan for improvement
Are you working towards a series of small secure services across the NW, so as to disaggregate large services and to place service users in their local services?			
Do you gear supports towards enabling people's rehabilitation?			
Do you ensure services have good quality of care, active treatment and proper discharge planning for all service users?			
Do you ensure that service users have a voice in secure services and have access to advocacy services?			
Do you ensure that the 'least restrictive' practice is adhered to for each service user?			
Do you have access to sufficient 'step-down' facilities, so that people do not stay in secure services longer than they need?			
Do you ensure good staff selection, staff training and methods of staff retention, to avoid over-stretched staff and abusive practices?			

Workforce Issues

	Yes	No	Plan for improvement
Is there training on learning disabilities available for staff in the police?			
Is there training on learning disabilities available for staff in the prisons?			
Is there training on learning disabilities available for staff in the probation?			
Is there training on learning disabilities available for staff in the courts?			
Is there training available on CJS issues and offending for staff on CLDTs and in Intensive Support Services?			
Is there training available on CJS issues and offending for staff in secure services?			
Is there training available for staff in day and residential support services on CJS issues and offending?			
Are there clear, agreed procedures for non-aversive restraint and are there training courses available to any staff who need this?			

Appendix A: Prevalence of learning disabilities and offending

Prevalence figures derive from two kinds of studies: those conducted in the CJS (eg prisons, probation), which ask how many of the people have learning disabilities, and those conducted in learning disability services, which ask how many people have offended. In interpreting the results from both kinds of studies, it must be remembered that:

- The figures that studies obtain will depend on who is included in the study and how learning disabilities are assessed. In general, **studies of offenders are liable to overestimate the numbers of people with learning disabilities** if insufficient care is taken to carefully assess the presence of learning disabilities
- On the other hand, **studies of people with learning disabilities are liable to miss people who are not in touch with services** and so they need good methods for identifying who has learning disabilities in the general population.

The first contact with the Criminal Justice System is usually with the police. Following police arrest, questioning at the police station and charging with an offence, the next stage is usually a trial of the facts in court. Only then, in most Western countries, can someone be convicted of a crime and only then, technically, can they be considered an 'offender'.

The prevalence of offending for people with learning disabilities will of course depend on the particular jurisdiction in question: the laws, the policing system, the safeguards for people's rights in the Criminal Justice System, the court and trial systems, the types of 'disposal' available. In some countries, especially those which do not have the possibility of diversion from custody into hospital following conviction (e.g. USA, Australia) there maybe higher numbers of people with learning disabilities in prison. In England, a variety of disposals are possible following conviction, including fines, prison, being sent to hospital and being put on probation.

Police station

Relatively few studies have been conducted at the police station stage. However, two British studies, one in Cambridge and one in London, have shown that between 5% and 9% of people who are arrested for questioning by the police have a learning disability (Gudjonsson et al., 1993; Lyall et al., 1995). Both studies used screening questions at the custody sergeant stage to find people likely to have learning disabilities. The Gudjonsson et al. study then tested people's IQ at the police station, if they were screened positive, but were not able to assess adaptive behaviour, so their figure of 9% needs to be interpreted with this in mind. The Lyall et al study, did not assess people's IQ formally, nor their adaptive behaviour, so their figure of 5% needs to be interpreted accordingly. Lyall et al did examine outcome for the people they identified: none was sent to prison.

Probation

In England, it is possible to receive a community sentence following a criminal conviction. Such sentences are administered through the probation service. Sentences

involving the probation service for people with learning disabilities are likely to be almost entirely community rehabilitation orders or CROS (previously probation orders). These can be for a maximum of 3 years and usually involve regular appointments with a probation officer. There may also be conditions of residence or treatment attached, requiring the person to live in a specified place or attaned a specified place for treatment.

There seem to be proportionately more people with learning disabilities dealt with through probation services than through prisons. A recent study showed that about 6% of people on probation orders (now termed community rehabilitation orders) have a learning disability (Mason & Murphy, 2002).

Hospital
In England and Wales, people who are in court on trial for criminal offences, may be remanded, or sentenced, to hospital under part III of the Mental Health Act 1983, if they have mental impairment, severe mental impairment, mental illness or psychopathic disorder. They may also be transferred to hospital from prison following conviction, given the same disorders.

'Mental impairment' is the term which refers to learning disabilities and serious challenging behaviour. It is defined as a '*state of arrested or incomplete development of mind …. which includes significant impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct (Mental Health Act, 1983).* 'Severe mental impairment' is the term which refers to severe learning disabilities and serious challenging behaviour. It is defined as '*state of arrested or incomplete development of mind …. which includes severe impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct (Mental Health Act, 1983).*

Government figures for the numbers of people detained in hospital (Department of Health, 2004), show that

- far more people are formally detained under civil sections (part II of the MHA 1983), than under criminal sections (part III of the MHA 1983)
- far more people with mental health needs enter hospital in this way than do people with learning disabilities

For example, in the year 2003-2004, there were 23,468 admissions to hospital under part II (the vast majority of these were for people with mental health needs) but only 1322 admissions to hospital under Part III of the Mental Health Act (counting NHS facilities only). Of the 1322 people admitted under part III of the MHA 1983, 1,155 were detained under the mental illness category, 71 under 'psychopathic disorder', and only 41 under 'mental impairment' and 2 under 'severe mental impairment'.

Prisons
Many early studies, particularly in the USA in the eugenics era, only looked at prisons when studying offending and learning disabilities. They often reported that quite high proportions of people in prison had learning disabilities: for example, Brown and Courtless, 1971, reported 10% of prisoners in the USA had 'mental retardation'. However, these early studies were criticised for not assessing learning disabilities properly (e.g. for including people with poor literacy skills rather than just people

with true learning disabilities; for not using proper individualised IQ tests). Later studies, using more careful methodology suggested the early figures had been overestimates, with the real figure being more like 2-3% of prisoners having 'mental retardation' in the USA (MacEachron, 1979; Noble & Conley, 1992).

British studies in prisons have consistently found very low rates of learning disabilities amongst both remanded and convicted prisoners, usually below 1% – see Table 2. Where higher figures have been found, the studies have used poor methodology (eg Singleton et al., 1998). Nevertheless, anecdotal reports continue to suggest there are more people with learning disabilities in prison than thought, so Shackell and colleagues are completing a further study in the NW and London.

Table 2: Prevalence studies in UK prisons

Reference	Location in UK	Number of participants	Tests used	% with learning disabilities
Coid, 1988	1 prison in South West	Retrospective study of 10,000 prisoners	None specified	0.3%
Gunn et al., 1991	16 prisons, 9 YOIs	1365 men & 404 youths	None specified	0.4%
Murphy et al., 1995	1 remand prison in SE	157 men	WAIS-R	0% with IQ<70
Birmingham et al. 1996	1 remand prison in North	569 men	None specified	1%
Brooke et al., 1996	13 prisons & 3 YOIs	750 youths and men	Quick Test	1%
Shackell et al	NW and elsewhere	Study underway		

Community

Community and CJS studies

Three studies have looked at the people with learning disabilities known to community services to find out how many have been in contact with the criminal justice system.

1. One study in Cambridge looked at the incidence of offending amongst people known to learning disability day and residential services and found that 2% of the 358 people with learning disabilities known to services had been in contact with the police as suspects in the previous year (Lyall et al., 1995). None were prosecuted.

2. A small study by McNulty et al. (1995) examined two large residential service providers in South London. They found 9% of 180 the adults with learning disabilities served by the two large residential service providers had been in contact with the police as suspects in the previous year. This study did not include people living with

families and thus may have produced an inflated figure (since those who have challenging behaviour are disproportionately more likely to be in residential care).

3. The largest study of learning disability services, by McBrien et al (2003), surveyed a city (with a general adult population of about 200,000) and found that, of people with learning disabilities known to health and social services:

- 0.8% had a current conviction (i.e. were serving a sentence at the time)
- 3% had had a criminal conviction of some kind in the past
- 7% had a history of contact with the criminal justice system as a suspect, at some time in their lives (but no conviction)
- 17% had 'risky behaviours' that could have been construed as criminal offences (but they had not had CJS contact).

McBrien et al. also reported that 48% of the settings involved in the study (including day, residential and respite services) and 93% of the care managers had experienced caring for at least some clients with a history of CJS contact.

Finally, Vaughan et al (2000) examined community teams for people with mental health needs and for people with learning disability, in relationship to their capacity to serve mentally disordered offenders. Their study covered 85 community teams, across a population of 1.8 million (in Wessex) and found that on average MDOs constituted 7% of referrals to mental health teams and 13% of referrals to learning disability teams.

Community and challenging behaviour studies
Numerous studies have examined the numbers of people with learning disabilities who have challenging behaviour. Studies have looked at children and adults, both in the community and in hospitals.

Children with learning disabilities generally have higher rates of challenging behaviour than children without disabilities. The reasons for this are complex (see Table 3) but it is known that challenging behaviour can be chronic, so that those who show challenging behaviour in childhood often also show such behaviour in adulthood. If this behaviour is serious (especially if it is likely to cause harm to others), the person may be 'at risk offending'. In practice, though, very few people with severe or profound learning disabilities are ever charged, so that in general only people with mild or moderate learning disabilities are considered at risk of offending. They very often come from backgrounds characterised by extreme social deprivation and disturbed family backgrounds.

Large studies of challenging behaviour have suggested that between 8% and 14% of all the people with learning disabilities in touch with services show serious challenging behaviour, depending on the precise definition used and the period of time asked about (see Emerson, 2001, pp 18-20 for details). Some challenging behaviour, however, consists of behaviours like self-injury and stereotypies which are not relevant to offending. Others, such as physical aggression and property destruction are more directly relevant. According to Emerson (2001), the prevalence of physical aggression averaged about 2% in a number of studies, while property destruction varied between 1% and 7% depending on how it was defined.

Table 3: Challenging behaviour in children with learning disabilities

Reasons for raised rates of challenging behaviour in children with learning disabilities
• Developmental delays (some behaviours, like stereotypies, are common at certain developmental stages and disappear as the child matures) • Poor language skills. Many children with learning disabilities have poor language skills and it is known that challenging behaviour may develop communicative functions (i.e. it may seem to replace some language functions in some children) • Side effects of particular disorders and/or sensory impairments. For example, self-injury occurs in all children with Lesch Nyhan syndrome; over-eating occurs in most children with Prader Willi syndrome; eye-poking is very common in children with severe visual impairment; various challenging behaviours are common in autism) • Challenging behaviour may be associated with the raised risk of mental health needs in children with learning disabilities • There is an increased vulnerability to bullying and abuse as a result of having learning disabilities. Bullying and abuse are known to lead to challenging behaviour • For children with milder learning disabilities and no identifiable biological cause for the learning disabilities, many of the conditions which predispose the child to developing learning disabilities also predispose him/her to developing challenging behaviour (e.g. social deprivation; disturbed and inadequate parenting)

Appendix B: Levels of security

Appendix C: Offence-related services

Police

Overall, in England and Wales, the police recorded just under 5.9 million crimes in 2002-2003 (almost 30 crimes per 1000 of the general population, according to the Home Office website – www.crimestatistics.org.uk). These are thought to represent only a proportion of the total crime occurring, however, as it is known that not all crimes are reported to the police (especially crimes of sexual abuse, of which only about 10% is thought to be reported). For this reason, victim surveys are thought to be more accurate portraits of the total crimes committed, than are police statistics. According to the British Crime Survey of 2002/3, which is a large scale victim survey, just over 9.5 million crimes occurred in the period 2002/3 (counting only crimes that were comparable to those recorded by the police), suggesting that about 43% of all crime is reported to and recorded by the police. The majority of crimes (about 57%) committed against adults living in private households are theft, according to the BCS.

When a person with a learning disability commits a crime in public, it is likely to be reported to the police. However, very often the offences of people with learning disabilities take place in service settings, such as day or residential services and frequently it appears that these are not reported. Research by Lyall et al (1995b), interviewing senior staff in learning disability services in one area, showed that senior staff only report to the police a proportion of the offending behaviour that comes to their notice: none of the staff interviewed said that they *always* reported minor assaults, theft or criminal damage by people with learning disabilities; 40% said they would *always* report a major assault by a person with a learning disability; 23% said they would *always* report a sexual assault but 10% said they would not necessarily even report a rape by a person with a learning disability.

Consequently it is clear that not all potential offending by people with a learning disability is reported to the police. Nevertheless, when such behaviour is reported, the police have a duty to investigate and it is known from research referred to earlier that between 5% and 9% of the people questioned by the police as suspects have a learning disability (Lyall et al., 1995a; Gudjonsson et al., 1993). Many police officers, however, are unclear what precisely a 'learning disability' means and relatively few have good training in how to interview people with learning disabilities.

Nevertheless, when someone is arrested and taken to the police station for questioning, the police have to proceed according to the regulations of the Police and Criminal Evidence Act 1984 (PACE, Code C, revised July 2004). This means that the suspect must be informed of:

- their right to have someone told of their whereabouts
- their right to a solicitor (for free legal advice)
- their right to consult the Codes of Practice.

They must also be given the caution (see below) and be provided with a copy of the Notice to Detained Persons, which sets out their rights, the words of the caution and the arrangements for obtaining legal advice. The words of the current caution are:

> *You do not have to say anything. But it may harm your defence if you do not mention when questioned something which you later rely on in court. Anything you do say may be given in evidence.*

In addition, according to PACE, the custody officer must determine whether the person needs medical attention or needs an *Appropriate Adult.* The Appropriate Adult (AA) is intended to protect the rights of mentally vulnerable people and has to be called to attend police interviews. The AA's role is not simply that of an observer but:

- to advise the person being interviewed
- to ensure the interview is conducted fairly
- to facilitate communication with the person being interviewed.

However, historically, there have been a large number of miscarriages of justice, involving wrongful convictions of people with learning disabilities (Gudjonsson, 1992). Research by Clare and her colleagues (Clare & Gudjonsson, 1991; Clare & Gudjonsson, 1993; Clare et al., 1995; Clare et al., 1998) has shown that people with learning disabilities:

- Do not normally fully understand the meaning of the caution
- Do not normally fully understand the notice to detained persons, even when it is read out to them
- Are very likely to be acquiescent and suggestible when being interviewed by the police (and may therefore admit to something they did not do)
- Do not always make wise decisions during police interviews (for example, they may admit to crimes, in order to be allowed to go home, thinking they can correct any errors later)

The AA provision in PACE was intended to provide people with learning disabilities (and other vulnerable people) some protection against the likelihood of false confession. However, it has become clear that the police do not always know when someone has a learning disability and the AA provision is offered far less than it should be (Bean & Nemitz, 1994; Medford et al, 2000). Moreover, many AAs (who may be family members, social workers, community nurses or others) themselves seem to feel intimidated in the police station and many do not speak at all.

Probation

The National Probation Service for England and Wales is divided into 42 areas (including Cumbria, Lancashire, Cheshire, Merseyside, Greater Manchester in the North West). Nationally, the probation service supervises over 200,000 offenders at any one time (mostly young men) and provides over 245,000 reports to the court annually, as well as doing other work (see below).

Most probation staff are based in local centres, from where they provide services to the courts, such as Pre-Sentence Reports or PSRs for offenders (detailing why the offence occurred, an assessment of the offender and the risk he/she poses and the appropriateness of a community order) and Specific Sentence Reports or SSRs (a same day assessment of an offender where the court is considering a specific sentence). They are also responsible for bail reports (assessing offender's suitability for bail) and arranging hostel places for offenders. In addition, probation staff supervise offenders who receive Community Rehabilitation Orders (CROs, previously Probation Orders), Community Punishment Orders (CPOs, previously community service orders), Combination Orders, Post-Release Licences (for offenders released

from prison) and Drug Treatment and Testing Orders. They run a number of accredited programmes for the treatment of sex offenders, drink impaired drivers, substance offenders, domestic violence offenders and general offenders, as well as running basic skills programmes for offenders, assessing offenders on the new Offender Assessment System (OASys), providing victim services, liaising with prisons and the police, and leading the Multi-Agency Public Protection Panels with the police. Probation services are extremely closely monitored by the Home Office, to whom they have to provide very detailed annual reports (these can be found, for each area, on www.probation.homeoffice.gov.uk).

In Lancashire, for example, there are about 600 probation staff, who are based in 21 local centres, two hostels, and six prisons, including a young offender's institution. In 2003-4, Lancashire probation services produced over 5000 reports for courts and supervised over 6000 community orders and post-release licences. In Cheshire there are over 400 probation staff, based in 10 centres, who in the last year produced over 2,500 PSRs for courts and supervised over 3000 offenders on community orders and post-release licences.

Research has shown that about 6% of the people on community orders, supervised by probation staff, have a learning disability (Mason & Murphy, 2002). Yet probation staff often:

- Do not know which of their clients have a learning disability (many clients cover up their difficulties)
- Say they feel unsure how to help people with learning disabilities
- Realise that many of their procedures need adapting for people with learning disabilities
- Cannot include people with learning disabilities on their accredited programmes of treatment
- Are unsure how learning disability community services are organised and do not always know who to contact in CLDTs for help with particular clients

<u>Prisons</u>

There are over 130 prisons in England and Wales, of which 17 are women's prisons (women make up 51% of the general population in England and Wales but only 6% of the prison population) and 10 are contracted prisons. Overall, the prisons are currently holding over 68,000 prisoners, of which over 11,000 are remand prisoners, nearly 10,000 are young persons (between 15 and 20 yrs) and over 4,000 are women (HM Prison Service Annual Report, 2004). Generally, the prisons are characterised by overcrowding (in 2004, total average occupancy in prisons was 66,939, whereas certified normal levels were 63,105), high rates of assault (around 2.5% per annum) and high rates of self-harm (about 13 per 10,000 prisoners commit suicide, per annum, varying somewhat across prisons).

Sixteen of the 130 prisons are in the North West, one of these being a high security prison, two being for women, three being for young offenders and two being contracted prisons (see Table 4).

Table 4: Prisons in the North West

Prisons in the North West	No of prisoners (2003-2004)
Altcourse (contracted)	Not known
Buckley Hall (female)	299
Forest Bank (contracted)	Not known
Garth	649
Haverigg	553
Hindley (young offender)	504
Kirkham (male open prison)	526
Lancaster Castle	237
Lancaster Farms (young offender)	465
Liverpool	1438
Manchester (high security)	1251
Preston	664
Risley	1055
Styal (female)	424
Thorn Cross (young offender, open prison)	208
Wymott	841

UK Government policy is that people with a learning disability should be diverted from custody where possible and should not be in prison unless absolutely necessary. Most studies of people in prison in England and Wales have shown very low rates of learning disabilities (usually less than 1% of prisoners is thought to have a learning disability, using a strict definition of IQ below 70 – few studies have measured social competence as well). Many prisoners do have mental health needs however and many prisoners have abilities just above the cut-off for learning disabilities and are probably significantly vulnerable. Where people with learning disabilities are in prison they seem to be extremely vulnerable to ill treatment, frequently experiencing abuse at the hands of other prisoners.

Secure services

Secure services in England and Wales are designed to care for people with mental health needs, learning disabilities and /or psychopathic disorder who present such risks to others that community services or other health service provision is inadequate for their needs. Normally people living in secure services are detained under part III of the Mental Health Act 1983, following appearances in court; less often, they are detained under civil sections of the MHA 1983.

High Secure Services

High secure services in England and Wales are for people who present a grave and immediate danger to others and they are provided in Ashworth, Rampton and Broadmoor hospitals, with most people with learning disabilities being in Rampton (380 beds). Since 1996, these high secure hospitals have been authorities in their own

right and since 2000 central funding and commissioning for high secure services has been devolved to regions.

The high secure service in the North West is Ashworth Hospital, near Liverpool (previously Moss Side and Park Lane hospitals, until 1990). Ashworth currently has around 420 beds (male:female ration 8:1), mostly for people with mental health needs (260 beds) or psychopathic disorder (110 beds). The hospital does not admit people with severe learning disabilities. The average length of stay is 8 years. The service has had a chequered history, with numerous critical reports, including two large scale enquiries (one into ill treatment in 1992, headed by Sir Louis Blom-Cooper and one into the personality disorder unit in 1997). The 1997 report recommended that the hospital close. It was immediately rejected by the Health Minister (Frank Dobson).

Rampton special hospital, although not in the NW, specialises in people with learning disability. In 2000[14], there were 447 places in Rampton (male:female 6:1). Of these places, 90 were for people with mental impairment: 10 had severe mental impairment with/without additional mental illness; the remainder had mental impairment ((42), or mental impairment with additional mental illness (13) and/or additional psychopathic disorder (20) or all three (5). In 2004, there were somewhat fewer mental impairment places: 68, of whom 4 came from the NW region.

Medium secure services
There are three medium secure services in the North West for people with learning disabilities: Calderstones in Lancashire, the Auden Unit in Warrington and the Mary Dandy Unit in Macclesfield, South Cheshire. Details of these are given on page XXX. The Regional Secure Commissioning Team have had lead responsibility for the strategic management of medium secure services in the North West but devolved commissioning responsibility is with the PCTs and Strategic Health Authorities.

There are also a growing number of privately run secure facilities. Recent figures from a Healthcare Commission survey of independent sector hospitals showed that about a quarter (46) of the 204 registered mental health hospitals, were for people with a learning disability (providing 968 of the total of 5849 individual places). One third of these learning disabilities hospitals had over 20 places and 5 had between 40 and 90 places. Only a quarter of the people living in these hospitals were detained under part III of the Mental Health Act 1983, the remainder being detained under civil sections (41%) or being informal (34%). Many people were a very long way from their original homes (up to 385 miles).

<u>MAPPA</u>
The Multi-Agency Public Protection Arrangements were set up in each of the prison and probation areas in England and Wales, following the *Criminal Justice and Court Services Act* in 2000. In the North West, these areas include Cumbria, Lancashire, Cheshire, Merseyside and Greater Manchester.

Each area has Multi-Agency Public Protection Panels (MAPPs), which are led by probation and police services. They are required to make joint arrangements for the

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[14] These figures are from the Tilt report ‘Review of Security at the High Security Hospitals’, Dept of Health, 2000.

assessment and management of sexual, violent and other dangerous offenders in their areas. Offenders who pose high risks of serious harm or whose management is difficult or sensitive have to be referred to MAPPs. Probation, police, prison, youth offender team, social services, mental health, drug & alcohol, education, prison services, and child protection representatives, as well as lay advisors serve on MAPPs.

MAPPs work by assigning levels of risk to offenders:

- level 1 is the lowest level of risk and offenders assigned to level 1 can be managed by single agencies, with only occasional involvement from other agencies
- level 2 is the medium level of risk and offenders assigned to level 2 require an inter-agency meeting, sharing of information about risks, a management plan and monitoring
- level 3 is high risk, requiring inter-agency meetings of senior staff, information sharing on risk, an action plan, close monitoring, (including, for example, electronic monitoring) and disclosure to specified people.

MAPPS have powers to use legislation such as the Sex Offender Register to monitor sex offenders even after their prison licence expires and they may make Sex Offender Orders where someone's behaviour causes concern (breaches of the order leading to imprisonment).

MAPPs provide annual reports with summary statistics. They can be accessed on www.probation.homeoffice.gov.uk. In Lancashire, for example, in the year up to March 2004, there were 726 registered sex offenders and nearly 400 violent/other offenders living in the county. MAPP arrangements managed 101 level 2 and 26 level 3 offenders. In Greater Manchester, in the year up to March 2004, there were 1388 registered sex offenders and over 1400 violent/other offenders living in the community. A special unit the Violent and Sex Offender Registration Unit (ViSOR) was set up to help deal with violent and sex offenders. Over 150 level 3 offenders were dealt with under MAPP arrangements.

No details are given in MAPP reports as to the number of these offenders who may have had learning disabilities; it is likely to be relatively few.

Appendix D: Screening form for people with learning disabilities

FORM 57M - 'APPROPRIATE ADULT AND MEDICAL CARE' (METROPOLITAN POLICE SERVICE, INTRODUCED 1998)

METROPOLITAN POLICE SERVICE **Form 57M**

Custody Record — *Continuation Sheet* Appropriate Adult and Medical Care

Custody No. .... | Name ....

The questions in Parts A and B are to be read aloud to the arrested person.

Part A Need for an appropriate adult (Tick ✓ relevant boxes and complete as applicable)

1. *"There is help that police must give to people with reading problems."*
   "Do you need this help?" YES ☐ NO ☐
2. *"There is special help that police must give to people who have learning difficulties or learning disabilities (mental handicap).*
   *"Do you need this **special help**?"* YES ☐ NO ☐
3. *"The police must give **special help** to people who went to a special school."*
   *"Do you need this **special help**?"* YES ☐ NO ☐
4. *"The police must also give **special help** to people who have a mental health problem or who suffer from mental illness."*
   *"Do you need this **special help**?"* YES ☐ NO ☐
5. *"Do you need help for any other reason?"* YES ☐ NO ☐
   If YES *"For what other reason do you need help?"* ....

The term ***"special help"*** relates to the provision of an **appropriate adult** as defined within PACE Codes of Practice and the custody officer should explain the role of the appropriate adult to the detained person and the appropriate adult (see below).

Regardless of the answers to the above, if the custody officer has "any suspicion, or is told in good faith, that a person of any age may be mentally disordered or mentally handicapped, or mentally incapable of understanding the significance of questions put to him or his replies", an appropriate adult must be called. In an interview, the appropriate adult is not expected to act simply as an observer. The purposes of his/her presence are, first, to advise the person being questioned and to observe whether or not the interview is being conducted properly and fairly, and secondly, to facilitate communication with the person being interviewed. **Arrested persons who need special help are those who may, without knowing or wishing to do so be particularly prone in certain circumstances to provide information which is unreliable, misleading or self-incriminating.**

Part B Need for medical attention (Tick ✓ relevant boxes and complete as applicable)

1. *"Are you suffering from any medical condition, illness or injury?"* YES ☐ NO ☐ (If NO go to 3)
   If YES, please specify................................
2. *"Are you receiving treatment for this condition, illness or injury?"* YES ☐ NO ☐
   If YES, please specify................................
3. *"Are you taking any medication?"* YES ☐ NO ☐
   If YES, please specify................................
4. *"Have you ever tried to harm yourself?"* YES ☐ NO ☐
   If YES, please specify................................

Regardless of the answers, if there are any doubts about the arrested person's medical condition, action to secure medical attention should be taken in accordance with Code C section 9 and current MPS policy.

Signed .... (Custody Officer) Date................................ (Enter year in full) Time................ (24 Hr.)

M.P. 2170/98

Appendix E: Recent government reports of relevance

Cabinet Office (2005) Improving the Life Chances of Disabled People – see www.strategy.gov.uk/work-areas/disability

Department of Health (1992) (Chairman Dr John Reed) *Review of Health and Social Services for Mentally Disordered Offenders and Others Requiring Similar Services* (see especially vol. 5). London: HMSO

Department of Health (1993) (Chairman Prof J. Mansell) *Services for People with Learning Disabilities and Challenging Behaviour or Mental Health Needs.* London: HMSO.

Department of Health (1999) *Facing the Facts: Services for People with Learning Disabilities: Policy Impact Study of Social Care and Health Services.* London: HMSO

Department of Health (1999) *National Service Framework for Mental Health: Modern Standards and Service Models*. London: HMSO

Department of Health (2000) (Chairman Richard Tilt) *Review of Security at the High Security Hospitals.* Norwich: The Stationery Office

Department of Health (2001) *Changing the Outlook: A Strategy for Developing and Modernising Mental Health Services in Prisons*. Norwich: The Stationery Office

Department of Health (2001)*Valuing People: A New Strategy for Learning Disability for the 21st Century*. Norwich: The Stationery Office

Department of Health (2005) *Independence, Well-Being and Choice: Our Vision of the Future of Social Care for Adults in England*. Norwich: The Stationery Office

Green Light for Mental Health: A Service Improvement Toolkit (2004) - see www.learningdisabilities.org.uk

Appendix F: Recent legislation of relevance

Disability Discrimination Act 1995 – see www.disability.gov.uk/dda

Human Rights Act 1998 – see www.hmso.gov.uk/acts/acts1998

Youth Justice and Criminal Evidence Act 1999 - see www.hmso.gov.uk/acts/acts1999

Sexual Offences Act 2003 - see www.hmso.gov.uk/acts/acts2003

Mental Capacity Act 2005 - see www.hmso.gov.uk/acts/acts2005

Currently under revision: Mental Health Act

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Clare, I.C.H. & Gudjonsson, G. H. (1993) Interrogative suggestibility, confabulation, and acquiescence in people with mild learning disabilities (mental handicap):

Implications for reliability during police interview. *British Journal of Clinical Psychology*, **32,** 295-301.

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