People with Learning Disabilities and Offending Behaviours:

Prevalence, Treatment, Risk Assessment and Services

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1.1 Purpose of the review

The recent scandal of Winterbourne View in England demonstrated that some people with LD and challenging behaviour receive very poor quality services. Subsequent investigations showed that many people with LD and/or autism were still in hospitals in England: over 3000 of them, according to the two Learning Disability censuses (for the 2014 census results, see www.hscic.gov.uk/catalogue/PUB16760). Just over half of the facilities surveyed were run by the NHS, the remainder were run by independent providers. Over 70% of those in hospital were male and 5% were under 18 years old. Most people were detained, rather than informal: in 2014, only 20% were informal; 45% were detained under part II and 33% under part III of the MHA (2% were under Guardianship or DoLS). Over 70% of the people in hospital were receiving anti-psychotic medication, despite few relevant diagnoses. People were often far from home (average 60 Km), and many remained in hospital for years (those further from home remaining longer).

The purpose of this review was to provide information for NHS-England to assist it in devising better health services for people with LD who have been (or are at risk of being) involved in the criminal justice system, as a result of behaviour that could be construed as criminal. In particular, NHS-England wanted to know about the kinds of services that would help this group stay in the community without endangering their own or others’ safety. Prevalence data were considered, due to their relevance for designing services, and attention was also paid to the kinds of activities that such services might need to provide (for example, risk assessments and treatment).
1.2 Background

Very few people with severe ID go through the criminal justice system, despite the fact that challenging behaviour is known to be more common in people with more severe disabilities. This is mainly because of the requirement in law, that the court must show not just *actus reus* but also *mens rea* on the part of an individual before conviction. Moreover, in England and Wales, for prosecutions, decisions are made by the Crown Prosecution Service (CPS) about whether cases should go to court, using a number of criteria, including the likelihood of conviction and public interest (similar arrangements occur in other parts of the UK).

People with LD who are suspected or convicted of offences therefore tend to have mild LD, for the reasons given above. They are mostly young and mostly male, much as in other non-disabled offender populations (Noble and Conley, 1992; Barron, Hassiotis & Banes, 2004; Lindsay et al, 2004; Cockram, 2005a; Lindsay et al, 2010a). In addition, people with LD and suspected or convicted criminal behaviour frequently have mental health needs, including Autistic Spectrum Disorder, Personality Disorder, depression and ADHD (Noble and Conley, 1992; McGee and Menolascino, 1992; O’Brien, 2002; Crocker et al, 2007; SOTSEC-ID, 2010; Lindsay et al, 2010a; Alexander et al, 2010; Lindsay et al, 2013c; Stinson & Robbins, 2014), though again this is similar to non-disabled offenders. They have often been abused themselves (Lindsay et al., 2001; Barron et al, 2004; SOTSEC-ID, 2010; Lindsay et al, 2010a; Stinson & Robbins, 2014) and frequently have a history of alcohol misuse (Lindsay et al, 2013a). They often have a history of similar behaviour in childhood, and it is well known that in services for children and young people in contact with the CJS, a sizable proportion will have learning disabilities (James et al, 1996; Kroll et al, 2002; Lader et al, 2000; Hughes et al, 2012; Ryan & Tunnard, 2012; Hackett et al, 2013).
People with LD suffer a number of disadvantages in the Criminal Justice System, including not understanding information given to them (such as about their rights); being suggestible and acquiescent on interview and in court; and not making wise decisions at crucial points in the CJS (Clare & Gudjonsson, 1991; Clare et al., 1998; Fulero and Everington, 1995; Clare and Gudjonsson, 1993; Clare & Gudjonsson, 1995; Cardone & Dent, 1996; Everington & Fulero, 1999; Kebbell & Hatton, 1999; Fenner et al., 2002; O’Connell et al, 2005; Talbot, 2008). Consequently they are known to be at risk of making false confessions, especially as adolescents (Gudjonsson, 1992; Leo & Offshe, 1998; Drizin & Leo, 2004; Perske, 1991, 2005, 2008, 2011; Kassin et al, 2010). They are often receive poor services, at least partly because they fall close to the boundaries of mental health, forensic and learning disability services (Barron et al, 2004).

Some protections for people with LD have been built into the criminal justice system, including the provision of Appropriate Adults in the police station, when people with LD are interviewed. However, sometimes the police do not realise a person has LD and it is known that far fewer AAs are provided than should be (Bean and Nemitz, 1994; Medford et al., 2000; Talbot, 2008). Often, even when an AA is called for, there are few AAs available. This means it is common for family members to take this role and all too often family members find this a very difficult task (Pearse & Gudjonsson, 1996). In any case, people with LD who are suspected of criminal behaviour tend to come from families with multiple difficulties, who are not well placed to be AAs. Typically the families have a history of social deprivation and family breakdown (e.g. Day, 1988; Winter et al., 1997; Barron et al., 2004; Wheeler et al, 2009; Lindsay et al, 2010a; Stinson & Robbins, 2014), high rates of adult unemployment with few qualifications (Murphy et al., 1995; Barron et al, 2004; Cockram, 2005a), and with frequent mental health needs amongst other family members.
1.3 Method

A systematic search was completed of the following research databases: PubMed, Cochrane, Scopus & EBSCo (which includes PsycINFO). Initial searches using terms in columns one and two of the Table below, combined with terms for therapy and rehabilitation, resulted in very large numbers of papers identified. Subsequently, following discussions with NHS-E, the search terms were focused on UK and on community services, and the final search terms are shown in the Table 1 (the specified dates were 1980-2015). All terms in column one were combined with all those in columns two and three. The majority of the resulting articles were peer-reviewed academic papers, however, non-peer reviewed articles were included on the grounds that forensic learning disability services are relatively new and under-researched. Dissertations and articles not in English were excluded.

Table 1: Terms used in the search

<table>
<thead>
<tr>
<th>Terms for learning disability</th>
<th>Terms for criminal behaviour</th>
<th>Terms for community services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intellectual disability OR mental retardation OR learning disability OR developmental delay OR developmental disability</td>
<td>Criminal OR forensic OR offending</td>
<td>Community OR services OR team</td>
</tr>
</tbody>
</table>

| * all search terms were truncated where necessary with * to ensure alternatives were covered, eg. offen* was used to cover ‘offending’, ‘offence’, ‘offences’. |

The outcome was that EBSCO listed 1116 articles, PubMed 113, Scopus 83 and Cochrane
119. Further details, including numbers of duplicates, directly relevant articles, topics, and contents are shown in Appendix 1.

In addition the grey literature was searched through emailing professional contacts (such as clinical psychologists, via the British Psychological Society’s Faculty for People with Learning Disabilities, psychiatrists and nursing). A hand search was also made through relevant (non-academic) journals, such as the Journal of Learning Disabilities and Offending Behaviour.

1.4 Prevalence and types of offences

The prevalence of criminal behaviour amongst people with LD is hard to establish with certainty, for a number of reasons (Holland et al, 2002; Murphy & Mason, 2014). Research on total population cohorts has shown that young people with lower abilities are more likely to be convicted of crimes than those who are more able (Farrington & West, 1993; Farrington, 1995; Herrnstein & Murray, 1994) but it seems that social deprivation is probably responsible for this effect (Dickson et al, 2005). In any case, such studies treat IQ as a continuous variable and it is usually not clear in these studies how many people actually have a learning disability (ie. IQ <70, with significant deficits in adaptive behaviour, present from the developmental period). Instead, two other types of studies need to be considered: firstly, those studies which take place in the CJS, such as in the police station, prison, or probation, and examine what proportion of those there have LD, and secondly, those studies which take total populations of people with ID, to examine what proportion of them are involved in the CJS. The former type of research has been more common but is less useful for planning services. Table 2 shows a summary of these kinds of projects (it is important to note that those using screening tools tend to produce higher figures than those using full assessments,
not surprisingly). Only those focused on LD are included (those also including learning difficulties are excluded).

For our purposes though, the focus needed to be on the smaller number of studies that considered what proportion of people with LD known to services were likely to have needs related to criminal behaviour, keeping in mind that broadly speaking only those with mild LD are involved in the CJS, and that the true prevalence of mild LD is approximately 2%, while administrative prevalence is lower, often considerably less than 1% (and dependant on services’ eligibility criteria).

In two small studies, Lyall et al (1995a), in Cambridge, found that 2% of the 385 people, known to services for people with ID, had been in contact with the police as potential suspects over the previous year and McNulty et al. (1995), in a study of two residential providers for people with ID (serving 180 residents), in London, found 9% of people had had contact with the police over the previous year, as suspects. In the Cambridge study, none of the individuals was prosecuted and only one was formally cautioned, whereas in the London study, most were cautioned and about one third were charged (however, the numbers in both studies were very small). These differences may have partly resulted from the fact that the London sample was entirely recruited from residential services. Arguably, people with challenging behaviour (including that of the offender type) were more likely to be in such services than living with families.

In a third and larger study, McBrien et al (2003), based in a city with a general population of almost 200,000, examined the numbers of convictions and contacts (as suspects), with the Criminal Justice Service, of all 1326 adults known to ID services. It transpired that:
- 0.8% of the 1326 were serving a current sentence
- 3% had a conviction of some kind (current or past)
- A further 7% had had contact with the Criminal Justice System (CJS) as a suspect at some time but had no conviction
- An additional 17% had challenging behaviour that was ‘risky’, but was not considered to constitute offending.

This study suggested that about 10% of the adults in touch with ID services will have had contact with the CJS at some time in their lives, as suspects. Vaughan et al (2000), in a study of mentally disordered offenders and community learning disability teams in Wessex (total population 1.8 million), found a slightly higher figure: 13% of the people known to LD Teams fitted a definition of ‘mentally disordered offender’. These two studies probably provide the best prevalence figures for people with LD in touch with services who have had CJS contact.

Finally, as regards incidence figures, Wheeler et al (2009) examined the rates of adults with LD referred to CLDTs in three health regions (total general population of 1.04 million), for anti-social or offending behaviour, in one year. Of the 237 people referred for such behaviour, 188 had no CJS contact and only 49 had CJS contact. People with more severe LD were more likely to have no CJS contact and those with less dangerous behaviour (eg just verbal aggression) were likewise more likely to have no CJS contact. In addition those already receiving a range of LD services (ie in day services and living in a group home) were more likely to be in the no-CJS group. The referral rates indicated that the average number of non-CJS referrals was 18 (ranging from 4 to 41), and the average number of CJS referrals was 4 (ranging from 3 to 13 in the different areas), per 100,000 general population. This implied that in one year for a typical CLDT covering a population of 200,000, there would be
about 36 referrals for anti-social behaviour that did not result in CJS contact and 8 referrals for anti-social behaviour that did result in CJS contact. This study probably provides the best incidence figures and it illustrates how the incidence varies across districts.

In all probability, these kinds of studies are only an approximate estimate of the real proportion of adults with LD who offend, since it is thought that around 1/3 to 2/3s of adults with mild disabilities lose touch with services when they leave school (Richardson & Koller, 1985) and all such studies only count those in touch with services (i.e. they miss people with mild LD who are not known to disability services). Moreover they usually do not count people who may be known to the police but not prosecuted (it is not uncommon for police to decide not to arrest or charge a person with LD, following reports of criminal behaviour, especially if the victim of the crime also has LD). Nevertheless the studies are useful for indicating the numbers of people with LD likely to need community-based forensic services.

The types of offences of people with LD seem to be similar to those of other offenders, when careful unbiased samples are taken, though with relatively fewer road traffic and substance abuse offences (Hodgins et al., 1996; Glaser & Deane, 1999; Barron et al., 2004; Cockram 2005a; Lindsay et al, 2010). MacEachron (1979), for example, compared offenders with LD to those with borderline abilities in two USA prisons and found no significant differences in the types or severity of the most recent offence, the length of current sentence, the degree of recidivism, participation in rehabilitation programmes, recommendations for parole, degree to which parole had ever been revoked and the use of probation as a juvenile. Crocker et al (2007) in their French Canadian study of 281 men in pre-trial holding centres also found no differences in the history of types of offences between those with LD and those without. Cockram in her longitudinal study of offenders with and without LD charged with offences in
Western Australia, examined the *most serious offences* in all of her sample and found that while people with LD were slightly more likely to be sent to prison for offences against good order and offences against property than people without LD, they were slightly 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, 2005a, Table 2). Holland and Persson (2011) in their large study of people leaving prisons in Victoria, Australia, also found prisoners with LD were more likely to have had a property offence and less likely to have had a drug offence than non-LD prisoners. They were not significantly more likely to have committed sexual offences or violent offences than non-LD prisoners. Meanwhile, Lindsay et al (2010) in their study of patterns of offending and pathways into services for 477 people with LD in the UK reported that verbal and physical aggression were the most common behaviours, property damage the next most common, and sexual offences followed, while theft, arson, road traffic offences and substance abuse were all much rarer.

1.5 Services for people with LD who are at risk of breaking the law

1.5.1 Identifying people with LD in the CJS

Most research has demonstrated that the routine identification of people with LD in the CJS is poor, both in the pre-trial and post-trial phases, in the US, Canada, Australasia and the UK (Cooke et al, 1991; Gudjonsson et al. 1993; Joseph & Potter, 1993; Bean and Nemitz, 1994; James, 1996; Talbot, 2008; Scheyett et al, 2009; Pakes & Winstone, 2010). While Youth Offending Teams use a routine tool, the CHAT, most other criminal justice agencies for children, young people and adults, including police, probation, prisons, and the Liaison and Diversion services (which have expanded following the Bradley report, 2009) use no specific
tools to routinely assess whether people have learning disabilities, even though such tools exist and have been trialled in research studies (Smith & Hudson, 1995; Clare, 2003; Hayes, 2002; Mason & Murphy, 2002b; McKenzie et al, 2012a & b; Young et al, 2013; Gardner, Freeman & Murphy, in press). This means that the identification of people with LD in the CJS is somewhat hit and miss, and a number of reports have called for better identification and screening at the custody suite stage and beyond (Bradley, 2009; British Psychological Society, 2015). In some areas good links exist between police, probation, prisons, liaison and diversion, and learning disability services (see below under 1.5.3), but this is fairly rare (see also Royal College of Psychiatry, 2014) and anecdotal evidence suggests that in many areas CJS agencies are not aware of who to contact when they do suspect someone has LD.

1.5.2 Assessment, treatment, and risk

Assessment for adults with LD who are at risk of offending has included specific measures developed for the assessment of people at risk of aggression (Benson et al., 1992; Taylor, 2002), people who set fires (Murphy & Clare, 1995) and men who engage in sexually abusive behaviour (Lindsay et al., 2007). As regards treatment, many of those in secure services receive anti-psychotic medication though there is very little evidence of its effectiveness and considerable evidence of undesirable side-effects. Service users in any case seem to prefer ‘talking treatments’ and recently, cognitive-behavioural treatment has been seen as the method of choice (Clare & Murphy, 2012) and a number of studies have now demonstrated that techniques such as anger management training are effective in reducing anger (Benson et al., 1986; Rose et al, 2000; Whitaker, 2001; Allen et al, 2001; Taylor et al, 2002a; Willner et al, 2002; Willner et al, 2013; Novaco & Taylor, 2015), and that cognitive-behavioural treatment for sexual offenders can reduce recidivism (Lindsay & Smith, 1998) and cognitive distortions (Lindsay et al, 1998a, b, c; Williams et al, 2007; SOTSEC-ID 2010; Heaton &
Murphy, 2013) and improve empathy (Rose et al., 2002; SOTSEC-ID, 2010; Heaton & Murphy, 2013), while Taylor et al (2002b) have some evidence for a CBT programme for people with LD who set fires. Nevertheless, few of the studies investigating the effectiveness of CBT in reducing offending-type behaviour have involved control or comparison groups of any kind, and even fewer have involved large randomised control trials, with the exception of an anger management trial that took place in community settings (Willner et al, 2013), so that Ali, Hall, Bickwedel & Hassiotis (2015) concluded that much stronger evidence was required. Beail et al (2005) have argued that psychodynamic psychotherapy can also be helpful for people with LD at risk of offending, though again no controlled trials exist.

Assessment and treatment for children and young people with LD and suspected/convicted criminal behaviour is less well developed. For example, a recent systematic search for assessment measures adapted for adolescents with LD and harmful sexual behaviour found no such measures available (though several are in the process of being developed). Likewise, very few treatment programmes seem to exist that have been adapted for young people with LD and harmful behaviours, though again some are being developed. The Youth Justice Board (2005), for example, voices concerns over lack of services for young people with sexually abusive behaviour, calling for service development, provision and research especially for children and young people with ID.

Whether or not treatment has been provided for people with LD with criminal behaviour, risk assessment and risk management methods are necessary, so as to ensure public safety and to reduce the risk of re-offending. In the past, as Halstead (1997) and Johnston (2002) have commented, many services for people with ID simply employed structured clinical judgments of risk for this purpose and, while this method of risk assessment may have some face
validity, there have been criticisms that such methods are not as good as actuarial methods in predicting risk at least in the non-disabled population (Grove, 2000; Monahan, 2002). For non-disabled offenders, risk is predicted using measures that combine actuarial historical variables (such as age, gender, numbers of previous offences), with clinical variables (such as diagnoses, PCL-R scores). The result is that a variety of measures abound, such as the Violence Risk Appraisal Guide (VRAG) (Quinsey et al., 1998) and the Sex Offender Risk Appraisal Guide (SORAG) (Quinsey et al., 1995), the Historical Clinical Risk-20 (HCR-20) (Webster et al., 1995), the Sexual Violence Risk-20 (SVR-20) (Boer et al., 1997), the SONAR, the Static-99 (Hanson & Thornton, 1999) and the Rapid Risk Assessment of Sexual Offence Recidivism (RRASOR) (Hanson, 1997). A number of large-scale studies have found that these instruments do predict risk well for non-disabled offenders (Barbaree et al, 2001; Sjostedt & Langstrom, 2002; Harris et al, 2003). Nevertheless, research into the use of these instruments is only just beginning in relation to people with LD at risk of offending (Lindsay, 2004) and it is likely that parts of the instruments will need adapting. Recent attempts to validate use of risk assessments instruments with people with ID include, for example, the following: Harris & Tough (2004) have found that the RRASOR did predict sexual offending amongst men with ID and sexually abusive behaviour, Quinsey et al. (2004) and Gray et al (2007) reported that the VRAG was a good predictor of violent behaviours in people with ID, and several researchers found the HCR-20 appeared to be a valid measure of risk and predictive of reoffending for people with ID (Gray et al, 2007; Lindsay et al, 2008; Morrissey et al 2014).

Increasingly, there have been attempts to improve prediction of re-offending by non-disabled offenders, by including dynamic factors (such as mood) in the risk measure, to supplement the normally static actuarial and clinical factors. Attempts to do this for people with ID are
just beginning (Boer et al, 2004) and some measures have shown some initial success: Lindsay et al (2004b), for example, have developed a measure called Dynamic Risk Assessment and Management System (DRAMS) which is showing promise as a predictor of aggressive incidents in residential settings, and Boer et al’s ARMIDILLO-S, a risk measure for predicting reoffending in sex offenders, is also showing promise (Lofthouse et al, 2013).

1.5.3 Community Services

Services for children and young people with harmful behaviours are extremely diverse and complex. The settings in which such young people are found include community settings (such as family care, foster care, specialist educational settings), in-patient mental health units, secure mental health services, secure children’s homes (SCH), secure training centres (STCs) and young offender institutions (YOIs). A range of professionals may be involved with them, including those from education, social services, police, courts, youth offending teams (YOTs), child and adolescent mental health services (CAMHS) and forensic CAMHS teams (Peto et al, 2015). A series of studies has suggested that a relatively high proportion of all the children and young people in such circumstances have LD but very few adapted provisions exist for them.

Meanwhile, for adults with LD, despite the burgeoning of treatment and risk assessment available in some settings, it is often the case that people with LD at risk of offending in the community are excluded from mainstream mental health and forensic services because of their LD, but also excluded from LD services because they are considered too able or too risky, thus finding themselves with no services at all (Hayes, 2004). In a current research project, following up people with LD who were being released from prison, Murphy et al (personal communication) found that over 1/3 were re-arrested by police with one month
after leaving prison and nearly 20% were back in prison within one month, mainly as a result of a lack of any support. Similar findings have been reported in Australia (Cockram, 2005b; Holland & Persson, 2011).

In England, some people with LD after conviction for offences in court, are sent to prison (see Table 2), some are sent to hospital under part III of the MHA or under fitness to plead legislation (see the learning disability census figures mentioned earlier), and some remain in the community, at times with probation oversight (Table 2 & Mason & Murphy, 2002a & c). Often the decisions of the police, liaison and diversion services and/or court in relation to disposal seem rather arbitrary, and the same seems true pre-trial. However, analyses of a large sample of people with LD referred to community LDTs, forensic community LDTs, low and medium secure, and high secure services (n= 477) found that if the suspected/convicted criminal behaviour involved serious aggressive behaviour or contact sexual assaults, it was more likely to result in referral to secure services, especially if it was a reoccurrence (Lindsay et al 2010), and this has also been found by previous studies (Hogue et al, 2006; Smith et al, 2008; Carson et al, 2010; Lindsay et al 2010a & b; Lindsay et al, 2013b). It is likely that where behaviour recurs, especially if it becomes more serious, professionals in community teams start to view the person as ‘untreatable’ in the community and in need of secure services. Given that some people without LD need such secure services at times, it has been argued that it is unrealistic to think that everyone with LD can be managed in the community at all times (Alexander et al, 2015).

Where people are admitted to hospital, follow-up studies of those leaving secure units have shown that in the short term most people go to lower security settings or the community (Murphy et al, 1996; Reed et al, 2004; Alexander et al, 2006; Morrissey et al, 2007; Gray et
al, 2007; Alexander et al, 2011), but it seems that outcome is not easily predicted from diagnostic variables (Alexander et al, 2010) or length of hospital stay (Alexander et al, 2006; Alexander et al 2011). Risk tools predict outcome better (Gray et al 2007; Morrissey et al, 2007) and it may also be that outcome on discharge from hospital is very dependent on the support people receive from local services (no well-controlled studies were found that compared outcome for matched individuals with and without support). To complicate matters, in the community setting CLDT members, who are often expected to take on the care of those discharged from secure units, may not feel they have the skills to provide services for people with forensic needs, even where such individuals are considered eligible for the CLDT (Devapriam & Alexander, 2012).

One alternative, however, is to set up a forensic LD community team, to support people in the community and prevent their re-arrest, since all of the treatment and risk assessment methods described above are perfectly feasible for community settings. There is a well-known and well-researched team of this kind in Scotland that has been existence for over 20 years (see for example, Lindsay, Steptoe et al, 2013) but there have been fewer in England. Recent research suggests that teams of this kind provide better access to relevant treatment than do both community services and in-patient services (Lindsay et al, 2012). Such teams have been described as being in tier 3 of services, standing above the ordinary CLDTs but below the tier 4 in-patient services (Royal College of Psychiatry, 2011, 2013, 2014). They have been set up in a number of parts of England (Avon, Birmingham, Leicestershire, East Kent, Hampshire, Calderstones and the NW, Cheshire & Merseyside, Derbyshire, and several areas in the NE)\(^1\), usually spanning several CLDTs and covering a (general) population of about 1 million. No formal research has demonstrated with robust methods that they provide better or cheaper or

\(^1\) I am grateful to team members for information from all of these areas.
more effective services than other alternatives, but several forensic LD teams have collected at least some data on their outcomes, including service user views and referrer’s views (e.g. Benton & Roy, 2008; Dinani et al, 2010; and see below). Most teams are multi-disciplinary (with access to psychiatry, psychology and nursing, and sometimes OT and speech therapy) and they provide only for those with LD (i.e. IQ<70, adaptive skills deficits, from the developmental period), though at least one team uses a wider definition of those with learning disabilities or learning difficulties (the Calderstones & NW team). In some cases the team is linked to a local LD forensic secure unit (e.g. the Cheshire & Merseyside team; East Kent team) and in all cases members of the teams provide at least some direct assessment and treatment. The teams differ in the ways they accept referrals (for example, East Kent has a very restrictive procedure in which referrals can only come from the CLDTs; Avon has a much more open referral process - see below), and some teams are ‘virtual’ teams (e.g. in Leicester, Devapriam & Alexander, 2012).

As an example, the Avon team\(^2\) had 60 referrals in 2013, 21 of which were re-referrals, from an area of general population of 1.1 million (figures for 2014 were similar). In only 2 cases in 2013 were people with LD and offending, from the area covered, deemed to require in-patient services. The 60 referrals mainly came from CLDTs and Probation, but some also came from police, courts, prison, mental health teams, social services, etc. The most common types of criminal behaviour at referral were theft, violence, sexual behaviour, and fire-setting. Assessments were completed on eligibility and on risk; consultations and advice were provided, e.g. on risk management and interventions, or attendance at MAPPA & CPA meetings; and individual and group therapies were also available. The team, which is small (and obtains psychiatry services from the CLDTs) also provided training for local probation

\(^2\) Covers Bristol, Bath & North East Somerset, South Gloucestershire, & North Somerset
services, nurses, clinical psychologists and psychiatrists, and spent considerable time liaising with other teams (such as, CLDTs, mental health teams, in-patient services, the local prison LD nurse). About 15% of referrals were considered ineligible for the team. These came mainly from Probation and usually the individuals had mild cognitive impairments and/or Asperger syndrome (and were unable to access probation treatment programmes which typically have an ability limit set at IQ 80). While the team felt able to assist them they were not commissioned to provide for this group.

Several teams have collected service user views, and views of referrers, all of which have been generally very positive (e.g. Birmingham; Avon). The criticisms teams have described have included the sense that the forensic LD team may exclude CLDTs from this kind of work, and most teams have tackled this by working into local CLDTs to directly train them to handle the less risky cases and/or to provide monthly drop-in advice sessions for CLDT members.

Summary

People with learning disabilities (LD) who engage in what could be construed as criminal behaviours, and have contact with parts of the criminal justice system, are thought to number approximately 10% of people known to LD services. They are mostly male, from deprived social backgrounds, have mild or moderate (not severe) disabilities and often have mental health needs. They commit a range of offences and typically have a number of well-recognised vulnerabilities in the CJS, including not understanding the process or their rights, being suggestible and acquiescent on interview and making unwise decisions at crucial points in the CJS. In England (and elsewhere), screening for LD is not routinely used in the CJS and needs to be far more widespread, so that services can be accessed where appropriate.
The services currently provided in England for people with LD at risk of offending are often poor and over-restrictive, sometimes involving long prison or hospital placements, far from home, and frequently involving anti-psychotic medication, despite little evidence for its efficacy. Nevertheless, there are an increasing number of possible assessments, ‘talking’ treatments and risk assessment tools available, which are just as usable in the community as in hospital or other settings. A number of community-based forensic LD teams have appeared over the last few years that provide direct services to people with LD at risk of offending and which also liaise with CJS agencies, CLDTs and other health teams, and are very positively viewed by service users. They have mostly not been well researched, however, and there is a need to examine their effectiveness more formally.

.Acknowledgements

I am grateful to Aida Malovic for her help with the systematic literature searches and to Alison Giraud-Saunders and forensic learning disability teams members for helpful information.
Table 2. Prevalence of offenders with learning disabilities in UK police stations, prisons and probation (studies from 1990 onwards)

<table>
<thead>
<tr>
<th>Author &amp; Year of Study</th>
<th>Location of Study</th>
<th>Number of Participants</th>
<th>Test (s) used</th>
<th>% of prisoners with LD.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gunn et al., 1991</td>
<td>UK, 16 prisons, 9 Young Offender Instns</td>
<td>404 youths 1365 men</td>
<td>None specified</td>
<td>0.4%</td>
</tr>
<tr>
<td>Murphy et al., 1995</td>
<td>1 London prison (remand)</td>
<td>157 men</td>
<td>WAIS-R</td>
<td>0% &lt; IQ70 5.7% &lt; IQ75</td>
</tr>
<tr>
<td>Birmingham et al., 1996</td>
<td>1 prison, northern UK (remand)</td>
<td>569 men</td>
<td>None specified</td>
<td>1%</td>
</tr>
<tr>
<td>Brooke et al., 1996</td>
<td>13 Prisons &amp; 3 YOI’s in UK</td>
<td>750 youths and men</td>
<td>Quick Test</td>
<td>1%</td>
</tr>
<tr>
<td>Hayes et al, 2007</td>
<td>One prison in UK (male)</td>
<td>140 randomly selected men (10% of prison’s population)</td>
<td>WAIS-III and VABS</td>
<td>WAIS: 7%&lt;70 VABS: 10%&lt;70 Both WAIS &amp; VABS &lt;70: 3%</td>
</tr>
<tr>
<td>Herrington, 2009</td>
<td>One young offender prison (18-21yr old males) in</td>
<td>185 randomly selected prisoners</td>
<td>K-BIT 2 and VABS</td>
<td>K-BIT: 10% &lt;70 VABS: 0%&lt;70 Both: 0%&lt;70</td>
</tr>
<tr>
<td>Study</td>
<td>Location</td>
<td>Sample Size</td>
<td>Screening Method</td>
<td>IQ and Social Functioning</td>
</tr>
<tr>
<td>------------------------------------</td>
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</tr>
<tr>
<td>Fazel et al 2008</td>
<td>London, UK</td>
<td>12,000</td>
<td>Variety (see paper)</td>
<td>1% approx</td>
</tr>
<tr>
<td>Gardner, Freeman &amp; Murphy (in press)</td>
<td>Three male prisons in UK</td>
<td>Over 2000 men</td>
<td>Screening using LDSQ</td>
<td>7% screened positive (NB screening only)</td>
</tr>
<tr>
<td>Mason &amp; Murphy (2000a &amp; c)</td>
<td>Two studies in Kent probation</td>
<td>Screening using the LIPS</td>
<td>6% and 7% with IQs below 70 &amp; deficits in social functioning</td>
<td></td>
</tr>
<tr>
<td>Gudjonsson et al, 1993</td>
<td>Two London police stations</td>
<td>156 suspects</td>
<td>Brief questionnaire &amp; then WAIS-R short form</td>
<td>9% scored below IQ 70</td>
</tr>
<tr>
<td>Lyall et al, 1995b</td>
<td>Cambridge police station</td>
<td>251 suspects</td>
<td>Brief questionnaire</td>
<td>5% had attended special schools for those with LD</td>
</tr>
<tr>
<td>Young et al 2013</td>
<td>Police station in South London</td>
<td>200 suspects</td>
<td>LDSQ</td>
<td>6.7% with LD (NB screening only)</td>
</tr>
</tbody>
</table>
References


Bradley, K. (2009). Lord Bradley’s review of people with mental health problems or learning
disabilities in the criminal justice system.


Chitsabesan, P., Kroll, L., Bailey, S., Kenning, C., Sneider, S., MacDonald, W., &


Disability, 32, 125–33.


Royal College of Psychiatrists (2011) Future Role of Psychiatrists Working with People with Learning Disability (Faculty Report FR/LD/1). Royal College of Psychiatrists.

Royal College of Psychiatrists (2013) People with Learning Disability and Mental Health, Behavioural or Forensic Problems: The Role of In-Patient Services (Faculty Report FR/ID/03). Royal College of Psychiatrists.

Royal College of Psychiatrists (2014). Forensic care pathways for adults with intellectual disability involved with the criminal justice system. (Faculty Report FR/ID/04). Faculty of Psychiatry of Intellectual Disability and Faculty of Forensic Psychiatry, London

Ryan, M., & Tunnard, J. (2012). Evidence about the health and well-being needs of children and young people in contact with the youth justice system. London:
Department of Health.


