Chapter 3

Overview of Offenders with Intellectual Disability

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The Offending Journey

Challenging and Offending Behaviour

How an individual with intellectual disability (ID) is categorised as an offender is less straightforward than in the general population. This is because the dividing line between 'challenging behaviour' and 'offending behaviour' is often blurred in this group [1]. Challenging behaviour is defined as behaviour 'of such an intensity, frequency or duration as to threaten the quality of life and/or the physical safety of the individual or others and is likely to lead to responses that are restrictive, aversive or result in exclusion' [2]. Not all challenging behaviour gets characterised as offending, and that distinction can therefore depend on a combination of offence factors, patient factors and system factors. Offence factors include the seriousness of the act, visibility of the act, pattern of repetition or escalation, etc. Patient factors include the degree of ID, visibility of the disability, presence of mental illness and personality disorder comorbidity, etc. System factors include the availability of supportive specialist services, court diversion schemes, advocacy from family members, nature of coverage in the media, the values or attitudes of key professionals, etc. Thus, the decision of whether a person with ID and a particular kind of challenging behaviour is characterised as being an offender or not can sometimes appear to be rather arbitrary. Further, under the law in England and Wales, a crime is defined by two components: actus reus (the act of crime) and mens rea (the intent to commit that crime). Intent can be difficult to elicit in people with ID, due to communication difficulties. This can make ascertaining legal responsibility particularly problematic [3].

Risk Factors for Offending and Population Characteristics

Patients treated within forensic ID services are predominantly male [4], and are typically from significantly disadvantaged psychosocial backgrounds [5]. Histories of emotional, physical and sexual abuse are common. While patients are approximately 30 years of age on admission, it has been highlighted that violent or antisocial behaviour is first observed in childhood or adolescence for the majority of inpatients [6].

The level of ID is usually in the borderline to mild range, with an occasional patient with difficulties classified as moderate. Patients are diagnostically complex, with multiple diagnoses (including major mental illness, personality disorders, autism spectrum disorder (ASD), attention deficit hyperactivity disorder and substance use disorders) [5, 7]. Mental health presentations can be atypical in those with ID, with primary and secondary diagnoses overshadowing other clinically relevant symptoms, such as difficulties differentiating or

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diagnosing both autism and psychosis in this population [8]. Rates of self-injury are very high, with approximately 80% of inpatients having a history [5].

Winter et al. [9] examined factors predisposing to suspected offending by adults with ID. These authors reported the relevance of factors such as losing contact with their father, forensic contact of family members, past homelessness, illicit drug/alcohol use/dependence, experiencing an excess of recent life events, behavioural problems at school, truancy, childhood police contact and contact with probation services. A recent study has also highlighted the potential role of traumatic brain injury as a risk factor for offending in those with ID, with rates at a similar level as the general prison population [10]. Indeed, risk-assessment tools that have not been specifically developed for those with ID, which are based on an extensive evidence base investigating risk factors in the general offending population, have been demonstrated to be of equal or superior validity regard to predicting future offending [11, 12].

Prevalence

Just as in the general population, where the criminal offences recorded in official statistics provide only limited information about the incidence and prevalence of illegal behaviours, offending behaviour can be under-reported in those with ID [13]. Family and paid carers of people with ID can be less likely to involve the police when an offence is committed [14]. The availability of specialist community ID forensic teams who can respond to incidents can also affect whether behaviour reaches the attention of police [15]. The ID teams provide interventions and manage risk in the community setting, avoiding the need for further processing by the criminal justice system. Behaviour is often managed within community/inpatient mental health or ID services until it reaches a threshold that is unmanageable within such settings. The individual is then referred to forensic services known as an 'upwards referral'. When a person has moderate to severe ID, unless the crime is very serious, they are unlikely to be dealt with through the criminal justice system. In those with mild ID, however, there are still challenges often requiring specialist evaluation to determine their understanding of the offence [16].

Police Involvement

Studies have suggested that between 5% and 9% of suspects seen at police stations have ID [17]. In the UK, several cases involving miscarriages of justice have shown that suspects with ID are disadvantaged when interviewed by the police, because they may 'without knowing or wishing to do so, be particularly prone in certain circumstances to provide information which is unreliable, misleading or self-incriminating' [18]. Therefore, safeguards must be put in place and the Code of Practice sets out a specific process at police stations: being cautioned first, then informed verbally by the custody officer of the rights to obtain legal advice and to have someone informed of the arrest, followed by a written leaflet (the 'Notice to Detained Persons') reiterating and expanding upon the information already given verbally. Finally, the right to have a copy of the custody record is also explained [19].

People with ID are more prone to suggestibility, confabulation, compliance and false confessions [20–23]. Therefore, they have a right to have an appropriate adult at the police interview, in addition to their legal representative. This safeguard is to support them in communication during questioning, observe whether the police are acting with respect for the detainee's rights and to ensure the detainee understands these. However, there are

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several potential problems in this process. Screening for ID is not well established in police stations [24]. Even when screening systems are in place, some people with ID remain unidentified [25]. The appropriate adult may not be trained to facilitate communication between the police and a person with ID [21]. There are also circumstances where there is significant police dissatisfaction with the support given by an appropriate adult during the interview [26]. Liaison and diversion schemes at the police station can ensure appropriate assessment and links with services at the court, but their availability varies geographically [27].

Courts

If an offender with a suspected ID is arrested by the police and charged with an offence, they will be taken to a magistrates' court [28]. Where an alleged offence is non-indictable or triable either way (i.e., in a magistrates' court or Crown Court) the alleged offence may progress no further. A magistrates' trial is commenced by a summons sent to the defendant, whereas a Crown Court trial is preceded by a charge. At the commencement of a Crown Court trial, the defendant hears the charge, and is asked to plead either guilty or not guilty. It is possible for the defendant's barrister to claim that their client is unfit to plead at this stage [29].

At trial, ID may be relevant when assessing whether the defendant has mens rea for the offence, regarding fitness to plead [29, 30] or the defence of insanity [29] and for the provision of courtroom support. Ascertaining mens rea in a case involving a person with ID can be a core part of serious cases involving murder, rape and violence against the person. It involves the defendant intending the consequence of their act or recognising the risk and taking it [29].

Fitness to plead is an important consideration in defendants with ID. The main criteria used in determining fitness to plead are capacity to plead with understanding, ability to follow the proceedings, being able to challenge a juror, ability to question the evidence and ability to instruct counsel. The defendant's fitness to plead is decided by the judge, usually on the basis of reports from psychiatry or medical practitioners and does not require a jury [17]. If fitness to plead is present, the judge can provide further support for the defendant but, if absent, the case may proceed on a 'trial of facts'.

For there to be a defence of insanity, the disease of the mind must cause the defendant to have a 'defect of reason'. If it is determined that the defendant is guilty by reason of insanity, the judge can use a range of sentencing options including hospital, guardianship, supervision and treatment, or absolute discharge orders [31]. If the defendant has ID, experts will be sought to provide evidence to the court in each individual case. 'Diminished responsibility' is a defence that can only be used when charged with murder; if successful, the conviction is reduced from murder to manslaughter [32]. ID can also be stated as the basis of diminished responsibility [31]. However, the burden of proof in both these cases is on the defendant and must be proven on the balance of probabilities and not beyond reasonable doubt. It is important to note that psychiatric defence differs between countries and examples of these differences can be seen in McCarthy et al. [33].

Sentencing

The first sentencing decision takes place when a defendant appears in court for the first time, and concerns whether to offer bail or to remand in custody [17]. Sentencing also marks the final stage of the criminal justice process. The Criminal Justice Act 2003 [34] sets out the

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objectives of sentencing: punishment of offenders; reduction of crime (including reduction by deterrence); reform and rehabilitation of offenders; protection of the public; and making of reparation by offenders to persons affected by their offences. The court requests access to information on a defendant's needs at the pre-sentence stage, to inform the sentencing decision through a pre-sentence report prepared by a probation officer. This should include information pertaining to any mental health conditions, which would enable the court to decide on an appropriate disposal or outcome for the defendant [27]. With patients who have ASD, with or without ID, it has been suggested that the courts may misinterpret certain behaviours as lack of empathy and thus sentence them more harshly [35].

Courtroom support arrangements for those with ID, and other developmental disorders such as ASD, support the principle of justice by ensuring the defendant has the right to a fair trial, by avoiding miscarriages of justice and limiting the need for an appeal. The arrangement of support within the court is dependent on accurately identifying defendants with ID. The Nacro report [36] noted that most court diversion schemes were focused on offenders with mental illness and that there were only three schemes in England and Wales that had either ID practitioners or links with ID services. The Bradley report [27] recognised the problems resulting from these limited schemes and the non-recognition of ID at the court stage. The report recommends that the probation service and the judiciary should receive mental health and ID awareness training [16].

A registered intermediary is sometimes employed to support defendants with ID [21]. They are impartial, not working for the prosecution or the defence. The registered intermediary's role was introduced to facilitate communication between the police, the courts and vulnerable witnesses, for example those with ID. They can assist the police in communicating with witnesses at the investigation stage, take part in pre-trial meetings and court familiarisation visits and assist in communication with the witness at trial. Access to such an intermediary, however, is not currently a legal right across England and Wales.

Models of Treatment

The Legal Structure

Few of the programmes designed to address recidivism within prison or probation services are modified to make them accessible for people with ID [17]. This means that people with ID who receive custodial or non-custodial sentences often have a lack of equity, not just in access to remedial programmes but also in long-term prognosis and outcomes. This is precisely why this group requires diversion to access treatment and achieve rehabilitation through health services, whether based in hospitals or in the community.

Under the Mental Health Act in England and Wales, 'learning disability' (or ID) is named as a mental disorder if it is associated with abnormally aggressive behaviour or seriously irresponsible conduct. Although there is currently a proposal to remove ID from the remit of the Mental Health Act, Part III of the Act (i.e., the part that refers to the courts and criminal disposals) is not earmarked for change [37]. This means that the option for someone with ID to be diverted away from prisons to hospitals or the community for treatment and rehabilitation will remain the predominant model.

The following factors determine whether a community disposal is appropriate: nature of the current offence, history of previous offending, the presence of mental illness, personality disorders, comorbid substance misuse, capacity to consent, the need for public protection,

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issues of vulnerability in prison settings, availability of adapted treatment programmes, etc. In England and Wales, a person with ID can be treated in the community via a guardianship order or a supervision and treatment order. This route has been shown to manage risk and avert the need for expensive secure hospital admission. The full range of sentencing or diversion options available within the criminal justice system has been described earlier [16] and is examined in some detail in chapter 17 of this book.

Forensic Hospitals

Forensic psychiatry services have grown and become more complex in structures, processes and pathways [38]. In the UK, there are forensic hospital beds at three levels of security – high, medium and low. Treatment options in hospital under the Mental Health Act can involve hospital orders to either specialist forensic ID hospitals or, occasionally, mainstream forensic psychiatry facilities. When electing to transfer or remand an individual to hospital, the individual's antecedents, presentation and (alleged) offence governs the level of security in the hospital they are sent to, for example, a general psychiatric hospital vs a forensic hospital. In the UK, forensic hospitals are commissioned differently and attract higher funding than their general psychiatric counterparts, typically resulting in a better provision and availability of specialist psychologists, social workers and occupational therapists together with a medical and nursing team with higher staff-patient ratios. In theory, this allows time and expertise for a thorough assessment for people with ID and other developmental disorders. Treatment outcomes from these services are described later in this chapter.

Forensic Community ID Teams

While hospital-based services have been well developed in the UK, community forensic ID teams are still in their relatively early stages. Published literature in this area is limited to service descriptions and initial service evaluations that are limited to single services [15, 39, 40]; see also Chapter 13.

Treatment Programmes

One of the persistent criticisms of the treatment model within forensic settings has been a lack of definition. Chapter 13 describes a four-phase approach to treatments with phase 1 involving the interface with the courts and criminal justice system, phase 2 being the acute treatment and alleviation of distress, phase 3 being rehabilitation and phase 4 reintegration. Chapter 14 describes the methods of risk assessment and management that are quite central to the treatment plans. Both Chapters 13 and 14 describe in some detail the various assessment tools that are used in the assessment and treatment process. Assessing and treating a patient is a collaborative effort between a multidisciplinary treating team and the patient. The 10-point treatment plan described by Alexander et al. [5] (see Table 3.1) covers phases 2, 3 and 4 and offers a useful framework for the assessment, treatment and rehabilitation of individuals with ID and offending behaviours, whether in a hospital or community settings.

Measuring healthcare outcomes is paramount for evaluating the effectiveness of various treatment options to provide the best patient care. This has become particularly relevant following the Winterbourne View abuse scandal, after which an agenda to care for people

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Table 3.1 The 10-point treatment programme

A multi-axial diagnostic assessment	Covers the degree of intellectual disability, cause of intellectual disability, pervasive developmental disorders, other developmental disabilities, mental illnesses, substance misuse or dependence, personality disorders, physical disorders, trauma and other psychosocial disadvantages, types of behavioural problems
A psychological formulation	Developed collaboratively with the patient.
A behaviour support plan	Incorporating positive behaviour support principles
Risk assessment and management plans	Using actuarial and structured clinical judgement tools
Pharmacotherapy	Targeting both comorbid mental illnesses and the predominant symptom clusters that are problematic. Physical conditions are treated with input from primary and secondary care.
Individual and group psychotherapy	Guided by the psychological formulation and will include motivational work, supportive therapy, social skills training, assertiveness training, management of emotions, addressing comorbidities like substance misuse or issues like bereavement, etc.
Offence-specific, individual and group psychotherapies	Particularly those targeting anger and interpersonal violence, sexual offending, fire setting, etc.
Education, skills acquisition, and occupational/ vocational rehabilitation	Providing a structured, predictable and rehabilitation-focused programme of daily activity
Community participation	Providing rehabilitation and reintegration through a system of graded escorted, shadowed and unescorted leave periods.
Discharge and community transition.	Rehabilitation and reintegration into the community

with ID within mainstream psychiatric services, as well as provide good quality of care in the community rather than be kept unnecessarily in hospitals or other restrictive environments, was recommended [41]. The Winterbourne View review also highlighted concerns over inappropriate care models, lack of personalised care plans allowing the patient to stay within easy reach of their families and poor care standards, all of which underline why measuring outcomes are vital in this population.

A systematic review involving 60 studies extracted data on outcome domains in people with ID who had involvement with forensic services [42]. In consultation with patients and family members, the authors formulated a framework to examine treatment effectiveness, patient safety and patient, and carer experience. Table 3.2 summarises the key outcome

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Table 3.2 Framework of outcome domains (reproduced from Morrissey et al., 2017 [42])

Effectiveness
Discharge outcome/direction of care pathway
Delayed discharge/current placement appropriateness
Readmission (i.e., readmitted to hospital or prison)
Length of hospital stay
Adaptive functioning
Clinical symptom severity/treatment needs: patient rated
Clinical symptom severity/treatment needs: clinician rated
Recovery/engagement/progress on treatment goals: clinician rated
Recovery/engagement/progress on treatment goals: patient/carer rated
Re offending (i.e., charges/convictions) on discharge
Offending-like behaviour (no criminal justice system involvement) on discharge
Incidents (violence/self-harm) (in care setting)
Risk-assessment measures
Security need (i.e., physical/procedural/escort/leave)
Patient safety
Premature death/suicide
Physical health
Medication (i.e., PRN usage/exceeding BNF limits/side effects patient rating)
Restrictive practices (restraint)
Restrictive practices (seclusion/segregation)
Victimisation/safeguarding
Patient/carer experience
Patient experience: involvement in care
Patient experience: satisfaction/complaints
Quality of life: patient rated
Therapeutic climate
Access to work/meaningful activity (where appropriate)
Level of support/involvement in community/social network (post discharge)
Carer experience: communication with services/involvement in care

domains identified. Notwithstanding its limitations, this evidence base suggests that treatment within specialised services delivers good treatment outcomes.

It can be difficult to measure outcomes in a forensic ID setting due to numerous factors. First, the views of the healthcare professionals, patients and carers may vary as carers and

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patients may look at the quality-of-service provision and their experience of receiving the service as well as the clinical outcome, but healthcare professionals may only focus on the clinical outcome. In any case, even the outcome variables that have been used have question marks against their reliability and validity. Secondly, conventional methods of measuring long-term outcomes by examining reconviction or reoffending rates may not be appropriate for this group, a point made with clarity in one of the first outcome studies in this area that showed that, while reconviction rates were low at around 10%, the rate of 'offending-like behaviours' was well over the 50% mark [43]. Thirdly, many of the outcome studies so far are either from single sites or from the same country. This may not reflect the potential differences between different geographic areas within a country as well as internationally.

Finally, most studies looked at the cohort of patients who were discharged successfully from the hospital and hence did not account for those who continued as inpatients for long periods. Interestingly, one of the few large-scale studies using a countrywide stratified random sample of long-stay patients in medium and high secure settings found that those with ID were not disproportionately higher in comparison to those without ID (44). This suggests that while there is indeed a sub-group of patients in forensic settings who stay for long periods of time, there may be factors mediating that which go beyond the presence of ID. There is an urgent need to explore the other clinical, risk and socio-demographic variables that mediate treatment outcomes for this vulnerable group.

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