

Working in community settings with people with learning disabilities and autistic people who are at risk of coming into contact with the criminal justice system.

A resource for health and social care staff



Developing people
for health and
healthcare

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Note on Terminology

The term “people with learning disabilities and autistic people” is referred to throughout this publication to increase readability.

It includes:-

People with a learning disability,
Autistic people,
Autistic people with a learning disability

The term reflects the groups of people who may receive services from a variety of NHS teams which can include specialist learning disability forensic teams, specialist mental health forensic teams, community learning disability teams and community mental health teams alongside other supporting social care and statutory teams. The shape of service delivery may differ within the regions of England.



Foreword

We all have the right to live as valued members of an inclusive society, people with learning disabilities and autistic people are no exception. All too often, however, many are not afforded this right and when they find themselves facing challenges, they encounter barriers which further disempower them or disrupt access to health and social care interventions that could meet their needs and facilitate inclusion.

As part of the NHS long-term plan, there is an increasing focus on the improvement and delivery of community-based support to help ensure that there is not a reliance on help being sought within specialist hospitals, away from people's communities. The NHS, together with key partners, is working to improve the health and wellbeing of people with learning disabilities and autistic people, and this includes those who are at risk of encountering criminal justice agencies, many of whom may end up inappropriately in prison or in hospital. This work includes increased investment in community-based crisis and forensic support for those who need it, when they need it.

This forensic resource will help health and social care staff to work more effectively with people with learning disabilities and autistic people who are at risk of coming into contact with criminal justice agencies. It is timely and fits well with the NHS long-term plans to ensure that people who need it have access to high-quality, skilled support, close to home and when needed. This should help to reduce admission to specialist hospital or prison for those who are at risk. I hope it proves useful to you and your team and, above all, effective for the people you support.



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Preface

The Abuse Exposed

In 2011, BBC Panorama aired **Undercover Care: The Abuse Exposed**, and the systematic abuse of people with learning disabilities and autistic people detained within Winterbourne View, a psychiatric hospital, was exposed. The suffering enduring by these individuals, at the hands of those who were meant to care and protect them, is often considered to have sparked into life, Building the Right Support (NHS England, 2015a, 2015b), and the drive to get and keep people with learning disabilities and autistic people out of psychiatric hospitals. However, eight years later, BBC Panorama aired **Undercover Hospital Abuse Scandal**, and yet again more systematic abuse of people with learning disabilities and autistic people at the hands of those employed to care for them within another hospital, Whorlton Hall, was exposed. More recently, continuing examples of the abuse of people with learning disabilities and autistic people in hospital, by people who are meant to care for them, have been revealed. In 2020, the Care Quality Commission reported that women with learning disabilities were being abused by the staff employed to care for them at Yew Trees Hospital.

A further expansion of high-quality community-based health and social care is one of the key and important ingredients to Building the Right Support and our shared vision to work towards a society where people with learning disabilities and autistic people are full and inclusive citizens. Community-based services are meant to help get people out of hospital and prevent people from being admitted to hospital by providing people with the right help and support when it is needed. This help and support should be person-centred, and specialist health and social care should help people to stay out of trouble, which includes offending behaviours or behaviours that could be construed as criminal. Specialist community-based forensic support is vital to help us all achieve our goal of keeping our shared and inclusive communities safe for everyone. As part of Building the Right Support, Transforming Care Partnerships were established across England which are local partnerships between Clinical Commissioning Groups, Local Authorities, and NHS England Specialised Commissioning. These partnerships aimed to develop and implement joint transformation plans to commission more community-based services, inclusive of specialist community-based forensic support, and fewer inpatient services, for people with learning disabilities and autistic people.

A national service model

A national service model was developed for the provision of better services for people with learning disabilities and autistic people, focused around nine key principles (NHS England, 2015a, 2015b). The first focused upon helping people with learning disabilities and autistic people to live good and meaningful lives in their communities, something which is exceptionally important for those who may be at risk of engaging in offending behaviours. The further principles focused upon ensuring that family and paid care staff are appropriately supported, individuals have choice as to where they live and who they live with, individuals have access to mainstream and specialist health and social care support within community settings, inclusive of specialist forensic support, and when hospital is needed, there are clear safeguards in place to help ensure the provision of high quality care and a short length of stay, Figure 1.

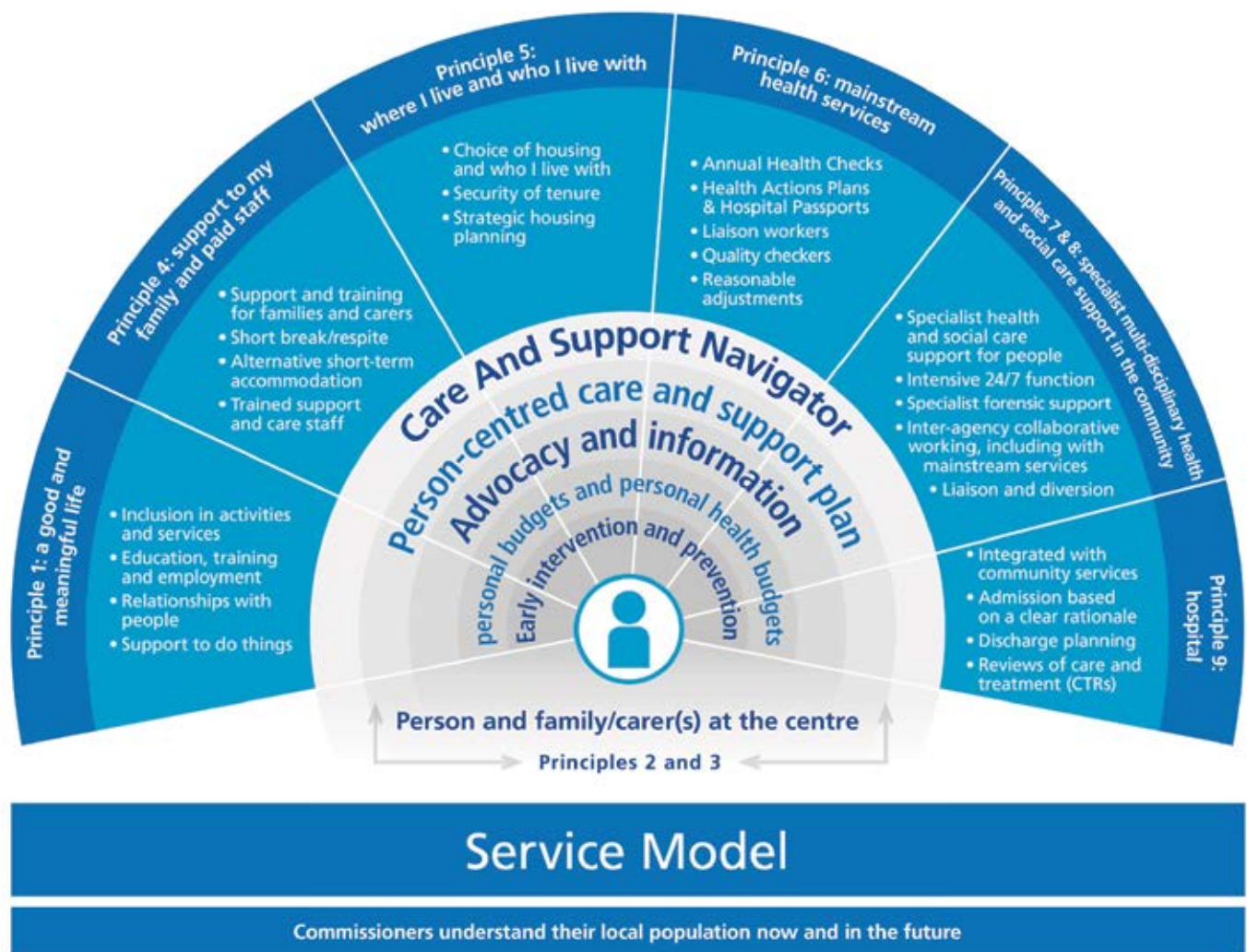


Figure 1: National Service Model (NHS England, 2015b)

Developing a community forensic service – national specification

Following on, and with a focus on Principles 7 and 8 within the National Service Model, NHS England (2017) developed a series of model service specifications to help commissioners implement the national service model. This included community-based forensic support for people with learning disabilities and autistic people inclusive of high-quality specialist risk assessment and management. The aims of community-based forensic support were outlined by NHS England, and these included: (a) specialist risk assessment in the community, (b) offence-specific interventions to help reduce risk, (c) active case management, (d) training and consultancy to other agencies and partners, and (e) in-reach work with those who are detained in hospital, or prison.

Community-based forensic support should be provided by teams comprised of psychiatry, clinical psychology, learning disability nursing, social work, occupational and speech and language therapy (NHS England, 2017). Multidisciplinary teams are needed to help actively manage forensic risk, and this must occur within the context of active working with multiple partner organisations. Numerous individuals and organisations have a responsibility for helping to manage forensic risk. Many of these have been outlined within the [Workforce Competency Framework](#) for providing community forensic services for people with learning disabilities and autistic people published by Health Education England, Figure 2.

Working collaboratively

There is a much wider workforce who need to be actively involved in helping to manage forensic risk amongst people with learning disabilities and autistic people. Community-based forensic teams are responsible for working collaboratively with these organisations to make sure that risk is actively and effectively managed. Partner organisations include schools, colleges, training centres and employers, along with the police, prison service, and others within the criminal justice system.



Figure 2: Multiple agencies are involved in helping to deliver high quality support to people with learning disabilities and autistic people who are at risk of engaging in offending behaviours.

Effective working is also needed with social care providers, local authorities, charities, the voluntary sector, including those who provide care, which may be family members or other unpaid carers, as well as paid carers. Health partner organisations also have a key role which includes mental health, along with community learning disabilities teams and liaison and diversion teams. The number of organisations and individuals involved in the care of someone with learning disabilities and autistic people may seem complex,

but effectively collaborating and/or coordinating across organisations is needed to help manage risk successfully. This is an important and vital role of community-based forensic teams for people with learning disabilities and autistic people. Furthermore, teams need to be able to help promote genuine and inclusive access to services for people with learning disabilities and autistic people, while working effectively to formulate and act to reduce risk, which will not only involve directly working with individuals, but within the systems that surround each and every individuals, which includes their carers and families.

This resource is a further step towards helping to develop better services for people with learning disabilities and autistic people who are at risk of coming into contact with criminal justice agencies. It brings together authors who are experienced in working with people with learning disabilities and autistic people who are at risk of engaging in offending-like or criminal behaviours. The resource aims to support both community learning disabilities teams and established community forensic teams when working with people with learning disabilities and autistic people.

In undertaking this work, Warwick University was able to bring together a group of men with learning disabilities and autistic people who have a history of engaging in offending-like or criminal behaviours and had been detained under the Mental Health Act. This group have reviewed and contributed to the development of the content, and their comments are found throughout the chapters. These men made it clear that they wanted to work together with good teams in the community to help manage risk to keep them and others safe, and to stay out of hospital. They clearly described the marked advantages of shared and inclusive risk assessment and management for them and those provide care and support.

The first chapter of the resource is focused upon the commissioning process, and contains information about the commissioning cycle, the role of a commissioner, and how services for people with learning disabilities and autistic people are commissioned. The authors of chapter two then present information about the prevalence of people with learning disabilities and autistic people who commit criminal offences, while also explaining the factors or characteristics of this group and the implications for services.

Following this, within chapters three and four, static and dynamic risk factors, and a variety of actuarial and structured clinical judgment approaches to risk assessment and management with people with learning disabilities and autistic people are outlined. The strengths, challenges, and barriers to managing and sharing forensic risk is then considered, along with the ways in which teams can work collaboratively to manage risk across agencies. Chapter five focusses on autistic people within the criminal justice system, outlining their vulnerabilities, and some of the interventions and associated sources of support that are available. In chapter six, the use of positive behavioural support, as a organisational framework for the delivery of care to those who present with forensic risk is then discussed and outlined, followed by a focus in chapter seven on a range of psychological interventions and associated adaptations for people with learning disabilities and autistic people who present with forensic risk. The importance of support staff in the implementation of these interventions is outlined.

The authors of chapter eight focus on some of the challenges associated with recognising and treating mental health problems amongst people with learning disabilities and autistic people and associated prescribing practice. Chapter nine outlines the communication challenges faced by people with learning disabilities and autistic people who engage in offending-like or criminal behaviours and provided practical ways to help improve communication. The authors of chapter ten explored factors contributing to delayed discharge from hospital for people with learning disabilities and autistic people who present with forensic risk. The roles and tasks of community-based forensic teams are outlined, and the important function these teams have in facilitating timely, safe, and effective discharge and after-care is discussed, along with a model and template to support discharge planning. Within the final chapter, focused upon social care provision within the community, the authors consider how to promote socially appropriate behaviour for people with learning disabilities and autistic people who have forensic risk. They consider factors which are associated with good quality care and support, with a focus upon one model that they use within their own service to help mitigate forensic risk.

For well-established teams, it is hoped that this proves to be a useful resource in addition to your vast experience. For those who are developing or commissioning new teams, and for those who are about to start to work to provide help and support to people with learning disabilities and autistic people with forensic risk, this resource should also provide a valuable contribution to help you develop your teams and skills.



Chapter 1:

Commissioning community services

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Aims

The aims of this chapter are:

1. To explain commissioning with a focus upon commissioning services for people with learning disabilities and autistic people.
2. To explain the commissioning cycle.
3. To explain that commissioning for people with learning disabilities and autistic people is based upon information about what is needed within a region, and should draw upon co-production with those who will use the service to make sure that needs are met effectively.
4. To outline the role of the lead commissioner.

Introduction

This section aims to give a brief overview of what commissioning is and why it is an important aspect of health and social care. We will consider forensic teams for people with learning disabilities and autistic people, summarising how commissioners work with these teams to develop packages of care and purchase services to meet the needs of the patient.

Commissioning services and support for people with learning disabilities and autistic people, particularly those with complex needs, which might include those who have come in to contact with the criminal justice system, requires commissioners to work on both a strategic and individual level. This is quite different to other areas of commissioning such as, for example, orthopaedics, primary care, or services for older people. Commissioners benefit from understanding the technical aspects of commissioning and strategy development, but also need to understand the needs of the specific population they are serving, and guidance from the National Institute for Health and Care Excellence now supports this and recognises that commissioners must understand the experiences of people with learning disabilities and autistic people.

What is commissioning?

Commissioning is about getting the best possible health and wellbeing outcomes for a local population and requires commissioners to secure the best value in using public money. This involves assessing local needs, deciding priorities and strategies, designing and buying services on behalf of the population from providers

of health and social care across the public and independent sector, and evaluating and assessing the quality and effectiveness of those services. It is an on-going cyclical process; clinical commissioning groups (CCGs) and local authorities must constantly respond and adapt to changing local circumstances, as well as legal and policy changes. They are responsible for the health and wellbeing of their entire population and this is measured by how much they improve outcomes.

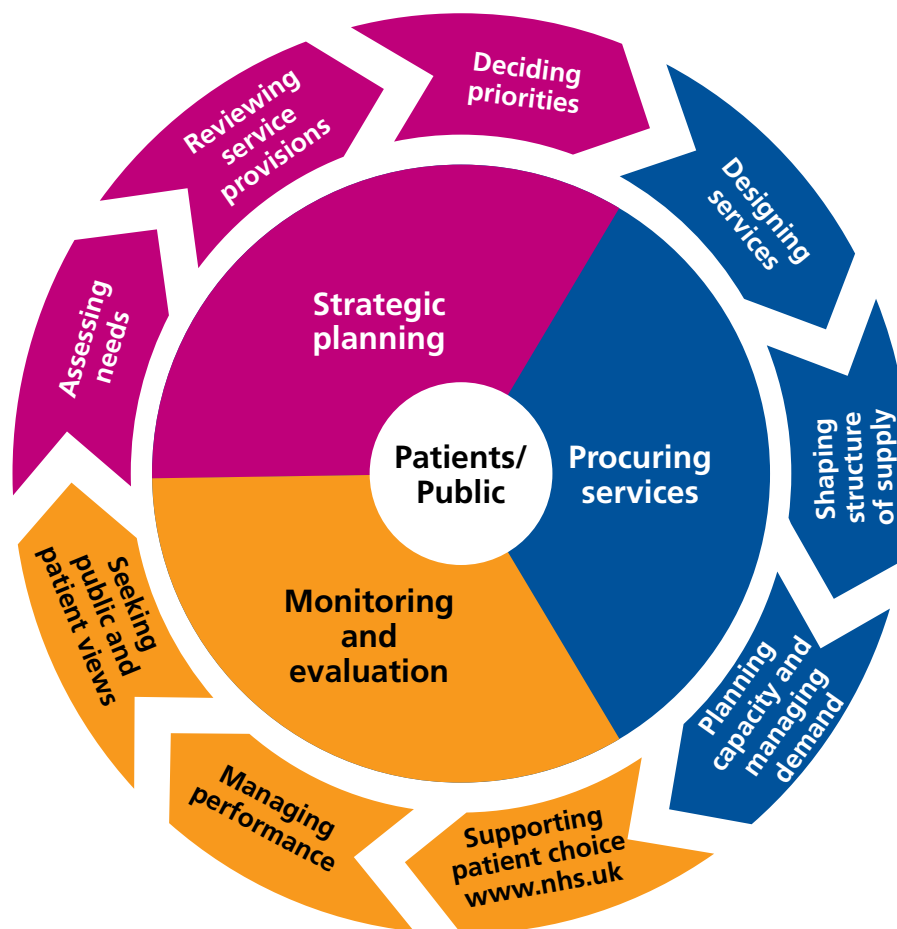
The commissioning system is continually evolving. Currently in the NHS, CCGs are statutory bodies, and were created following the implementation of the Health and Social Care Act, 2012, and replaced Primary Care Trusts on 1 April 2013. CCGs are clinically led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area. As of 1 April 2020, following a series of mergers, there are 135 CCGs in England. At the time of writing, legislative proposals are being considered to make Integrated Care Systems (ICSs) statutory. Many CCGs are already working with other local partners such as local authorities to commission services for their population and will have a lead or joint commissioning role for services for people with learning disabilities and autistic people.

Commissioning is not just about procurement and managing contracts. It also involves:

1. Maintaining good relationships - increasingly across the local system inclusive of police, probation, MAPPA, social care, housing
2. Understanding of relevant policy and legislation (particularly the Mental Health Act and Mental Capacity Act)
3. Strategic planning
4. Understanding the needs of people
5. Understanding and using co-production/creation with people who use services
6. Knowing what the local market has to offer and being able to shape it to address specific gaps
7. Monitoring the quality of services and the outcomes they produce.

The Commissioning cycle

The diagram below helps to illustrate the commissioning cycle and how it is an on-going interrelated cycle of activity. It is important to understand that not all stages of the commissioning cycle are carried out by a commissioner – some elements, such as population needs analysis might be led by those working within public health. Similarly procuring, monitoring, and reviewing contracts in some areas might be incorporated into a commissioner's role, but they are distinct areas of activity, requiring different skills and knowledge of different legal frameworks. All health and social care organisations when presented with a proposal that is likely to result in a procurement exercise and contract award, will require a business case, followed by a detailed project plan and at least access to procurement expertise.



The starting point with commissioning services should be an understanding of local need. Commissioners should have access to relevant data from the local joint strategic needs assessment or they might have their own population health management tools to help them collate and analyse data. There will be local strategies for supporting people with learning disabilities and autistic people which commissioners are likely to have led, but in collaboration with people with learning disabilities, autistic people and their families, and professional stakeholders. Commissioners will also work with providers and other system partners to understand the needs and demands, and the services required to meet them.

CCGs and local authorities have a duty to ensure they are working to reduce inequalities both in terms of access to services, and the outcomes they achieve. It is also critical to ensure that people with learning disabilities and autistic people are at the centre of the planning and decisions which shape and design their care and support. Clearly, this should also include family members, carers, loved ones or independent representatives wherever possible and appropriate. Additionally, it is important for commissioners to develop networks with people and their families who have lived experience of learning disabilities and autistic people, and local independent advocacy organisations. Working on these two levels – individual and community - will increase the likelihood of support packages being effective. From a wider population perspective, it will provide a rich information source about experiences which will enable commissioners to shape and nuance the services they commission. This can result in imaginative solutions that will truly transform services to help meet their needs.

People with learning disabilities and autistic people said:

- // We want commissioners to talk to us, our families and supporters.**
- // It is important that commissioners get to know us as we do not really know them. They need to get to know us so they can get support right.**

Commissioning community forensic services

The National Institute for Health and Care Excellence (2018) have produced guidance on commissioning for those with learning disabilities and challenging behaviour and this includes advice about community forensic learning disabilities services. This guideline comes with a suite of resources to help commissioners and providers plan, commission and deliver high quality services (see <https://www.nice.org.uk/guidance/ng93/resources>).

Where a population analysis has indicated the need for a community forensic learning disabilities team, consideration should be given to the benefit of this comprising health and social care professionals. In addition, there will be a need to shape and develop specialist accommodation and support providers in the community who are able to support people with a learning disability and/or autistic people who may be at risk of coming into contact with criminal justice or have a history of engaging in behaviour that is likely criminal. This requires community providers with additional skills and insights – as approaches to and the understanding of risk assessment and management can at times be different to related positive risk-taking approaches which characterise the way services for other people with learning disabilities, autism or mental health needs operate.

Public money must be used as effectively as possible. This requires commissioners to use the best evidence – which could be research data, but also service evaluation data, and patient satisfaction data. This is to ensure that services being commissioned provide effective interventions or support for people that improve outcomes. The numbers of individuals who require this level of specialist support in a locality are likely to be small, but the risks and costs associated with not getting the support right will be significant, both in terms of individual outcomes and public protection. The small numbers of individuals can raise challenges for commissioners in working with community providers to develop viable models of service provision. It may be necessary to consider collaboration with commissioners within a wider geographical area to have sufficient volume of specialist activity.

It is important to think about where people will live who are at risk of coming into contact with criminal justice agencies or have such a history. They may be restricted in terms of locality by the Ministry of Justice or Court orders. There may also be areas where risks will be considered higher for re-offending due to other groups and criminal activities in that locality. It is important to work with MAPPA, housing, and community safety teams to ensure that appropriate accommodation is available in a suitable locality that gives people the best chance of a successful transition to living in the community.

Business case

When developing new services, or transforming existing provision, commissioners will probably need to put forward a business case that sets out what the service could look like, why the service is necessary and what the need is, inclusive of how much it will cost, the values and the outcomes they want to see. The National Institute for Health and Care Excellence provides access to useful material in developing a business case, but organisations may have their own template that they expect to be used (see <https://www.nice.org.uk/guidance/ng93/resources>).

A business case generally incorporates information about the problem that is being solved, inclusive of evidence to support the effectiveness of the service model and associated interventions. The benefits in terms of cost and quality must be outlined, along with consideration of a series of options, inclusive of taking no action. The costs, balanced against any likely associated savings, coupled with details of any associated risk and strategies to mitigate this risk are required. The implementation of the scheme must be planned carefully, including arrangements for management, and engagement with all stakeholders, including people with learning disabilities and autistic people, their carers and family members. Plans as to how outcomes will be monitored to consider effectiveness going forward is a crucial and important part of any business case.



Commissioning arrangements

Often, within a given area, there is a lead commissioner for learning disability and/or services for autistic people, and they are frequently referred to as Joint Commissioners. Their role involves strategy and service development as noted earlier in this chapter, but they work across the health and social care system as a joint appointment, often with the ability to manage combined health and social care budgets; this is an important role, as the alternative is a number of different commissioners from CCGs and local authorities each commissioning different aspects of services across community and inpatient provision. This joint commissioning approach can help streamline this process, reducing the fragmentation in and between services which people using health and social care frequently report defines their experiences.

The lead commissioner is responsible for planning and oversight of commissioning for people with learning disabilities and autistic people. Further, they should be experts who are experienced in working with people with learning disabilities and autistic people, and when commissioning, they should develop services that meet needs across all ages, promoting and allowing for easy and sensible transitions between services (e.g. services for children to services for adults).

When commissioning services for people with learning disabilities and autistic people who are at risk of coming into contact with criminal justice, lead commissioners should have an understanding of the number of people within their area who present with this risk, allowing them to plan services to meet needs effectively. These services must be planned using co-production, and commissioners should take joint responsibility for managing risk using person-centred support and care (life planning), allowing, where possible, people to live as close to home within the least restrictive setting. Alongside this, commissioners should be working in collaboration with services to operate a risk register that captures data about behaviours that are likely to lead to contact with criminal justice agencies to help inform the commissioning process by identifying need. Further information about these recommendations and the responsibilities of the lead commissioner can be found with the National Institute for Health and Care Excellence Guidance (National Institute for Health and Care Excellence, 2018).

People with learning disabilities and autistic people said:

// Commissioners need to make sure that we have good support when you are in the community by having a good plan.

NHS England (2017) have previously produced a model service specification to help commissioners as part of the Transforming Care Programme. This includes a model service specification for community based forensic support where recommendations were made that for each 1 million of the general population, there should be a community forensic team for people with learning disabilities and autistic people with an active case load of 40 to 60 people. They outlined that these teams have six core functions: (1) undertaking forensic risk assessment and management in the community to help mitigate risk and protect the public, (2) deliver offence specific interventions, (3) case manage complexity, (4) support and train other stakeholder organisations who are providing support, (5) provide consultancy and advice to stakeholders, and (6) provide in-reach to secure inpatient services to help promote discharge. The functions of a community forensic learning disability and/or autistic people team were expected to be delivered by existing community forensic mental health teams, or community learning disabilities teams, or through the establishment of specialist forensic learning disabilities and autistic people teams, or some combination of each. Teams are expected to be comprised of psychiatry, clinical psychology, learning disability nursing, social work, occupational and speech and language therapy.

Conclusions

1. Commissioning is essential for the planning and procurement of services, as well as helping to ensure that services provide value for money, meet local need and produce agreed outcomes.
2. Commissioning for people who have learning disabilities and autistic people who are at risk of coming into contact with criminal justice requires collaboration with a wider range of public sector stakeholders, understanding of the requirements of the Mental Health Act, 2007, and the Mental Capacity Act, 2005.
3. There will be a need to develop a 'market' of providers able to meet the needs of people with learning disabilities and autistic people who are at risk of coming into contact with criminal justice agencies.
4. Many areas will have a lead commissioner – frequently named a joint commissioner - who will commission services for people with learning disabilities and autistic people, across geographical area defined by either the local authority or CCG footprint.
5. Commissioners should work with service users and their families, providers, and other stakeholders to plan, commission, and evaluate services.
6. Commissioners have a critical role in ensuring that planning places an individual at the heart of their support/care plan design by ensuring key professionals are adept in the use of person-centred planning techniques (also referred to as life planning) and that this is reflected in the practice of support providers.



Chapter 2:

What proportion of people with learning disabilities and autistic people commit offences?

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Aims

1. To discuss and outline the prevalence of people with learning disabilities and autistic people within the criminal justice system, and to consider those who commit criminal offences.
2. To briefly consider the challenges faced by people with learning disabilities and autistic people when they come into contact with the justice system and make some recommendations for practice about how these could be overcome more effectively.
3. To describe the characteristics and backgrounds of offenders with learning disabilities and autistic people who come into contact with the justice system and consider the implications for services.

Introduction

Concerns about people with learning disabilities in the criminal justice system have existed for many years, both because they may become suspects (as a consequence of illegal behaviour), and because they are likely to be disadvantaged during criminal justice proceedings. However, autism, on the other hand, has only been recognised more recently, and there are fewer studies about autism as a potential factor in offending and as a source of vulnerability within the criminal justice system.

This chapter will examine what is known about the two central questions of:

- The prevalence of learning disabilities and autistic people within the criminal justice system
- The percentage of people with learning disabilities and autistic people who commit crimes.

These topics are contentious but are vital to inform the effective commissioning of community services, although the relevant data are frequently misinterpreted. In the case of the prevalence within parts of the criminal justice system (such as the police station, courts, prisons, probation), we should expect that if people with learning disabilities are not over-represented, compared to the general population, they will be found at about 2-3% of the relevant populations, since that is the true prevalence of learning disabilities in the general population. For autism, a similar argument would suggest figures of 1%.

Meanwhile for the very different question of what percentage of the population of people with learning disabilities and autistic people commit crimes, we can only judge over-representation by comparing to a similar group (similar in age, gender and social deprivation) from the general population. It is worth keeping in mind that West and Farrington's (1977) study, of 411 boys from state primary schools in a socially deprived area of South London, 39% had criminal convictions by the time they were 40 years old (Farrington, 2003; Farrington et al., 1996).

We will also consider the types of crimes, the characteristics, and vulnerabilities of people with learning disabilities and autistic people who have been convicted or suspected of committing a criminal offence.

Prevalence of learning disabilities and autistic people in parts of the criminal justice system

Learning disabilities and autistic people are not easy to identify in suspects and offenders, as only those mildly affected by their learning disabilities and autistic people enter the criminal justice system, due to mens rea. Within England and Wales, and within many other jurisdictions around the world, mens rea, or a "guilty state of mind" is a necessary element for an act to be considered a crime and a person to be considered culpable. For people with moderate to profound learning disabilities, they may be judged to lack mens rea and therefore they are less likely to enter the criminal justice system.

Initially, contact with the criminal justice system occurs when a possible crime is reported to the police. If arrested, the suspect would be questioned, and may be charged, necessitating an eventual court appearance. They could be bailed or remanded into custody, while awaiting the court appearance, then tried in court for alleged crimes. Finally, they may reach the 'disposal' stage (the possible outcomes including being found not guilty, receiving a fine or a community sentence, being sentenced prison, or sent to hospital using the Mental Health Act, 1983, as amended, 2007).

It is known, of course, that not all illegal behaviours are reported to the police, especially when the alleged suspect has learning disabilities and autistic people (Lyall et al., 1995; McBrien & Murphy, 2006). The police may (but do not always) interview the suspect(s) and may release them back home with no further action or may charge them with a crime. A few studies have examined the prevalence of people with learning disabilities and autistic people attending police stations and appearing in courts as suspects, and these are described below (there are relatively few studies of autism). Far more numerous, though, have been investigations of the prevalence of people with learning disabilities in prison, and this type of study has a long and chequered history. However, there are still very few investigations about autistic people in prisons. We have summarised below what is known about the prevalence of learning disabilities and autistic people at each of these stages of the criminal justice system, beginning with police stations, since that is typically where people start their criminal justice contact.

Police stations

Research studies examining the prevalence of learning disabilities amongst suspects at police stations have typically involved assessing all detainees for learning disabilities, within a specified period, using a short intelligence quotient (IQ) test or a screening tool for learning disabilities. Gudjonsson et al. (1993), for example, assessed 156 detainees on a shortened Wechsler Adult Intelligence Scale -Revised at two London police stations and found 9% of suspects had an IQ below 70. Meanwhile Lyall et al.(1995), in Cambridge, used a short screening questionnaire asking about special schooling, reading and writing skills, and special education support, and reported that 5% of suspects had attended special schools for children with learning disabilities, and a further 10% had attended schools for children with emotional/behavioural difficulties or a learning support unit in a mainstream school. More recent studies, since then, have employed the Learning Disabilities Screening Questionnaire (LDSQ), a validated screening instrument (McKenzie & Paxton, 2006), and reported 3% of 225 detainees screened positive for learning disabilities in Yorkshire (Middlemiss, 2012), while 7% of 200 screened positive in

London (Young et al., 2013). Lastly, McKinnon et al. (2015) found that 3% of 248 detainees in London had probable learning disabilities, as judged by psychiatrists, and only 25% of these were detected as probably having learning disabilities by the police. Following the development of a new screening instrument called the Health screening of People in Police Custody (HELP-PC), psychiatrists judged 2% of 351 detainees had learning disabilities but, while police detected proportionately more people with suspected learning disabilities using the new tool, the false positive rate was very high (McKinnon et al., 2015).

This kind of research is difficult to do. Police stations are busy places and a variety of mental health difficulties need to be detected (psychosis, dementia, substance misuse, etc), as well as learning disabilities. At best, custody sergeants have time for a very short screening tool and the studies reviewed above have not included large samples (all were less than 400 detainees, and if learning disabilities were at 2% this would only mean 8 people were detected). The conclusion seems to be that between 2% and 9% of detainees in police stations may have learning disabilities. There has been no research screening suspects for autism in police stations, as far as we can ascertain.

Courts

There have been very few studies in courts in the UK. However, those in other countries have suggested that people with learning disabilities are overrepresented in courts. Hayes (2003) for example in New South Wales, Australia, reported 14% of defendants in Magistrate Courts had an IQ below 70. In a subsequent study she found 21% scored below IQ = 70 in a rural court (Hayes 1996). However, she was using the Kaufman Brief Intelligence Test (K-BIT) and many of those assessed were First Nations people, so it may not have been a culturally fair test. Moreover, she was using no measure of adaptive behaviour (a problem in most prevalence studies in the criminal justice system). In a later court study in Australia in which Adaptive Behaviour was also assessed, the prevalence of learning disabilities was 3.5% (Vanny et al., 2009). It would be unwise, however, to extrapolate these figures to the UK, as there are probably more opportunities for diversion (prior to court) than in Australia.

There has only been one study of the prevalence of autism in court that we know about, and that took place in a juvenile court in Japan. Psychiatrists undertook semi-structured interviews (using DSM-IV) and examined school records of over 400 young people appearing in the juvenile court. They concluded that 3% probably had 'pervasive developmental disorder' or autism (Kumagami & Matsuura, 2009).

Prisons

There have been many studies of the prevalence of learning disabilities in prisons, and such research was particularly prominent at the end of the 19th, and beginning of the 20th century, when eugenics was popular and there were fears of the possible over-representation of criminal behaviour amongst people with learning disabilities (e.g. Goddard, 1912; Clarke, 1894, quoted in Brown and Courtless, 1971). Early research appeared to confirm these fears, but it was clear by as early as the 1950s that the apparently high prevalence figures arose in large part from poor methodology (Woodward, 1955).

People with learning disabilities and autistic people said:

// In prison, they cannot help you so much because you got a disability and mental health.

Nevertheless, investigations into the prevalence of people with learning disabilities in the prison system have continued sporadically since then and they have led to divergent opinions. Figures from recent studies in a number of countries, showed that, generally, there were a whole variety of assessment methods used (van Esch et al., 2018). However, in those where a full IQ test was employed, a lower prevalence figure was reported, especially if adaptive behaviour measures were also completed (MacEachron, 1979; Murphy et al., 1995; Hayes et al., 2007; Herrington 2009; Holland and Persson, 2011). Where only screening tests were used, or measures short of a full gold-standard IQ test, higher prevalence figures resulted (e.g. 10% in USA, Brown & Courtless, 1971; 7% in Norway, Sondenaa et al., 2008; 19% in Canada according to Crocker et al., 2007) – see Table 1. Systematic reviews have concluded that the true prevalence of learning disabilities in prisons is about 1% (Fazel et al., 2008).

Table 1. A selection of prison studies of prevalence

Author & Year of Study	Location of Study	Number of Participants	Test (s) used	% of prisoners with I.D.
Brown & Courtless, 1971	Inmates in USA prisons	90,000 (80% of prison pop)	Large variety	9.5%
MacEachron, 1979	Inmates in 2 USA prisons	436 of the 3938 total pop.	Variety	1.5% - 5.6% (depending on how measured)
Coid, 1988	1 prison in England	Retrospective study, 10,000.	None specified	0.34%
Murphy et al., 1995	1 London prison (remand)	157 men	WAIS-R	0% < IQ70 5.7% < IQ75
Birmingham et al., 1996	1 prison, northern UK (remand)	569 men	None specified	1%
Brooke et al., 1996	13 Prisons & 3 YOI's in UK	750 youths and men	Quick Test	1%
Hayes et al., 2007	One NW prison in UK (male)	140 randomly selected men (10% of prison's population)	WAIS-III and VABS	WAIS: 7% < 70 VABS: 10% < 70 Both < 70: 3%
Sondenaa et al., 2008	6 prisons in the north of Norway	143 prisoners (136 men and 7 women), randomly selected	WASI and HASI	WASI: 11% < 70 HASI: 10% < 70 Both: 7% < 70
Holland and Persson, 2011	All sentenced male prisoners released from prison in a 3 year period in Victoria, Australia	7805 prisoners	WAIS-III	1.3% with IQ < 70

Interestingly, at least until recently, despite the considerable research in this area, as well as recommendations for screening in the Bradley report (Bradley, 2009), extremely few prisons or criminal justice system settings seemed to use routine screening for learning disabilities within the UK (Talbot, 2008) or US (Scheyett, Vaughn, Taylor & Parrish, 2009). In England and Wales, it has been suggested that mental health teams in prisons should use the LDSQ, and this was employed in the feasibility study with 3000 prisoners in three prisons by Murphy et al. (2017a), where 7% of prisoners were screened positive on the LDSQ. Meanwhile, Education departments in prisons have been trialling the use of the Do-It-Profiler, which detects a broader range of difficulties (www.doitprofiler.com/sectors/justice-2/prison), and Wakeling (2018) has proposed the application of items from the OASys for screening. It seems likely therefore that screening will take place in prisons in England and Wales in a haphazard way (see <https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/08/equal-access-equal-care-guidance-patients-ld.pdf>). Nevertheless, this should allow prisons to make at least some 'reasonable adjustments' for prisoners with learning disabilities, as required under the Equality Act 2010.

Considering autism, research into the prevalence of autistic people in prison has a much shorter history (King & Murphy, 2014). Of three recent studies, one took place across 12 Scottish prisons (Robinson et al., 2012), one was based in a maximum security prison in USA (Fazio et al., 2012) and one in a Swedish prison for young offenders (Billstedt et al., 2017). In the first, a random sample of 2458 prisoners from 12 prisons were screened on the Autism Spectrum Diagnostic Interview (ASDI), and then a sub-sample of 126 were also screened on the Autism Quotient (AQ; Allison et al., 2012). Four percent of prisoners screened positive for autism on the ASDI but the agreement between the ASDI and AQ was very poor, leading to questions about the validity of the ASDI (Robinson et al., 2012). In the second study, in a maximum security jail in USA, using the Autism Screening Questionnaire, a similar proportion, 4.4%, of prisoners screened positive but the researchers commented on the possibility that the low participation rate of 24% may have biased the results (Fazio et al., 2012). In the third study, in a Swedish prison, young offenders were screened using the AQ and a clinical interview (Billstedt et al., 2017). Researchers reported that 10% had suspected autism. However, the mean score on the AQ for this group was only 21 (the usual mean score on the AQ for groups with diagnosed autism is about 32), so it was possible that Billstedt and colleagues had over-estimated the number of those with possible ASD.

Key points

1. Those with mild learning disabilities and autistic people are likely to come into contact with the criminal justice system at times and may be difficult to identify.
2. Between 2% and 9% of detainees in police stations may have learning disabilities. We do not know enough about autistic people who are detainees within police stations as identification is challenging due to the environment.
3. Between 3 to 21% of people appearing in court may have learning disabilities or autism, according to Australian studies. These estimates were not generated using samples from the United Kingdom, and we need to know more about what is happening in courts in Britain.
4. Systematic reviews have concluded that the true prevalence of learning disabilities in prisons is about 1%, though some studies find higher figures.
5. We know less about autistic people in such settings. It seems they may be slightly overrepresented in prisons.
6. No routine screening is in place for learning disabilities or autism within prisons or police stations and variations in methodology potentially bias prevalence estimates.



Implications for practice

1. Community Learning Disability Teams (forensic or otherwise) should make contact with their local police, liaison and diversion, courts, prisons and probation services. They may well be unaware of learning disabilities and autism services locally. If possible, joint training events should be held– for them to learn about CLDTs and forensic health services, and for health and social care staff to learn about the local prison/probation services. Introduce them to pictorial easy read materials for people with learning disabilities and /or autism.
2. Advise staff working within criminal justice settings to ask whether someone has a learning disability or autism. Instead of asking open questions such as, “Is there anything I should know?”, staff should be direct and clear by asking questions like, “Do you have a learning disability? Or autism? Did you go to a special school? Did you attend a day service? Do you have daily support with living? Do you have any specific needs?”
3. Remain aware that some people may deny or hide needs, to “save face.”
4. Remind criminal justice service staff that some people with learning disabilities may have difficulties with orientation to tasks, speed of processing of information, comprehension, and memory during interactions. They may seem non-compliant when they are simply not understanding instructions.
5. If it is possible for the criminal justice service setting to use a screen for learning disabilities, encourage them to use a validated screening tool, e.g., the Learning Disability Screening Questionnaire (McKenzie & Paxton, 2006) or Hayes Ability Screening Index (Hayes, 2000). Follow this with a full assessment of IQ and adaptive behaviour to be certain.
6. Ask them to consider screening for autism, as suggested in the National Institute for Health and Care Excellence clinical guideline CG142, www.nice.org.uk/CG142, but bear in mind this is only a screen and further assessment would be required for diagnosis.
7. Alert staff within the criminal justice system that they need to consider an advocate, appropriate adult or registered intermediary during the various criminal justice system processes, depending on the outcome of screening and assessments.

Percentage of people with learning disabilities and autistic people who commit crimes

In contrast to the research discussed above, where the percentage of people with learning disabilities or autism is measured in parts of the criminal justice system (and where over-representation would be marked by figures over 2% for learning disabilities and over 1% for autism), some research has examined the question of how many people with learning disabilities and autistic people engage in criminal or illegal behaviour. Typically, the authors of these studies analyse the percentage of people with learning disabilities and autistic people who become suspects in police stations or who acquire a criminal conviction, out of all those with learning disabilities and autistic people within specific geographical areas. Over- (or under-) representation can only be established by comparison to non-disabled matched groups from the same area. Many of the relevant studies make use of large pre-existing health, social care and criminal justice datasets, and their validity consequently depends on the reliability and validity of these databases.

For example, Hodgins and colleagues (1992; 1996) conducted two very large studies of people with learning disabilities, one in Sweden (of a birth cohort of over 15,000 people) and one in Denmark (of over 300,000 people). In the first, Hodgins (1992) linked data about special education with data on convictions in later life, and reported that men

with learning disabilities were 3 times more likely and women with learning disabilities were 4 times more likely than non-disabled individuals to have a conviction. In the second study, Hodgins et al. (1996) linked admissions to psychiatric wards (excluding those for mental illness) with data on convictions, and reported men with learning disabilities were 6.9 times more likely and women with learning disabilities were 5.5 times more likely to have a conviction, than those without disabilities. These studies of course have a number of flaws, most notably, within the Swedish study, it was unclear whether the participants had learning disabilities or included disproportionate numbers of children with conduct problems in special schools, potentially biasing the sample (Lindsay & Dernevik, 2013). In the Danish study, meanwhile, people with learning disabilities may well have had mental health difficulties as well as disabilities, thus not being a representative sample of all people with learning disabilities.



Within England, McBrien et al. (2003) sampled 1326 adults known to learning disabilities services in a city with a general population of about 200,000. They found that 3% of those with learning disabilities had a conviction of some kind (either current or past) and a further 7% had had contact with the police as a suspect but had no conviction. Interestingly, an additional 17% had challenging behaviour that was considered 'risky' as it could be construed as criminal behaviour but had not been. This study estimates the prevalence of people with learning disabilities known to services within a single geographical region in England who have had contact with the criminal justice system though it should be noted that:

- it uses **administrative prevalence** not true prevalence of learning disabilities.
- other cities may differ somewhat as their relative social deprivation levels may affect the proportions of cases.

Moreover, although McBrien et al. (2003) had no non-disabled comparison group, it is worth noting that in West and Farrington (1977) study of 411 boys from state primary schools in a socially deprived area of South London, 39% had criminal convictions by the time they were 40 years old (Farrington, 2003). Conviction rates for those with learning disabilities are much lower according to McBrien et al. (2003), though there are probably multiple reasons for this.

There have been no total population studies involving autistic people in the UK, as far as is known (there have been some small community-based studies but these cannot claim to include total populations in defined areas (see King and Murphy, 2014 for details). However, there have been three recent studies in the USA, as well as one in Sweden and one in Denmark, linking existing datasets. In the first two, in the USA, the researchers examined proportions of teenagers on an autism register and a juvenile justice register (Brookman-Frazee et al., 2009; Cheely et al., 2012). Both found that autistic people committed less crime than teenagers without autism, implying that young autistic people are more law-abiding overall than other young people. The third American study used a national longitudinal special education database, and selected 920 autistic youth, finding that about 20% had been questioned by police, but only 5% had been arrested by age 21-22 years (Rava et al., 2017). Within the Swedish and Danish studies, the authors used comprehensive child and adolescent mental health registers and national crime registers, and reported no over-representation of autistic young people amongst those who had committed crimes, compared to young people without autism (Mouridsen et al., 2008; Lundstrom et al., 2014).

Key points

1. There have been some reports suggesting people with learning disabilities commit more crimes than the general population. There are methodological problems with these studies. Authors of well-designed studies have found that people with learning disabilities are less likely to be involved with criminal justice agencies than people from the general population.
2. There is also evidence from well-designed studies that autistic people commit fewer crimes than the general population.

Characteristics of people with learning disabilities and autistic people in the criminal justice system

Many prevalence studies have also examined whether people with learning disabilities and autistic people tend to commit specific types of crimes. Assertions based on biased samples (such as that of Walker, 1973) of those detained in hospital under the Mental Health Act, and without proper comparison groups, should be discounted as they are unhelpful, and thus only a small number of studies are available providing robust evidence.

In general, these tend to show that where people with learning disabilities commit crimes, they commit similar types of crimes to those without learning disabilities (MacEachron, 1979; Crocker et al., 2007). Some authors have suggested that people with learning disabilities are slightly more likely to be sent to prison for property offences, but are less likely to be sent to prison for offences against the person (sexual offences, assault, murder, etc), and much less likely to be sent to prison for drug or drunk driving offences (Cockram, 2005), in comparison to people without learning disabilities. Holland and Persson (2011) in their large study of people leaving prisons in Victoria, Australia, found prisoners with learning disabilities were more likely to have had committed a property offence and less likely to have committed a drug offence than prisoners without learning disabilities. They were no more likely to have committed sexual offences or violent offences than prisoners without learning disabilities.

For autistic people, on the other hand, though this is based on a smaller number of studies, it seems that if they do commit crimes they are proportionately less likely to commit property offences, drug offences, or driving offences, and more likely to commit crimes against the person, when compared to people without autism (Cheely et al., 2012; Kumagami & Matsuura, 2009; Mouridsen, 2008). Crimes related to their special interests do occur but seem to be rare (Woodbury-Smith et al., 2010).

The characteristics of people with learning disabilities and autistic people involved in the criminal justice system seem to be similar to the characteristics of other offenders. Both are overwhelmingly male (especially in the autistic group), and numerous published studies have demonstrated that those with learning disabilities and autistic people have backgrounds of social deprivation and family breakdown, a raised incidence of abuse in childhood, low educational attainment and/or employment, and higher mental health needs (Murphy & Mason, 2014; King & Murphy, 2014) than those not involved in the criminal justice system.

People with learning disabilities and autistic people said:

// We got into trouble because of unemployment and going to prison and stuff that happened to us like life experiences and life problems.

// Stuff like drugs, drink and not having much money and trauma led us to get into trouble, and peer pressure because you are vulnerable.

In addition, it is widely accepted that people with learning disabilities and autistic people are very vulnerable in the criminal justice system, as they tend to have difficulties understanding their rights, have been wrongly convicted at times, are commonly suggestible in police interviews and in court, and vulnerable in prisons (see Murphy & Mason, 2014, for a review). Thus, Clare & Gudjonsson (1991) demonstrated that people with learning disabilities struggle to understand the police caution and Notice to Detained Persons in England, while Fulero & Everington (1995) found much the same in the US with the understanding of their Miranda

rights (which warns suspects of the right to remain silent). In police interviews, research from the UK and the USA, has shown that people with learning disabilities and autistic people are often highly suggestible and acquiescent (Clare & Gudjonsson, 1993; Everington & Fulero, 1999; Maras & Bowler, 2012) and they often do not understand legal terms, including 'guilty' and 'not guilty' (Smith, 1993). They frequently do not comprehend the process of what happens in the police station or in court, with one person with learning disability in Talbot's (2008) study saying this about his time in court:

“I just felt out of place, being in court, that’s the only way I can explain it. Everyone was talking. I didn’t know what was going on.”

They may also fail to understand legal processes generally, so that they make very unwise decisions early on, such as thinking that if they confess to a crime to the police (so as to go home, for example), they can correct this later in court (Clare & Gudjonsson, 1995). Not surprisingly, this means that false confessions are not uncommon amongst people with learning disabilities and autistic people (Perske, 2011), especially when they have poor legal advice. Some countries have safeguards in place to protect people's rights, such as the Appropriate Adults scheme in England and Wales (at the police station stage) and Registered Intermediaries (at the court stage), but evidence has suggested these are insufficiently provided (Bean & Nemitz, 1994; Medford et al., 2000; McKinnon et al., 2015). Moreover, if people with learning disabilities and autistic people eventually find themselves in prison, again they tend to be disadvantaged in a number of ways compared to other prisoners, being bullied more often, struggling to understand information, such as how to use a pin number to make phone calls, how to fill in forms to obtain meals or see the doctor or obtain a visitor (Talbot, 2008). Easy read information has now been made available on the prison intranet in England and Wales, but it is uncertain how much this is used. On being released from prison, people with learning disabilities and autistic people often receive no services and frequently end up being rearrested as a result (Chiu et al., 2019; Murphy et al., 2017).

People with learning disabilities and autistic people said:

// Having a rough background can lead you to get into the wrong crowd and have no support.

// When you are younger, your past childhood, things can get out of hand. People do not care or bother, and you suffer for the rest of your life.

Key points

1. Those with learning disabilities and autistic people commit a variety of types of crimes, similar to offenders without disabilities; there may be some slight differences only, in types of crimes.
2. The characteristics and backgrounds of offenders with learning disabilities and autistic people are similar to those of others with a history of criminal offending. Namely they are often male, from socially deprived backgrounds, experience higher rates of childhood abuse and/or neglect, have lower educational attainment and employment rates, and increased mental health needs.
3. Those with learning disabilities and autistic people are vulnerable to not understanding criminal justice processes throughout the entire criminal justice system and need reasonable adjustments and support to ensure that the justice system is equitable.



Implications for practice

Consider asking yourself the following questions when working with people with learning disabilities and autistic people who are at risk of coming into contact with criminal justice:

1. Is your communication (or questioning) style appropriate for the individual? Do they understand the process as well as the situation? Do they have the capacity to take part in legal proceedings?
2. Do they need an Appropriate Adult, Advocate, or Registered Intermediary?
3. Would they benefit from (additional) orientation? i.e. being shown the interrogation room or Court, given time to acclimatise, ask questions, or look around? In prison, would they benefit from multiple tours/guides of the unit and repeated verbal inductions to procedures and routines, as well as being provided with visual support and Easy Read materials?
4. Should a vulnerable prisoner with learning disabilities and autistic people be referred to transfer to specialist secure services under the provisions of the Mental Health Act?
5. At release from a police station or custody or discharge from secure services, do they have an appropriate support package? Are there any measures that can be put in place in advance of release, such as contacting community learning disabilities teams, including forensic teams, or social services, in addition to probation services to improve their support in the community?

Conclusions

Historically, people with learning disabilities and autistic people were thought to be over-represented in the criminal justice system. Early studies, using poorer methodologies, led to conclusions that people with learning disabilities were more likely to commit criminal offences. However, with the use of more robust methodologies leading to more accurate estimates of criminal offending rates, there is increasing evidence to indicate that people with learning disabilities and autistic people are not more likely to commit crimes than other people.

Nevertheless, it is widely accepted that people with learning disabilities and autistic people do occasionally commit crimes, and the contributory factors appear to be very similar to those found amongst offenders without learning disabilities (e.g. social deprivation, family breakdown). People with learning disabilities and autistic people are vulnerable in all parts of the criminal justice system, due partly to not understanding their rights, and not understanding court processes and language. They are frequently poorly treated in prison and need much better support when they leave.

Further Resources

- The SOTSEC-ID (Sex Offenders Treatment Collaborative – Intellectual Disabilities) website provides free Easy Read information for understanding the Criminal Justice System. This includes all stages from questioning and arrest, the trial and being in court, custody and prison and probation – <https://www.kent.ac.uk/tizard/sotsec/CRIMINAL JUSTICE SYSTEMexplained.html>.
- The SOTSEC-ID web-site also provides an Easy-Read Guides for Licensing Conditions and for staying out of trouble in relation to Pornography – <https://www.kent.ac.uk/tizard/sotsec/CRIMINAL JUSTICE SYSTEMexplained.html>.
- Three Books Beyond Words are designed for people with learning disabilities and autistic people to guide them through the police station, court and prison. These are obtainable from www.booksbeyondwords.co.uk:
 Hollins, S., Murphy, G. & Clare, I.C.H. (2016) You're on Trial. London: Gaskell Press. 2nd edition.
 Hollins, S., Clare, I.C.H. & Murphy, G. (2016) You're Under Arrest. London: Gaskell Press. 2nd edition.
 Hollins, S., Giraud-Saunders, A. & Ryan, M. (2018) You're in Prison. London: Gaskell Press.
- Equal Access, Equal Care: Guidance for Prison Healthcare Staff treating Patients with Learning Disabilities (2015). NHS England, Health & Justice Team, London, UK.
<https://www.england.nhs.uk/publication/service-specifications-for-primary-medical-and-nursing-and-dental-care-provision-in-prisons-and-immigration-removal-centres-in-england/>
- National Autistic Society Guide for Police Officers and Staff – <https://www.autism.org.uk/products/core-nas-publications/autism-a-guide-for-criminal-justice-professionals.aspx>

Chapter 3:

Assessing and managing risk: risk profiling tools and where to find specialist help

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Aims

1. To define static and dynamic risk factors and set out the actuarial and structured clinical judgment (SCJ) approaches to risk assessment and management.
2. To describe the key risk assessment instruments, their characteristics and where to access them or get specialist help.

Introduction

While as a group, people with learning disabilities and autistic people are more likely to be victims of crime than perpetrators, a significant number do have other mental health problems and behaviour that is described as challenging (National Institute for Health and Care Excellence, 2016; 2018). The dividing line between challenging behaviour and offending behaviour can be thin and depend upon a number of factors including: the seriousness of the act, the visibility of the act, the visibility of disability, the availability of advocacy, the availability of professional resources, and the values and attitudes of professionals who are involved (Alexander, 2020). The majority of those with behaviour that challenges receive therapeutic input from community learning disability teams. However, when they are described as having 'offending' behaviour that needs 'forensic' input, there is concern that staff working within community learning disabilities teams do not have adequate expertise and that they need access to more specialist skills. This is how the concept of a tiered model of community forensic provision becomes relevant (Royal College of Psychiatrists Reports 2013; 2014; Royal College of Psychiatrists, British Psychological Society and Learning Disability Senate, 2016; Devapriam and Alexander 2012).

The treatment approach with people who have learning disabilities and autistic people and a history of offending behaviour being treated in forensic hospital settings is best exemplified by the 10-point treatment programme. It has the following components: (1) a multi-axial diagnostic assessment that covers the degree of learning disability, cause of learning disability, pervasive developmental disorders, other developmental disabilities, mental illnesses, substance misuse or dependence, personality disorders, physical disorders, psychosocial disadvantage and types of behavioural problems (2) a collaboratively developed psychological formulation (3) risk assessments and management plans, that inform the psychological formulation, (4) a behaviour support plan, guided by the psychological formulation, (5) pharmacotherapy (6) individual and group psychotherapy, guided by the psychological formulation (7) offence-specific therapies, which are again guided by the psychological formulation, (8) education, skills acquisition and occupational/vocational rehabilitation (9) community participation through a system of graded leave periods, and (10) preparation for transition (Taylor et al., 2020, Chester et al., 2018).

The same approach would apply to those people being treated in community settings. However, being in a very much less restrictive setting, they are exposed to a wider range of hazards. A hazard is something that has the potential to cause harm, while risk is the likelihood of that hazard causing harm. It therefore follows for this group, that it is crucial to have a risk assessment and management plan that helps decide whether they need to be referred on to more specialist and arguably restrictive services. Within this chapter, an overview of the risk assessment and management of violence towards others will be presented (excluding risk of self-harm or suicide).

People with learning disabilities and autistic people said:

- // We don't really see our risk assessment, but we think we should. Then we will know what to do and what not to do.**
- // We need joint risk assessments and do them together with us, so we understand.**
- // We need to know what makes us high risk so we can stop it.**
- // When you are in the community, you've got to be sure you don't mess up because if you do, you'll not be in the community anymore, so you need to know your risks and you need insight.**

Static Risk Factors

Professionals and carers will need not only to accurately assess the risk of future offending, but also identify those factors and contexts in which such offending may occur. While there is an extensive body of knowledge available in this field regarding general offender populations and those in contact with mainstream mental health services, it is relatively less well developed for people with learning disabilities and autistic people and 'offending behaviours' (Nicholas et al., 2018).

Risk factors may be divided into static and dynamic. Static risk factors are those that are historical or unchanging. These risk factors are used in actuarial risk assessment instruments that are described in the next section.

Though not as robust as that in general offender and mental health groups, there is evidence that some static risk factors are predictive of recidivism ("reoffending") amongst people with learning disabilities. Of particular relevance are: (1) being younger and male, (2) having a history of substance misuse, (3) a diagnosis of personality disorder, and (4) a history of violence and offending (Nicholas et al., 2018). These factors do not significantly differ from those for mentally disordered offenders and hence those risk assessment instruments developed for that group should be valid for use here too (Fitzgerald et al., 2011).

Implications for practice

It is important to understand the difference between static and dynamic risk factors:

1. Static risk factors are those which happened in the past and cannot be changed. These include things like being male, having a history of substance misuse, or a history of violent offending.
2. Dynamic risk factors reflect changeable environmental variables and internal states that are temporary such as attitudes, cognitions or impulsivity. They can change, and may change with intervention, thus lowering risk.

Actuarial risk assessment instruments

Risk assessment of violence towards others, when based purely on clinical opinions, has been shown to be poor and inaccurate (Monahan, 1981) and hence the drive to develop actuarial risk assessment instruments based on static risk factors. Actuarial in this context means a statistically calculated prediction of the likelihood that an individual will pose a threat to others or engage in a certain behaviour (e.g., violence) within a given period. However, actuarial risk assessment tools do not calculate the probability that a specific individual whom has been assessed will engage in violence or other risk-related behaviour. Instead, these instruments report a probability of engaging in such behaviour derived from data generated using a standardisation sample, and the specific person assessed will share these characteristics with those in the standardisation sample who re-offended or engaged in risk-related behaviour with a certain probability over time. Attempts to estimate a person's individual probability of re-offending or engaging in risk-related behaviour has been shown to be imprecise (e.g. Hart and Cooke, 2013).

However, actuarial risk assessment tools rely on a smaller and more relevant set of factors that predicted future violence within a standardisation sample, combined into a statistical model that was highly reliable and potentially free from personal bias. This approach, which could be used to predict a future risk of violence within standardisation samples have been shown to be superior to clinical

judgement when predicting violence (Nicholas et al., 2018; Quinsey et al., 1998; Dawes et al., 1989; Meehl, 1954).

The applicability of these tools for offenders with learning disabilities and autistic people is affected by the fact that, in spite of high recidivism rates, many people with learning disabilities and autistic people do not receive formal convictions (Lindsay et al., 2006; Alexander et al., 2006). A long-term follow-up of discharges from a forensic unit, showed that while the reconviction rate was only around 11%, 59% reportedly had offending behaviour that did not attract a formal conviction (Alexander et al., 2006).

Notwithstanding these limitations, the three actuarial risk assessment instruments recommended for this group, have reasonable predictive validity (that is the ability to correctly assess the likelihood of recidivism or violence) and these are explained in the next sections.

Actuarial risk assessment instruments: Violence Risk Appraisal Guide (VRAG)

This well validated 12-item tool (Harris et al., 1993) has been consistently shown to predict future violent offences in mentally disordered offenders (Harris et al., 1993, Quinsey et al., 2015, Campbell et al., 2009).

Its predictive accuracy in patients within forensic learning disability units has been demonstrated in a series of studies to be comparable to that in mentally disordered offenders (Gray et al., 2007, Lindsay et al., 2008, Fitzgerald et al., 2013). There is preliminary evidence to suggest the same in community settings (Quinsey et al., 2004, 2011, Camilleri and Quinsey 2011).

The 12 items of the VRAG are: (1) lived with biological parents till the age of 16, (2) elementary school maladjustment, (3) history of alcohol problems, (4) marital status, (5) total Cormier-Lang score for non-violent offences, (6) failure of conditional discharge, (7) age at index offence, (8) victim injury, (9) any female victim, (10) diagnosis of personality disorder, (11) diagnosis of schizophrenia-inversely scored, and (12) psychopathy as measured by PCL-R or PCL-SV.



As this instrument includes the use of PCL-R/ PCL-SV (the Hare Psychopathy Checklist – an assessment of psychopathic and antisocial traits), it will need input from professionals who are trained in its use. In the UK context, this may need the involvement of professionals within the community learning disability or forensic teams.

Actuarial risk assessment instrument: Offender Group Reconviction Scale (OGRS)

The OGRS (Copas and Marshall, 1998) was originally developed within the prison service in the UK, and is now routinely used by the probation service and looks at the likelihood of committing any offence within 2 years leading to reconviction within a standardisation sample.

It is now in its third version - OGRS 3 - and has 6 items. A score of 50% or more means that an offender within the standardisation sample is more likely than not to commit a proven re-offence within 2 years. The OGRS 2 was shown to have good predictive utility when used with those treated in forensic learning disability hospital settings (Fitzgerald et al., 2011). The use of this instrument may need the involvement of professionals within the community learning disability or forensic teams. Further details are available on <https://www.gov.uk/guidance/risk-assessment-of-offenders>

Actuarial risk assessment instrument: H subscale of the HCR-20

The History, Clinical, Risk management 20 (HCR-20) is a structured clinical guide which looks at the risk of future violence (Webster et al., 1997). Its history subscale has 10-items, and when treated in isolation from its clinical and risk management subscales, has been used as a static risk assessment.

The HCR-20 is now in its third version and the 10 historical items include: (1) violence, (2) other anti-social behaviour, (3) relationships, (4) employment, (5) substance misuse, (6) major mental disorder, (7) personality

disorder, (8) traumatic experiences, (9) violent attitudes, and (10) treatment or supervision response. The manual provides detailed descriptions for each item. It has been shown to have good predictive utility when used with those treated in forensic learning disability hospital settings (Fitzgerald et al., 2013; Lindsay et al., 2008; Gray et al., 2007). The use of this instrument may need the involvement of professionals within the community learning disability or forensic teams. Further details are available on <http://hcr-20.com/>

Actuarial risk assessment instrument: Risk Assessment Protocol for Intellectual Disabilities (RAPID)

RAPID is a screening tool developed for use with offenders with learning disabilities (Fitzgerald 2008). It has 8 items namely: (1) adult violent behaviour, (2) violent behaviour in childhood or adolescence, (3) childhood deprivation, maltreatment or abuse, (4) childhood delinquency, (5) drug or alcohol use and related problems, (6) enduring problems of personality, (7) rule breaking, problems with authority or lack of respect, and (8) compliance with treatment and management. The tool was found to have predictive efficacy for violent and general reconvictions and institutional aggression among in-patients with learning disabilities and those in the community (Fitzgerald 2008; Lindsay et al., 2011; Fitzgerald, 2012). The tool is designed to be completed by non-specialist assessors. This is a particular benefit. Further details may be available on request from suzanne.nicholas@wales.nhs.uk

Actuarial risk assessment instruments for sexual offending: STATIC-99 and RRASOR

Static-99 is a 10-item instrument (Hanson & Thornton, 1999) for use with adult male sexual offenders who are at least 18 years of age at time of release to the community. In 2012, the age item for the scale was updated, creating the Static-99R. Its ten items include: (1) age at release from index sex offence, (2) ever lived with a lover, (3) index non-sexual violence - any convictions, (4) prior non-sexual violence - any convictions, (5) prior sex offences, (6) four or more prior sentencing dates, (7) any convictions for non-contact sex offences, (8) any unrelated victims, (9) any stranger victims, and (10) any male victims. It generates 5 risk levels: very low risk, below average risk, average risk, above average risk and well above average risk. The tool was found to have good predictive efficacy for offenders with learning disability (Hanson et al., 2013; Lindsay et al., 2008). The use of this instrument may need the involvement of professionals within the community learning disability or forensic teams. Further details are available on <http://www.static99.org/>

The STATIC-99 was developed as an improvement on the Rapid Risk Assessment for Sexual Offence Recidivism (RRASOR) scale which considered 4 variables: (1) prior sex offences, (2) age at release, (3) victim gender, and (4) relationship to victim (Hanson, 1997). The RRASOR's predictive efficacy for offenders with learning disabilities was modest (Lindsay et al., 2008).

Key points

1. Actuarial risk assessment draws together historical risk factors to make a prediction about the risk of future offending based upon probabilities as drawn from a standardisation sample.
2. There are multiple actuarial risk assessment tools that can be used with people with learning disabilities and autistic people to help inform the development of risk mitigation strategies including resource deployment.

Dynamic risk factors

Dynamic factors reflect changeable environmental variables and internal states that are temporary such as attitudes, cognitions or impulsivity (McGuire, 2008; Lofthouse et al., 2018). Research shows there are nine issues commonly associated with offending behaviour - unstable accommodation, a lack of employment, no positive recreation activities, poor personal relationships, alcohol misuse, drug misuse, impulsivity and poor emotional control, anti-social peers and attitudes that support crime. These dynamic risk factors are also sometimes called criminogenic needs. (<https://www.gov.uk/guidance/risk-assessment-of-offenders#what-are-risk-and-protective-factors>)

In line with the risk-needs-responsivity model of understanding risk (Andrews & Bonta, 2003), static risk factors may be seen as determining 'who' should be treated (i.e. by identifying the higher risk offender), while dynamic measures determine 'what' should be treated (i.e. by identifying the criminogenic needs to be targeted) and the responsivity principle can be viewed as determining 'how' to deliver that treatment (i.e. by targeting the individual's unique characteristics) (Lofthouse et al., 2018).

People with learning disabilities and autistic people said:

- // It is important to get a balance. We've all done stuff in the past but it's also about how we are now, and in the future. We should understand our risks.**
- // Make sure risk assessments are up to date. We should review them with support staff.**

Structured professional (clinical) judgement instruments

The structured professional judgement approach covers both static and dynamic factors and attempts to bridge the gap between unstructured clinical judgement and actuarial approaches (Hart et al., 2017). Widely used in general offender populations and in the field of offenders with mental health problems, they are also relevant in people with learning disabilities and autistic people and offending behaviours.

Structured professional (clinical) judgement instruments: HCR 20

As already mentioned, the HCR-20 is a structured clinical guide which looks at the risk of future violence. It contains extensive guidelines for the evaluation of not only the presence of 10 historical, 5 clinical and 5 risk management variables, but also their relevance to the patient being assessed. It also helps to construct meaningful formulations of violence risk, future risk scenarios, appropriate risk management plans, and information to help with the communication of risk. It can contribute heavily to an overall psychological formulation and directly inform treatment.

While the predictive validity and utility of the historical subscale in people with learning disabilities and offending behaviour has been described earlier in this chapter, the instrument as a whole also has similar predictive validity (O'Shea et al., 2015) and also offers a case for early interventions (Chester et al., 2019). The use of this instrument may need the involvement of professionals within the community learning disability or forensic teams, and training in applying the HCR-20 is needed. Further details are available on <http://hcr-20.com>

Structured professional (clinical) judgement instruments: START

The Short-Term Assessment of Risk and Treatability (START) is a structured professional judgment scheme made up of 20 dynamic items relevant to treatment and risk management (Webster et al., 2006). Each item is rated as both a vulnerability and a strength on a three-point Likert scale from 0 to 2, to yield an overall risk estimate for violence to others, suicide, self-harm, self-neglect, unauthorized absence, substance use, risk of being victimized and general offending. While it appears to have face validity, data on its predictive validity with people who have learning disabilities and autistic people and offending behaviour has not been published to date. The use of this instrument may need the involvement of professionals within the community learning disability or forensic teams, and training is needed for conducting the START. Further details are available on <http://www.bcmhsus.ca/health-professionals/clinical-professional-resources/risk-assessment-start-manuals>.

Structured professional (clinical) judgement instruments: CuRV

The Current Risk of Violence (CuRV) (Lofthouse et al., 2013b) is a 34-item instrument which requires a yes/no response to each question. It can be completed in about 10 minutes by a staff informant who knows the patient. No specialist training is required. Initial evaluation suggests good predictive accuracy for aggression in adults with learning disability and offending behaviour (Lofthouse et al., 2013a). Further information can be found here: https://livrepository.liverpool.ac.uk/3004221/1/201002687_Oct2016.pdf

Structured professional (clinical) judgement instruments: ARMIDIO-S

The Assessment of Risk and Manageability for Individuals with Developmental and Intellectual limitations who Offend Sexually (ARMIDIO-S) (Boer et al., 2004) is a 30-item tool that covers four categories of risk factors: stable dynamic (staff and environment), acute dynamic (staff and environment), stable dynamic (offenders) and acute dynamic (offenders). It also has a protective scale which mirrors the risk scale and examines how each item could be a protection against future incidents. Initial data suggests good predictive accuracy for offenders with learning disability (Blacker et al., 2010, Lofthouse et al., 2013b). The use of this instrument may need the involvement of professionals within the community learning disability or forensic teams. Further details are available on <http://www.armidilo.net/> and training is recommended. The ARMIDIO-S is a helpful risk appraisal tool that will provide a wealth of information to inform the development of a psychological formulation and subsequent treatment plan.

Key points

- (a) The approach to the risk assessment of violence (or other offences) in psychiatric or mental health settings has been well summarised elsewhere as a cycle of: assessing risk, drawing up a risk management plan, communicating that plan to all concerned, ensuring that the plan is carried out, evaluating the outcome of the plan, undertaking a clinical review, and then reassessing the risk (RCPsych, 2016).
- (b) The following dynamic factors contribute to the risk of committing crimes and a community forensic learning disability and/or autistic people teams should be skilled at assessing these risks and developing effective risk mitigation plans:
 - a. unstable accommodation
 - b. lack of employment
 - c. no positive recreation activities
 - d. poor personal relationships
 - e. alcohol misuse
 - f. drug misuse
 - g. impulsivity and poor emotional control
 - h. anti-social peers
 - i. attitudes that support crime
- (c) There are a range of structured professional judgement risk assessment tools that can be used with those with learning disabilities who may be at risk of coming into contact with criminal justice agencies.

Implications for practice

1. Community forensic learning disabilities and autistic people teams should have expertise in actuarial risk assessment tools. Teams may need to develop their skills within this area through additional training and ensure they have systems to allow for ongoing supervision with those who are experienced in completing risk assessments.
2. This also includes expertise in structured professional judgement, and teams may need to develop their skills through the provision of additional training and supervision from experienced clinicians.
3. Clinicians working within community forensic learning disabilities and autistic people teams should use risk assessment tools to contribute to the development of psychological formulations which will help inform resource allocation and treatment needs, directly informing the range of interventions that should be used to mitigate risk with individuals.

Chapter 4:

Managing forensic risk across multi agency teams

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Aims

1. To explore the strengths, challenges, and barriers to managing and sharing forensic risk to meet the needs of individuals with learning disabilities and autistic people who are at risk of coming into contact with criminal justice agencies.
2. To consider the ways in which teams can work collaboratively to manage this risk.
3. To develop practical strategies to manage risk across different agencies.

Introduction

The NHS Transforming Care agenda (Department of Health, 2012) set out plans to reduce the number of inpatient beds for people with learning disabilities and autistic people and increase provision of community services. A small minority of those individuals with learning disabilities and autistic people present an increased level of risk to others (e.g., through violence, absconding, arson & sexual violence) and/or themselves (self-harm, suicide). This population has a particular set of characteristics. Individuals who are more likely to engage in offending behaviours leading to criminal conviction or detention under the Mental Health Act, 2007, are likely to be within the mild/borderline range of cognitive functioning, and to experience high levels of psychiatric comorbidity and to attract a diagnosis of personality disorder (Taylor et al., 2017). With the introduction of the Transforming Care Agenda, the likelihood is of more individuals who present an on-going risk of offending living in the community, so that the assessment and management of risk in this population is of greater relevance (Chester et al., 2017). Consequentially, this has meant that many community learning disabilities teams now have an increasing shared multi-agency responsibility for the assessment and management of forensic risk amongst people with learning disabilities and autistic people. This chapter will focus on effective multi-agency working and information sharing focusing on the 'core business' of risk assessment and management.

Multiagency working with individuals with learning disabilities and autistic people at risk of offending

Within England and Wales, individuals (those with learning disabilities and autistic people and without) at risk of causing harm to others through sexual and violent offending are managed by 'Public Protection Panels' (PPOs) or 'risk management' partnerships. The introduction of the Sexual Offenders Act, 1997

brought additional requirements for those individuals convicted of sexual offences. Under this Act, risk management partnerships may apply to the court for a 'Sexual Harm Prevention Order' (SHPO) to impose restrictions on the movements of those who engage in harmful sexual behaviours. The Criminal Justice Act, 2003 introduced the establishment of MAPPA (Multi Agency Public Protection Arrangements) to ensure successful management of violent and sexual offenders. Local criminal justice agencies and agencies dealing with offenders are supposed to work together in partnership to ensure the risk posed by the individual is appropriately assessed and managed. For offenders with learning disabilities and autistic people, other relevant agencies are likely to include Adult Social Care, the Police Service, Probation, Management of Sexual or Violent Offenders (MOSOVO), Mental Health Teams, Forensic Outreach Teams and Housing Agencies. See Figure 1 for an example of the potential multiagencies involved with managing the risk of an individual with learning disabilities and autistic people at the point of discharge from inpatient to community services.

Other key functions of the collaborations are the setting up of multiagency public protection panels to review individuals, development of protocols regarding the exchange of confidential information, maintenance of a database of offenders, classification of offenders into risk groups and developing, monitoring and implementing risk management plans (Kemshall & Maguire, 2001).

The role of clinicians working with individuals with learning disabilities and autistic people at risk of offending is an increasingly specialised one (Hutchinson, Lovell, & Mason, 2012). Within secure hospitals, the clinical team is multi-disciplinary, typically comprising of professionals from psychiatry, nursing, social work, psychology, occupational therapy, and speech and language therapy. Members of the multi-disciplinary team (MDT) bring together diverse skills, perspectives and expertise (Kozłowski & Ilgen, 2006). Professionals typically meet frequently (e.g. weekly or fortnightly) to discuss the individual's care and treatment. Alongside clinical needs, risk assessment and management are a fundamental component of the MDT's role and responsibilities, whether within the community or inpatient services (DoH, 2012).

Interpersonal relationships amongst the MDT members, with the individual, and with the individual's family are central to being able to safely and effectively manage and reduce the individual's risk. Within the MDT, effective team working relies on the development and maintenance of trusting relationships, appreciation of members unique skill set, mutual emotional support, particularly when dealing with complex and distressing clinical work. Perhaps a particular strength of an MDT working with people with learning disabilities and autistic people is that core principles, attitudes and approaches to understanding the individual are underpinned by values based movements such as Social Role Valorisation (Wolfensburger 1983), Person Centred Planning, (O'Brien & O'Brien, 2002), Self-Determination (Wehmeyer, Kelchner, & Richards, 1996) and positive behavioural support.

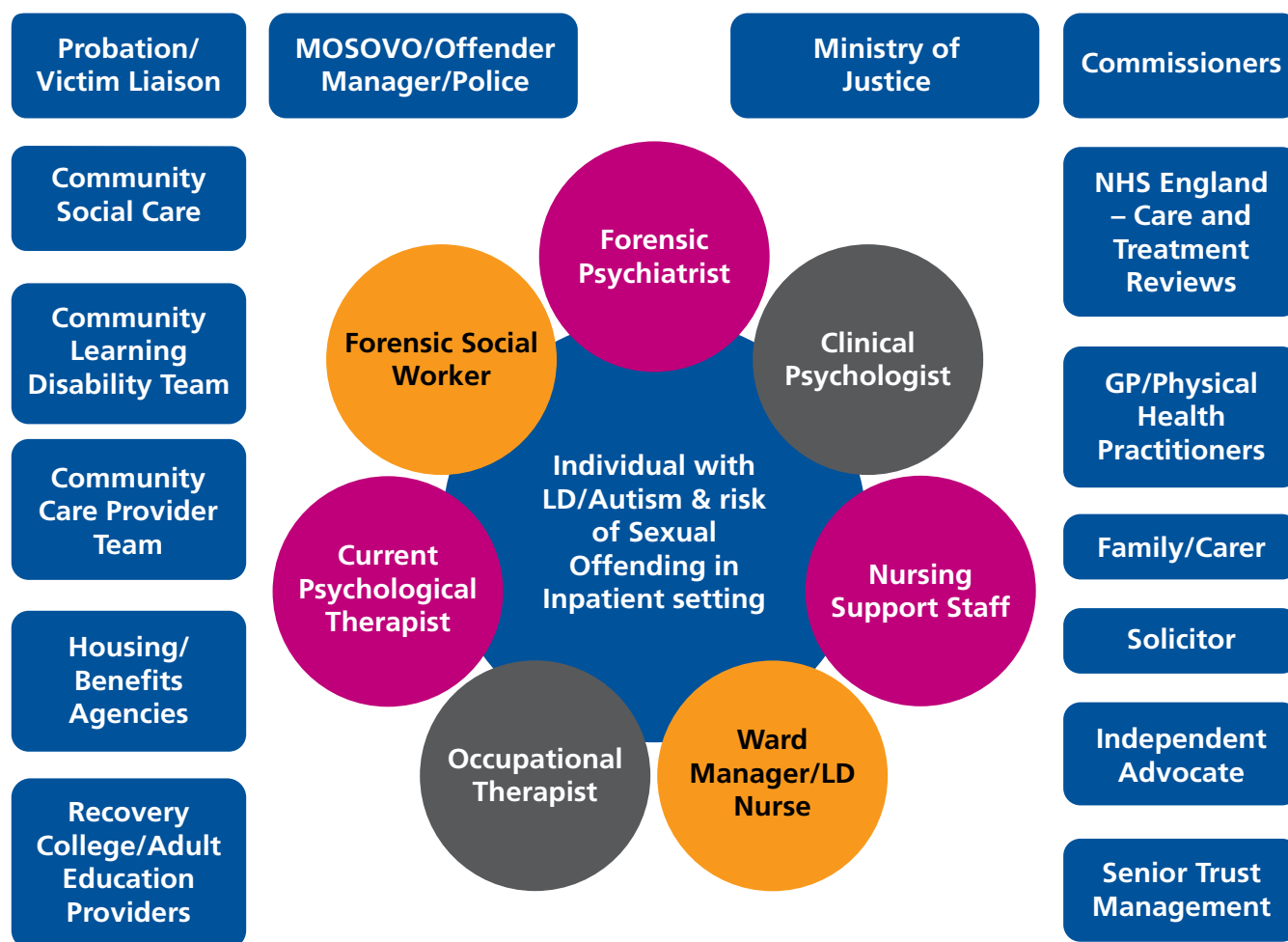
Multiagency working is perhaps most pertinent at the pre- and post-discharge stage of the care pathway. Therefore, relationships between the inpatient MDT and relevant external agencies should commence whilst the individual is in hospital (or prison) to avoid lengthy admissions and to ensure timely and effective transitions to the community. In the absence of clear guidance regarding the approach to organising the discharge process, Taylor and colleagues (2017) developed a discharge pathway protocol for inpatient learning disabilities teams with the aim of ensuring effective and safe discharge preparation and planning.

Successful discharge planning also involves multiagency collaboration following discharge. Research indicates that some individuals detained in secure hospitals have who have received treatment for their offending behaviours, will still have enduring support needs following discharge (Chester et al., 2017). To prevent readmission and ensure the continuity of the placement, the clinical team should continue to offer direct support and advice to the receiving team and relevant agencies in addition to consultation and support for the individual (Taylor, et al., 2017).

Key points

1. Forensic risk assessment and management is a multiagency responsibility.
2. A variety of health, social care and criminal justice agencies need to collaborate effectively to mitigate risk.
3. The establishment and maintenance of excellent collaborative working is a necessary and important ingredient of effective risk mitigation.
4. Community teams are comprised of skilled practitioners who are experienced with working from care models directly informed by value-based movements, that are person-centred. They are used to working with complexity, and many of these skills are likely to be beneficial when attempting to mitigate forensic risk.

Figure 1. Example of potential multiagencies involved with managing the risk of an individual with learning disabilities and autistic people and a history of sexual offending.



People with learning disabilities and autistic people said:

// Things like MAPPA help you because they share risk and help you not to slip up again.

Identifying forensic risk

When assessing and managing risk, it is important to achieve a balance between the needs of the individual and the needs of the community. For the individual, the focus is on upholding their civil liberties and delivering effective care and treatment; for the community, the focus is on minimising risk to others. Best practice in managing risk involves making decisions based on the research evidence base (e.g., risk assessment), knowledge of the individual, and clinical judgement (DoH, 2009). For some agencies involved with the individual, face to face contact may be minimal making it difficult to build a relationship. Holding multiagency workshops to share the MDT formulation of the individual, and to discuss risk management needs, is useful to prepare the service user for discharge and the receiving community service (Taylor et al., 2017).

A systematic approach to assessment, formulation, and management of the risk that an individual presents to others, are key features of current practice within forensic services. The way community teams assess and manage risk presented by individuals with learning disabilities and autistic people transferring from secure to community services is largely unknown (Chester et al., 2017). Compared to the general offender literature, the evidence base for empirically based risk assessment and management measures for individuals with learning disabilities has been slower to evolve. A recent meta-analysis looking at physical aggression (Lofthouse et al., 2017) concluded that actuarial, structured professional judgement and dynamic risk measures are able to predict aggression better than chance in this population. Similarly, with regards to sexual offending, meta-analytic (Pouls & Jeandarme, 2015) findings indicated that dynamic risk assessment instruments add additional predictive value to static risk assessment and are useful for guiding treatment approaches and levels. Risk assessments are typically completed by the individual's MDT, drawing upon the different professionals' knowledge of the individual. For a comprehensive assessment, supportive information should be gathered from the family members or significant others, from the individual, and using official and historical sources of information. These may include Police National Computer records of criminal offences, social services records, and incident data from current and previous placements.

Key points

1. Community teams are skilled at using a systematic approach to assessment, formulation, and management and can work with complexity (e.g. physical or mental health problems).
2. Community teams have a role to play in carrying out comprehensive forensic risk assessments that are used to inform the development of a multi-disciplinary formulation which directly informs treatment, or in other words, risk mitigation strategies.

Managing Forensic risk

Risk management plans should include a summary of all identified relevant risk factors and a formulation of the situations in which risk may occur and actions need to be taken by practitioners and the individual (DoH, 2009). Whilst this overarching guidance suggests that the route to assessment should be relatively straightforward, the practice can be very different, with different agencies taking a wholly different perspective on and approach to risk management. Effective risk management requires clear and honest communication regarding the expectations of each agency, what they are intending to do and what they are expecting other agencies to be responsible for. This is especially true for the receiving services in the community following discharge from hospital or release from prison, as the service user will usually not have a focused team working with them and so the risk becomes more dispersed and care services harder to link up. The risk management strategies and care plans developed by the inpatient MDT offer a framework to guide the development of community risk management plans (Taylor et al., 2017). Taylor and colleagues propose that in order to facilitate a smooth transition to the community and minimise potential delays, a multi-agency workshop should be held to discuss adapting the care plans. This should be consolidated with a report outlining the discussion and the proposed community risk management plan. For those individuals who have no history of admission to secure hospitals, or prison, community-based services within the context of multi-agency working need to take responsibility for both the assessment and management of forensic risk. This should be the development of a community risk management plan.

Alongside the management and reduction of individual's difficulties and risk factors, risk management and discharge planning should also consider how to move the service user toward a better life that promotes desistance from offending (strength based). The Good Lives Model (GLM; Ward & Gannon, 2006; Ward et al., 2007) is an overarching theoretical framework for managing risk focusing on the individual's strengths and actively engaging the individual in their rehabilitation (Willis & Ward, 2013). The GLM focuses on helping the individual focus on their core commitments and capabilities to develop and implement a meaningful

life plan that is incompatible with future offending. In essence, it lowers or eliminates risk factors by filling the service user's life with greater meaning and fulfilled needs, so that there is no reason to offend and therefore is considered a strength based approach to risk reduction.

This occurs through a focus upon enabling service users to replace risky behaviours and associated factors with alternative ways of achieving basic human needs that are socially acceptable and rewarding. The model is based upon the idea that we need to build capabilities and strengths amongst people to reduce their recidivism risk. The framework that is the GLM suggests that offending behaviours are associated with an attempt to secure some kind of valued outcome within life, and often offending behaviours are essentially the product of a desire for something that is inherently human. However, difficulties prevent someone from achieving their desired goals in a sustainable manner, and therefore, they resort to inappropriate or damaging methods. The GLM offers a balance between risk management and meeting fundamental human needs; risk management and reduction requires that consideration be given to how someone can meet their fundamental human needs in a socially acceptable and desired manner. Further information about how the Good Lives Model is used with people with learning disabilities and autistic people within one Community Forensic Team in England is detailed within the box below.

Using the Good Lives Model with people with learning disabilities within the Birmingham Community Forensic Team

The Good Lives Model (GLM) is integral to the structure of the Community Forensic Team (CFT) within Birmingham Community Learning Disability Service. It is a working framework that affects the day to day lives of our services users and is not simply a document stored in our files. The GLM is implemented by the team in conjunction with the service user and their carers. The Multidisciplinary Team (MDT) meet to receive feedback from the interdisciplinary initial assessment which is completed by two professionals within the team. After this feedback, a formulation is constructed which incorporates the presenting issues, and the predisposing, precipitating, perpetuating, and protective factors (the 5Ps). This 5P's formulation is drawn up by the MDT and care plans are agreed to ensure the holistic needs identified in formulation are addressed.

The GLM is embedded into person centred care by completing a pre-CPA meeting questionnaire with the service user to ask what is important to them, what they can do to meet their wants and desires, and how the CFT can support that. The service user is supported to chair their own CPA meeting, and their questionnaire can be used to as a prompt to help them say what they planned in their pre-CPA meeting, while the team can contribute with suggestions about how they can meet their needs pro-socially. The GLM then becomes a genuine reality and results in a plan of activities that the service user has identified to meet their needs. The Birmingham CFT have found, in the eight years that they have used the GLM, that service users who have a full life of rewarding activities and a balanced lifestyle have more pride in themselves and reason to work hard to stay out of hospital or prison. Voluntary work and supporting steps towards paid employment have proven to be an essential element of developing their self-esteem and feeling they have something to offer to both themselves and their communities.

Each week the CFT meets to discuss key service users, review the case, formulation and care plans which are then updated as we learn more about the service user, their needs and the potential motive behind any offending or offence paralleling behaviours. This is a strength of the GLM and when the team can further plan how to enable the service user to meet their needs/desires without the use of antisocial or illegal means.

The role of the occupational therapist is crucial at this point to secure the meaningful activity identified through the GLM process into a balanced lifestyle plan for each service user. The risk assessments that are required to ensure each activity is completed as safely as possible for the service user and the wider community are vitally important at this stage of the intervention. The balance between public safety and meeting service users' needs are discussed and carefully considered. Positive risk taking is essential when effectively managing risky individuals in the community, but the weight of this responsibility must be respected and given the necessary time and thought. The weight of this responsibility within the Birmingham CFT is not left with the Responsible Clinician; the risks are discussed as a team and held as a team. This shared responsibility helps to strengthen the bond within the team and contributes to close working relationships.

Continues over...

The risk assessments for activity often indicates there needs to be some form of disclosure of risk information to hosts of the identified activity or others involved in the lives of service users. It is our responsibility as clinicians to ensure that people with learning disabilities make a fully informed decision about disclosures. The disclosures need to be carefully thought through as they need to be proportionate to the risk and made to the right people. Telling others of their offences or risks forms an important part of the service user accepting responsibility for their offence and acceptance of how their life has been shaped because of that. Being supported to make appropriate disclosures to the right people can help our service users to form a solid, and very importantly, an honest foundation for their future relationships both personal and professional. The Birmingham CFT has attended additional training around disclosure to ensure they are fully equipped to manage this responsibility well. As a result of this training and the realisation of the complexity of this topic, a flexible modular course has been developed by the team to run with service users to breakdown disclosure to partners, colleagues, activity hosts, and others. This enables them to consider the benefits and drawbacks of disclosure and ensures they really are making an informed decision to share information. Crucially this is when we can also talk about when not to disclose risk or offence information. For example, prior to the introduction of this modular course, a service user had made the informed decision to disclose aspects of his risk to his voluntary work manager, but he then disclosed the same information to colleagues. Unfortunately, both he and his support staff had to leave this placement for their own safety and were unable to return.

Occupational therapists have a clear role with setting up courses, placements and activities that are vital as they need to be pitched at the right skill level for the service user. If someone with learning disabilities are put into a situation that places excessive demands this may provoke stress and quickly become unhelpful for an individual who is trying to change/manage their behaviour.

If someone with a learning disability or an autistic person is coming out of hospital or prison, after a long time away from community living, another important role for the occupational therapist within a CFT is liaison with the inpatient MDT to ensure assessment of community living skills is completed prior to discharge/release. These may be skills such as using public transport, crossing roads safely, menu planning, or any number of other activities of daily living. If these activities are causing stress for the service user, this is unhelpful in supporting them to manage their risks. Once these skills assessments are completed, the right package of care can be organised to ensure any additional stress is avoided and the service user can focus their efforts on their risk management and leading a good life.

When they are back in the community the service user is supported by occupational therapy to optimise their independent living skills as this can lead to a reduced reliance on carers and help ensure that care is the least restrictive. An area that regularly demands a lot of occupational therapy input for service users within the Birmingham CFT is helping people with learning disabilities to regain their financial independence. Returning to the community, and immediately handling all your own financial affairs independently has often proved unrealistic. Ensuring a full history of the previous support received is helpful, but not always possible, so the use of a supported, staged, and graded approach to regaining financial responsibilities is important. Assessments can help determine when ongoing support is required to help minimise future debts, problems, and stress for our service users.

In summary the Birmingham CFT have found the GLM and the full MDT approach vital in successfully supporting our complex service user group through the criminal justice system and into the least restrictive and sustainable community packages.

Key points

1. Different organisations may focus upon risk assessment and management differently, and these differing perspectives need to be brought together effectively.
2. When developing a risk management plan, there should be clear and honest communication regarding the expectations of each agency, what they are intending to do and who is responsible for what.
3. Teams need to develop a community risk management plan which also considers positive attributes that mitigate risk. This should also include trying to fill a person's life with greater meaning and fulfilled needs, so that there is no reason to offend. Work should be nested within the Good Lives Model.

“Most agencies will talk about risk, but it means very different things within each agency... this can cause confusion and frustration. Have the conversation about why someone is high risk or whatever and what that means within the context of the assessment and decisions being made.”

– National Probation Service

Challenges and barriers to multi-agency working

Partnership working across agencies

One of the most apparent obstacles in achieving collaborative multi agency work is the fact that different organisations work independently and have competing organisational interests and goals (Noga et al., 2016). Criminal Justice and Health Services differ in whether they centralise the needs of the community or the needs of the service user, and this difference can cause confusion and frustration when the different agencies are unable to understand why they are working at cross-purposes. These challenges bring us to considering what barriers might be in place to effective multi-agency working.

In general, I greatly value multi-agency working as it enables you to see things from a more holistic perspective and gives you more insight at the same time—but there are times when you request reports, ie. social history regarding a patient's background, and you need to go around the houses to get any progression...

– Social Worker

Communication, communication, more communication

Across every agency, discipline, and team, when asked what the greatest challenge or barrier is to work to assess and manage risk across multiple agencies, the answer is consistently: Communication.

Data Protection rules and regulations, particularly following the changes in line with General Data Protection Regulation (GDPR), can cause many teams to 'err on the side of caution' by not sharing information. Although this may leave that particular team feeling more protected in relationship to confidentiality, it can leave other agencies frustrated and without the information that they need in order to create the appropriate risk assessment and to manage on-going risk.

Open and regular communication is necessary between the staff / different disciplines working directly with the individual. Clear and informative clinical note keeping is essential as are regular opportunities to reflect on risk as an MDT. Immediate behavioural risks presented by an individual within their current environment are generally recorded and shared within a team (incidents recorded, monitored, and discussed within clinical meetings). However, more subtle indicators of risk escalation or the underlying factors and triggers can be missed depending on the observers' knowledge of the potential risk, their personal interpretation of events, and how positive their relationship is with the service user and within the wider team and across agencies.

Recommendations for effective multi agency working

Specialist partnerships between health, social care and criminal justice with supportive policies and structures.

A planned, coordinated and well-managed approach to discharge is associated with timely, successful discharge to community placements for individuals with learning disabilities with low rates of readmission (Taylor, et al., 2017). When multi-agency working is effective, there is clarity of purpose, joined-up thinking, and a structure in place so that everyone involved in the case knows who is doing what and why. However, it is only possible to have effective joint working when supportive policies and structures have been put into place as early as possible, and such an approach is likely to reduce the probability of a custodial sentence, or admission to hospital. This requires each agency to understand their remit with regards to an individual, have a mutual understanding of the work that the other agencies will be completing, and a structure to enable any challenges to be quickly identified and resolved.

Where possible, relationships should be developed across the agencies, so that when challenges arise, it is easier to communicate that openly and honestly, with an expectation that each team will be willing to work with the other. Although email and web chats are identified as a way to move quickly and effectively with day-to-day operations, it was also recommended that this follows the initial meetings and relationship-building that can only really be done in person or over the telephone/video conferencing.

“Emails are convenient, but not as effective...at least until a relationship has been established. Talk to other agencies and wherever feasible, meet with other professionals – it makes a huge difference to the information you receive and the shared understanding”
– Intensive Integrated Risk Management Service

The effective care and treatment of an individual can only come from a multi-agency team that has common goals and adopts a holistic perspective of the needs of an individual and creates a person-centred plan. For this to be successful, it requires that there be an effectively communicated risk assessment, formulation, and management plan across all teams. It is not possible for one team to carry out a risk assessment as a stand-alone exercise and hold that information for itself, whilst looking for effective multiagency working. Instead, it is necessary for the teams to clearly communicate together what information they are holding, how this information needs to come together for a full risk assessment, and then consideration needs to be given to how the teams will work together going forward to effectively manage risk. Following discharge from secure services or prison, for example, it is important to have continuity of representation from the sending team to the receiving team, so that their knowledge of the service user is utilised, care and risk management plans are adhered to, or adapted in light of the individual's response to the new environment.

An additional challenge to risk assessments that are completed and held by one agency acting alone is that risk is a dynamic enterprise, and it changes across time and circumstances. Therefore, risk assessments need to be flexible and receptive to change. This can only be done if there are already clear protocols in place for communicating change and adapting working strategies. Inaccessibility of risk assessments and management plans can also hinder the effective sharing of risk. Unnecessarily lengthy reports and different agencies duplicating or using risk assessments developed within their own services (often with unknown validity and reliability) hinders the ability to accurately describe and communicate risk amongst agencies. Worst still, copying and pasting from other agencies' reports often means that the focus is on historical risk, not current risk, and may repeat inaccurate information. This ultimately fails to acknowledge the progress the individual may have made in their treatment and care, and the dynamic nature of risk, which will be detrimental to the progress they make when transitioning into the community. This underscores the importance of a dynamic multiagency formulation which allows for contemporaneous risk assessment and adaptation as the individual progresses through their care pathway.

Positive risk taking

For an individual to make progress in their care and treatment, it is necessary to consider how to move towards a positive risk management strategy that recognises and builds upon the individual's strengths and protective factors. Where one team is holding (or perceives that they are holding) all the risk related to an individual, there can be a real fear associated with taking any form of positive risk. Therefore, joined up working can help to ensure that an individual is given the opportunity to progress and develop, by dispersing responsibility and accountability for risk across teams. Where carefully constructed, positive risk management plans are created, in collaboration, a service user can have a far greater opportunity to build upon the skills and techniques that they are picking up from each team's work.

Key points

1. Effective risk assessment and management only happens when different agencies communicate with each other, adopting shared goals for individuals.
2. Risk assessments should be holistic, multi-professional and multi-agency where possible.
3. Teams need to ensure that risk assessment and management plans are readily accessible to those who need to make use of them.
4. Working collaboratively with other agencies helps to ensure that risk assessment and management is shared.
5. Teams need to engage in positive risk management that recognises and builds upon the individual's strengths and protective factors.

Risk management plans: dynamic risk factors relevant to individuals with learning disabilities and autistic people

To achieve the best possible outcome for individuals with learning disabilities and autistic people, it is essential that agencies understand, manage and communicate knowledge about risk factors that are known to increase the likelihood of the individual reoffending. Research about people with learning disabilities and autistic people stipulates that supervision, consistency in staff and routine, and environment are prominent dynamic risk factors for individuals that need to be included in risk management plans (Boer et al., 2004). Supervision, both within a team and straddling across different disciplines, can be an effective tool to ensure that there is a delegation of responsibilities and that the risk is being managed safely. Awareness that the individual is being monitored should help to limit access to potential victims (Boer et al., 2004).

Supervision by familiar staff, who know the individual, means they are more likely to be sensitive to and recognise important, often subtle, change in the individual's presentation. Changes may occur in emotional state, behavioural stability, or mental health, that highlight the need for an adapted risk management strategy to be implemented (Boer et al., 2004). Changes may be relatively obvious, such as changes to lifestyle or behaviour, which may indicate an attempt to access victims. For example, taking a different route to the shops, via a school, may indicate an increase in risk-taking behaviour for individuals with a sexual offending past. Such changes should not be ignored but should be challenged with the individual concerned and incorporated into the risk management plan.

People with learning disabilities and autistic people said:

- // Families and supporters should know about our risks. We should help choose who gets to know. The people who work with us need to know, and some jobs need to know about our risks, but it still needs to be confidential.**
- // Make sure our support staff know our risks. They can help us not to slip up, but they need to know about it first.**
- // Most of the responsibility for keeping me safe comes from me.**

Boer and colleagues (2004) reported that individuals with learning disabilities and autistic people become accustomed to a particular style of supervision and therefore changes in staff approach, staff turnover and new staff members can increase the risk the individual presents. What this means for multiagency working can be both a challenge and an opportunity. Although an individual may have a strong preference for one particular supervisor, agency, or type of working, having a clear joining up of agencies can allow for this preference to become a management style wherein all professionals who are working with an individual can be seen as a network of support who understand a person's preferences. Research indicates that poor social support, inadequate accommodation, and absence of employment combined increase the likelihood of the individual's community placement breaking down, and reoffending occurring (Lindsay, Hayes & Taylor, 2018).

Key points

1. There are specific dynamic risk factors that need to be considered when working with people with learning disabilities and autistic people. These include the important and valuable role of paid and unpaid carer support, including health and social care staff.
2. Those who work most closely with someone are often best placed to recognise the subtle changes which suggest that risk is changing. It is important that they are part of the assessment of risk and the development of a risk management plan.
3. Social factors, including poor accommodation, lack of meaningful activity, loneliness/isolation and social support are important factors to mitigate risk.

Conclusion

The goal for agencies involved with individuals with learning disabilities and autistic people, and offending histories, is for that individual to lead a meaningful, fulfilled life in the community following discharge from hospital and to reduce the probability of custodial prison sentences or re-admission to hospital. For this to stand the best chance of being a reality, all agencies involved must have a clear understanding of the individual's needs and risk. Communication between agencies must be open and transparent, with clear protocols and goals. Buy-in and support from all stakeholders is essential to successfully managing risk, ensuring treatment adherence and preventing re-admission. Stakeholders include the individual and their significant others, the advocate, the in-patient MDT, the receiving community service, commissioners, and social care (Taylor et al. 2017). Finally, resources in the community must be available to meet the individual's needs/risk profile and these must be deployed in sufficient measure to the client.

Implications for practice

1. When completing risk assessments, working with other agencies and professionals, and collaborative working, is vital.
2. Community forensic learning disabilities and autistic people teams should be able to carry out comprehensive forensic risk assessments, develop psychological formulations, and risk mitigation strategies.
3. Teams will need to work to help people with learning disabilities and autistic people to fill their lives with greater meaning. This involves working in such a way that you are building upon strengths and protective factors.
4. Remember and make use of the important role of paid and unpaid carer support, social factors, including accommodation, and access to meaningful activity, as they all help to mitigate risk.

Chapter 5:

Working with autistic people who are at risk of committing crimes

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Aims

1. To consider how autistic people are vulnerable within the criminal justice system.
2. To identify and discuss ways that autistic people can be more effectively supported within the criminal justice system.
3. To provide a brief overview of some of the interventions and associated sources of support that are available for autistic people who have a history of criminal offending.

Introduction

Autism is a lifelong developmental disorder associated with difficulties or differences in communication, social interaction and restricted or repetitive patterns of behaviour (Figure 1). Difficulties in communication can range from being completely non-verbal to having a literal understanding of language, leading to trouble with 'small talk', flirting or certain types of humour such as sarcasm. Autistic people may also use idiosyncratic speech e.g. saying 'he' instead of 'I', or 'they' instead of 'we', and they may have atypical eye contact. These difficulties may cause challenges when navigating different contexts and social situations, and leave them vulnerable to teasing, manipulation, rejection, coercion, or harassment as well as appearing 'odd', 'aloof' or lacking in social reciprocity in some contexts.

Repetitive and restrictive patterns of behaviour can take the form of overt actions such as routines and rituals, stereotypies, including repetitive motor behaviours, or thought patterns, and again may create difficulties in social interaction. For example, if an individual is focused upon their own topic of interest, they may appear 'rigid' in their point of view, or inflexible regarding their needs or demands, and insensitive to the needs of others. Sensory sensitivities are also seen in autistic people and can present as a sensation seeking or avoidance of certain sensations. Such behaviour may serve a soothing function, for example, repeated touching of certain materials or surfaces, or may be indicative of oversensitivity and need for escape, for example, aversion to loud noises, or strong smells etc.

Autism can occur with and without learning disabilities (Bryson et al., 2008), and frequently co-occurs with anxiety, depression, obsessive compulsive disorder, and psychosis (Lundström et al., 2015). Other neurodevelopmental disabilities may also frequently co-occur with autism, such as attention deficit hyperactivity disorder (ADHD) (Goldstein & Schwebach, 2004), and dyspraxia (Cassidy et al. 2016), while there is also evidence for an increased prevalence of epilepsy (Lukmanji et al. 2019) amongst autistic people.

Autism and criminal offending behaviour

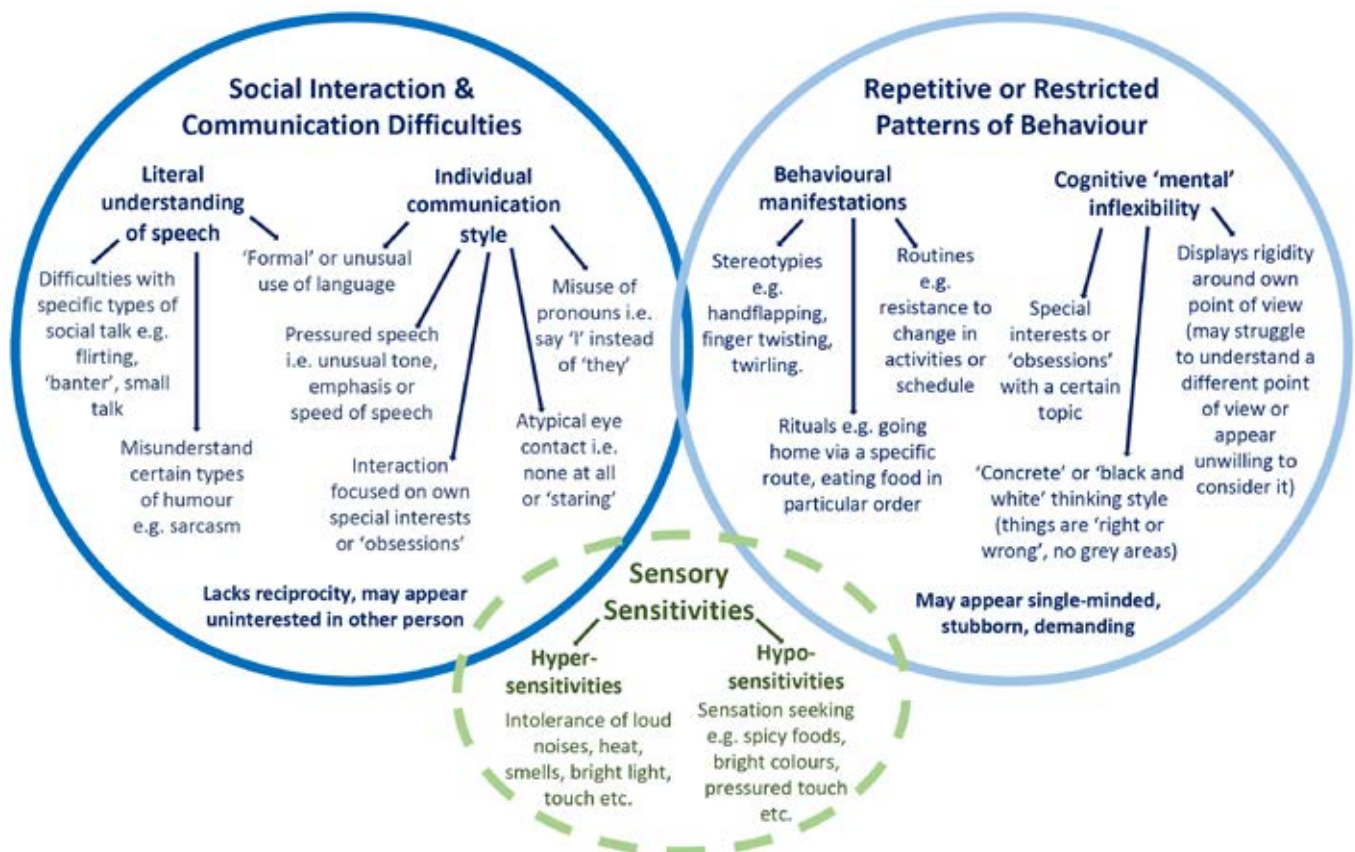
There is evidence from careful research with proper samples to indicate that autistic people are less likely, or at least no more likely, to break the law than anyone else (King & Murphy, 2014; Hippler et al., 2010). Nevertheless, a small percentage of autistic people do commit crimes, including various types of crimes, such as theft, arson, violence, vandalism, sexual offences, firearms offences, terrorism, manslaughter, and murder (Faccini & Allely, 2019; Melvin et al., 2017).

However, autistic people can present with some characteristics that may increase the risk of criminal offending (Figure 2). For example, these may include increasing frustration because of sensory sensitivities, distress at changes in routine, or difficulties with communication. These may lead some autistic people to display aggression directed at property or other people. It has been suggested that autistic people may also commit a disproportionate number of certain types of crimes, such as sexual offences or arson (Kohn et al. 1998; Siponmaa et al., 2001), some of which may be related to circumscribed interests, but this has not been confirmed (King & Murphy, 2014; Lindsay et al., 2014). Meanwhile, other autistic people appear to have a preference for rule-following, which, at least in theory, may reduce their risk of offending (Howlin, 2004). It may be that these two sets of characteristics (distress, sometimes with aggression, and a preference for rule-following) balance each other out across the autistic population, such that they do not commit more crimes than non-autistic people.

Autism co-occurring with learning disabilities can influence whether an individual is perceived as fully culpable and liable for punishment and/or rehabilitation within the criminal justice system. In some instances, autistic people may be diverted to community-based health and social care, through liaison and diversion services. The crime committed or behaviour displayed does not always predict the pathway an individual will take (Carson et al., 2010), however the comorbidity and associated severity of learning disabilities and/or mental health conditions are likely to result in diversion from criminal justice and could lead to detention under the Mental Health Act or community treatment, rather than a custodial sentence.

Case formulation and risk assessments will often play an important part in decisions by the Crown Prosecution, the Judge or Magistrate, and at Parole hearings, Mental Health Tribunals and Care Pathway Approach (CPA) meetings. As such, it is important to incorporate the potential impact of a diagnosis of autism when developing formulations. This includes appraising the utility of assessments or measures that have not been standardised or validated on autistic populations. For those with both learning disabilities and autism, a number of adapted assessments and measures are available (Richardson et al., 2016; Broxholme & Lindsay, 2003), with a handful, including a formulation framework, specifically considering autism (e.g. Shine & Cooper-Evans, 2016). However, due to the developing evidence base in this area, guidance regarding untested adaptations or novel tools should be followed alongside established methods and measures of risk assessment and formulation.

Figure 1: Autism



Key points

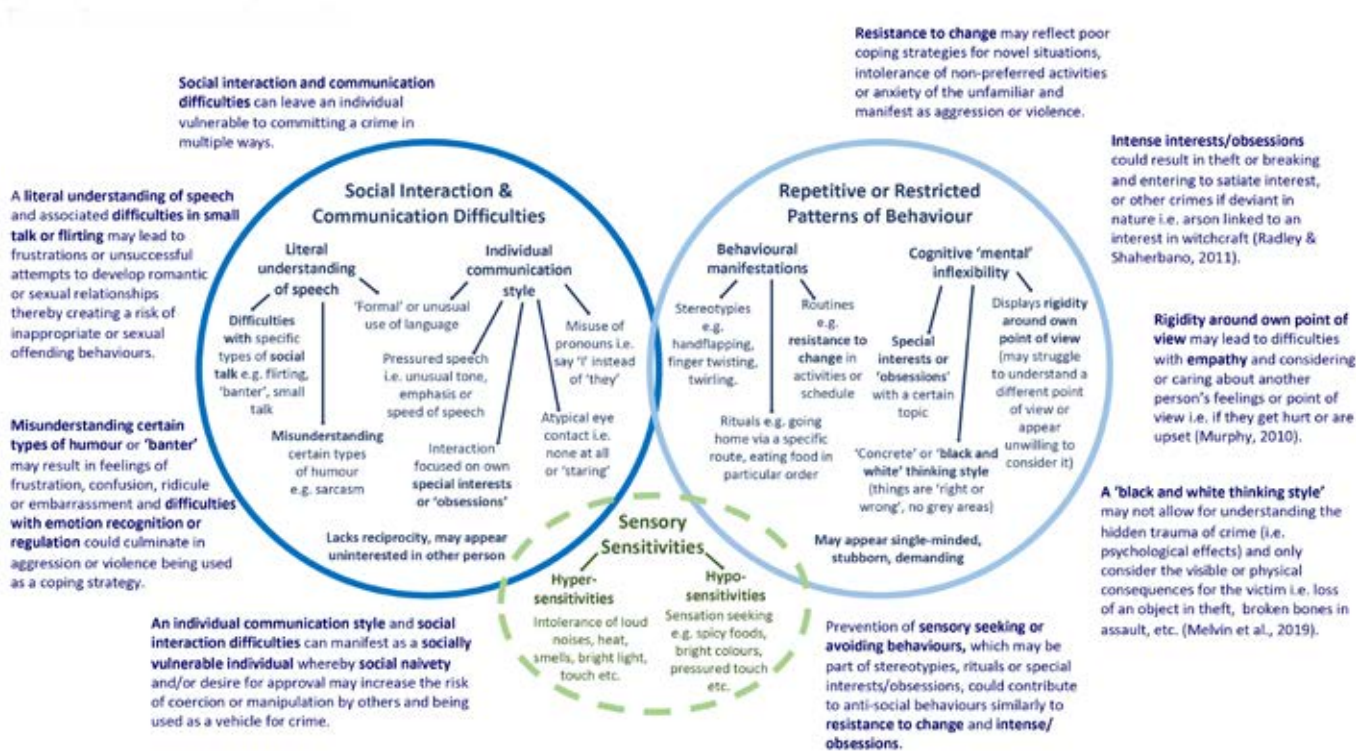
- Evidence suggests that autistic people are generally not over-represented on criminal justice registers.
- Autistic people are likely to be vulnerable if they do end up in the criminal justice system.
- Autistic people may present with some characteristics that increase the risk of criminal offending (e.g. sensory issues, rigid routines, communication difficulties).

Implications for practice

It may be helpful to consider the following questions when working within someone with autism who has encountered the criminal justice system, or may be at risk of coming into contact:

- (a) Is the person's crime related to their autism?
- (b) Does the behaviour fulfil a sensory need or a special interest?
- (c) Are they a victim? Have they been coerced or manipulated?
- (d) Was the crime related to poor management of negative emotions or distress i.e. anxiety, embarrassment, frustration, rejection?
- (e) Do they understand the social rules or the law? And what the consequences for themselves may be?
- (f) Do they understand the possible consequences for others?
- (g) Do they have the skills such as emotional regulation, including impulse control and a degree of emotional literacy to manage their behaviour?
- (h) Are they able to understand and express frustration or negative emotions without using aggression or violence?

Figure 2: Vulnerabilities that may increase the risk of engaging in behaviour that could be construed as criminal in some contexts.



Effective Support

Whether going through the courts or mental healthcare systems, several considerations need to be taken into account when responding to criminal behaviour displayed by a vulnerable individual with autism. These will apply across multiple situations from the point of arrest, police questioning, instructing solicitors and barristers, attending court, and giving evidence. Further, they also include issues liable to arise in meetings with health and social care professionals, as well as probation. A list of these vulnerabilities and possible solutions is found in Table 1. Some of these considerations are applicable to all vulnerable individuals whereas other are specific to autism.

Table 1: Supporting autistic people who display criminal behaviours

Challenges and suggestions for possible supports	
Ability to understand and process the situation	Clearly explain the situation and what happens next. Books Beyond Words may be helpful. Do they need an Advocate, Appropriate Adult or Registered Intermediary?
Atypical processing of information	May require visual support, smaller chunks of information, longer processing time. Adjust your communication to meet the needs of the individual.
Anxiety around new situations or people	Provide familiarisation with surroundings or new environment (e.g. visiting and/or providing pictures). Introduce or make aware of new people in advance. Can reasonable adjustments or 'special measures' be put in place for any official or legal proceedings? Make use of clear structures for meetings which you also follow. Consider providing information about each meeting in advance of the meeting taking place.
'Concrete' thinking style, literal interpretation of language	Use clear language and examples, refrain from using abstract or general terms, inclusive of metaphor.
Poor tolerance of uncertainty	Explain any processes, step-by-step. Include stages or events that may cause distress in order to be able to address them in advance i.e. if need to be put in handcuffs, searched or 'led' somewhere. Check for alternatives or, where possible, what would create least distress for the individual. As far as possible stick to the order discussed with the individual with autism.
Difficulties with emotion recognition and regulation	May require support/need to be offered opportunity to express emotions verbally i.e. if anxious or fearful, feels guilt or shame, may not self-initiate verbal expression of this, or have the words to do so and therefore manifests behaviourally e.g. lashing out, running away. Some autistic people have alexithymia.
Sensory sensitivities	Minimise potential sensory triggers e.g. sounds, brightness, smells, temperature, etc. by changing the environment; consider a careful assessment of sensory needs and look towards disentangling relationship with anxiety
Carers and support persons	Carers and supporters are likely to have a wealth of knowledge about how to best support someone with autism. There may be some challenges with involving some of them within aspects of the criminal justice system, but nevertheless, they have an important role in helping others to understand the needs of autistic people.

People with learning disabilities and autistic people said:

- // Autistic people need extra support.**
- // We need specialist support to help us get a job and make sure that we work with the right people.**
- // It is important to make sure that people understand what autism means.**
- // It is important that people know that sometimes autistic people do not understand what other people mean.**

Key points

1. Some autistic people who commit crimes may be diverted into specialist inpatient services via the Mental Health Act because of their involvement within the criminal justice system. Others may receive community-based sentences and require specialist support from appropriately qualified and experienced professionals and teams. Where probation is involved, consider joint health/probation working.
2. The behaviour displayed or crime committed is not necessarily indicative of which path an individual will take.

Implications for practice

1. Has the individual had access to all the support they are legally entitled to? Is there a case for liaison and diversion?
2. When developing a formulation of risk and treatment needs, has autism been appropriately incorporated?

Interventions

Current treatment options

Offenders with autism are often currently treated alongside offenders who may not have autism but may have other developmental disabilities. For example, within secure inpatient services, some autistic people may be treated alongside those with learning disabilities, others may be in specialist autism only services, while some may find themselves in prisons, or within forensic secure units with others who have mental illness. There are no “validated” autism-specific treatment programmes for criminal behaviour currently available and use of programmes adapted for use with people with learning disabilities, or other mainstream (non-adapted) programmes have shown inconsistent results in reducing future risk of crimes in autistic people (Melvin et al., 2017). Treatment programmes for criminal behaviours typically use cognitive behavioural therapy approaches. These can be offence specific, such as for arson (Clare et al., 1992; Taylor et al., 2002, 2006) or sexual offending (SOTSEC-ID, 2010), or they may be generalised, such as anger management as part of therapy addressing violent behaviour (Taylor et al., 2016; Langdon et al., 2013).

Treatment within a cognitive behavioural framework focuses on the link between thoughts, feelings and actions, with programmes typically addressing unhelpful thinking styles (attitudes and beliefs which maintain or facilitate criminal behaviour) while attempting to increase victim empathy and collaboratively develop a relapse prevention plan. Group therapy is the usual mode of delivery for CBT addressing criminal behaviours, but individual therapy can be an alternative or addition. Other forms of talking therapy are available to address criminal behaviours, including dialectal behavioural therapy and psychodynamic or psychoanalytic therapies, however their application for individuals with learning disabilities and autistic people, who commit crimes, is very sparse (Beaill, 2001; Beaill et al., 2005; Brown et al., 2013; Morrissey & Ingamells, 2011).

Pharmacological treatments are also used for certain crime types e.g. testosterone lowering medication for sexual behaviours, and antipsychotics or benzodiazepines for aggression (Turner et al., 2013; Turner & Briken, 2019). Behavioural interventions are often employed for those with more severe learning disabilities, however these may be used and framed in relation to ‘challenging behaviour’ rather than criminal behaviour due to the level of assumed culpability.

Challenges in treating autistic people

Autistic responsiveness to therapeutic treatment has been widely commented upon, with much discussion regarding the potential challenges a diagnosis of autism may present to achieving positive therapeutic outcomes (Dein & Woodbury-Smith, 2010; Melvin et al., 2019, 2020; Murphy, 2010). There are numerous ways in which difficulties with social interaction, communication and repetitive or restrictive patterns of behaviour associated with autism are considered to create challenges in achieving positive treatment outcomes for autistic people who display criminal behaviours. Figure 3 illustrates a number of these challenges in relation to cognitive behavioural treatment and talking therapies. Challenges are also present in the ethical use of pharmacological treatments (similar to those raised in relation to people with intellectual disabilities who break the law or display challenging behaviour) and the appropriateness of such treatment is debated (Sawyer et al., 2014). As such, careful consideration of such factors should be undertaken when devising a treatment programme to address criminal behaviour in autistic people. As an increasing evidence-base develops for interventions to reduce forensic risk with autistic people, there are a few ways in which existing programmes and methods can be adapted. Some of these factors have been taken into consideration and are detailed within Table 2.

Figure 3: Autism and Treatment Responsivity.

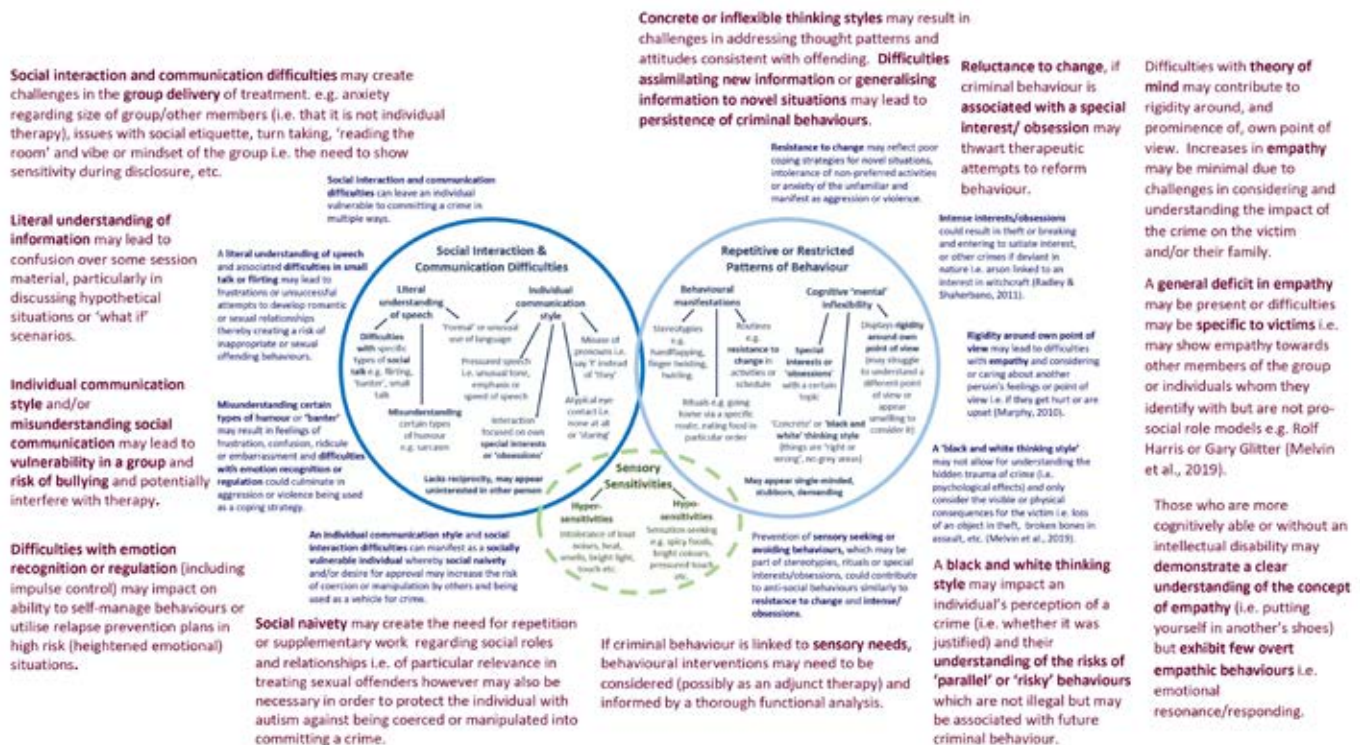


Table 2: Treatment considerations and/or adaptations for working with autistic people who may commit criminal offences.

Challenge	Consideration/Adaptation
Group delivery of programme	<p>Support individual to attend, meet fellow group members in advance, provide session material in advance and/or allow some preparation of answers. Use a clear and predictable agenda and try to avoid deviating.</p> <p>Opportunity for group to provide forum for developing pro-social behaviours e.g. mentoring of others, assigned a specific role (refreshments, reading the minutes etc.) and provide indirect positive treatment outcomes.</p> <p>Social skills training prior to starting treatment may be beneficial (could be done concurrently but need to be mindful of therapeutic load).</p> <p>Consider offering parallel individual sessions.</p> <p>Consider the use of supportive technology (e.g. computers, iPads, or other devices which can support learning).</p> <p>Sessions may have to be shorter (and more numerous) or longer (but same number) depending on needs, and where possible, try to include carers.</p>
Emotion recognition and regulation	<p>Visual support such as emotion thermometers (intensity of feeling) or emotion cards (depicting different feelings) may be required for each session. Retention of such social information may be more challenging for individuals with autism therefore prompts/visual aids may be required each week and not simply during early sessions or in the 'emotion module' of treatment programmes.</p> <p>Psychoeducation for emotion recognition concurrently or prior to treatment may be beneficial, as well as mindfulness or assertiveness skills to develop self-management of behaviours and impulse control.</p> <p>Lack of emotional vocabulary (alexithymia) and insight into own feelings regarding criminal behaviour may result in overt difficulties discussing behaviour (and any impact on victim), potentially resulting in a cold or callous presentation that may impact upon relationships with staff (also see Empathy below).</p>
Social vulnerability	<p>Use of programmes adapted for people with learning disabilities e.g. SOTSEC-ID (sex offending), fire setting, and EQUIP (anger management, social skills training, and social problem solving).</p> <p>Consideration as to the vulnerabilities and risk of all group members is needed.</p>
Atypical Information Processing	<p>Use of adapted programmes will allow for a slower pace of delivery and more visual support.</p> <p>Ensure that staff understand some of the unusual speech or communication that may be seen in autistic people.</p> <p>Some material or examples may need to be adapted, particularly in relation to language and literal processing of information i.e. it may not be helpful to discuss 'grey areas' of behaviours but focus on what is and not legal.</p> <p>Check understanding when referring to others, particularly regarding use of pronouns i.e. rather than 'he' or 'she', use names.</p>
Cognitive rigidity or inflexibility	<p>Challenges in motivation or ability to shift attitudes or thought patterns may lead to difficulties in self-management of behaviour and external strategies may be needed e.g. enhanced observation levels, monitored access to media or escorts in the community.</p>
Difficulties with empathy (victim or general)	<p>Focusing on consequences for self and family/friends (if relevant) may be more motivating for change/desistance from criminal behaviours than consideration of victim or social impact on self.</p> <p>Motivators can include loss of jobs, freedoms, or access. This may be because of difficulties with perspective-taking.</p> <p>Important to recognise the potential for impact on staff relationships with individual. A lack of empathy or consideration for the victim can be challenging for others to understand. Support, supervision and guidance should be provided to ensure staff wellbeing and subsequent care and treatment of individual.</p>
Sensory needs or sensitivities	<p>Need to be considered not only in relation to offence itself (if it played any role) but also in relation to the treatment environment and the future management of any sensory behaviours.</p>

Key points

1. A diagnosis of autism does not necessarily mean group therapy will be unsuitable. Group cognitive behavioural therapy remains accepted best practice, and should be considered but needs to be adapted, using a person-centred approach and individualised care and treatment plans.
2. Programmes adapted for those with learning disabilities provide additional support (more visual material, slower pace, increased repetition of content) than non-adapted programmes which may be of benefit to autistic people.
3. It is important to consider responsivity to treatment, that is, are they capable of the change being sought.
4. External management strategies may be required if internal motivation to change appears low or unachievable but must be as least restrictive as possible.
5. Use of avoidance goals and/or consequence for self (rather than victim) may be a stronger motivation for desistance from offending; however, response needs to be consistent and not unduly restrictive or 'punishment'.

Things to consider in your practice

1. Can the individual you are working with be supported to attend a group programme that aims to reduce criminogenic risk? Consider introducing the session material in advance, preparing some answers before the group, supplementary 'booster' sessions in between the group.
2. Insight, reflection, or sense of agency may not be as prominent in offenders with autism, and they may struggle to understand why they committed their offence.
3. Be aware of imbalances in verbal expression and actual understanding. Look for paraphrasing of information to show comprehension rather than just repetition of information or answers in agreement.
4. Remain aware of the potential impact of minimal therapeutic progress on staff morale and subsequent practice.
5. Close monitoring of external management strategies or relapse prevention plans emphasising 'consequences' to ensure practice does not become restrictive nor threaten 'punishment'.

Resources and further reading

Asperger's Syndrome and Jail: A Survival Guide written by Will Attwood is a guide for individuals with autism going to jail. The author is an ex-offender with autism.

The National Autistic Society Criminal Justice Webpage contains support for individuals with autism and professionals, including information regarding Special Measures (e.g. removal of wigs or viewing the court room in advance) and access to a Registered Intermediary (<https://www.autism.org.uk/advice-and-guidance/topics/criminal-justice/criminal-justice>).

This site provides a Professionals guide to Autism in the CJS (<https://www.justice-ni.gov.uk/sites/default/files/publications/doj/autism-guide-may-2015.pdf>) as well as information for police officers and staff (<https://www.autism.org.uk/shop/products/books-and-resources/autism-a-guide-for-police-officers-and-staff>) and associated online training.



Chapter 6: Positive behaviour support

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Aims

1. To outline positive behavioural support and the key components.
2. To consider some of the issues associated with the use of positive behavioural support for those who are at risk of coming into contact with criminal justice agencies and make some recommendations for practice.

Introduction

Individuals with learning disabilities and autistic people often have complex social, emotional, and behavioural needs, which require specialist support. Specialist support and intervention is not only required for their offending behaviour, but is also needed for other challenging behaviour which may occur amongst those who are at risk of committing crimes (Wardale, Davis, & Dalton, 2014), and can of course occur within community settings. Support and intervention for offending behaviour or behaviours which could be construed as criminal is vital for reducing risk, promoting rehabilitation, and facilitating opportunities for discharge back to the community. There are parallels between behaviours that may be construed as criminal, and those that are seen as challenging behaviours, as the function that drives the behaviour may be similar, but the nature or topography of the behaviour (i.e. what the behaviour looks like) may be different. For example, two different people may attempt to gain access to a desired activity or object, and while one person may bang their head, another may punch someone, but the function of the behaviour is similar.

Further, and while both challenging behaviour and crime are socially constructed, there are instances where some behaviours which would be construed as crime would not be seen as such when exhibited by some people with learning disabilities and autistic people. This is because of the way criminal acts are defined within England and Wales. *Mens rea*, or a “guilty state of mind” is necessary for a person to be judged to have committed a criminal act, and for many people with moderate to profound learning disabilities, the criminal justice may see them as unable to form *mens rea*, and as a consequence, they would not be subject to the criminal justice system. In such cases, behaviour that may be construed as “criminal” when exhibited by someone else may be seen as “challenging behaviour” because of the severity of their learning disability, whatever the topography of the behaviour and its impact upon others, or decisions made by gatekeepers such as health and social care staff, the police or the crown prosecution service.

There is frequently a complex overlap of mental health problems, offending behaviour, and challenging behaviour for those with learning disabilities and autistic people who have a history of committing crimes, and this often results in poorer outcomes following admission to secure services than for non-disabled people (Alexander et al., 2016). If admitted to secure services, people with learning disabilities and autistic people may be subject to higher levels of restraint, seclusion, enhanced observations, and 'as required medication' (pro re nata, PRN), as well as lengthy stays and delayed discharges from hospital settings, compared to those without learning disabilities and autistic people (Esan, Chester, Gunaratna, Hoare, & Alexander, 2015; Washington, Bull, & Woodrow, 2019). As such, community forensic learning disabilities and autistic people teams have a key role in helping to mitigate risk and prevent admission to hospital.

In response to this growing evidence base and following abuse scandals such as Winterbourne View (2011) and more recently Whorlton Hall (2019), current UK policy guidance advocates the use of behaviour support plans as part of a model of care based on proactive and preventative strategies for managing behaviours that challenge for vulnerable people within various settings (National Offenders Management Services (NOMS), 2013; NICE., 2015a; NICE., 2015b; Social Care, Local Government and Care Partnership Directorate., 2014). Thus, positive behavioural support with a focus upon recovery and rehabilitation is a key element of practice for community forensic learning disabilities and autistic people teams.

Implications for practice

1. There may be similarities between some forms of challenging behaviour and criminal offending behaviour. The function that led to the development and maintenance of both sets of behaviours can be similar, although the topography may be different.
2. For some individuals, behaviours may be seen as criminal and they may be held responsible by criminal justice agencies, while for other individuals, this may not happen because of the nature and degree of their learning disability. This individual difference may determine whether a behaviour is seen as challenging behaviour or a criminal act.
3. It is important to consider that positive behavioural support plans, when developed and implemented well by community forensic learning disabilities and autistic people teams and stakeholders may have the potential to help prevent admission to hospital.

What is positive behaviour support?

Positive behavioural support is a person centred framework for providing long term support to people with learning disabilities and autistic people, including those with mental health conditions and forensic needs, who have, or may be at risk of having challenging behaviour. It combines person centred approaches and evidence-based behavioural science to inform decision-making with the overall aim of improving the quality of a person's life and that of the people around them in the least restrictive way possible (Social Care, Local Government and Care Partnership Directorate., 2014). As a framework, it incorporates principles of applied behavioural analysis, and is strongly focused upon the values and rights of people with learning disabilities and autistic people. This includes a focus upon self-determination, outcomes that are meaningful for people, and increased social inclusion. With the right kind of support, at the right time, the likelihood of behaviour that challenges is reduced, and while most frequently used with people with learning disabilities and autistic people who have challenging behaviour, as a framework, positive behavioural support can be used with those who are at risk of coming into contact with criminal justice agencies.

Positive behavioural support is an organisational multicomponent framework for delivering intervention, informed by a functional assessment and psychological formulation. There is evidence that it is associated with good outcomes (e.g. Marquis et al., 2000). The overarching goal is to knit together a suite of interventions that are directly informed by the psychological formulation based upon a functional assessment to collaboratively bring about improvements in quality of life by reducing the probability that challenging behaviour will occur, or the probability of behaviours that increase the chances of coming into contact with criminal justice. This is done through the development and implementation of a variety of interventions that are formulation-driven, such as antecedent control strategies, which includes the manipulation of environmental conditions, along with reinforcement-based intervention strategies, and skill teaching. Interventions are organised into proactive, secondary prevention, and reactive strategies. Proactive strategies are those which are specifically designed to reduce the risk of challenging behaviour occurring, while secondary prevention are the strategies that are used when there is evidence to suggest that the probability of challenging behaviour occurring has increased, and attempts need to be made to prevent further escalation. Reactive strategies are those used to manage challenging behaviour in reaction to its occurrence. In other words, challenging behaviour has occurred, and reactive strategies are those that occur to safely manage the occurrence.

Interventions within a positive behaviour support framework are often organised into: (1) ecological strategies such as antecedent control strategies, (2) teaching functionally equivalent skills including communication and psychological therapies, (3) focused support strategies including interventions drawing on our understanding of learning theory (e.g. differential reinforcement), and (4) and reactive strategies.

Key points

1. Positive behavioural support is a framework for developing and delivering interventions. Positive behavioural support plans are person centred and no two plans are the same.
2. There is a strong focus upon self-determination, outcomes that are meaningful for people, and increased social inclusion and plans can be used with those who are at risk of encountering criminal justice agencies.
3. Positive behavioural support plans are developed using functional analysis and a psychological formulation. Interventions are organised into proactive, secondary prevention and reactive strategies.
4. Positive behavioural support plans are a vehicle for organising the delivery of care. A range of interventions can be included within a positive behavioural support plan. For example, making changes to the environment, such as providing supervision, or ensuring that someone does not live in a particular area where risk may be greater, providing anger management training and other psychological therapies that reduce criminogenic risk, or using differential reinforcement strategies or functional communication training. Interventions vary from person to person as it is formulation-driven and therefore tailored and individualised. It not just a description of what someone likes or dislikes, or what they look like when upset.

Key principles

Positive behavioural support approaches are based on a set of overarching values which include the commitment to providing support that promotes inclusion, choice, participation, and equality of opportunity (Gore et al., 2013). Behaviour that challenges usually happens for a reason and positive behavioural support helps practicing professionals (and carers) to understand the reason underlying the behaviour, so as to enable the individual's needs to be met, to enhance their quality of life, and reduce the likelihood that the behaviour will happen again. The same approach should be taken when working with those who are at risk of coming into contact with criminal justice; using forensic risk assessment, an understanding of the reasons why criminal or offending-like behaviours occur can be developed which can be developed into a psychological formulation that informs the risk-mitigation or treatment plan, that would be described within the positive behaviour support plan.

Gore et al. (2013) stated that positive behavioural support consists of ten overlapping elements which should be used concurrently, see Table 1. These should be applied when working with people who have behaviours that increase their risk of coming into contact with criminal justice and is inclusive of criminal offending.

Table 1. Key components of positive behavioural support (adapted from Gore et al., 2013)

Values	1. Prevention and reduction of behaviour that challenges (or offending-like or criminal behaviours) occurs within in the context of increased quality of life, inclusion, participation, and the defence and support of valued social roles.
	2. Constructional approaches to intervention design build service user skills and opportunities and reduce aversive and restrictive practices
	3. Service user and carer involvement to inform, implement, and validate assessment and intervention practices
Theory and Evidence Base	4. An understanding that challenging behaviour (or offending-like or criminal behaviours) develops to serve important functions for people
	5. The primary use of behavioural science to assess and support behaviour change
	6. The secondary use of other complementary, evidence-based approaches to support behaviour change at multiple levels of a system
Process	7. A data-driven approach to decision making at every stage
	8. Functional assessment to inform function-based intervention
	9. Multicomponent interventions to change behaviour (proactively) and manage behaviour (reactively)
	10. Implementation support, monitoring, and evaluation of interventions over the long term

People with learning disabilities and autistic people said:

- // Staff need to have the right attitudes and understand our risk and support us to understand our risk and a PBS plan can help with this.
- // PBS has got your treatment on it and your background, but it can change, and you must make sure that you tell everyone because they can help manage your risk.
- // We need to be involved in it and they need to help us understand it so we can understand our risk.

Implementing and delivering positive behavioural support within community forensic learning disabilities and autistic people teams

Within community forensic learning disabilities and autistic people teams, positive behaviour support can be implemented by a single practitioner, a team of professionals working together, or at an organisational level (Gore et al., 2013). In much the same way as in other settings, the implementation of positive behavioural support should be person-centred and values-based and include the following key elements:

- **Functional assessment.** Positive behavioural support should start with a comprehensive assessment of the person and their environment to understand the reasons why they may present behaviours which challenge or increase the risk of encountering criminal justice agencies. Detailed analysis of patterns of behaviour which consider the individual's personal circumstances, physical and mental health, communication skills, their ability to influence their environment, and their forensic needs should uncover the factors which predict, maintain, and sustain behaviour. When working with individuals who are at risk of encountering criminal justice agencies, the focus will be upon behaviour which could be or has been construed as criminal. In these instances, the functional assessment should also include relevant information drawn together from forensic risk assessments as outlined in the previous two chapters. This should include a detailed description of the behaviours, associated factors that increase risk and reduce risk. The positive behavioural support plan becomes a framework by which a risk mitigation strategy is designed and implemented and includes a suite for formulation-driven interventions.
- **Development of a detailed behaviour support plan.** The functional assessment should inform the contents of the positive behavioural plan and describe: (i) the psycho-social and environmental triggers for behaviour and/or alternative strategies by which the needs of the person can be met to enhance quality of life (i.e., primary preventative or proactive strategies) which includes psychological therapies designed to reduce criminogenic risk and other risk reducing interventions; (ii) a range of possible responses staff can utilise when a person displays early signs of distress (e.g., agitation, anxiety, frustration) such as de-escalation techniques, distraction, diversion, or disengagement in order to avoid further deterioration (i.e., secondary preventative strategies); and (iii) responses staff can utilise as a last resort and in the safest possible way when the person's behaviour means they are at risk of harm to themselves or others such as restrictive interventions (i.e., tertiary or reactive strategies).

- **Service user involvement.** Positive behaviour support plans may be integrated with the person's individual care and treatment plan and should be created with the individual themselves, their carers, relatives, or advocates where appropriate. The use of co-production when developing positive behavioural support plans for behaviours that increase the risk of encountering criminal justice agencies is crucial. This should include not only the service user, but those involved in the delivery of care who will need to follow and use the positive behavioural support plan, and those multi-agencies who have been involved in the risk assessment process. It is important that the individual is actively involved as much as possible as this is likely to help promote their understanding of their risk and the strategies that are needed to help mitigate this risk.

Implications for practice

1. A functional assessment should focus upon criminal offending behaviours, or behaviours that could be construed as criminal.
2. Carefully develop an operational definition of the behaviour. An operational definition of the behaviour is one which is written in such a way that two completely different people could read the definition and identify the behaviour, should they observe it, reliably across different settings.
3. Include information generated through the risk assessment process when developing the psychological formulation. This will directly inform the risk mitigation strategies (interventions) that you need to include within the positive behavioural support plan. These interventions may be complex for some individuals and can include psychological therapies and other interventions that are designed to proactively manage risk.
4. Develop positive behavioural support plans using co-production with the person, and relevant stakeholders, like carers, social workers, and criminal justice agencies. Like risk assessment, developing positive behavioural support plans should be multi-professional and multi-agency.
5. Involving the person in the development of the positive behavioural support plan may help to develop their understanding of their own risk and promote their independent management of their risk, leading to an increase in insight.

People with learning disabilities and autistic people said:

// It is important that PBS plans are ours and personal to us because everyone can be different. They should not be bog standard because everyone is different.

// It is important to put pictures in them to help us understand and make it around the person. Don't copy and paste. Make it individual.

Does positive behavioural support work in for people with learning disabilities and autistic people at risk of criminal offending?

Most of the research pertaining to the implementation and effectiveness of positive behavioural support in reducing challenging behaviour has been undertaken with adults and children with disabilities who do not have forensic needs (i.e., in schools and residential services for those with learning disabilities and autistic people). There is evidence that positive behaviour support within these contexts successfully reduces challenging behaviour and improves quality of life (Goh & Bambara, 2012; MacDonald & McGill, 2013; McClean et al., 2005; McClean, Grey, & McCracken, 2007). Despite being in its infancy, the research evidence evaluating the effectiveness of positive behaviour support for those with learning disabilities and autistic people with a history of criminal offending is encouraging. For example, Davies, Mallows and Hoare (2016) undertook qualitative interviews with men with learning disabilities within a medium secure forensic hospital to explore their experiences of positive behaviour support within the service. The men were asked about their own involvement in the development of their positive behavioural support plan, their understanding of positive behaviour support, what they liked and did not like about it, and how they felt positive behavioural support had influenced their care. Analyses revealed that they viewed their experiences of having a plan in a positive light, enabling them to better understand their own behaviours, needs, and support required, which suggests that it may have the potential to increase insight and improve risk management. Participant involvement in the development of the plan was valued, although some expressed frustrations when plans were not adhered to and struggled to understand why some had plans and others did not (Davies, Mallows, & Hoare, 2016).

In a more recent case-control study, Davies, Lowe, Morgan, John-Evans, & Fitoussi (2019) undertook functional assessments and developed positive behaviour support plans with 22 people with learning disabilities within a medium secure forensic hospital and compared behavioural outcomes against a group of comparison participants. They reported that the frequency of aggression, management difficulty and severity, and other

challenging behaviours were significantly reduced, relative to the comparison sample who did not have a positive behavioural support plan and this was sustained 12-months later.

A small number of studies have also examined the outcomes of implementing positive behavioural support in forensic settings supporting service users with learning disabilities. In a small Australian study, Wardale et al. (2014) implemented positive behavioural support training with a small number of staff within a Queensland forensic disability service and found staff knowledge and the quality of service user plans improved. In a larger UK study, Davies, Griffiths, Liddiard, Lowe, and Stead (2015) sought to examine whether training with positive behavioural support in a medium secure forensic service produced any changes in staff confidence in working with challenging behaviour and whether it altered staff understanding or beliefs about the functions and regulation of challenging behaviour. Pre- and post-training assessments revealed significant increases in both qualified and unqualified staff knowledge, understanding, and confidence in working with challenging behaviour. The study was replicated a year later with another group of staff in the same service setting and improvements in staff confidence and changes in the way staff understood challenging behaviour were again seen (Davies et al., 2016).

However, the evidence base for using positive behaviour support, inclusive of behaviour support plans, as a framework for the delivery of risk mitigation strategies for behaviours that are likely criminal has not been examined within the community. Nonetheless, behavioural support plans remains a recommended intervention for challenging behaviour in those with learning disabilities and autistic people by the National Institute for Health and Care Excellence, and implementation and use within community forensic learning disabilities and autistic people teams is likely to contribute positively towards reduction of risk, rehabilitation, and service user discharge to community settings.

People with learning disabilities and autistic people said:

- // Helping us to understand and communicate is part of PBS. Sometimes, we need to learn new ways of communicating, but we aren't helped.
- // I used to have pictures on my PBS plan, which helped me, and now I don't.
- // Staff need to understand your PBS plan. Make sure you educate staff about PBS plans.
- // PBS plans should include our RP (relapse prevention) plan and treatment so that everyone knows what to do to keep us safe.

Key points

1. There is evidence that behaviour support plans are effective for helping to reduce challenging behaviour, but we know less about this framework when used to help design and deliver interventions to mitigate forensic risk and reduce criminal offending behaviour within community settings.
2. There is promising evidence from inpatient forensic services that positive behavioural support could be advantageous, but further research is needed.
3. Regardless, and based upon National Institute for Health and Care Excellence recommendations, behaviour support plans should be developed and implemented with those with learning disabilities and autistic people, including those who are at risk of coming into contact with criminal justice agencies.

Chapter 7: Psychological Interventions

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Aims

1. This section introduces a range of psychological interventions and some of the adaptations required to deliver effective treatment for people with learning disabilities and autistic people who have additional forensic needs.
2. The evidence for the effectiveness of different psychological approaches is variable, particularly in offender populations, which pose some unique challenges. As a result, the focus of this section will be on specific areas of work, including interventions for anger, for sexually harmful behaviour and for firesetting, in all of which there is a more evidence for effectiveness than for other crimes.
3. This section will include examples of interventions for offenders in both secure and community services. While it is important to provide therapeutic interventions so that people can progress from secure settings to community placements, it is often also necessary to provide interventions in the community, to prevent reoffending or admission to secure services. There are similarities between interventions in different contexts, however there may be significant differences in the way they are applied, for example in relation to the risks posed in different environments.
4. The importance of support staff in the implementation of therapy and their vital role in the therapeutic process will also be considered.

Introduction

Psychological interventions for people with learning disabilities and autistic people, have an important part to play in forensic services, both in secure and community settings. They have been shown to help participants make real changes in their lives so that risk is reduced, and they can once again enjoy access to community activities safely. There are a wide variety of therapeutic approaches available to help people with learning disabilities and autistic people and careful consideration needs to be given as to which are used with particular individuals. The evidence for effectiveness of these approaches is limited but growing.

It was considered for many years that people with learning disabilities could not benefit from psychological therapies (Bender, 1993), however more recently this group have been offered a range of adapted psychotherapies and these interventions have been used extensively in offending populations (for examples see Lindsay and Taylor, 2018a). Offenders with learning disabilities and autistic people can pose a particular challenge as many do not present themselves for treatment but are directed to receive treatment; this can make their motivation and readiness to change questionable in some cases. Also, these clients can carry significant risk of harm to themselves and others that alters the therapeutic dynamics. However, offenders

with a learning disability or autism are often relatively intellectually able, which can may make the process of engaging them in therapy easier than for some others who may have more severe developmental disabilities (Rose et al, 2005; Taylor, Lindsay and Willner, 2008).

Psychological therapies have been used with a range of presenting issues in offenders with learning disabilities and autistic people. These include therapies that focus on:

- anger, aggression and violence;
- sexual offending;
- firesetting;
- alcohol-related offences, and;
- mental health and psychological conditions.

Cognitive behaviour therapy (CBT) is the main therapeutic modality that has been used in forensic services to address offending behaviours and related problems. For example, anger interventions, sex offender treatment and firesetting programmes have been developed as individual and group programmes with specific adaptations for people with learning disabilities (see Lindsay & Taylor, 2018; Rose, 2019). CBT examines the relationships between thoughts, feelings and emotions, physical symptoms and behaviours within the environment that an individual is living (see Figure 1). CBT interventions have been evaluated more frequently than other approaches and will be used to show how they can be adapted effectively. The following sections describe in more detail CBT interventions for anger, sexual aggression and firesetting behaviour. For more information on therapeutic approaches to alcohol-related problems in people with learning disabilities see Lindsay & Taylor (2018b); and for treatment of mental health and emotional problems, see National Institute for Health and Care Excellence (2016) guideline 54, and Taylor, Lindsay, Hastings and Hatton (2013).



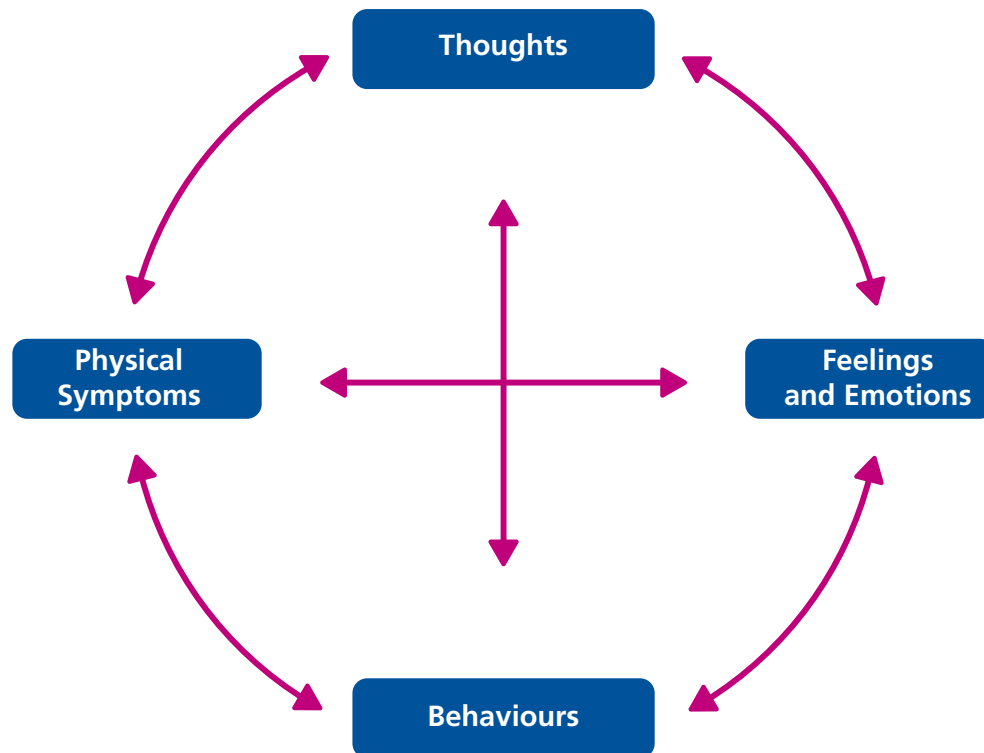


Figure 1. Elements of the CBT model

It is clearly of great importance that appropriate consent is taken from participants prior to interventions being implemented. There are examples of adapted consent forms that are suitable for this (e.g. Rose, Cook, Khatkar and Shead, 2013). Particular care needs to be exercised with individuals who are required to attend treatment order as part of a court order. The implications for these individuals needs to be explained in such a way to ensure that they understand the requirements and implications should they discontinue taking part.

Key points

1. Many offenders with learning disabilities and autistic people can take part in psychological therapies to address their criminogenic risk.
2. Psychological therapies for a range of issues can be offered, including anger management, and treatment for both sexual offending and fire setting.
3. These treatments can help mitigate risk and help people to live safer lives in the community.

People with learning disabilities and autistic people said:

- // You need to make sure that you do lots of groups like social skills, anger management and mental health. Therapy needs to be based on what you need.**
- // We need to be more involved because it helps us to learn how to reduce our risk.**
- // Staff need to support us with this, and if we got homework, they can help us with that. Psychology is there to help you talk about things and get better.**

Anger Interventions

Most of the work on reducing anger and aggression in offenders with learning disabilities and autistic people is based on the model developed by Novaco (1979) who used a stress-inoculation paradigm within a CBT framework. He suggested that anger is related to our thoughts and emotions which influence the behaviour of the individual and those around them. Anger interventions have been developed and used as individual therapeutic approaches with people who have learning disabilities in community and secure settings (e.g. Rose, Dodd and Rose, 2008; Taylor, Novaco, Gillmer, Robertson and Thorne, 2005). There is also evidence for the effectiveness of group anger interventions (Lindsay et al., 2004; Rose, Loftus, Flint & Carey, 2005; Vereenoghe & Langdon, 2013). Some of these studies have been specifically focused on forensic services while others have been more community based but have included participants with forensic risks and histories. Most of these interventions have led to significant improvements for participants, with less expressed anger recorded by participants in most studies over the course of the intervention and, though less often, lower rates of observed aggressive and violent behaviour have been found following treatment (e.g. Rose, 1996; Taylor, Novaco & Brown, 2016). As a result of the research carried out in this area, cognitive behavioural anger treatment is recommended by NICE for adults with disabilities who have anger management problems (National Institute for Health and Clinical Excellence, 2016).

In anger interventions, like most interventions based on CBT, participants are encouraged to keep a record of their thoughts and behaviours over the course of therapy. This is important as poor anger control is linked fundamentally to difficulties with self-monitoring of emotions (Novaco & Taylor, 2018). This can be quite a challenge for many people with learning disabilities and autistic people and even though various adaptations might be made to diaries or recording sheets, support staff will often be involved in helping participants to record what they have done and their thoughts (if possible) during the week, so that these can be discussed within the psychological therapy on a weekly basis. An important element of the therapy normally includes the presentation of a range of activities to participants in therapy to help them understand their thoughts and behaviour (psycho-educational topics). Set activities are supplemented by discussion about participants' particular issues that have been recorded in diaries. In some sessions, the use of role play can be useful to support learning for people with learning disabilities as a more active learning method. Role-play is an activity where it is particularly useful to have support staff involved as they will often have first-hand experience of some of the issues being role played.

Some of the psycho-educational activities that might be used in group sessions are shown in Table 1. With appropriate support and adaptation, it is likely that many people with learning disabilities and autistic people will be able to benefit from effective treatment. The different approaches described in Table 1 can be used with a wide variety of situations. Jim's story (see Box 1) illustrates how this work might impact on an individual and prevent them from entering a secure hospital or prison. There are many people with learning disabilities like Jim who, without effective treatment in the community, may enter secure services, if they don't get the right support. It is also quite feasible to adapt the same approaches to treatment for use in secure settings.

Table 1. Suggested Content of Group Sessions Showing Psycho-educational Input and Role-play Activities to Consolidate Learning, Understanding and Development of Skills

Psychoeducational topic	Complimentary role-play
What makes you happy – various exercises to help participants understand the connections between events and emotions.	Asking participants to make happy faces/ and sad faces, recording them on video where appropriate.
Photo exercise: identifying feelings in pictures and feeding back to group – for discussion, asking which moods apply to participants	Practicing role-plays:(i) Meeting someone for the first time (ii) What makes you happy
Describing and understanding signs and symptoms of anger (physical, behavioural and cognitive) in general and in the individual.	Staff demonstrate different responses to potentially anger provoking situations: (i) passive (ii) aggressive (iii) assertive Clients suggestions on appropriate behaviours then role-play assertive
Photo exercise: use pictures of angry individuals to generate discussion between participants: Discuss when it is OK to be angry? Why do people get angry? Why do they feel angry?	Use role-play of different situations, if possible focussing on issues that particular individuals have brought to the group. These can be recent or historic. Think about better ways of responding.
Anger thermometer: a “thermometer” drawn on paper with “hot” at the top signifying loss of control and “cool” at the bottom suggesting appropriate management of a situation.	As above but integrate the use of video and feedback using video records. Include the other members of the group and support staff in providing positive feedback, where appropriate.
Link the anger “thermometer” as a visual aide to diary feedback. Discuss other strategies participants could use in different situations.	Link what has been discussed in the psycho educational session to situations raised in diary feedback In role-plays, include the use of statements discussed in psycho-educational session to show how that self-talk can help prevent the emotion of anger resulting in aggression .
Introduce ‘self-talk’, positive and calming statements. That is, things that can be said either out loud or as a thought to help cope with different situations.	
Introduce a range of other techniques such as thought stopping (things that you can do in your head to interfere with impulsive thoughts and reduce the likelihood of an aggressive response).	Introduce a problem-solving approach through role play by using problem solving to suggest alternative responses and trying to consider alternative thoughts and actions that will lead to the best possible outcome.
What do you do to relax? Examine different methods of relaxation, mindfulness techniques etc.	

Box 1. Jim's Story: A 29-year-old man with mild learning disabilities who had moved from his parents' house to supported living in the community and who has been aggressive in the community

Jim was referred for group work after committing a number of assaults which had led to the involvement of the police. The assaults were apparently unconnected but seemed to have some similar characteristics. He wasn't charged for these assaults however the commissioner for services in the community had responded positively by providing an increase in staffing to try and maintain his supported living placement. He was also referred to the learning disabilities community forensic team in the NHS for treatment, where he was assessed and offered group anger management. Jim was happy to accept the increased support and supervision from staff who helped him to attend the group sessions, they also attended the session with him and supported him to complete his diary.

When reviewing diaries, one assault was discussed in the group that occurred on a bus, it became apparent that when the assault occurred, he was unaccompanied and the bus was very busy. His exit from the bus was blocked by people standing. As he tried to get off the bus, he pushed several people roughly, which led to them protesting, the incident soon escalated, he injured two people and the police were called.

After discussing this incident in the group, the development of his anger and how it led to aggression it was possible to discuss and role play a number of possible different coping strategies and to help him consider alternative behaviours in this and similar situations. It was important to make the potential different ways of responding as accessible as possible by using support staff to role play individuals involved in the incident. Measures to reduce anxiety and anger, such as becoming aware of his thoughts, reframing those thoughts, teaching simple distraction techniques (e.g. deep breathing, counting to 10) and meditation based relaxation were also used, with practice given in their application through role-play exercises. Practice was also provided of assertive alternatives to his aggressive behaviour within the group. Examples of more positive responses included simple strategies, such as using brief relaxation to calm himself, press the "bus stopping" button and practice saying 'excuse me' to the people on the bus.

Other situations where Jim had been aggressive included while waiting a long time at a hospital Accident and Emergency Unit and when attending a football match. These had similar environmental triggers (crowded and very busy environments) and were also used to help him understand how he could cope with his feelings in a more appropriate way. Using a range of similar techniques, it was possible to consider more appropriate ways of responding to difficulties.

As his staff support had been increased in response to these difficulties it was possible to include staff to support Jim within the group¹. Attendance at the group helped those staff to gain an insight into his needs and the range of situations that might lead to anger and aggressive behaviour. This meant that they could anticipate and support Jim in potentially difficult situations by reminding him about what he had been doing in the group and to help him consolidate what he had learnt while in community settings.

With staff support Jim progressively managed his anger better and after 12 months with no assaults it was possible to reduce his staff support within the community so that he is now independent outside of his home.

¹ In this case Jim was happy to consent to his carers being involved in the group to support him. This may not always be the case – particularly if one source of a person's anger is the behaviour of support staff. This needs to be discussed carefully and negotiated with the person in advance of treatment commencing and the wishes of the individual are paramount.

There is good evidence for the effectiveness of anger interventions with people who have learning disabilities in a range of settings. Interventions that use a range of both verbal and active approaches (such as role-play) can be effective even with individuals with more severe disabilities. It is often worth offering therapeutic interventions of this type to more severely disabled individuals as both participants and therapists can work together to develop adaptations as they can become familiar with their mutual communicative styles.

Psychotherapeutic interventions for sexual offenders with learning disabilities

Psychotherapeutic treatments for sex offenders with learning disabilities have had a similar focus to anger interventions – that is, using a CBT model based on understanding the cognitions, emotions and behaviours of participants. Multi-component sex offender treatment programmes (SOTP) have been adapted and used as the basis for a number of group evaluations. These include the SOTSEC-ID programme (Heaton & Murphy, 2013; Murphy et al., 2010) and the HM Prison Service ASOTP (Williams and Mann, 2010). The themes addressed in most interventions include the following (e.g. Rose, Rose, Hawkins & Anderson, 2012):

- Emotional recognition in themselves and others;
- Examining personal life stories and analysing motivation to offend;
- Describing offences in detail and introducing the offence cycle;
- Examining excuses, cognitive distortions and alternatives to offending;
- Victim empathy, and;
- Relapse prevention.

In common with other therapeutic approaches with people with learning disabilities, participants are engaged in a variety of group activities designed to develop group participation and commitment, however they are also challenged about their behaviour and thoughts. An important focus is often the development of individual keeping-safe plans,

in the form of an accessible booklet, given to the participants and shared with staff who are working closely with them. This record enables the staff to understand the process and focus of therapy and to support any work that has been done in the therapy at home.

Until recently the use of these groups for people with learning disabilities and autistic people has been common in many services, and a number of evaluations have suggested they do have a positive impact in reducing the risk posed by people who display harmful sexual behaviour who have learning disabilities (e.g. Cohen & Harvey, 2016; Marotta, 2017). The interventions were originally based on SOTP designed for non-disabled individuals and recent evaluations have suggested that similar interventions in the prison service may be ineffective (Mews, DiBella & Purver, 2017). However, there is a lot of research examining the effectiveness of SOTP and Gannon, Olver, Mallion and James (2019) have recently systematically reviewed the evidence for effectiveness of sex offender treatment in people without learning disabilities and found that there can be considerable variability in the outcome of these therapeutic interventions. They have found that a number of factors seem to be associated with improved effectiveness of SOTP. Most of these important elements for success are routinely integrated into working with offenders with learning disabilities, including ensuring the involvement of a qualified psychologist in the delivery of the treatment, providing therapy in groups, providing regular staff supervision, and delivering the therapy outside of prison/secure settings. There is a strong imperative to provide treatment for this group and the indications from the literature are that the adapted approaches do have a positive impact on most participants; however, it is possible that the nature and degree of change in individuals with autism may be different (Murphy et al., 2010).

Other psychological approaches to reduce sexual offending by people with learning disabilities and autistic people have been used, although the evidence for these is quite limited to date (compared to CBT). Mindfulness meditation has been used as an intervention either as part of a multicomponent intervention or as an intervention in its own right. For example, Singh et al, (2011) have reported excellent results in using a mindfulness intervention

to help control deviant arousal in sex offenders with learning disabilities. This promising approach requires further research and replication of these results by other groups would be helpful. Biofeedback in the form of heart rate variability has been used with sex offenders with learning disabilities to improve emotional regulation. This approach has been shown to be feasible but has yet to demonstrate any change in emotional regulation (Gray, Beech & Rose, 2019).

Firesetter treatment programmes

The research literature involving firesetters with learning disabilities is limited, but promising. Rice and Chaplin (1979) and Clare, Murphy, Cox and Chaplin (1992) reported early studies incorporating skills-based interventions that appeared helpful in working with firesetters with learning disabilities.

Taylor, Thorne and Slavkin (2004) reported on a case series of four detained men with learning disabilities and convictions for arson offences who received a cognitive-behavioural, 40-session group-based intervention that involved work on offence cycles, education about the costs associated with setting fires, training of skills to enhance future coping with emotional problems associated with previous firesetting behaviour, and work on personalised plans to prevent relapse. The treatment successfully engaged these patients, all of whom completed the programme delivered over a period of four months. In a further series of case studies on six women with mild-borderline learning disabilities and histories of firesetting, Taylor, Robertson, Thorne, Belshaw and Watson (2006) employed the same group intervention and found that scores on measures related to fire treatment targets improved following the intervention. All but one of the treatment group participants had been discharged to community placements and at two-year follow-up there had been no reports of participants setting any fires or engaging in fire risk-related behaviour.

Using the same assessment and treatment approach as that used by Taylor and colleagues above, Taylor, Thorne, Robertson, and Avery (2002) reported the outcomes for 14 men and women with learning disabilities and arson convictions. Following treatment, significant improvements were found on all fire-specific, anger, self-esteem and depression study measures. Finally, Taylor (2014) reported on a follow-up of 24 firesetters with learning disabilities who had completed a specialist group treatment programme. No arrests or convictions for firesetting behaviour had been recorded at four to 13 years post-treatment follow-up.



The results of these small and methodologically limited studies provide some limited encouragement and guidance to practitioners concerning the utility of group-based interventions for firesetting behaviour by people with learning disabilities.

Other approaches

Thinking Skills Programmes (TSPs) have been adapted for use with adults with learning disabilities and there is a growing evidence base. This programme is largely based on the Enhanced Thinking Skills course that has been run in the prison service (Offending Behaviour Programmes Unit, 2000). The programme is aimed at deficits in thinking associated with offending and is cognitive-behavioural in approach. There have been a number of attempts to adapt such an approach to treatment in a variety of settings including the community (Goodman, Leggett, Bladon, Swift, Treasure and Richardson, 2011; Lindsay, Hamilton, Moulton, Scott, Doyle and McMurran, 2011), hospital (Hickman, Thrift, Dhaliwal, and Taylor, 2017) and prison (Oakes, Murphy, Giraud-Saunders and Akinshegun, 2016). The studies include descriptions of individual participants, before and after evaluations of participants in a group and a description of the outcome of a programme that has been implemented over a number of years. Initial reports suggest that outcomes are positive with some evidence that thoughts can be changed, and this results in behaviour change.

Dialectical Behaviour Therapy (DBT) has been used with people with learning disabilities as a treatment for people with emotional dysregulation and impulsive behaviours (Crossland, Hewitt & Walden, 2017). There is evidence that DBT can be adapted and applied in secure and community settings. Studies have reported reductions in self-injury and aggression to others, facilitating a move to lower security settings following DBT, a reduction in psychological distress and, a decrease in anxiety and depression symptoms (Pearson, Austin, Rose & Rose, 2019).

Eye Movement Desensitisation Reprocessing (EMDR) is a treatment for post-traumatic stress disorder that involves bilateral stimulation of the eyes, or through touch, that is less reliant on language than many therapies and has also been

used in an adapted form with people with learning disabilities living in the community (Karatzias, et al., 2019). Given that many offenders have had traumatic experiences this may be a useful treatment to use for this group in the future.

Therapies based on psychoanalytic psychotherapy have been adapted effectively for use with people with ID in community settings (Beail, Warden, Morsley & Newman, 2005). However, the success of the application of these therapies in forensic services is unknown. Similarly, Lindsay et al. (2015) found significant improvements in a pilot-controlled trial of transdiagnostic CBT for adults with a range of mental health problems (mainly anxiety and depression), but these findings are yet to be replicated in a purely forensic population.

Although these alternative approaches are promising, the volume and quality of the evidence available to support their use routinely with offenders with learning disabilities is very limited – especially compared with more established CBT based interventions – and thus forensic practitioners should consider their use cautiously.

Involving support staff in therapy

The outcomes in studies where staff who have a professional training in psychological interventions have led the intervention seems to be significantly better (Gannon et al., 2019; Rose, 2013) than where staff without such training take the lead (Sandhu, Rose, Rostill-Brookes, & Thrift, 2012; Willner et al., 2013). However, there is also some evidence that suggests the involvement of untrained staff in therapy working closely with trained staff can improve outcomes. As a result it is suggested that most psychological interventions should be the result of a team approach that includes psychologically trained staff working closely with support staff, although as indicated above this needs to be negotiated carefully with the client in advance of therapy commencing; and the lack of availability of support staff to be involved in the therapy effort should not be a reason for denying or excluding people with learning disabilities from access to potentially beneficial interventions.

The active inclusion of support staff in groups can increase the effectiveness of interventions. Rose, Loftus, Flint and Carey (2005) found that participants in a community-based anger management group showed more improvement if they were supported in the group by a member of staff. It is not clear what might be the reason for these improvements but it is possible that by attending therapy sessions, support staff can provide information so that the people who are guiding the therapy are more able to understand the individuals with learning disabilities and autistic people which can lead to a more psychological approach to treatment overall. Spending time in an active therapeutic setting with the person with learning disabilities may also help support staff to understand the people they work with and anticipate difficulties thus making changes in the social and interpersonal environment in their home setting to reduce further difficulties (Jahoda, Trower, Pert & Flynn, 2001).

Support staff should consider consent and ethical issues with the people leading the therapy prior to group attendance. For example, respecting confidentiality and the rights of participants not to be accompanied are important considerations. The role of staff within the therapeutic process should be negotiated prior to their involvement. Often this can be done through discussion however, in the case of groups working with sex offenders where the content may be particularly challenging. Rose et al, (2012) provided a written summary of what was likely to occur in these groups and when staff could make the most effective contribution. The summary also gave staff the right to opt out and ensured that staff were appropriately prepared for the group. This is particularly important in community settings where many staff may not be used to working with offenders.

It is also important to be mindful of the impact that this sort of therapeutic work can have on staff who are involved in the treatment process (McNeillie and Rose, In press). It is vital that staff are supervised and have access to appropriate support structures to help them manage the potential stressors involved in this work.

People with learning disabilities and autistic people said:

- // If you talk about stuff, it can be hard to understand, and you need help to make it easier to understand. Some of us need to do therapy, but it needs to be at the right pace, and time to think so you are not bombarded with questions.**
- // You need to have 1 to 1 private conversations and seek support. Do not suffer in silence. Therapy is focused on you.**
- // We need more psychology groups to happen in the community, and not in hospital.**

Key points

1. Psychological approaches are becoming more widely available in forensic learning disabilities and autistic people services.
2. There is a growing body of evidence to support the effectiveness of these approaches – particularly CBT interventions for anger/aggression, sexual aggression and firesetting behaviour.
3. Support staff can make a significant contribution to the effectiveness of psychological therapy in conjunction with psychological therapists.
4. It is important to consider and negotiate the role of support staff in psychological interventions before the intervention starts.

Resources

- (1) Jahoda, A., Stenfert-Kroese, B., & Pert, C. (2017). Cognitive Behaviour Therapy for People with Intellectual Disabilities. Palgrave Macmillan UK.

This book provides guidance and practical examples of how to adapt and modify assessments and intervention techniques to provide CBT to people with learning and developmental disabilities in individual and group formats.

- (2) Taylor, J. L., & Novaco, R. W. (2005). Anger treatment for people with developmental disabilities: A theory, evidence and manual based approach. John Wiley & Sons.

This provides a session-by-session treatment guide for an individual CBT anger intervention developed for work with offenders with learning and developmental disabilities in secure settings.

- (3) Sex Offender Treatment Services Collaborative (SOTSEC-ID) website: <https://www.kent.ac.uk/tizard/sotsec/index.html>

Hosted by The Tizard Centre at the University of Kent, this website provides resources (therapy materials, training and research) for practitioners working with sex offenders with learning and developmental disabilities.

- (4) Taylor, J.L. & Thorne, I. (2018). The assessment and treatment of fire setting behaviour. In W.R. Lindsay & J.L Taylor (Eds.). The Wiley handbook on offenders with intellectual and developmental disabilities: Research, training and practice, pp 272-288. Chichester: Wiley-Blackwell.

This book chapter provides a detailed description of a model treatment programme developed for firesetters with learning and developmental disabilities.

Chapter 8: Medication

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Aims

1. To consider some of the challenges associated with recognising and treating mental health problems amongst people with learning disabilities and autistic people.
2. To outline prescribing practice for people with learning disabilities and autistic people, who have mental health problems, including those who present with challenging behaviour and consider effectiveness.
3. To consider how to effectively audit prescribing practice.

Introduction

In general, people with learning disabilities and autistic people may be prescribed psychotropic drugs including antipsychotics in three sets of circumstances: either because they have a psychiatric diagnosis, because they have behaviour that challenges or both.

Challenging behaviour is defined as behaviour of an intensity, frequency, or duration that threatens the physical safety of the person or others or restricts access to community facilities. It is a socially constructed, descriptive concept that has no diagnostic significance and makes no inferences about the aetiology of the behaviour. Its definition is broad enough to cover acts of aggression towards people, aggression to property, self-neglect, self-harm and risk of exploitation, and it therefore appears that almost anyone who has a mental health problem that reaches the threshold to need attention from primary or secondary care services would have some form of behaviour that challenges as a presenting feature. The reverse may not be true - i.e. everyone with challenging behaviour may not necessarily have a psychiatric problem.

The dividing line between challenging behaviour and offending or law breaking behaviour can often be blurred and depend on a number of factors including the degree of learning disability, the seriousness of the act in question, the availability of support services, the inclination of those around the perpetrator or victim to initiate legal action and the willingness of penal organisations to prosecute or convict.

People with learning disabilities and autistic people develop psychiatric problems at rates similar to or higher than the general population, but it may not be recognised due to communication difficulties, atypical presentations, diagnostic overshadowing or difficulties in accessing services. Thus, in clinical practice, a psychiatric diagnosis may be recorded only when the clinical features are clearly elicitable, e.g. delusions and hallucinations that support the diagnosis of schizophrenia. However, in many cases while the distress is real, the presentation is not that clear cut and this leaves clinicians with some uncertainty about the diagnostic process. While the narrative account of symptoms is important in all cases, it is even more important to record that in these cases. In practice however, some of these are often left out (for example, transient psychotic symptoms, quasi-psychotic experiences, affective lability, somatic anxiety, etc.). This may contribute to some under-recording of psychiatric diagnoses, unnecessary prescriptions, or inadequate monitoring.

While those with a psychiatric diagnosis may well need appropriate medication for that condition, the use of medication to manage challenging behaviour is more contentious. The need for ethical and evidence based prescribing practice is important in this group, particularly as studies from across the world show psychotropic medication prescription rates of 30 to 90% for those with learning disabilities and challenging behaviour. These rates are very high, given the relative lack of evidence for the effects of medication on challenging behaviour (see also below). Hence a national programme to stop over-medication of people with learning disabilities (STOMP-LD) has been developed in England and has been working to rationalize prescribing practice in this area.

The evidence base: psychotropic medication for people with learning disabilities and mental illness

The National Institute for Health and Care Excellence (2016), in their NG54 guideline, advised that people with learning disabilities and a mental illness should have treatment that is recommended for the mental illness. There is some concern that they may be more susceptible to side effects and hence it may be more prudent to 'start low and go slow' in terms of the dose schedule. However, this must be balanced clinically with the risk of under treating or delaying treatment of a serious mental illness.

The evidence base: psychotropic medication for people with learning disabilities and challenging behaviour

The National Institute for Health and Care Excellence (2015), in their NG11 guideline, summarised a number of studies and grade the quality of evidence as low or very low. It is worth noting that the National Institute for Health and Care Excellent has exacting standards for evidence and the grade for psychological interventions were similar.

For antipsychotic use in children and adolescents, there were 10 placebo controlled randomised control trials. Risperidone and Aripiprazole were more effective than placebo in reducing the severity of targeted behaviour that challenges, improving adaptive social functioning and increasing quality of life. Side effects of the former included elevated prolactin levels, weight gain, sedation and somnolence and the latter, weight gain and sedation. Aripiprazole was less effective than Risperidone in reducing the severity of targeted behaviour that challenges; Olanzapine was more effective than haloperidol in reducing the severity of behaviour that challenges but increased drowsiness and weight gain to a greater extent.

In antipsychotic use in adults, there were 6 randomised control trials, 5 of which were placebo controlled. There is some evidence that Risperidone, Olanzapine or Haloperidol reduced the severity of targeted behaviour that challenges and improved quality of life, however side effects were common. Studies focusing on the withdrawal of antipsychotics in people with learning disabilities reported three main problems-worsening of the behaviour, emergence or worsening of dyskinesias and autonomic instability.

Regarding antidepressants, there is mixed evidence about the benefit of SSRIs and Clomipramine for aggressive behaviour and some evidence that Clomipramine is useful in self injurious behaviour. The National Institute for Health and Care Excellence (2012) in its guidance on autism (CG 142) advised not to use antidepressants for the routine management of core symptoms of autism in adults. In addition, it provided no advice about the use of antidepressants for challenging behaviours associated with autism.

On mood stabilisers, there is little evidence from randomised control trials and mixed evidence about the usefulness of Lithium, Carbamazepine, Valproate and Topiramate.

On anxiolytics, there is little evidence from randomised control trials. Benzodiazepines are not recommended for long term use, but they appear to be useful for the short-term management of violent and aggressive behaviours.

Within the NG11 guideline (National Institute for Health and Care Excellence, 2015), medication to management behaviour that challenges should only be considered when psychological or other interventions along do not produce change within an agreed time, or treatment for any coexisting mental or physical health problem has not led to a reduction in the behaviour, or the risk to the person or others is very severe (e.g. because of violence, aggression or self-injury). Antipsychotic medication should only be prescribed in combination with psychological or other interventions.



How to approach prescribing

Apart from the National Institute for Health and Care Excellence guidelines which sets the gold standard of evidence, clinical guidance is available from the Royal College of Psychiatrists and the Frith Prescribing Guidelines for People with Intellectual Disability (Bhaumik, Gangadharan, Branford, & Barrett, 2015).

The conventional approach to prescribing in mental health is one that is based on the clinical diagnosis. If there is a clear-cut mental illness, treatment should follow the guidelines for that condition. However, recognising mental illness amongst people with learning disabilities and autistic people is complicated because of communication difficulties, atypical presentations, diagnostic overshadowing, or difficulties in accessing services.

In such cases, the clinician must rely on good descriptions of symptoms and symptom clusters. There are five such symptom clusters that a clinician should describe, and medication use, where absolutely necessary, has been suggested by the examination of those clusters if psychological interventions are unsuccessful and the symptoms are very distressing, causing a risk to the safety of the patient or others.

Cognitive perceptual symptoms (chronic, low level features like ideas of reference, pseudo hallucinations, persecutory ideas, fleeting hallucinations, etc): use of low dose antipsychotics and use of full doses for acute psychotic exacerbations.

Affective dysregulation symptoms (affective instability, mood swings, chronic dysthymia like features and emotional detachment): for mood swings where use of mood stabilisers and low dose antipsychotics may be indicated; for dysthymia like picture, use of antidepressants.

Symptoms of anxiety (can include somatic and cognitive elements): Use of SSRI antidepressants, short term use of benzodiazepines and use of beta blockers like propranolol for somatic anxiety.

Aggressive behaviour (can include affective aggression- impulsive, hot tempered behaviour related to mood swings, predatory aggression- associated with hostility and cruelty, organic aggression- impulsive and episodic & ictal aggression- associated with EEG changes and epilepsy): For affective aggression mood stabilisers or SSRI antidepressants as first line and low dose antipsychotics as second line. For ictal and organic aggression- anti epileptic mood stabilisers as first line and short-term benzodiazepines as second line, for predatory aggression- medication may not be useful- in some cases antipsychotics are found to provide some benefit).

Self-injurious behaviour (can include 5 sub types- repetitive stereotyped behaviour, extreme tissue damage, co-occurring self-injury & aggression, self-injury with agitation when interrupted and a mixed type): For repetitive stereotyped behaviour low dose antipsychotics, for extreme tissue damage opiate antagonists like Naltrexone, for co-existing self-injury and agitation mood stabilisers and beta blockers, for self-injury with agitation when interrupted an SSRI.

This prescribing would be off license, should be for the shortest possible time and needs to be monitored and audited carefully. The preferred position would be to avoid prescribing as far as possible.

Key points

1. There are five clusters of symptoms that should be assessed when considering psychotropic prescribing with people who have learning disabilities and autistic people, when making a clinical diagnosis is difficult or challenging:
 - Cognitive perceptual symptoms
 - Affective dysregulation
 - Anxiety
 - Aggressive behaviour
 - Self-injurious behaviour
2. It should be remembered that there can be a tendency is to over-prescribe. All medication has side effects and people should always be consulted about their views regarding their medication.

People with learning disabilities and autistic people said:

- // You need to get your medication in the community from your general practitioner. It is good for your health. You need to take it properly and at the right time.
- // You need to speak to the right people if it is not right and stopping it too quickly can make you ill. You need to talk to your doctor, pharmacist, or your family and supporters.
- // When you are angry, sometimes you might threaten not to take your medication. I do that sometimes because I want people to know I want support.

How to audit prescribing

The standards suggested by the Royal College of Psychiatrists (2016) for prescribing psychotropic medication to people with learning disabilities draws on the most up-to-date evidence base offered by the National Institute for Health and Care Excellence guidelines and is a useful basis for good clinical practice. Its key points are summarised below.

All patients for whom prescribing is considered should have a full diagnostic evaluation that covers: the degree of learning disability, the cause of learning disability (including syndromes, behavioural phenotypes, etc.), other developmental disorders (including autism spectrum disorders, hyperkinetic disorder, etc.), any mental illnesses, personality disorders, disorders related to substance misuse or dependence, physical disorders (including any of the causes of learning disability), psychosocial stressors (longstanding issues as well as recent environmental changes) and types of behaviours that challenge. Prescribers should accurately record all relevant diagnoses and, equally importantly, the narrative that underpins them.

If the diagnosis is such that there are no mental disorders and the behaviour that challenges (or has brought them into contact with criminal justice) is the result of psychosocial factors, there might be no role for prescribing other than in the very short term to alleviate a serious risk to the safety of the patient or others while other, non-pharmacological programmes are implemented to manage the behaviour.

On the other hand, if an independent mental illness or disorder is diagnosed, treatment should follow established guidelines for that condition, and the multidisciplinary team should consider the role this may have had in bringing them into contact with criminal justice.

As presentations are rarely straightforward in clinical practice, there is often a combination of several symptoms and this might not clearly meet the criteria for the categorical diagnoses of a mental illness. In those cases, there should be clear identification of the affective, psychotic, and behavioural symptoms or clusters of symptoms that are the target of treatment with medication. If the identified target symptoms are not improving satisfactorily within 3 months, then that drug should be tapered or stopped, and other options considered.

Clinicians should be aware that although off-label prescribing is not inappropriate, unlawful or unethical in itself, it can be if not done properly. When prescribing off-label, they should follow guidelines that are published by regulatory bodies like the General Medical Council and ensure that their practice would be considered to be of an adequate standard by their peers.

Medications are effective at the same doses as for those without learning disabilities and autistic people and there is no clear evidence that they have more side-effects. However, side-effects and potential drug interactions should be monitored carefully, particularly in those with more severe degrees of learning disability.

The prescribing clinician should explain the proposed treatment to patients, their families, and carers, as appropriate. This may involve providing information in an easy-to-read format, making reasonable adjustments, and involving independent advocates.

There should be a record of the patient's consent and capacity, any best-interest decisions, timeframes for reviews and the tapering off or stopping of drugs that are ineffective.

The medication reviews should cover not just clinical examination, but also laboratory tests as indicated.

The tapering off or stopping of drugs that are ineffective will be aided by a careful recording of progress (or otherwise) with medication using standardised outcome measures that can be quickly and easily rated (e.g. Clinical Global Impression scale).

Further reading

[NICE guidelines \[NG54\] Mental Health problems in people with learning disabilities - prevention, assessment and management 2016 NICE](#)

[NICE guidelines \[CG142\] Autism spectrum disorder in adults: diagnosis and management 2012 NICE](#)

[NICE Challenging Behaviour and Learning Disabilities: Prevention and Interventions for People with Learning Disabilities whose Behaviour Challenges \(NG11\). NICE 2015.](#)

Royal College of Psychiatrists: Faculty of Psychiatry of Intellectual Disability report (2016) Psychotropic Drug Prescribing for People with Intellectual Disabilities, mental health problems and/or behaviours that challenge: practice guidelines. FR/ID/09 [id-fr-id-095701b41885e84150b11ccc989330357c.pdf \(rcpsych.ac.uk\)](#)

[NHS England » Stopping over medication of people with a learning disability, autism or both \(STOMP\)](#)



Key points

1. People with learning disabilities and autistic people are more likely than people without disabilities to have a mental illness that may require treatment with medication.
2. However, it is sometimes harder to identify symptoms of mental illness when a person has learning disabilities and autistic people because of associated difficulties with communication, atypical symptom presentation, and diagnostic overshadowing.
3. Evidence for the use of medications in treating challenging behaviour is limited by the quality of existing studies; however, there is evidence that some medications may be associated with positive changes. However, their side effects should be seriously considered when balancing possible benefits. It should also be remembered that over-medication is common in this group.
4. There are five symptom clusters where medication can be considered when psychological interventions have not shown consistent effectiveness. These include (1) cognitive perceptual symptoms, (2) affective dysregulation, (3) symptoms of anxiety, (4) aggressive behaviour, and (5) self-injurious behaviour.
5. People with learning disabilities and autistic people are more likely to have comorbid mental health problems, and this includes challenging behaviour, which may be related to forensic risk for some individuals and bring them into contact with criminal justice. In these instances, prescribing effective medications may help mitigate forensic risk and could be a core part of their treatment.
6. There is a useful Self-Assessment Framework for prescribing practice and associated case examples available from the Royal College of Psychiatrists.

Chapter 9: Good communication

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Aims

1. To understand the challenges of communication faced by people with learning disabilities and autistic people who are at risk of coming into contact with criminal justice agencies.
2. To consider the different elements of communication that can be affected amongst people with intellectual disabilities or autistic people.
3. To provide practical strategies to communicate more effectively with people who have learning disabilities and autistic people who are at risk of coming into contact with criminal justice.

Introduction

Most people with learning disabilities and autistic people have difficulties with communication. Individual strengths and weaknesses in this area are likely to vary in line with the degree and form of the individual's disability. Individuals with autism, by the nature of the condition, experience lifelong communication difficulties relating to social communication, social interaction, and social imagination (Department of Health, 2010). Individuals with learning disabilities, on the other hand, also have difficulties with communication, and even those with mild disabilities will find complex words, and sentences with embedded phrases, or double negatives confusing. The criminal justice system is riddled with complex language and abstruse processes that even those without learning disabilities or autism find incomprehensible at times. The difficulties of those with learning disabilities can be illustrated by the following three quotes from people describing their experiences in the criminal justice system, the first one relates to a visit from a lawyer, the second two to appearances in court (from Talbot, 2008):

'The solicitor tried to talk to me but used big words and I found it difficult to understand. The solicitor came and spoke to me in the cell and when she left, I thought 'What was all that about?'

'The judges don't speak English; they say these long words that I never heard in my life'

'To be truthful, I couldn't understand them. They talk so fast; they were jumping up and down saying things. I gave up listening'

Effective communication is at the core of person centred and ethical approaches to social care and health services. In line with the Equality Act (Wadham, 2010), services must make reasonable adjustments to meet the diverse needs of this population. In terms of good communication, familiarity and understanding of the individuals' unique language and communication style is key to be able to provide good care (Hawkins, 2002). This chapter aims to explore the communication needs of individuals with a mild to borderline learning disabilities and consider effective strategies and adaptations to underpin good communication.

What are the communication needs for this population?

Communication is a dual process of both sending and receiving information through verbal or non-verbal means. Being able to communicate effectively is directly linked to quality of life. Compared to the general population, individuals with learning disabilities often have limited opportunities to develop their communication skills in social contexts and refine them in multiple environments over time (Hastings et al., 2013). Impoverished social networks and a lack of inclusivity, particularly for those individuals who present behaviours that challenge services, mean that social networks are often limited to staff employed to provide a service. In such cases, good communication by staff and meaningful interaction is vital for maximising engagement and inclusion for individuals with learning disabilities (Royal College of Speech & Language Therapists; RCSLT, 2013).

Individuals with learning disabilities may experience communication difficulties in the following areas:

Attention and listening: A person's level of attention may be affected by environmental factors, medication, co-morbid conditions such as depression, attention deficit hyperactivity disorder (ADHD), anxiety, and distractibility.

Understanding: Receptive skills relate to how individuals receive and understand information. That is, the ability to understand others' verbal language, body language, and non-verbal cues. These difficulties are often hard to identify and therefore tend to be over or underestimated in this population (Bradshaw, 2001). Complex words, jargon, sentences with embedded phrases, double negatives may well confuse people, but they may not say that they have not understood. They may be acquiescent (saying 'yes' regardless of the context) and suggestible (Clare & Gudjonsson, 1993 & 1995). Receptive difficulties can impact on processing speed, and ability to follow sequential instructions. This can lead to a multitude of possible difficulties. For example, if Jane is asked to brush her teeth, shower, make her bed, and get dressed before coming downstairs for breakfast, she may struggle to process the amount of information being presented to her at once. If she is only able to hold some of the information in mind, she may come down in her dressing gown and be perceived as non-compliant.

Additionally, individuals with learning disabilities and autistic people may interpret language literally. Practitioners should try to avoid phrases where the intended meaning is not reflected in the actual words used. For example, 'caught red handed'. It is necessary to check for understanding in a manner that allows for honest feedback.

Expression: This is the ability to express oneself using words, sentences, vocabulary, narrative skills, grammar and sequencing. Expressive language difficulties are often easier to identify than receptive difficulties. Individuals with learning disabilities are likely to have a limited range of vocabulary and use fewer complex sentences to express themselves in comparison with the general population. Sentence structure may be incomplete or grammatically incorrect at times (Hassiotis et al., 2012).



Box 1. Case Example: Cloak of Competence

In a Care Programme Approach (CPA) service user Joe has agreed to engage in multiple therapeutic groups because he believes that is what his team wants him to do, but he has not understood the content of what would be covered or what attending a therapeutic group would entail. He did not tell his team that he did not understand, however, and chose instead to mask his confusion with agreement.

This lack of understanding of what he has agreed to left him feeling anxious and nervous. He is later seen behaving in a way that appears 'agitated'. These behaviours escalate until they become challenging to his care team and he finds himself dealing with consequences of 'acting out'. This situation highlights the emotions that can be triggered when an individual does not understand what is communicated to them, and in turn behaves in a way that is misinterpreted by others.

Social interaction: Having adequate conversational skills, understanding reciprocity, theory of mind, and assertiveness are important features of communicating with others. Being able to take part in communication with others is integral to helping to reduce social isolation.

Non-verbal skills: Including the use of body language, gestures, facial expressions, and eye contact. Individuals with a greater degree of learning disability may rely more significantly on non-verbal communication to express themselves. Knowledge of an individual's nonverbal communication is generally acquired through being in the individual's presence over time and allows the staff to tune in to their idiosyncrasies. Autistic people, on the other hand, tend to use few gestures, may have poor or unusual eye contact, and may not understand other's body language.

Speech: Aspects of speech such as phonology, articulation, use of intonation, stress, volume, and pace may pose a barrier to communication, as it may be hard for others to decipher the meaning. Various physical health conditions, including anatomical differences related to developmental disorders, may impact upon the physical manifestation of speech (Hassiotis et al., 2012).

People with learning disabilities and autistic people said:

- // Communication needs and help should be in the PBS plan and not separate. I like it when it is easily accessible for me. Living in the community, this is important, and staff should know it.**
- // You need to make sure that you use easy read and pictures.**
- // Sometimes, some documents aren't easy read, but you should still have a copy, and someone will need to explain it to you. You should ask for help when you don't understand.**



What are the common barriers to communication?

Often, communication difficulties amongst those with learning disabilities and autistic people are unrecognised or poorly understood as the individual is skilled at masking such difficulties. Individuals rely upon social skills they know are appropriate and may use set phrases they understand to be contextually relevant, even if they are unsure of the meaning (Hassiotis et al., 2012). For example, using phrases such as 'better to be safe than sorry' may be helpful when the individual is unsure of the 'correct' response or does not have the verbal skills to express themselves. Depending on the skills (or willingness) of the person receiving the communication, someone with learning disabilities may be able to use stock phrases to avoid further in-depth conversation that would reveal their lack of understanding.

Box 2. Case Example: Sensory Elements

A service user's CPA is held in a big room that echoes when people speak and their voices feel amplified and very loud. Due to the service user's auditory sensitivity, the noises feel painful and overwhelming. The service user begins to struggle to focus on what professionals are saying and so begins to cover their ears to muffle the noise. This behaviour seems to the professionals to show them wanting to shut out the information being shared in the meeting. The service user is then thought of as being challenging and non-compliant.

Difficulties with communication may lead to feelings of frustration, failure, exclusion from events and problems in relationships (Royal College of Speech and Language Therapists; RCSLT, 2013). Furthermore, difficulty with communication is likely to increase an individual's vulnerability to a range of risks that may negatively impact on their quality of life and wellbeing. The Learning Disabilities Mortality Review (Heslop & Hoghton, 2018) found that although the median age at death was 83 years for men and 86 for women in the general population, it was reduced to 60 for men and 59 for women within the learning disability community. This is likely linked both directly and indirectly to poor communication within health care settings, as it was shown that the more profound the disability, the lower the median age at death for both genders. The Confidential Inquiry into Premature Deaths of People with a Learning Disability discovered that at least 38% of individuals with a learning disability died from what was defined as 'an avoidable cause' related to poor healthcare provision, which can be compared to the much lower rate of 9% in those without a learning disability (Heslop et al., 2013, p. 92).

Improving communication regarding health issues can help to address these health inequalities. Health passports, action plans and similar tools can assist people to describe their signs and symptoms and avoid misunderstandings. Such tools are useful when people's health needs require them to access primary and secondary services. An accurate understanding of people's communication abilities is essential when making decisions regarding capacity to consent to health treatment (RCSLT, 2013).

People with learning disabilities and autistic people said:

- // Communication with staff and staff communicating with you is important. You need to do a good job.**
- // When people talk to us, don't be blunt and treat us with respect. We are individuals and we all need to speak to others with respect.**

Information processing difficulties

Individuals may experience difficulties absorbing, processing or remembering new information. Learning new skills, problem solving, and/or developing coping strategies can also be challenging, for both novel and common situations. This is particularly challenging in forensic settings, as there are expectations placed on the individual to develop new coping strategies or enhance their problem-solving skills to demonstrate to the professionals that their risk of reoffending has been adequately mitigated. This is also true for developing an understanding of the causes of offending behaviour and an appreciation of the impact of those behaviours on others. Without the ability to communicate effectively, the individual is likely to experience a delay in progressing in their care and accessing effective treatment. Thus, increasing the time spent in secure services.

Sensory and perceptual difficulties

Sensory processing difficulties may also hinder communication. Sensory impairments such as sight and hearing difficulties are more common in people with learning disabilities and autistic people than the general population. Estimates suggest that up to 40% of individuals with learning disabilities may have an undiagnosed or unrecognised hearing loss (Emerson & Baines, 2010). In addition, most autistic people have trouble managing sensory stimuli. Individuals may be hyper- or hyposensitive to sensory stimuli. Sensory problems may lead to adapting stimulus seeking behaviours that provide additional sensory stimulation to meet their needs, including rocking, chewing, bumping into objects, or similar. It should also be recognised that some people may have both hyposensitivity and hypersensitivity co-occurring, with different sensory elements being expressed at variable levels.

Behaviour in communication difficulties

Having communication difficulties, such as those outlined above, is associated with engaging in behaviours that challenge services (Emerson & Einfield, 2011). Communication problems limit an individual's ability to influence their world (McClintock, Hall and Oliver, 2003) and may mean that individuals resort to other behaviours to get their needs met. For example, if an individual is in pain and does not have the skills to express this in a manner staff understand, they may instead throw something to show their frustration. This behaviour could be interpreted as challenging. Attempts at communication that manifest in behaviour are often misinterpreted as a conscious demand for attention and thought to need to be ignored or disregarded by staff (Hawkins, 2002).

It is important to seek to understand to the underlying function or message behind what a person's behaviour might be communicating. Positive Behaviour Support (PBS) is an evidenced based (Department of Health, 2012) framework for developing a functional understanding of challenging behaviors that challenge services whilst enhancing quality of life outcomes (Gore et al., 2013). Interventions organised within a PBS framework should consider the important role that communication has when understanding challenging behaviour at all levels.

How might communication difficulties impact on interventions and engagement?

An awareness of the way in which communication difficulties can manifest is particularly important when working with people with learning disabilities and autistic people who have forensic risk. Progress through care pathways place emphasis on compliance. Compliance is difficult to achieve where an individual has not been able to understand what is expected of them. It also causes greater pressure on a person to express appropriate levels of dissension, as this requires nuanced communication skills. As outlined above, this lack of understanding can often lead to behaviour that challenges and can create a cycle where the person does not understand expectations and professionals fail to understand the ensuing behaviours.

Suggestions for overcoming difficulties with communication

The Royal College of Speech and Language Therapists (2013) identified five good communication standards outlining reasonable adjustments to ensure effective communication with people with learning disabilities and autistic people.

Standard 1:	There is a detailed description of how best to communicate with individuals.
Standard 2:	Services demonstrate how they support individuals with communication needs to be involved with decisions about their care and their services.
Standard 3:	Staff value and use competently the best approaches to communication with everyone they support.
Standard 4:	Services create opportunities, relationships and environments that make individuals want to communicate.
Standard 5:	Individuals are supported to understand and express their needs in relation to their health and wellbeing.

People with learning disabilities and autistic people said:

It is important to understand what people are like. People might have an impression of you and it might be down to autism. Autistic people react in different ways and people might read it the wrong way. You need to get the communication right.

What would it mean to put these standards into practice?

Although it can feel daunting to be presented with formal standards, many learning disabilities and autism services are already working closely in line with these standards and need only make a few adjustments to better respond to the needs of the service users. Ensuring that each service user has a communication passport or guideline, that was created collaboratively, and clearly considers the holistic needs of the individual, will go a long way to ensuring that all future work with that individual is appropriately communicated. A continued focus on the dignity and autonomy of the service user to be supported to make decisions on their own care and treatment is paramount, as is the need to support the service user to build therapeutic relationships with his or her carers.

Suggestions for reasonable adjustments to communication

1. Check if there are things that might get in the way of good communication. It is important to check if the person's vision and hearing is impaired. If so, do they have their spectacles and, or hearing aids with them
2. Be familiar with the individuals' communication passport/profile/guidelines. Learn how to adapt your communication in line with the guidance. (See appendix A for an example communication plan). Communication plans should inform all interactions and care plans.
3. Spoken word: people may have trouble in assimilating new material. The greater the degree of abstraction the more difficult. Care should be taken to present material in a manner that the person can understand. Where possible verbally presented material should be augmented by non-verbal materials (written or pictures/photographs/visual aids e.g., timetable).

4. The use of jargon should be avoided, syntax should be simple, and messages broken down into small parts. Do not give too much information in a session. Care should be taken to check that the individual has understood what has been said. Checks should be made at some later point to ensure that messages have not been degraded.
5. Environment and attention: Are there particular environments in which communication is likely to be more successful, e.g. quiet with no one else present. Is the person easily distracted? How long can they concentrate/ pay attention? Does the person have any sensory sensitivity, e.g. noise, bright lights, touch?
6. Relationships and opportunities. Staff should ensure that interactions with people with LD are for social engagement not just functional reasons. People should be enabled to express themselves and to feel welcome and understood through warm and genuine interactions (RCSLT, 2013).
7. Communication profiles and passports must not be developed in isolation. A multi-disciplinary approach should be adopted, that is formulation driven, with full consultation with the person themselves. Such work needs to be collaboratively and effectively integrated into care using a PBS Framework alongside other interventions aimed at reducing forensic risk, improving mental health, and reducing challenging behaviour.



Example Communication Profile

Name: Frank (not his real name)

Date of Birth:

NHS Number:

This profile is a summary of Frank's communication strengths and difficulties. The strategies should be used by anyone who supports him.

Strengths

- When settled and in an appropriate environment, Frank can attend to 1:1 interactions and tasks for upwards of 60 minutes.
- Frank can use visual aids to direct and maintain his attention, and aid his processing of information.
- Frank can follow instructions when they are given in simple sentences and chronological order.
- Frank can interpret body language and facial expressions to identify simple emotions in others, such as happy, angry, sad and scared.
- Frank speaks in full well-structured sentences.
- Frank can use some complex vocabulary in certain learnt contexts.
- Frank can initiate needs-based interaction, for example to communicate his wants.
- Frank uses appropriate intonation, prosody and stress in his speech.
- Frank can access easy read information.

Difficulties	Strategies
<p>Attention and Listening:</p> <ul style="list-style-type: none"> • Frank has a history of experiencing difficulties listening, following instructions, and attending to information presented to him, especially when anxious or unsettled. • When anxious, Frank can perseverate on his own delusional, persecutory or paranoid thoughts. He can at times become fixated on one thing and therefore struggles to see the 'big picture'. He will repeatedly attempt to return to these topics during conversation and can at times be difficult to redirect. 	<ul style="list-style-type: none"> • Frank benefits from the environment being quiet with minimal distractors. • The use of visual aids (e.g. pictures, photographs, drawing, key words) are helpful to direct and maintain Frank's attention. • Frank responds well to the use of easy read information to support his understanding and retention of information. • Frank will require additional support in the form of easy read and consistent repetition of information if his mental health declines.
<p>Understanding of Language:</p> <ul style="list-style-type: none"> • Frank's receptive language skills can be overestimated as he is able to mask his difficulties very effectively. His expressive language skills often give the impression that he is more able than he is. • Although Frank may initially appear to understand and follow conversations, at times he is only able to pick up on key words within a sentence. This can lead to him responding to these key words only and misinterpreting what has been said. This can trigger anxiety, that at times escalate to aggression. • Frank can become overwhelmed if presented with too much verbal information at once. 	<ul style="list-style-type: none"> • Keep language clear, concise and simple. • Break information into small 'chunks'. • Provide repetition and reassurance. • Check Frank has understood by asking him to explain in his own words. • Allow extra time for Frank to process what has been said. • Use visual strategies (e.g. pictures, photographs, drawing, key words) to support Frank process and understand complex information.

Difficulties	Strategies
<ul style="list-style-type: none"> Frank can become anxious if information given to him is inconsistent or ambiguous. 	<ul style="list-style-type: none"> Be consistent with language used. Use Social Stories to support him to process and retain information.
<ul style="list-style-type: none"> Frank has difficulties understanding non-literal language and will often laugh along to jokes even if he does not fully understand. Frank can interpret ambiguous language very literally, or lack awareness of the intended meaning of these phrases. This can result in confusion and anxiety. 	<ul style="list-style-type: none"> Avoid the use of non-literal language. If ambiguous language is used, ensure Frank understands by asking him to explain what it means. If he has misunderstood provide clarification as necessary.
<ul style="list-style-type: none"> Frank has difficulties understanding, recognising and communicating his own and others' emotions. 	<ul style="list-style-type: none"> Frank may need support to understand how other people are feeling and how this will affect their behaviour. Use opportunities to label Frank's and others' emotions, for example "He is biting his nails, maybe he's worried". Be aware that Frank's difficulties in understanding others' feelings could also be interpreted as him lacking empathy and being inconsiderate of others.
<p>Expression:</p> <ul style="list-style-type: none"> Frank uses a lot of echolalia in his speech - he repeats what others have said. This can give the impression that he is more able and knowledgeable about a topic than he really is. Frank can at times use complex vocabulary appropriately within a sentence without necessarily knowing the full meaning of the word. He can appear very proficient during conversations, but in reality this may be superficial and is typically only in learnt contexts. 	<ul style="list-style-type: none"> Be aware that Frank may not always have a full understanding of the meaning of the words he uses. If Frank uses complex language, ask him to explain what he means by this.
<ul style="list-style-type: none"> Frank can present as very repetitive and scripted in his use of language, particularly when anxious. 	<ul style="list-style-type: none"> Strategies such as Social Stories have been successful in supporting Frank to understand and retain information in relation to his treatment and care.
<ul style="list-style-type: none"> Frank often describes himself as feeling "anxious" or "paranoid" (terms he has likely heard professionals use to describe his presentation). He struggles to recognise his own emotions and appears to lack the emotional vocabulary to describe how he is feeling in a meaningful way. 	<ul style="list-style-type: none"> Historically Frank has used red, amber and green cards to communicate feelings of distress Ongoing SLT interventions are designed to support him to understand and communicate his emotions.
<p>Social Interaction:</p> <ul style="list-style-type: none"> Frank can initiate needs-based interaction however he can often struggle to engage in reciprocal two-way conversation The content of Frank's speech is often about him and his pre-occupations. When anxious, Frank can interrupt others and ask repetitive questions without listening to others' responses. This impacts on his ability to form meaningful friendships. 	<ul style="list-style-type: none"> Model appropriate turn taking in conversation. Prompt Frank if he interrupts. Use visuals (e.g. pictures, photographs, drawing, key words) to direct and maintain his attention to the topic or task.

Difficulties	Strategies
<ul style="list-style-type: none"> Frank typically presents as very acquiescent in conversation. He can be very suggestible and vulnerable to leading questions. 	<ul style="list-style-type: none"> Ask Frank open questions such as “What do you think?” as opposed to leading questions such as “Is that okay?”. If Frank appears to agree to something, check this by giving him a forced choice such as “Do you want to go? Or, do you not want to go?”
<ul style="list-style-type: none"> Frank can struggle with social thinking and inferencing. This lack of social understanding can result in him misinterpreting social situations and lead him to react with aggression 	<ul style="list-style-type: none"> Use opportunities to explain social behaviour to Frank a part of everyday interaction. For explain, when watching television, comment on the behaviour of characters, such as “She is shouting because she is worried about what’s going to happen”.
<p>Speech:</p> <ul style="list-style-type: none"> When distressed Frank can use a rapid speech rate, which can impact on how easily he can be understood. 	<ul style="list-style-type: none"> Model appropriate speech rate when interacting with Frank. Ask him to repeat if you do not understand. Do not feign understanding. It can be useful to repeat back the parts of sentence you have understood so Frank is aware of what he needs to repeat.
<p>Literacy:</p> <ul style="list-style-type: none"> Frank can read simple words and texts but can sometimes struggle to extract the overall meaning of what he has read. 	<ul style="list-style-type: none"> Be aware that just because Frank has read information fluently, this does not necessarily mean that he has fully understood and processed information. Frank reports that he finds easy read information with visuals aids his understanding. Access should be supported by staff to ensure he fully understands.



Chapter 10:

Community forensic learning disability teams: Supporting people in the community, in-reach work, and discharge from hospital

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Aims

1. To provide a historical and policy context to the unjust association between criminal behaviour and learning disabilities that led to large-scale segregation and institutionalisation.
2. To outline the current Transforming Care policy context as continuation of normalisation and social role valorisation principles.
3. To explore the factors contributing to and the effects of delayed discharges from hospital for people with learning disabilities and autistic people – particularly those with forensic needs.
4. To consider the role and tasks of Community Forensic Learning Disability Teams, and to describe in-reach and discharge planning approaches that can facilitate timely, safe and effective discharge and after-care arrangements for people with learning disabilities and autistic people and histories of offending or offending-type behaviour.
5. To provide a model and template to support effective discharge planning.

Introduction

Historical perspectives on the development of institutions

During the nineteenth century there were several important influences that came together to promote the development of institutions for people with learning disabilities in the UK. John Conolly, chief physician at the Hanwell Asylum in London first came across the concept of educational institutions for people with learning disabilities when he visited two institutions in Paris in 1844 – the Salpêtrière and the Bicêtre. These establishments were opened by Edouard Seguin, a French physician who pioneered educational approaches for children with learning disabilities (Seguin, 1846). Conolly witnessed what he considered to be the humane management of people with learning disabilities, with even the most disabled receiving education and huge reductions in the use of restraint. His enthusiasm for Seguin's regime was reflected in his writings (Conolly, 1847) which became well known across Britain and North America. This resulted in widespread enthusiasm for institutional care. The superintendents of the early institutions expounded the educative potential of these places. In 1847 Park House, an asylum for people with learning disabilities was opened in Highgate, London and was soon followed by many others in England after the introduction of the 'Idiots Act' 1886² (Scull, 1979).

Despite the initial benign educative ethos underpinning the development of institutions for people we would now describe as having learning disabilities, quite soon influential figures were asserting a link between learning disabilities and delinquency. Isaac Newton Kerlin, an important early figure in the field of learning disabilities published a series of 22 case illustrations in which he coined the term 'moral imbecile' (Kerlin, 1890, p. 48). Subsequent institution superintendents were quite effective in exploiting the supposed links between learning disability and criminality to make arguments for the expansion of their services, with medicine rather than education becoming the dominant ethos.

The mistaken idea of an association between low intelligence and crime persisted well into the twentieth century and influenced policy on the management of people with learning disabilities. Thus, during the early twentieth century increasing numbers of people with learning disabilities were subject to lifelong segregation in isolated asylums and colonies. This was reinforced by the introduction of the Mental Health Act 1959 which enabled compulsory admission to hospital on the basis of 'mental subnormality'. By the mid-1970s there were tens of thousands of people with learning disabilities living in what had become known as 'mental handicap' hospitals.

This segregation policy was questioned following formal inquiries into abuse at Ely hospital in Cardiff in 1969 and Fairleigh hospital near Bristol in 1971 which uncovered serious ill-treatment of people with learning disabilities. Around the same time the deinstitutionalisation movement began to take root. This movement was informed by the normalisation (later re-named social role valorisation) principles developed by Wolfensburger (1972, 1983) and underpinned by the 1971 United Nations Declaration on the Rights of Mentally Retarded Persons. There were also a series of policy developments starting with Better Services for the Mentally Handicapped (Department of Health and Social Security, 1971) which called for greater emphasis on, and provision of, small-scale community-based residential services

for people with learning disabilities. The King's Fund argued for all people with learning disabilities to have 'ordinary lives' in ordinary homes and with ordinary jobs (King's Fund Centre, 1980).

As a result of these changes in thinking and public policy, the number of people with learning disabilities living in large-scale hospital settings reduced from more than 50,000 in 1976 to around 4,000 in 2001 (Emerson, 2004). By that time, with the publication of *Valuing People*, official policy in England was that all learning disability hospitals should be closed (Department of Health, 2001).

Current policy context

Even after controlling for socio-economic status, there would seem to be a clear relationship between offending behaviour and lower intellectual functioning (e.g. Farrington, 1995; Goodman et al., 1995; Moffitt and Henry, 1991). When studies are extended to include people with IQs below 80-85, however, the relationship does not appear to be simple or linear (Emerson & Halpin, 2013; McCord & McCord, 1959), and Langdon et al., (2011) and Wilson and Herrnstein (1985) proposed that the relationship between IQ and crime is curvilinear. The notion that learning disability is a significant risk factor for offending behaviour has been robustly critiqued (Lindsay & Dernevik, 2013; Taylor & Lindsay, 2018).

One might assume therefore, that the historical association between criminality and learning disabilities would have no currency today. It is sobering to note then that official UK government census data show that a disproportionate number of people with learning disabilities, that is 7.7% or one in 13 overall, are detained under Mental Health Act, 2007 in England (Health and Social Care Information Centre, 2014). In NHS hospitals the number is more than double what would be expected in the general population (5.6% or 1 in 18); this rises to more than five times the expected number in independent hospitals (13.1% or 1 in 8). The median length of stay for male inpatients with learning disabilities in NHS hospitals in England and Wales was five times

² Terminology in the late 1800s and early 1900s is very offensive now. Terms for people with learning disabilities included 'idiocy', 'imbecility' and 'subnormality', as well as (later) 'mental retardation' and 'mental handicap'. We have avoided such terms except where they appear in names of legal acts and policies documents from the time.



greater (at 31 months) than that (5.8 months) for male mental health inpatients without learning disabilities (Care Quality Commission, 2011). The situation was even worse for female inpatients with learning disabilities. Their median length of stay was 11 times longer than for women mental health inpatients without learning disabilities (31 months and 2.5 months respectively).

Partly as a result of the disproportionate number of people with learning disabilities and autistic people remaining in hospital, often for long periods, and in response to the Winterbourne View scandal in 2011 which involved the systematic abuse of people with learning disabilities in an independent sector hospital unit in Bristol (Department of Health, 2012a), the Building the Right Support national plan was published in 2015 by NHS England and its local authority partners. The plan aimed to develop community services and close hospital beds for people with learning disabilities and autistic people 'who display behaviour that challenges' (NHS England, 2015, p. 4). The objectives of the plan included the closure of 45-65% of local Clinical Commissioning Group commissioned, and 25-40% of NHS England commissioned learning disability inpatient beds by the end of March 2019.

Unfortunately, Building the Right Support did not achieve all of its objectives (Taylor, 2019a), with around the same number of people with learning disabilities (i.e. just under 2,500) remaining in hospital in March 2019 at the end of the programme as there were when the plan was implemented in 2015. This number has reduced to just over 2000 in May 2020. More specifically, it has been argued that the lack of investment in community services has had a disproportionate effect on the care and rehabilitation of offenders with learning disabilities (Taylor et al., 2017). As a result, there are particular challenges for those working in community learning disability teams, as well as colleagues in inpatient settings, to develop innovative approaches and models of working to both prevent the risk of offending or offending-type behaviour that could result in hospital admission, and to facilitate the safe and timely discharge of inpatients with learning disabilities with forensic backgrounds and ongoing risk management needs.

In-reach work

Local commissioners have recognised the importance of repatriating individuals with learning disabilities and autistic people and forensic issues from hospitals and it has been on the agenda for some years prior to the development of the transforming care agenda. Out of Area, Out of Sight (Ritchie et al., 2005) sought to review out of area placements made by Social and Health Services for people with learning disabilities in the West Midlands. The NHS within the West Midlands conducted a project to identify people who were placed out of area and to investigate predictors of out of area placement. They identified 623 adults with learning disabilities were known to be living out of area from a region with a population of around 3.8 million. A significant proportion of service users did not have person-centred plans or health action plans, and there was also a general lack of monitoring of out of area placements. The report called for a programme of resettlement to be undertaken to reduce the number of out of area placements. They also recommended that local specialist community services should be developed as this was a key reason why out of area placements have continued.

The findings of Ritchie et al. (2005) report were brought into sharp focus after the Winterbourne view scandal (Department of Health, 2012b) which led to the Transforming Care Agenda (Department of Health, 2012a). As part of Transforming Care large numbers of Care and Treatment Reviews (CTR; Department of Health, 2017a) have been carried out in England. CTRs are used to review progress and the suitability of placements for people with learning disabilities, many of whom also have associated forensic problems. CTRs are carried out by an independent panel including an expert by experience with lived experience of services, a clinical expert and the commissioner who pays for the person's care. The reviews have a number of functions including improving the quality of care in hospital but they also try to focus on issues of discharge planning and they offer an opportunity for commissioners to evaluate the realistic possibility of effective discharge for individuals and the people they are supporting within hospitals as a group. The Care Quality Commission also regularly inspects hospitals and as part of those inspections requires evidence from hospitals of regular and meaningful contact with commissioning case managers for the individuals living in hospital.

In order to support effective in-reach services leading to discharge, significant investment is required in community services and the Department of Health (2017b) has provided guidance on service specifications. One of the ways enhanced services have been provided is through the development of community forensic learning disability teams of which a number have been reported in the literature (e.g. Benton & Roy, 2008; Goodman, Swift, Treasure, Tozer & Anstee, 2013; Browning, Gray & Tomlins, 2016; Chester, Scott-Brown, Devapriam, Axby, Hargreaves & Shankar, 2017; Graham, Harbottle, & King, 2016). These teams do vary in terms of their function and composition however, they do follow a similar pattern.

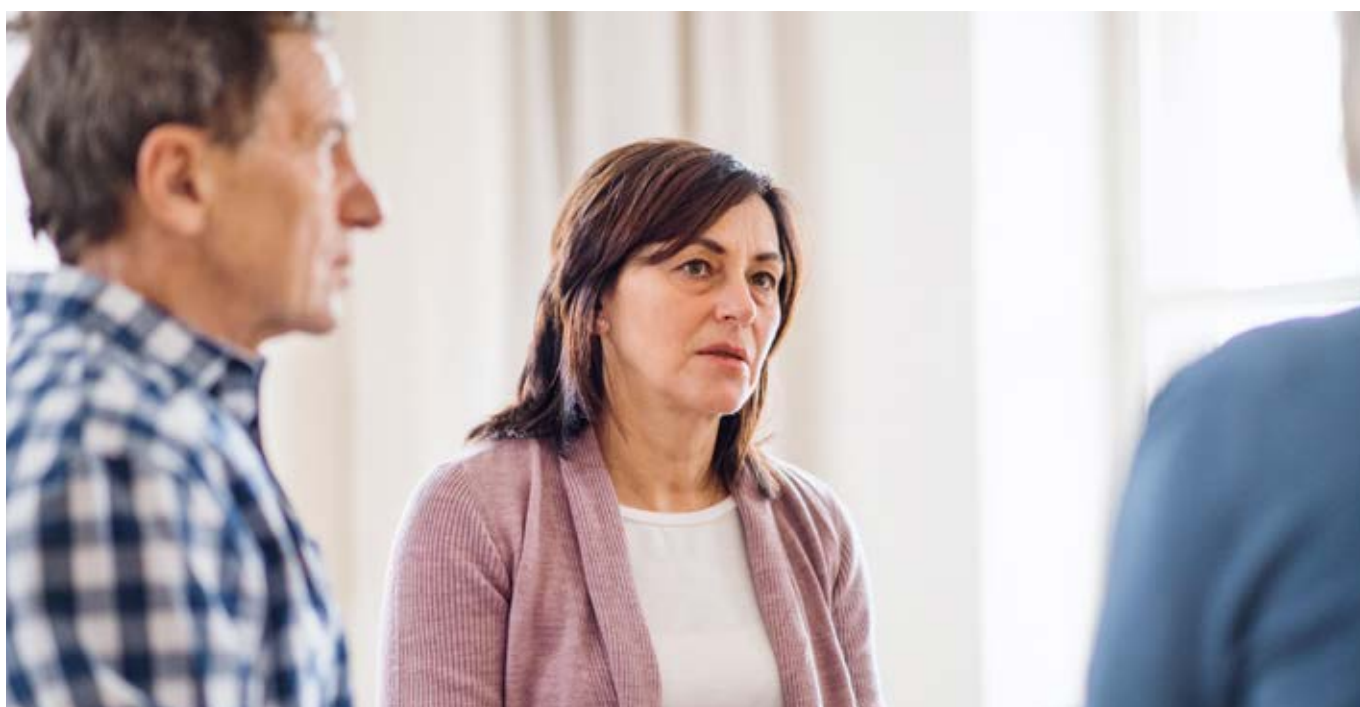
The Community Forensic Team in Birmingham (Benton & Roy, 2008) was established in 2002 to provide tertiary forensic learning disability services to the city. The team uses a multi-professional model including input from the full multi-disciplinary team to provide assessments (including of risk) and tailored individualised interventions. Key team members include Psychology, Psychiatry Nursing, Occupational Therapy, Speech and Language Therapy and support workers. Initially, a semi-structured interview and psychometric assessments are completed, specifically tailored to the service user's needs. The team uses the Health of the Nation Outcome Scale for use in Secure and Forensic Services (Dickens, Sugarman & Walker, 2007), a risk checklist and team discussion. The Questionnaire on Attitudes Consistent with Sex Offenders (QACSO; Lindsay, Carson and Whitefield, 2000) assessment tool is used for those with sexually abusive behaviours. Speech and language therapists provide assessment of any communication difficulties and make recommendations for other practitioners on individual communication needs. The forensic team works with the Community Learning Disability Team who may refer to generic services to treat underlying health conditions.

Community forensic teams should take an individualised approach to risk management and engagement. It is important to develop joint protocols with other agencies to ensure that all of those involved in the process have a clear appreciation of their role and commitments. Service users who were nearing completion of treatment and are ready to be 'stepped-down' or discharged into the community need to be identified and informed about the specialist service at an appropriate time. This should involve working closely with commissioners and hospital staff to provide individually tailored support.

Community forensic teams need to work closely with organisations discharging service users from outside the locality into the community. Transition from hospital to community is recognised as a critical time so increased specific support should be made available for the first few months after the transition. The NHSE Central 12-point tool for discharge planning needs to be followed to ensure that community and hospital services work closely together. Effective links need to be established with Learning disability teams, forensic mental health services, police, probation, court and prison liaison teams as well as neighbouring NHS Trusts that provided inpatient facilities. The framework of available services is continually evolving and it is important for forensic learning disability teams to work in association with other services such as liaison and diversion services (Burch and Rose, 2020) that are likely to need the support of community forensic teams to be able to do their jobs effectively.

Browning, Gray and Tomlins (2016) provided a service evaluation of the Birmingham forensic learning disabilities service, showing that a wide range of multi-disciplinary interventions have been provided to service users over the years. After involvement from the forensic team there was an increase in service users living in supported living in the community and a decrease in people in secure or out of area placements. After team involvement there were reductions in offending behaviour and often reductions in the severity of offending when it did reoccur.

While community forensic expertise either in the form of teams or experienced learning disability clinicians is important, this is often not available and there are other important elements to ensure successful community placements. One of the obvious key requirements is the provision of well-resourced community residential placements with appropriate staff support.



Key points

1. Community forensic teams for people with learning disabilities and autistic people have an important role in helping to reduce the risk of offending.
2. These teams are multi-disciplinary and provide assessments (including risk) and tailored individualised interventions. They develop and make use of effective collaborative working with established forensic mental health services, police, probation, court and prison liaison teams as well inpatient facilities.
3. We need increasing well-resourced community residential placement with good staff to help successfully keep people with learning disabilities who are at risk of offending living safely in the community.

Discharge preparation

Delayed discharges

Delayed discharges of inpatients who are clinically fit to leave hospital are distressing for patients and costly for services supporting them. They can negatively affect therapeutic alliances, disrupt discharge pathways and create dependency in vulnerable groups, including people with learning disabilities and autistic people, who may become increasingly anxious about leaving a hospital environment. The Department of Health has acknowledged that delayed discharges can lead to an increased risk of patients experiencing serious incidents in hospital units (Care Services Improvement Partnership, 2007). This was confirmed in the results of the 2010 Count Me In census when it was found that over a three-month period 28% of hospital inpatients with learning disabilities had been the victim of one or more physical assaults compared with 11% of non-learning disability mental health inpatients (Care Quality Commission, 2011). During the same period 30% of inpatients with learning disabilities and autistic people had been physically restrained and 22% had self-harmed. The comparison figures for non-learning disability mental health inpatients were 12% and 8% respectively.

Rorden and Taft (1990) have described hospital discharge planning as involving a process that is made up of a number of phases; the immediate goal of which is to anticipate changes in patient care needs and the long-term goal of which is to ensure continuity of health care. Without good discharge planning, people leaving hospital settings have difficulties with getting the help they need from a range of agencies at this critical transition point (Bowles et al., 2002; Tyson & Turner, 2000; Yost, 1995). In general healthcare settings, discharge planning has been shown to be essential for facilitating effective transition from hospital to the community (Holland et al., 2013). Mistiaen et al. (2007) outlined the core components of discharge planning and distinguished between discharge preparation (interventions during inpatient stays aimed at organising care and preparing patients and community care providers for a smooth transition) and discharge support/aftercare (interventions that focus on prevention and problem-solving post-discharge).

People with learning disabilities and autistic people said:

- // Community teams need to come into the hospital and visit you so they can get to know you. We need to get to know the staff in the community.**
- // We should have a part in choosing where we want to live. We need to pick somewhere we like. We need the right support for good help, and the right level of staff. We need opportunities and live where we can have hobbies and work. We might like to do games, sports and shopping, or have a job. Where we live need to give us independence and choice, and we should not just be put in the deep end.**

Effective Discharge Planning

The Department of Health developed a 'good practice toolkit' to improve discharges from inpatient mental health services (Care Services Improvement Partnership, 2007). The guidance indicates that timely and effective discharge is facilitated by:

- (i) effective clinical leadership;
- (ii) a clear risk management model;
- (iii) a defined discharge protocol;
- (iv) rapid follow-up arrangements; and
- (v) partnership working across agencies.

Petch et al. (2013) found that the features of health and social care partnership working that led to better outcomes included co-location of services and multidisciplinary team working. Also important were specialist partnerships that could support the needs of specific user groups. Partnerships that extended into other sectors such as housing, benefits and the third sector were found to improve outcomes for service users.

Steffen et al. (2009) completed a systematic review and meta-analysis of 11 studies involving discharge planning interventions for patients in mental health care services (N = 5,456). They suggested that in these services the primary objective of discharge planning should be 'to smooth the transition from in-patient to out-patient care by coordinating fragmented services, and thus to improve patient outcome and medication adherence, to prevent rehospitalisation and save costs.' Six of the studies included in this review were randomised controlled trials, three were non-randomised controlled trials and two were cohort studies. Discharge planning interventions resulted in significantly lower readmission rates, higher adherence to treatment following discharge, and better mental health outcomes compared with control conditions.

In the offender realm, Willis and Grace (2009) looked at prison pre-release planning for male sex offenders and found that post-release placement breakdown and re-offending was associated with poorly planned social support, accommodation and employment. Lindsay et al. (2002) reviewed the extent to which discharge planning from a specialist community treatment service was related to outcomes for 62 offenders with learning disabilities. Successful placements and lower reoffending rates were associated with clear discharge plans incorporating regular follow-up reviews from the treatment team, stable accommodation arrangements and organised meaningful daytime occupation.

Key points

1. Effective discharge planning is key to ensuring successful discharge. This will ensure that people get access to the right support when they need it within the community which helps mitigate risk and reduce the probability of admission.
2. A vital component of effective discharge planning is multi-agency collaborative working.

A model discharge planning protocol

Effective planning can prevent delays in the discharge of clinically fit patients from hospital and can improve clinical outcomes following discharge. However, within secure settings there are no specific guidelines concerning effective discharge planning. Griffiths et al. (2016) described the principles and stages involved in 'transitional planning' to support an individualised and values-based approach to a large-scale deinstitutionalisation programme in Ontario, Canada. This provides a helpful framework and guidelines for practitioners supporting people with learning disabilities and autistic people in moving out of hospital, however it was not developed specifically for people with learning disabilities and autistic people who were either convicted offenders or those with histories of offending-type behaviour that had resulted in their compulsory detention in hospital.

Taylor et al. (2017) described the development and service evaluation of a 'discharge pathway protocol' that was designed to specifically support discharge of offenders and those with significant histories of offending-like behaviour detained under the Mental Health Act 1983 from Northgate Hospital, a specialist learning disability inpatient service in Northumberland. The protocol was developed by the staff of an 18-bedded locked rehabilitation unit of a specialist forensic learning disability and autism inpatient service, in collaboration with patients and other key stakeholders including colleagues from community learning disability and social services. The protocol takes into account Department of Health guidance and the limited evidence available in the literature. It comprises a number of core components that are delivered in both pre- and post-discharge stages of the pathway. The components of the protocol are implemented in a manner that reflects the needs of individual patients and can be applied flexibly in terms of order and pace. The main components of the protocol are outlined in Table 1, and a more detailed description of the approach is given in Taylor et al. (2017).³

³ Copies of the Northgate Community Discharge Pathway Protocol are available from the first author (JLT).

Table 1. Outline Description of the Northgate Community Discharge Planning Protocol*

A. Pre-Discharge Phase	
1. Pre-discharge planning meetings (PDPM)	These take place between scheduled care programme approach (CPA) meetings to ensure progress is maintained with developing plans for the patient's discharge. They are led by the RC and are attended by the unit clinical team and community colleagues involved in the planning process.
2. Identifying a community service	During initial PDPM meetings, the clinical team and other stakeholders work to identify an appropriate service to meet the patient's clinical needs and manage their forensic risks. This process involves a number of discrete stages starting with a draft service specification using a specially designed template.
3. Identifying a programme of occupation	A schedule of occupation and leisure activities is developed with the patient based on their needs and interests and informed by occupational therapy assessments.
4. Secure placement funding	The care manager approaches the responsible local authority and clinical commissioning group to seek funding approval for the package of care which has been identified with the patient through the planning process.
5. Transition plan	Once funding has been approved a transition plan timetable is agreed and may involve a number stages, including: orientation visits by members of the receiving community support team; orientation visits to the community service by the patient; attendance at identified community-based occupation/education/leisure activities; and overnight leave to the community service in the care of the receiving staff support team
6. Risk management planning workshops (RMPW)	These are facilitated jointly by the clinical psychologist working with the patient and the named nurse. They are normally delivered in the identified community placement, to the service provider support team, occupation services staff and other relevant professionals who will be involved within the patient's care within the community.
7. Care planning/ risk management planning	Based on the RMPW, the clinical psychologist and named nurse meet with key staff from care and day service providers to discuss the draft care and risk management plans utilising the templates used within their own services.
8. Discharge	Patients detained under civil and unrestricted criminal sections of the MHA 1983 are discharged from hospital at the appropriate stage by the RC. Patients subject to restricted sections are required to apply to the Secretary of State for Justice or a mental health tribunal for conditional discharge from hospital.
B. Post-Discharge Phase	
1. RC transition period	The inpatient RC remains the RC for the patient for 3-6 months following discharge from hospital and reviews the patient regularly to ensure continuity of care during this transition period.
2. Consultation with hospital clinical team	Identified members of the hospital clinical team continue to offer regular, scheduled consultation and support to the patient, and direct support and advice to the service provider team and community learning disability team.
3. Forensic outreach clinics	Discharged patients, their families, carers and professional supporters are invited to discuss progress and any emerging issues at monthly multidisciplinary outreach clinics provided by the hospital clinical team in local community areas.

*Adapted from Taylor et al. (2017).

The unit where this protocol was introduced worked with a total of 67 patients over the first four years following its implementation (see Figure 1). Forty-eight patients (72%) were discharged from the unit during this period; 37 (55%) to community placements and 11 (16%) to other units/services. A further five patients (7.5%) had active discharge plans at the end of this four-year period. Just three of the 37 patients discharged to community settings were re-admitted to hospital during the study period. For comparison purposes, during the four-year period prior to the introduction of the discharge pathway protocol the rehabilitation just 12 patients had been discharged and seven of those 12 had been re-admitted during that interval (Taylor, 2019b). The mean length of stay for the 37 patients discharged to community placements was 6 years 1 month (range: 2 months - 22 years 6 months). During the four-year post-intervention period, the mean length of stay on the unit decreased by over 60% from 39 to 14 months.

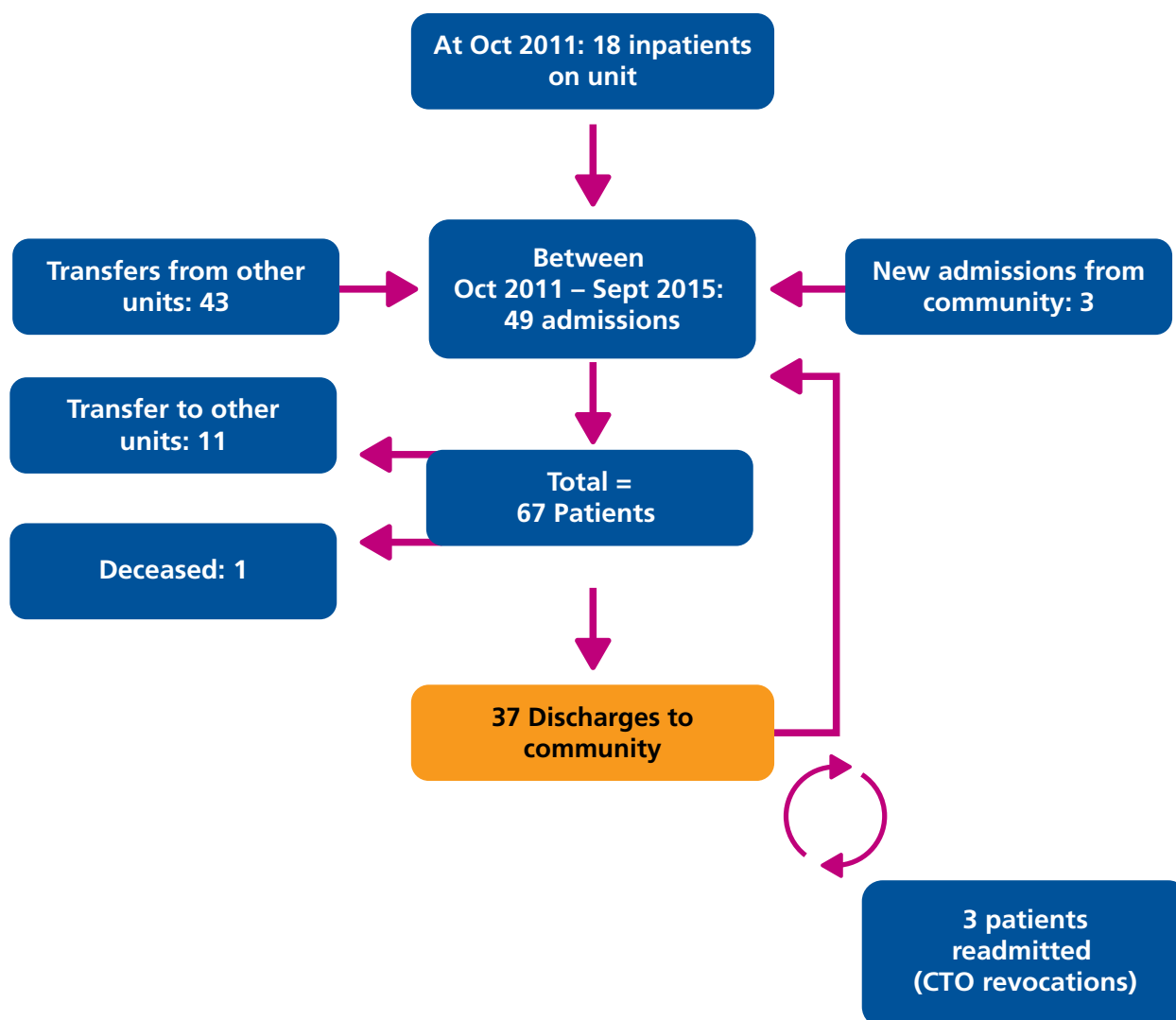


Figure 1. Locked rehabilitation unit patient flows between 1st October 2011 and 30th September 2015.

The views of a range of stakeholders were gathered concerning the utility discharge pathway protocol. A range of professional colleagues (community nurses, clinical psychologists, consultant psychiatrists, social workers, community service providers, a CCG commissioner and a solicitor) indicated that they had found the protocol useful and helpful and would recommend that the approach was adopted in other service areas. The main areas identified as being helpful were: (i) clarification of the process and roles; (ii) partnership working; (iii) risk management training; and (iv) post-discharge support and follow-up.

People with learning disabilities and autistic people said:

- // We need a well organised discharge, and you need to communicate our risk properly.**
- // We need good structures and family need to know where we are and be involved. But we might not want some people to know where we are, and so staff need to respect that.**

Conclusions

In the mid-nineteenth century institutional care for people with learning disabilities was introduced in the UK as a means of supporting and educating people considered to be vulnerable in wider society. Over the next 100 years this segregation approach prevailed but the model of care quickly shifted from pedagogic to eugenicist and medical. This conceptual shift resulted in change of attitude whereby people with learning disabilities and autistic people came to be viewed as a threat to society. This was exacerbated by the promulgation of the completely mistaken notion that people with learning disabilities were inherently delinquent, morally defective and predisposed to criminal behaviour. Increasing numbers of people with learning disabilities (including children) were subsequently segregated and housed in asylums and colonies.

During the 1960s and 1970s the uncovering of abuse and mistreatment of people living in these institutions and the parallel development of the principles of normalisation – and later social role valorisation – resulted in a change in attitudes, and policy developments that led to a large scale programme of deinstitutionalisation with increasing numbers of people with learning disabilities and autistic people living outside of institutions in the wider community. By the beginning of the 2010s there were relatively few people with learning disabilities and autistic people living long-term in large-scale hospital settings. However, in the wake of the Winterbourne View scandal in 2011 a national plan to develop community services and close hospital beds for people with learning disabilities and autistic people in England (Building the Right Support) was implemented in 2015.

Unfortunately, for a number of reasons the Building the Right Support plan has not achieved its primary aims. One reason for this is that many of those with learning disabilities and autistic people who remain in long-term hospital settings are people detained under the Mental Health Act due to offending or offending-type behaviours which is considered to place them and/or others at risk of harm. The high level of clinical complexity and associated forensic risk exhibited by this group of patients can make it difficult for them to be discharged from hospital in a timely and safe manner. While specialist community forensic teams exist in some areas, community learning disability teams may not have sufficient resources available to meet the requirements of this client group, and they may feel that they do not have the necessary training or support to manage the forensic risks presented. This can result in delayed discharges that have serious negative effects on the individuals with learning disabilities and autistic people affected (not least prolonged incarceration and denial of liberty and autonomy), as well as for those caring for them, and creates unnecessary additional costs for services.

In this chapter approaches to providing in-reach support and implementing effective discharge planning are described to assist practitioners working in community learning disability teams – and inpatient services. It is hoped that these approaches will provide a framework for achieving discharges from hospital that is consistent good practice guidance including the incorporation of risk management principles, partnership working across agencies and sustained after-care support and follow-up arrangements.

Effective discharge planning should be viewed as a multi-faceted systemic intervention that to be effective requires buy-in from all stakeholders – including the patients and their family. All involved need to be focussed upon achieving a successful transition from hospital to community living, and to participation consistent with the Good Lives Model (Ward & Gannon, 2006). This will help the individual to develop a lifestyle inconsistent with offending. It also avoids 'planning-drift' and undue delays in discharge.

Key points

1. Learning disability, crime and delinquency have been unjustly associated historically.
2. Large-scale segregation and institutionalisation resulted from these mistaken ideas for over 100 years.
3. Policies based on normalisation and social role valorisation principles have been effective in reducing the learning disability hospital inpatient population from more than 50,000 in the mid-1970s to around 2,500 in 2019.
4. Delayed discharges due to poor leadership and partnership working, along with a lack of defined protocols continue to hinder the timely and effective discharge from hospital of people with learning disabilities with histories of offending or offending-type behaviour.
5. Effective in-reach working, and discharge planning protocols can result in safe and effective discharges from forensic learning disabilities and autistic people inpatient services.
6. Such approaches need to be systemic, multi-professional and involve all relevant stakeholders to be effective.

Chapter 11: Maximising support in the community

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Aims

1. To consider how to promote socially appropriate behaviour within the community for people with learning disabilities and autistic people who are at risk of engaging in criminal offending.
2. To outline the importance of ensuring that social care providers are full partners with other organisations who are responsible for managing forensic risk.
3. To consider factors which will help social care providers to provide good quality care and support to people with learning disabilities and autistic people who are at risk of criminal offending.
4. To outline one model of social care within the community which focuses upon psychological needs and criminogenic risk.

Introduction

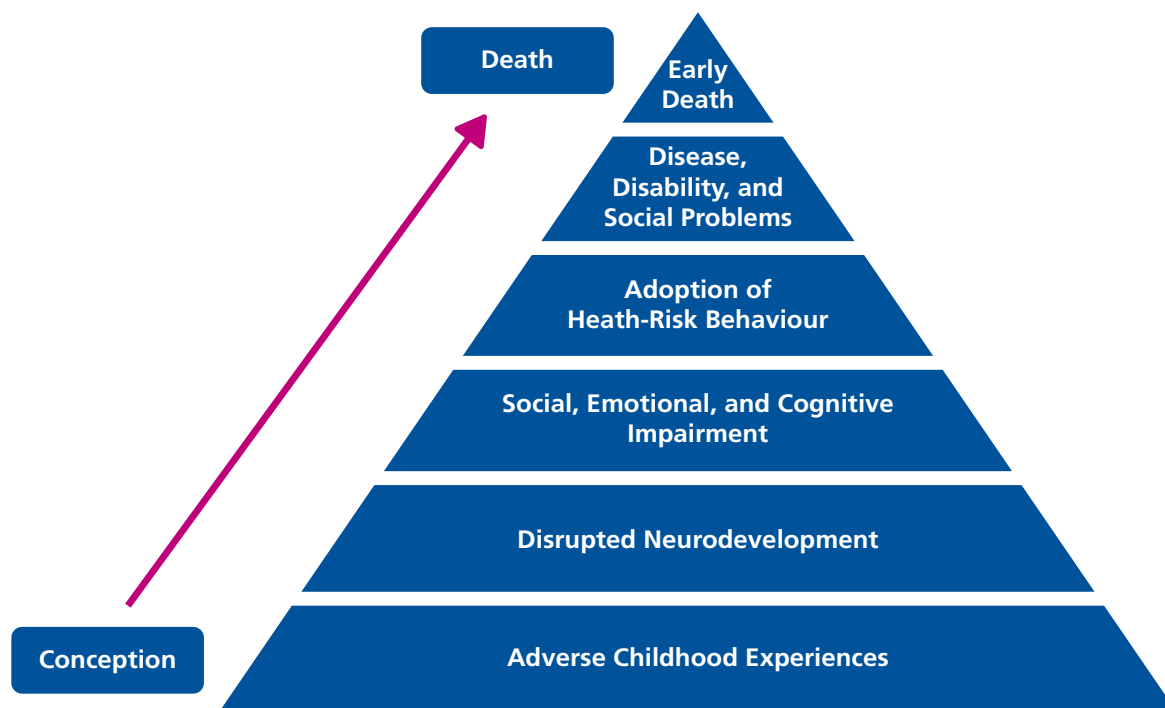
The title of this chapter invites an exploration of the relationship between a person with learning disability and/or autistic person who is at risk of engaging in offending behaviours, and how best to address these risks and promote socially appropriate behaviour within a community setting.

There is considerable guidance written for statutory services in health and social care on forensic care pathways (Royal College of Psychiatrists, 2004). These pathways include prison, hospital, and community disposal. It is, however, long-established policy to prefer a community disposal, wherever possible, over prison and hospital (The Reed Report, 1992; The Bradley Report, 2009). However, this presents a challenge of agency co-ordination, as there are likely to be a greater number of services that become involved in the person's care, support, and management. Amongst the many agencies involved, we would include Social Care Providers (SCP). SCPs are mostly private, for profit, or not for profit, enterprises that operate in a highly regulated but, nevertheless, competitive marketplace. SCPs are often perceived and/or relegated to playing a peripheral role of providing residential care or supported living arrangements in comparison to the role played by our health and social care colleagues. Nevertheless, SCPs are by far the greatest providers of direct or supportive community services. However, there is little written by SCPs on how such care and support can be best organised, co-ordinated, and delivered.

Much more than just offending behaviour

People with learning disabilities and autistic people are a heterogeneous group of individuals often defined by a diagnosis that identifies cognitive, social, and adaptive "deficits". However, within such a diverse

population of individuals there is a small number that have a history of offending behaviours. The behaviour of these individuals includes but also extends, in a somewhat undefined fashion, beyond what we might understand by 'challenging behaviours' and into the potential of causing significant harm to others (Lindsay, Taylor, & Sturmey, 2004). Their histories are often marked by numerous psychiatric conditions, developmental difficulties, trauma and abuse, poor social circumstances, and family disruption (Alexander et al., 2003; Hogue et al., 2006). The recent advances in our understanding in adverse childhood experiences clearly demonstrates the relationship to early developmental challenges and poorer outcomes in mental and physical health in adulthood (Thorley, 2019; Hicks & Pardo, 2017; Waite & Ryan, 2020)



Mechanism by Which Adverse Childhood Experiences Influence Health and Well-being Throughout the lifespan.
Diagram produced by Centers for Disease Control and Prevention.⁴

It is reasonable to assert that there are some individuals with learning disabilities and autistic individual who have experienced significant and multiple challenging events that also have a risk of engaging in offending behaviours, including behaviours that are likely to bring them into contact with criminal justice. These individuals are often described as having complex needs and are most in need of effective and well-co-ordinated services.

Community Inclusion

There are numerous policy papers describing good practice guidance and preferred service models towards community inclusion including; 'Valuing People'; 'Valuing People Now'; the 'Mansell Reports (1993; 2007)'; and most recently, 'Supporting people with learning disability and/or autistic people who display behaviour that challenges, including those with mental health conditions', and the 'Transforming Care Programme'. However, much of this guidance is of a strategic, large-scale nature. Therefore, when an SCPs considers how to operationalise 'community inclusion' at a local level, we have found it helpful to consider O'Brien's Five Accomplishments (Murray, 2009). These accomplishments include having both a presence in their

⁴ Adapted from Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine*, 14(4), 245-258.

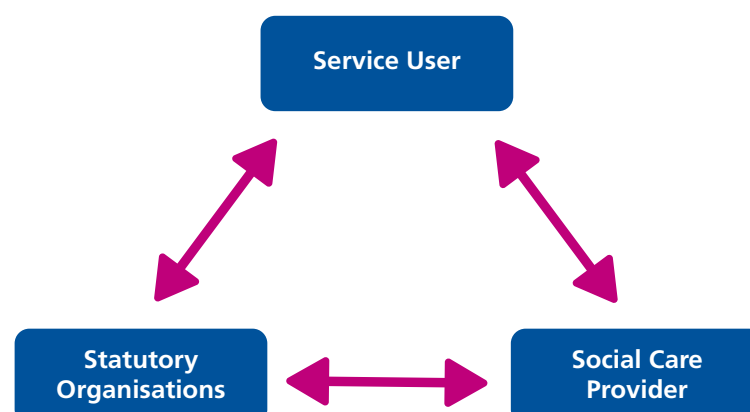
chosen community and being able to participate in the opportunities and activities of the wider community setting. This should not only include viable housing options but also access to preferred culturally desired networks, for example, social networks that also support ethnic, social, and political identities, such as LGBT communities. However, this capacity on behalf of the SCP to encourage social networking requires knowledge of local communities, encouragement, and persistence. It is also important to consider the opportunities available to express choice, feel respected, be treated with dignity, and experience care practices that encourage greater degrees of competency in social and adaptive performance that serve to enhance quality of life outcomes. Increasing choice and social inclusion will reduce the probability of behaviours that are likely to bring a person into contact with criminal justice; as a consequence, a SCP has a remarkably important role in mitigating forensic work collaboratively with all stakeholders, but most importantly, the individual.

Supporting the development of social care providers

The major emphasis of government policy is to place people with learning disabilities and autistic people in community settings close to the person's family and wider social support network. Therefore, the clear option is to have an identified group of preferred and suitable SCPs, who can meet the complex needs of the service user in their chosen locality. There is often a lack of specialised SCPs who can deliver high quality services to people with complex needs. This often results in a choice between placing someone away from their preferred community or taking a chance that a local SCP might meet their needs. Such limited options may, from the outset, impose certain inherent restrictions on the outcome of 'community inclusion'. It therefore follows that the commissioning process needs to stimulate and incentivise SCPs to invest in developing services that have the capacity to meet the complex needs of service users. However, rather than regarding SCPs as an extension of public health and social care provision, this must be progressed in partnership with a better understanding from commissioners of what private enterprise needs by way of investment to address this problem of supply and demand.

A multiagency relationship

In supporting people with learning disabilities and autistic people who have forensic risks in the community, it is helpful for us to conceive of a dynamic relationship that includes the Service User, the SCP and the many other organisations that usually have a statutory function. These central and local government statutory organisations include commissioning, regulatory, health and social care, advocacy, police, probation, public protection procedures, safeguarding and housing. These organisations often have comparatively diverse ways of operating and place numerous statutory requirements upon the provider. These diverse requirements, coupled with the complexity of the service user's presentation and needs, in their turn, increases the operating complexity required from the provider.



People with learning disabilities and autistic people said:

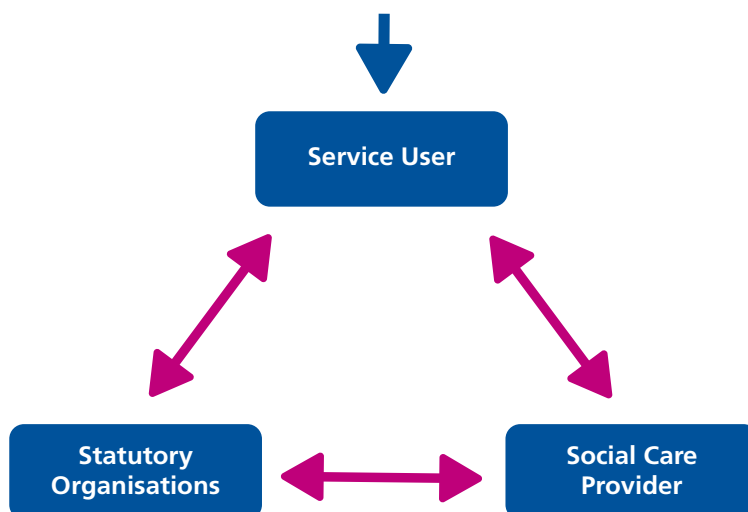
- // We need a good supportive team. We need a say, but we also need help and support not to worry about things. There might be some things that we don't need to know about or get involved in.**
- // We like choice about the colours of the walls, wallpaper, furniture, and the décor. We want to choose.**
- // We need the right team to support us who talk to us politely and respect us. Staff need to make eye contact and speak to us.**

Whilst we fully support the person-centred primacy of the service user, we nevertheless suggest that multiagency working can be best achieved when each party relies on forming an alliance with each other in the interest of mutual support and genuine partnership. For example, the service user is best served when the statutory organisations and the SCP recognise the contribution and the operating parameters of each other and work together in support of the service user. It has been our experience that the best outcomes are achieved when there is a collective understanding and a shared risk appraisal. However, anxiety, hostility and allocating blame often occurs when this mutual respect and support fails. It also fails when one party feels that the other party is in a subjugated relationship to the other. This typically manifests when the service users' rights are unjustly infringed by the SCP subject to the implicit desires or explicit instructions of the statutory organisation.

Defining 'complexity'

People with learning disabilities and autistic people who present with forensic risk are complex, and this suggests that the nature of the person is multifaceted and evidently requires more than a cursory or simple understanding. For example, such individuals may have a number of medical and psychiatric conditions that, for diagnostic purposes have been subdivided, such as, autism, ADHD, personality disorder, psychosis, depression, self-harming etc., but are, in-fact, a multifaceted picture of the unified condition of a whole person. The complexity of such a person often confounds and interacts in a non-linear fashion and therefore their behaviour is only captured in well-developed positive behaviour support plans, using the framework as intended, drawing upon a range of evidence-based interventions that are formulation driven. We suggest that greater levels of knowledge are required, set to the purpose of interpreting, or formulating behaviour from having gained experience of the person, preferably from various settings, which should be incorporated into positive behaviour support plans using co-production. From this position, the complexity of the person is often rooted in the historical experience of that person, that manifests in the present, that in return demands equally complex management strategies from the various agencies involved.

**Personal History (e.g. adverse childhood experiences)
Complexity of Clinical Conditions
Nature and Risk of Offending Behaviour**



Expertise, complexity, and risk management

We also propose that, although helpful, it is not enough for SCPs to rely entirely on external professionals informing them of the clinical complexity of the person and the nature of any associated risk of offending. The relationship between the various professionals involved and the SCP should be discursive with a shared understanding developed through mutual contributions. Otherwise, the SCP will always be reliant on the contributions of other agencies and, therefore, usually insufficiently informed, and vulnerable to either false-positive or false-negative errors in risk management strategies. It simply does not make sense to have all, or most, of the expertise external to any organisation who has such frequent direct contact with service users. Such a situation will frustrate making appropriate decisions, which at times of heightened difficulties, are sometimes required daily.

The need to balance complexity

SCPs need to work effectively to maximise social inclusion, but this can be complex. This complexity is associated with an interaction between the service user, statutory compliance, and multiagency working, and often, the SCP must navigate this complexity together with the service user to maximise placement success and mitigate risk.

This basic principle of balancing the clinical complexity of the service user with the operational complexity of the social care provider is clearly necessary but sometimes poorly considered. There is often an over-reliance on the other statutory organisations involved, who may possess greater clinical knowledge, but may be only capable of limited, infrequent, and distant involvement. This balancing is further confounded within in a climate where the commissioning and brokerage process strives to demand reduced cost, which restricts resources and investment in the SCPs workforce to well below what is required to meet the demands of the service users who have forensic or other complex needs. This simple balancing relationship is at the core of why people with learning disabilities and autistic people are inappropriately detained within hospitals, where a suitable community placement is required but not available.

What does a 'complex' social care provider look like?

A capable environment

A capable and psychologically informed environment has many contributing factors. We propose that the following are amongst the core considerations:



A well-led, values-based organisation

An essential requirement is that the organisation has a management structure that ensures it is well-led. This provides an assurance that the organisation has maintained its marketplace viability and has strengthened its governance and operational abilities. If the organisation is to meet the needs of complex service users, the need for effective systems of operations, human resources, finances, health & safety, and maintenance should not be under-estimated. Such operational maturity should also be evident in its decision-making processes that reflects a solid values-based approach, such as those described as the 'golden threads' in 'Supporting people with learning disability and/or autistic people who display behaviour that challenges, including those with mental health conditions'.

The golden threads:

- Quality of Life
- Keeping People Safe
- Choice and Control
- Support and Interventions
- Equitable Outcomes

However, for values, policies, and procedures to have any meaningful impact, we wish to place an emphasis upon the necessity of experience acquired over time. Otherwise, such values are claimed but may be little more than untested aspirations.

Operating within lawful parameters

The SCP must be knowledgeable about the lawful arrangements in which it will operate. We have regrettably experienced numerous occasions when other agencies have expectations that SCPs can enforce restrictions, remove private property, limit freedom of movement or return a service user back to their home, all without any lawful authority, other than a misplaced belief that SCPs are responsible and are, therefore, compelled to act. It is the experience of many SCPs that this has been the misguided position of, not only the public, but many other professionals including the police, probation services and other public protection agencies. It requires assertive effort to resist and inform others that SCPs do not possess such powers unless they are acting under lawfully ascribed authority. Often, SCPs have little else at their disposal, other than relying on a positive therapeutic relationship to influence the behaviour of potentially offending service users. On the other hand, it is equally important for SCPs to have a good understanding of what criminal or civil actions can, and sometimes must, be implemented to ensure public safety and ultimately the welfare of the person concerned.

Managing specific risks

The all too frequent and necessary requirement for appropriate risk appraisal is often responded to with poorly conceived ideas as to the nature, purpose, and function of risk assessments. It, therefore, goes without saying that the insights gained from poorly structured risk assessments are often not only misleading, they can also misdirect interventions and potentially expose many service users to unjustified restrictions. There is no such thing as a generic risk-assessment. Therefore, all risk assessments, to claim legitimacy, must be evidence-based and follow a clear procedure in data gathering and have clarity as to what can, and what cannot, be concluded in relation to risk management plans. Therefore, we suggest that SCPs invest in having the appropriate training, licence, and expertise to conduct evidence-based risk-assessments and, where-permitted, other psychometric assessments. Any risk assessment must be able to allow a decision to be made as to the probability, severity, and imminence of the identified risk. It should also contribute to the developing and evolving formulation and give direction as to

the legitimacy of any risk-reduction interventions in risk management plans. Clearly, these risk assessments are best performed in a multidisciplinary arrangement and periodically reviewed in collaboration with all stakeholders.

Practice leadership

Practice Leadership is central in ensuring that the knowledge and action of best practice is effectively delivered at the point of direct contact between the person and the staff team (Jukes, 2013). This means that the SCP must be able to invest in supervision and training to develop expertise through knowledge and experience. This approach must also be supported within the organisation's structure and practices, such as, providing time and support for relevant information to be meaningfully exchanged through supervision, briefings, keyworker, and multi-professional meetings. These activities should be regarded as necessary and should be expected and supported by commissioners. Practice Leadership should also be reflected in the structure of the SCPs staffing arrangements where, for example, employees have structured and progressive roles and responsibilities as their careers develop.

Supervision arrangements

We suggest that SCPs provide opportunities for 'peer-to-peer' team supervisions to review, plan and prepare their therapeutic interventions, that, by necessity of the direct care services provided, will run in parallel through the ordinary happenings of the day. Therefore, we suggest that supervision arrangements go beyond the usual 'one-to-one' approach involving a senior member of staff informing and directing a subordinate member of staff. We suggest a more open forum that facilitates the mutual sharing of understanding and ideas that contribute towards finding a therapeutic pathway. This encourages creativity and a whole team investment in developing our therapeutic interventions and an opportunity to develop and review risk management strategies. It also enables a collective approach to identifying burn-out, promoting self-care and resilience and developing reflective practitioner skills.

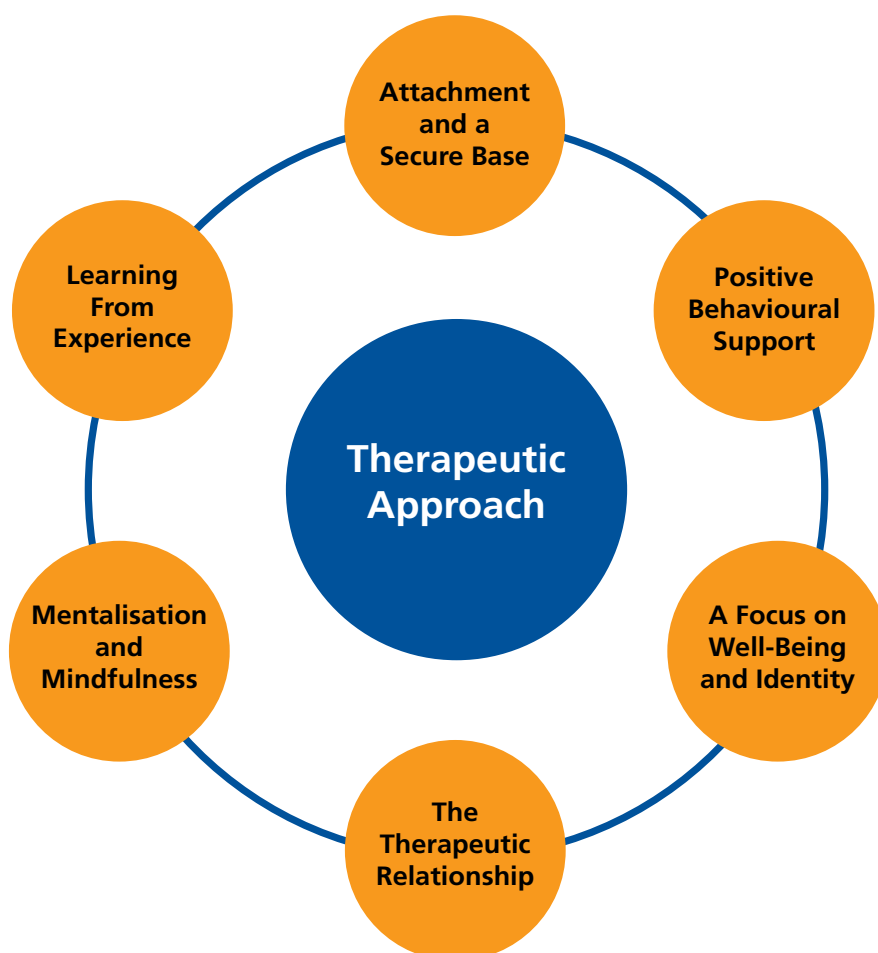
Managing professional boundaries

We devote considerable efforts to focusing on the challenges involved in managing the tensions between professional, interpersonal, and social boundaries. We recognise that one of the everyday, but by no means insignificant, challenges of frontline staff is the challenge of 'role confusion' (Gutheil & Brodsky, 2008). This is where the realms of professional and social behaviour intersect and creates confusion and possible professional boundary management issues. Where these issues are not thoughtfully considered and explicitly addressed, it invites a blaming culture, encourages poor practices that may allow for offending behaviours to occur and may also lead to safeguarding concerns. It is therefore important to recognise the differences between 'best practice', 'boundary-crossings' and 'boundary-violations' (Gutheil & Brodsky, 2008). It is also important to recognise when appropriate boundary management has lapsed into rigid and harsh positions, which emerge as a defence against criticism, that also inhibits reasonable positive risk-taking behaviour. These unaddressed boundary issues, seldom, if ever, serve the best interests of the person with learning disabilities and autistic people, but rather serve to protect the staff team or organisation.

Psychologically informed practice & management

Our therapeutic approach

Our therapeutic approach consists of a number of inter-related psychologically informed interventions. We consider these interventions as essential to provide a solid base from which more specific interventions for offending behaviours can proceed.



Attachment and the necessity of a secure base

Central to all therapeutic interventions is the necessity of creating a safe physical, emotional and psychologically secure base. Many of the people with offending risk that SCPs provide services for, have experienced enforced separations, poor care practices and disruptions in family structures. These troubling events may have also taken place at critical periods of personal development. Such events may cause deep emotional upset and leave the person in need of a safe, emotionally secure base to re-establish and focus their motivation towards achieving future positive outcomes. However, for some, the disruption is too severe and interrupts the development of a healthy identity, impairs the capacity to relate to others and predisposes the person to higher risks of physical and psychiatric illness. For these people, a safe secure home is necessary, but clearly not sufficient, to bring about a change in their often-troubled circumstances. It is therefore essential that services provided for people with learning disabilities and autistic people can understand the clinical and behavioural presentation through the lens of developmental trauma and the influential contributions from attachment theory. Without such insights, the arrested developmental progression from the disruptive influence of poor and insecure familial relationships and other adverse childhood experiences will not be properly understood, and the opportunity to provide the correct therapeutic interventions will also be denied. However, once these therapeutic interventions are provided for within an appropriate relationship, the person is much more able to use the felt experience of psychological security to be able to explore from, and retreat to, as they begin to gain agency and actively participate in achieving their therapeutic goals.

The therapeutic relationship

There is a long history of enquiry into the nature and qualities necessary for a therapeutic relationship to be developed (Wallin, 2015). Drawing upon a significant body of evidence that describes the necessary dimensions of such relationships, SCPs need to invest in the therapeutic experience of being in a relationship with their service users. SCPs are well placed to use the therapeutic relationship as the means to bring about such benefits as regulating

highly emotionally driven, physically aroused states, that often act as a precursor to offending behaviour. Such relationships, of course, rely on building trust that promotes pro-social behaviour through role-modelling (Cherry, 2010) and effective social problem-solving (McMurrin & McGuire, 2005). However, over time and through the capacity to co-regulate emotions, the person with a learning disability and/or autistic people begins to internalise this positive experience into their own patterns of behaviour. This process of relational intersubjectivity is how we all naturally learn to manage our emotions and behaviour, and develop a deeper sense of safety, personal security, and resilience. However, this is only possible once the person feels safe from within an attachment related framework. It is, however, demanding work and requires the staff team to be able to take a critically reflective stance. It also required efforts to remain open and aware of the contribution of others and to work as a co-operating and cohesive whole team. We suggest that this can only be achieved through an informed and effective senior management team able to direct practice from a top-down approach.

A focus on wellbeing and identity

There are often multiple and competing outcomes expected from the various parties within the multiagency model described above. Such expectations are best made clear, open to debate and revision, and finally, agreed upon. However, as part of the SCPs remit, we suggest that they might focus on the gains possible in physical, psychological, and behavioural competency in the social world. SCPs might also explore with the service user the personal meaning of identity, diversity, conformity, and acceptance. It is our experience that, for many people with learning disabilities and autistic people who commit crimes, these psycho-social constructs that help form a healthy differentiated personality, have often been neglected or have diminished through poor life opportunities. It should be of no surprise that it will take some time for the service user to develop and flourish, and often requires tolerance and patience on behalf of the SCP, as the service user explores how best to express their identity.

The positive behavioural support

The application of behaviour analysis and intervention, governed by a positive value system, has been very useful in helping people with learning disabilities and autistic people experience increased social inclusion. We would encourage all SCPs to invest in training and support in positive behavioural support to guide staff teams in effective decision-making as we strive to be a well-led, ethically accountable, and therapeutically informed organisation. We have found that a positive behavioural support framework, inclusive of proactive strategies that aim to address criminogenic risk, leads to individualised person-centred interventions that maximise opportunities for social inclusion. However, the necessary investment in training should not be under-estimated and requires enduring commitment from the SCP and all staff.

Mentalisation and mindfulness

There has been considerable advancement in the delivery of therapeutic interventions based on the process of mentalisation. Mentalisation is the capacity to 'hold the other person's mind in mind' that facilitates a sense of knowing and accepting the other. It is also an essential requirement for the psychological benefit of being felt to be understood. This experience brings with it the benefits of being held in a trusting 'mentalised' relationship. It allows for the mutual exploration of cognitive events that often remain hidden but are, nevertheless, the source of distress and can drive challenging and offending behaviour. These higher meta-cognitive skills may be difficult for some with learning disabilities and autistic people, thus leaving the person at some significant social and psychological disadvantage. It, therefore, remains an open question as to the possibility of developing such skills, but nevertheless there is much to be gained from the efforts to encourage the development of such mental skills. We have found that the use of these skills complements the therapeutic benefits obtained from attachment theory and positive behavioural support.

The benefits of practicing mindfulness are becoming increasingly evident. It has many positive benefits to psychological and physical health. By becoming 'attentionally aware' of the present moment, mindfulness re-establishes healthy regulation of the autonomic nervous system and the body/emotion regulation systems. Acquiring the skills to engage in mindfulness practice can be difficult for some people with learning disabilities and autistic people but can often be encouraged by facilitating relaxation with meaningful attention. We try to weave this skill into everyday activities whenever possible.



The need for service user to learn constructively from experience **Conclusions**

The reciprocal relationship between feeling physically and psychologically safe and exploring the social world, with a desire to learn and take part in the surrounding community, is the cornerstone of our therapeutic approach. However, as previously stated, the necessity of creating an emotionally safe place from which healthy exploration can proceed can be easily disrupted by adverse life events, developmental trauma and psychopathology that has occurred across the life course. Such events are also acknowledged as contributing to the risk of offending behaviours.

We therefore need to approach these therapeutic challenges with care, compassion, and insightful intervention. However, we also need to encourage the desire for curiosity and adventure that allows for the person to act and learn from their mistakes but to also know that their safety and wellbeing is foremost in our minds. We have found that in-line with the development of rigid and harsh boundaries, some SCPs also inhibit natural curiosity and appropriate risk-taking in their service users to protect the organisation from criticism. However, it is clear that without a thoughtful approach to risk taking, the greatest casualty is the person with learning disabilities and autistic people, whose every-day opportunities are stifled and inhibited in the pretence of protecting the person and others against the risk of offending behaviours. We recognise that there is dignity in risk-taking but that such risk-taking also needs to be contemplated, judged, and considered in partnership with the service user and the other agencies involved. We therefore will always encourage mutual decision-making and the development of personal agency and responsibility from within our service users.

We have proposed that the primary vehicle for providing effective social care strategies to maximise community inclusion is a viable SCP with the ability to balance the complexity inherent in the service user who is at risk of offending behaviour. We have not focused on specific offending behaviour interventions as our interventions, as this may not be within the professional scope of SCPs and may be best performed by other involved agencies. However, we have stressed the role played by SCP in providing a psychologically safe place for the service user to address the many concerns that contribute to the risk of offending behaviours. We believe that the greatest asset SCPs have is the amount of time they support a service user in direct care and support activities. We consider this an opportunity to engage in a therapeutic process informed from an understanding of the psychological processes that contribute to normal development, such as, attachment, mentalisation and mindful awareness. We believe that these skill sets are well within the capability for SCPs. There is a need for continued investment and a focus upon developing multiagency working.

Key points

1. Social care providers have an important role in providing direct care and support to people with learning disabilities and autistic people with forensic risk. Their role must not be forgotten by health, social care, and criminal justice agencies.
2. People with learning disabilities and autistic people who have histories of engaging in criminal offending behaviour tend to come from backgrounds of marked social disadvantage, and they require carefully coordinated support and care, recognising the contribution that trauma may have had upon their behaviour.
3. Social care providers need to work to promote community inclusion, inclusive of viable housing options, access to social networks, while supporting ethnic, social, political, or religious identities.
4. Social care providers also need to help people with learning disabilities and autistic people express choice, feel respected, and be treated with dignity, while enhancing quality of life outcomes.
5. This means that social care providers have an important role in helping people with learning disabilities who have a history of committing criminal offences achieve positive goals which will help reduce forensic risk.
6. Multi-agency working, inclusive of social care providers, is needed to help manage forensic risk successfully where social care providers are inclusive partners within risk assessment and mitigation.
7. Social care providers need to provide capable and well-led services. This includes working towards ensuring providers are a well-led and values-led organisation, operating within lawful parameters, managing specific risks, entailing robust practice leadership, and ensuring that there are robust arrangements for staff supervision while managing professional boundaries.
8. Incorporating psychologically informed practice and management throughout social care provision is likely to be of marked benefit to both the organisation and people with learning disabilities and autistic people, enabling more appropriate and effective positive risk taking and recovery.

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