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Working together: Making the case for integrated forensic services for people with intellectual disabilities

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Abstract

Introduction: There is a general consensus that healthcare for people with intellectual disabilities should be provided by multi-disciplinary teams. Within a forensic setting, recommendations are often made for separate or 'parallel' forensic teams, operating independently of generic mental health or intellectual disability teams. An alternative to this model is an 'integrated' service, where specialist forensic clinicians work within the general intellectual disability service, to provide support for clients with forensic needs. For clients with intellectual disabilities and forensic needs, there may be advantages to providing access to a wider multi-disciplinary team, through the application of an integrated model.

Purpose: To illustrate the working of an integrated forensic service within a learning disability team. To identify positive aspects of this model, and how potential shortcomings may be overcome.

Design/ Methodology/ Approach: Literature review, description of service outline with case example.

Findings: Although some studies have compared parallel and integrated forensic models within mental health services, there are no evaluations that compare models of forensic services for individuals with intellectual disabilities. However, specific advantages of an integrated model may include availability of multi-disciplinary clinicians, development of forensic skills across wider groups of clinicians, reduction in stigma and avoidance of delay in transfer of care between services. In addition, in areas with smaller populations, parallel services may not be feasible due to low case numbers.

Originality/ Value: There has been no formal evaluation of parallel versus integrated forensic services within an intellectual disability setting. However, we describe a fully integrated service and suggest means by which the potential shortcomings of an integrated model may be overcome.

Keywords:

intellectual disability, forensic, offending, multi-disciplinary, integrated, parallel

Introduction

Over recent decades, there have been substantial developments in the provision of community services for offenders with mental illness and those with intellectual disabilities. These followed the closure of long-stay psychiatric hospitals and, more recently, reductions in the provision of high-secure beds (Henderson, Bindman & Thornicroft, 1998). There is therefore an ever-increasing need for responsive services, within the community, for such individuals who may present an on-going risk of offending.

Models of Service Delivery

Thus, whilst there is clear agreement on the need for such community teams, there is not similar agreement on how these services should operate. At present, there are two conceptual models of service delivery for forensic mental health services in the UK: the 'parallel' model and the 'integrated' model (Mohan, Slade & Fahey, 2004; Judge, Harty & Fahey, 2004). Parallel services have been described as those where specialist forensic staff work in a team that is separate to generic services, working specifically with individuals identified as mentally disordered offenders. (SoFMH, 2009). An integrated service, on the other hand, involves specialist forensic staff, working within the general community health team, with no distinct boundaries between teams.

The adoption of a parallel system assumes that there will be greater access to specialist forensic intervention, such as sex offending or violence treatment, and good links with criminal justice services and secure hospitals. With this, goes the assumption that such specialisation will lead to better care for patients, and reduced risk to public safety. However, there is not a substantive evidence base to support this model (Malik, Mohan & Fahy, 2007). Furthermore, such a model risks stigmatisation of patients from a group already at high risk for this (Ali, Hassiotis, Strydom & King, 2012; Brown, 1999; Scior, Connolly & Williams, 2013), and the potential isolation of forensic services from other community services.

Within an integrated team, specialist forensic staff work within the general community health team, with no separate referral process. This should, in theory, lead to greater continuity of care and good communication, readier access to community resources, access to non-forensic specialists within the team is straightforward with no issues in regard to which team would carry clinical responsibility. In addition, there is no need for transfer to a generic team when forensic issues have been addressed. Instead, if the individual will remain with the community team for as long as they have health needs. Hence, continuity of care is provided for the individual.

However, it might be argued that there is a risk that such integrated services may lack the depth of specialist skills required and the opportunity to practice these skills on a regular basis. In addition, such integrated teams may lack the resources, in terms of access to forensic in-patient services, that would be available to parallel

teams that include in-patient services. In addition, clinicians within generic teams may be more likely to carry high caseloads, in comparison to parallel services where caseloads are generally accepted to be lower (Mohan, Slade & Fahey, 2004). This may result in a group of patients with a high level of needs, not receiving the same extent of dedicated clinical resources than would be possible within a parallel model.

Who is a 'Forensic' Patient?

A specific issue that arises with parallel teams is the question of core referral criteria: specifically, what constitutes a 'forensic' service user? Attempts to define this include the use of legal definitions, such as considering whether a person might come under mental health care legislation (e.g., Mental Health (Care and Treatment) (Scotland) Act 2003) and has involvement with criminal justice services. However, the question then arises of whether on-going or historical contact with criminal justice services is sufficient to come under the remit of a parallel team, or indeed where simply posing a risk of offending is sufficient to merit inclusion within a forensic service (SoFMH, 2009). Studies of differing caseloads of forensic and generic community teams have found that judgements of historical risk are greater in forensic patients, often due to the nature of the index offence, but offences are typically remote, with estimates of current risk factors comparable to those in generic services (Coid, Hickey, & Yang, 2007). Indeed, it has been argued that there is actually no such entity as the 'forensic patient' (Mohan, Slade & Fahey, 2004).

Offenders with Intellectual Disabilities

The issue of definition is compounded when it comes to individuals with intellectual disabilities. There is a fundamental challenge in defining the difference between offending behaviour and behaviour that challenges (Doyle, 2004). Although it can be said that *mens rea* ('to have criminal intent') is the defining feature, which may simplify matters when considering those with severe to profound intellectual disabilities, the situation is less clear with regard to those with milder intellectual disabilities, the group who most often fall within the remit of specialist forensic intellectual disability services (e.g., Lindsay et al., 2006).

Furthermore, a criticism that some authors have levelled against parallel forensic services in the past is that there is an absence of acceptance of risk as a dynamic concept (Turner & Salter, 2008). Thus, patients may be retained within specialist services where there would be the option of transferring them to generic services without increasing risk. However, because of the nature of the index offence, this often does not happen (Dowsett, 2005). This may be a particular issue for those with intellectual disabilities for whom it is not possible to 'change' their intellectual disability (in the same way as, for example, risk of substance misuse may be moderated); hence, the probability of remaining in a restricted environment is increased. This may result in a reticence to transfer patients to a lower level of security, to discharge to the community, or, indeed, to reduce the levels of supervision and restrictions on activities within a community setting.

Human Rights approaches to risk management have highlighted the need to ensure that the rights of the person are acknowledged within risk assessment and management, with an emphasis upon ensuring that overly-restrictive conditions, which may themselves increase risk, are not imposed (Bannister et al., 2008; Greenhill & Whitehead, 2010). For those people with intellectual disabilities, who may be less able to self-advocate, the potential for on-going restrictions may be greater.

A further issue that arises in the context of intellectual disability is the involvement of multiple disciplines in providing healthcare. It is generally accepted that appropriate support for people with intellectual disabilities involves multi-disciplinary teams with members drawn from a number of professions, including clinical psychology, psychiatry, nursing, occupational therapy and speech and language therapy. With professionals from these disciplines, it is possible to address the multiple health needs that people with intellectual disabilities may present with (Slevin et al., 2007, 2008). In order to provide the breadth of multi-disciplinary expertise needed, some parallel teams may operate with core staff, in particular, forensic nursing and psychiatry, with additional disciplines such as clinical psychology, occupational therapy and speech and language therapy being drawn from generic services.

Thus, the need for professionals from differing disciplines, with forensic expertise, places a significant demand upon staff resources for what is a relatively small population of individuals, albeit that they may have significant needs in terms of services. Only around 2% of the general population has an intellectual disability, with a far smaller population engaging in offending behaviour, hence operation of a parallel model may be difficult to operationalise outwith large centres of population. This suggests that, arguably, some form of integrated service may actually be optimal within an intellectual disability context.

An Example Integrated Forensic Intellectual Disability Service

Within any forensic service, there is a need to provide: (i) effective risk assessment and management, (ii) training and consultation to other professionals, (iii) links with criminal justice services and (iv) interventions that are specific to forensic population. Hence, it is essential to embed this expertise within a service. Within the NHS Lanarkshire intellectual disability service, a model of working has been developed over a number of years to overcome some of the inherent limitations of an integrated service, whilst taking advantage of the potential positive aspects of this way of working.

Central to the model are the posts of Forensic Nurse Practitioner and Clinical Psychologist with a special interest in forensic working. These posts have responsibility for developing the forensic aspect of the intellectual disability service, but are full members of the multi-disciplinary in- and out-patient intellectual disability teams, and carry caseloads that include individuals who do not engage in offending behaviour. Thus, they remain embedded within the intellectual disability

service as a whole. Although the essential forensic strands, as outlined above, run across their roles, there is an overarching theme of increasing the levels of competence and confidence of other members of the multi-disciplinary team in working with offenders with intellectual disabilities. As such, the aim has not been for these individuals alone to work with this client group, but to enable all professionals within the service to be able to work with individuals with forensic issues

Effective Risk Assessment and Management

One potential criticism of an integrated service is the absence of staff who have expertise in completing specialist risk assessments, that single 'specialist' risk assessors might become isolated, or that staff more generally would have limited opportunity to develop the skills needed to do this. Within NHS Lanarkshire, the Clinical Risk Management Team (CRMT) has been developed in order to enable specialist risk assessments. This consists of health professionals who have experience of working with clients identified as being 'high risk'. These practitioners (who may include clinical psychologists, forensic nurse practitioners, community nurses and speech and language therapists) have training in the use of specialist risk assessment tools and development of risk management plans, but, crucially, also expertise in working with clients with intellectual disabilities (Camilleri & Quinsey, 2011). However, a structure of peer support, mentoring and group review of completed assessments, with a process of audit, ensures that such assessments are of sufficient quality and that skill-development is an on-going, supportive process.

Training and Consultation

Development of skills and confidence in forensic working across the wider service is facilitated through a programme of training in the New to Forensic Mental Health programme (SoFMH/ NES, 2009). Additional awareness-raising training is also provided around the use of the Care Programming Approach (CPA) and risk assessment and management. Such training is not intended to develop 'expert' practitioners, but to increase confidence and familiarity of working in this area more generally. The provision of a multi-disciplinary formal consultation on risk issues, the Risk Consultation Group, provides advice and support to staff in relation to clients with high risk behaviours. This group also maintains a record of high-risk individuals referred to the service, including those managed under Multi-Agency Public Protection Arrangements (MAPPA), CPA and those from the health board area who are currently inpatients in secure hospitals and prison.

Links with Criminal Justice Services

A number of reviews have highlighted the need for additional support for workers within the justice system in order to identify and effectively support people with intellectual disabilities and/or autistic spectrum disorder who come into contact with the justice system (e.g., Forensic Mental Health Managed Care Network, 2004; Scottish Executive, 2004). In order to facilitate this, training sessions for agencies

within the criminal justice system have been developed and are offered on a regular basis. These sessions are delivered to a variety of staff groups, including social workers, nurses within prisons and prison officers. The content of sessions includes indicators of intellectual disability, issues that might arise when interviewing people who have intellectual disabilities, and agreement of liaison points and information sharing processes. The response to these sessions has been positive, and they continue to be offered on an on-going basis.

Pre-release plans are developed through co-ordination with the prison services. In addition, electronic resource packs with relevant information about intellectual disability, and the health services available, are distributed across relevant criminal justice agencies.

In addition, such contacts between wider health services and prisons may increase the probability that prisoners with intellectual disabilities will receive appropriate support and interventions. The case of Dennis Gill (see McArdle, 2010 for a discussion of this), where his intellectual disability precluded engagement in offending behaviour programmes, thereby significantly extending his detention, highlights the need for such co-operative working.

Specialist Forensic Interventions

Although an integrated service would seek to utilise the generic skills of practitioner, there are interventions, such as sex offender treatment, that would not ordinarily come under the remit of generic services. In this respect, a specialist sex offender programme is available within the service, staffed by clinicians experienced in working with this population and with training in the model of treatment. Nonetheless, there is still an on-going process of widening the skills of other clinicians within the service in order to allow them to become facilitators for treatment sessions. Furthermore, treatment needs identified through such specialist interventions may, however, be met by the wider service, such as identification of occupational activity and management of emotional difficulties.

Case Example

Mr A is a 35 year-old man with a significant forensic history (three sexual assaults against stranger females and other violent assaults) and a mild-to-moderate intellectual disability. He spent several years in prison before his intellectual disability was identified; this followed awareness-raising training provided to the prison. Involvement through the forensic practitioner within the intellectual disability health service facilitated both occupational therapy and speech and language therapy assessments that highlighted additional needs in terms of daily support and communication.

Although Mr A had completed several offending behaviour programmes within prison, reports identified that he failed to benefit sufficiently from these. The provision of an offending behaviour programme within the community team facilitated the process of release from prison, with positive links with provider agencies and accommodation supporting this.

Mr A was gradually transferred to the wider intellectual disability team, with the forensic practitioner only required to offer oversight of on-going risk management, and a consultancy role as necessary. Mr A became integrated with intellectual disability services more generally, taking advantage of occupational and health programmes offered within the intellectual disability service. As such, Mr A's forensic needs, in terms of risk and transfer from a secure setting were met, but he was able to move to utilising the general services available from clinicians within the wider service, without the need for referral between forensic and generic services.

Discussion

As noted previously, it has been argued that there is no clear consensus on the features that denote a 'forensic' client. Such difficulties are compounded in relation to people with intellectual disabilities, where the difference between offending behaviour and behaviour that challenges is often not clear. In addition, it is not possible to 'treat' a person's intellectual disability in the same manner as, for example, substance misuse or a psychotic illness. Hence, there may be an increased risk of individuals remaining within forensic services when their risk no longer justifies this, or conversely, difficulties transferring clients to forensic services when there may be disagreements about what constitutes a 'sufficient' level of risk to merit this. Furthermore, individuals with intellectual disabilities often have multiple health needs, which may only be met with a wide range of clinicians from differing disciplines. For a very small proportion of the population, it may be difficult to justify this level of investment in order to operate a parallel service, and there is a risk that such services may become isolated from generic health teams.

It is our contention that an integrated model of working may provide a means of overcoming these difficulties, with the opportunity to develop the skills of clinicians across a service more generally. However, it is also suggested that clinicians with specialist forensic skills, and a clear structure for risk assessment and management, training, links with criminal justice services and specialist interventions are key to this process. Hence, such a model does not propose 'doing away' with forensic services, instead it suggests embedding such working within generic services more generally, in order to increase the skills of all clinicians working with this population.

It is acknowledged that we are able to describe an integrated service and areas of need that it meets, but there is not evidence to conclude whether this actually provides quantifiable advantages over a parallel model. It is possible that the demographics of particular areas may preclude the operation of a true parallel service in areas of with small populations. Yet, the evidence for areas where both models may be possible is not available.

It is suggested that there are several areas of research that could be considered to evidence this. Firstly, it is our contention that integrated working will increase the confidence of staff within the wider multi-disciplinary team to work with clients with forensic issues. In order to examine this assertion, it would be helpful to find adjoining areas, with similar socio-demographic profiles, as comparator sites. Levels of staff confidence in working with clients with forensic histories, or where there is the potential for offending behaviour, could then be compared between areas, to identify whether indeed an integrated service leads to increased confidence amongst generic clinicians.

Secondly, and similarly to Coid, Hickey & Lamb's (2007) study, it would be of interest to review the cases held by generic and specialist teams (in areas where a parallel service exists). Differences in client profiles, and whether these match with the notion of 'challenging' behaviour being distinct from 'offending' behaviour (Doyle, 2004), may be highlighted in this process.

A similar methodology might then be followed within integrated teams, but with consideration of to what extent the caseloads differ between those identified as forensic specialists and more generic clinicians. It might, perhaps, be hoped that sharing expertise in forensic working would allow generic clinicians to hold a greater share of cases with a forensic element than is the case in generic teams where a parallel service operates. Of course, work to establish levels of confidence in managing such cases may also be crucial, to ensure that it is not lack of availability of forensic expertise that influences the cases that such clinicians hold.

Perhaps the most difficult question to evidence is, ultimately, which model leads to greatest reduction in recidivism. Ultimately, this is a question that may be difficult to answer, particularly in the field of intellectual disabilities. Issues such as differences in levels of support and availability of services across areas, a lack of reporting and reluctance on some occasions to prosecute may give a false picture of recidivism (Lindsay et al., 2013; McGrath, Livingston & Falk, 2007). However, large-scale retrospective studies have addressed this question (Lindsay et al., 2013). With clearly defined criteria for recidivism, and awareness of potential confounding factors, it is a question that should not be ignored, but instead something that should be approached as focus for research (Camilleri & Quinsey, 2011).

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