Community Forensic Support for people with a learning disability and or autism - a national perspective?

March 2017
Service Model

Service model vision statement

Children, young people and adults with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition* have the right to the same opportunities as anyone else to live satisfying and valued lives and, to be treated with the same dignity and respect. They should have a home within their community, be able to develop and maintain relationships and get the support they need to live a healthy, safe and fulfilling life.

*This is a new term used to describe mental health conditions.
National Service Model

Commissioners understand their local population now and in the future

Service Model

Person and family/carer(s) at the centre

Principles 2 and 3

Care And Support Navigator

Person-centred care and support plan

Advocacy and information

Personal budgets and personal health budgets

Early intervention and prevention

Inclusion in activities and services

Education, training and employment

Relationships with people

Support to do things

Support and training for families and carers

Short break/respite

Alternative short-term accommodation

Trained support and care staff

Choice of housing and who I live with

Security of tenure

Strategic housing planning

Annual Health Checks

Health Actions Plans & Hospital Passports

Liaison workers

Quality checkers

Reasonable adjustments

Specialist health and social care support for people

Intensive 24/7 function

Specialist forensic support

Inter-agency collaborative working, including with mainstream services

Liaison and diversion

Integrated with community services

Admission based on a clear rationale

Discharge planning

Reviews of care and treatment (CTR)

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Issues identified in developing Service Model

- The service model describes how people with a learning disability and/or autism who come into contact with the criminal justice system, or those at risk of such contact, often ‘fall through the gaps’ of existing provision;
- Often known to Child services but lost in adulthood
- Options at court often limited to hospital admission
- Lack of community provision both specialist health & social care teams, & social care providers
- Professor Murphy’s paper - People with Learning Disabilities and Offending Behaviours: Prevalence, Treatment, Risk Assessment and Services
There are an estimated **1.2 million people** in England, of which **286,000 are children and young people** under the age of 18, with a learning disability (Emerson et al. 2012).

Of the adult population, it is estimated that **189,000 (21%) are known to learning disability services**

Studies to screen for learning disability in police custody suites, probation services and prisons all suggest **prevalence of 5-10%** (higher in youth justice).

This could mean there are about **6,000 people with a learning disability in prison** (Landman, 2016)

Estimated that **between 5 and 10% of those people known to learning disability services** have had contact with parts of the criminal justice system (Murphy, 2015)

Approximately 8,500 to 19,000 people, equating to approximately **200-400 per million population**.
Within the secure inpatient population

- The Assuring Transformation data (as at 30/09/2016) tells us that, nationally, there are around **1,300 people with a learning disability and/or autism currently in secure forensic inpatient settings**.
- **975 people in inpatients** are under Part Three of the Mental Health Act.
- Of these 975, **605 are restricted patients**, with Ministry of Justice involvement.
- Current policy (see Building the right support) anticipates a **reduction of 25-40% in secure hospital settings** by March 2019.
- With local areas using no more than **20-25 beds per million population**.
- This equates to **215 -440 fewer people in secure settings**.
- There is a **need for increased forensic capacity within the community** to support this ambition.
The planning assumptions imply bigger change in some parts of England.
Prevalence per 1 million population

• Taking all of the above into consideration, all things being equal and what we know of existing ‘distinct’ community forensic teams for people with a learning disability, we would expect that for every 1 million general population, a community forensic support function would likely need to be able to support:
  • An active caseload of between 40-60 people (plus a monitoring caseload and support to wider services), plus
  • Those people being discharged from secure care. (Capacity requirements will vary dependent on number of people currently in inpatient care and in line with the current policy ambitions to reduce overall inpatient numbers).
Support commissioners to develop local service specifications which support implementation of the national service model.

Build on the service model by providing additional detail for commissioners about the purpose, functions and intended outcomes of three aspects of the service model:

1. Enhanced/Intensive Support (Principle 7)
2. Community-based Forensic Support (Principle 8)
3. Acute Learning Disability Inpatient Services (Principle 9)
Structure of Service Specification

• Population Needs
  • National context and evidence base
  • Prevalence
  • Local prevalence

• Scope, Functions and Outcomes
  • Aims and objectives
  • Delivery structure
  • Workforce competencies
  • Population covered
  • Any acceptance and exclusion criteria and thresholds
  • Interdependence with other services/providers

• Applicable Service Standards
  • Applicable national standards (e.g. NICE)
  • Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)
  • Applicable local standards

• Applicable quality requirements and CQUIN goals
  • Applicable Quality Requirements
  • Applicable CQUIN goals
Aims and Objectives

• Reduce or safely manage behaviour which may put members of the public at risk, and would otherwise lead to contact with the criminal justice system or admission to a secure hospital.
• Ensure a focus on prevention and early intervention through collaboration with other services.

Achieved through 6 core functions of support:

1. Forensic risk assessment and management of risk in the community
2. Offence-specific therapeutic interventions (e.g. sexual/violent offences)
3. Case management of the most complex cases
4. Support and training to agencies providing day to day support to this group
5. Consultancy and advice to system partners
6. In-reach support to ensure safe and timely discharge
A reduction in the number of people with a learning disability and/or autism who require inpatient facilities.
A reduction in the behaviours of people with a learning disability and/or autism that lead to them coming into contact with the criminal justice system.
Improved support to people through the criminal justice system.

<table>
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<tr>
<th>Functions of support</th>
<th>Description</th>
<th>Outputs</th>
<th>Outcomes</th>
<th>Outcomes for the person</th>
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| Forensic risk assessment and management of risk in the community | Specialist forensic risk assessment, and/or training in the assessment of risk and expertise in the management of risks in the community. Detailed assessments are developed in partnership with individuals and families and facilitate the formulation of robust multi-disciplinary risk management strategies. These inform the therapeutic process whilst promoting public safety and emphasising a strong recovery based ethos to support. Delivery of adapted community-based offender/health programmes that meet the needs of people with a learning disability and/or autism (e.g. for substance misuse, social skills or sex offender treatment) that support choice and control alongside positive risk management. Direct and urgent support in a crisis which might otherwise lead to admission to an inpatient setting. Operates flexibly across 24/7 to meet needs. | Risk assessments and management strategies that ensure the wellbeing and safety of all. Innovative solutions to positive risk management. Early identification of those at risk of offending. Co-design and development of individualised and person-centred treatment and support plans that mitigate risk. Meaningful, less restrictive alternatives to hospital admission are in place in the community. Reasonably adjusted mainstream programmes for offenders that meet the needs of people with a learning disability and/or autism. Evidence of the application of MCA (including Best interests and DoLS) being followed and documented for people who may lack capacity. | Risk of harm (to self and others) is reduced. Reduced hospital admissions. Prevention and reduction in offending/forensic behaviours. Reduced use of restrictive interventions. Increased confidence and skills of families and other sources of support in supporting the individual. **Potential measure(s):** Reduction in risk scores relating to: - HCR-20 (Historical Clinical Risk Management - violence risk assessment scheme) - SVR-20 (Sexual Violence Risk) HoNOS-LD scores – (Health of the Nation Outcome Scale – Learning Disability) Reduction in numbers of people in hospital settings Increased numbers of people with a learning disability and/or autism accessing programmes for offenders in the community. **Health Equalities Framework (HEF)** | “I am getting expert support from people with the right skills and expertise.”  
“I am supported to be safe and a part of my community.”  
“I am recognised and respected as the person I am.”  
“I understand how the care and support I am getting is responsive to my needs.”  
“I understand what I must do and what I must not do to stay out of trouble”  
“I know what to do if I am in a situation I know is risky.” |
Key Messages

- Relates to adults only (Health and Justice FCAMHS Specification for children and young people) Possible issues around transition for most vulnerable group (16-25 year-olds)

- Function required per 1,000,000 population - smaller CCGs should consider co-commissioning

- Small (dedicated) caseloads within existing CLDTs

- Workforce development/ upskilling

- Holding risk within community will increase confidence of Responsible Clinicians
Next Steps

• Webinars/ events for TCPs

• MOOC module & resources on Yammer

• Development of consistent measures – for example do existing teams support people with Autism?

• Promotion/ support via delivery team (including CYP team)

• Development of an assurance tool (for Regional Leads)
Other activity going on

- Transforming Care Partnerships – development of Community forensic teams
- FCAMHs service specification in development
- SEND – youth offending
- HEE - workforce
- NICE – Service Model
- NHS England specialist commissioning – review of all Low & Medium specs inc Forensic Outreach spec
- NHS Benchmarking – NHS England Commissioned provision
- Community Forensic teams – mapping
Thanks for listening


- See link to Model Service Specifications