Offenders with Intellectual Disabilities in the Criminal Justice and Forensic Mental Health System – an Overview

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Overview

- What is intellectual disability (ID)?
- Relationship between IQ/ID and offending behaviour
- How are people with ID managed at various stages the Criminal Justice System?
- Prevalence, needs and outcomes of people with ID in prison
- Prevalence, needs and outcomes of people with ID in secure hospital
- Conclusions re possible reasons for over-representation and challenges

What is intellectual disability?

DSM-V

- Deficits in **intellectual functioning** - *but shift away from primary reliance on IQ scores*
- Deficits or impairments in **adaptive functioning**
- Present in the **developmental period** (before 18)

- Around 2-2.5% of the general population
- In the contexts of offenders, primarily mild ID (IQ 50-70)

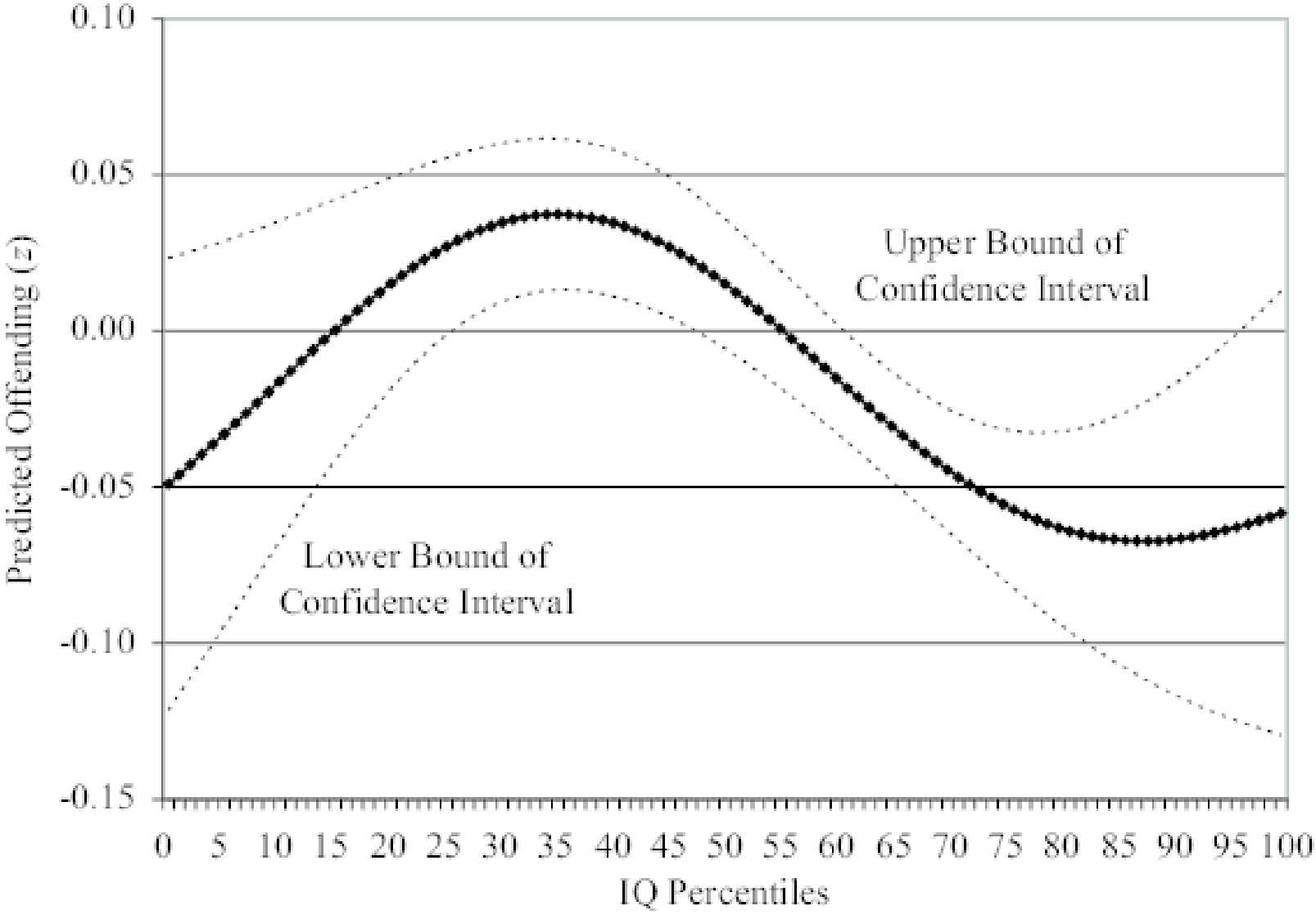
Relationship between IQ-ID and offending

- Historical: Terman (1918) '*Not all criminals are feebleminded, but all feebleminded are at least potentially criminal*'
- Although naturally resisted as an idea, large body of research has shown that lower intelligence is one of the most consistent predictors of antisocial behaviour
- Consistent across geographic regions and cultural contexts (controlling for covariates)

(Hirshi & Hindelang, 1977; Hernstein & Murray, 1994; Kratzer & Hodgins, 1999; Joliffe & Farrington, 2004; Rushton & Templer, 2009; Diamond et al., 2012 etc)

Relationship between IQ-ID and offending

- More recent research has focused on the functional relationship – linear or curvilinear?
- **Mears & Cochrane (2013)**
- Using modelling techniques (GPS/PSM) n=3253
- Suggest curvilinear relationship
- Lower and higher IQs associated with ***lower*** levels of offending (of all types)
- However:
- lowest IQ was 78
- self-report of crime utilised

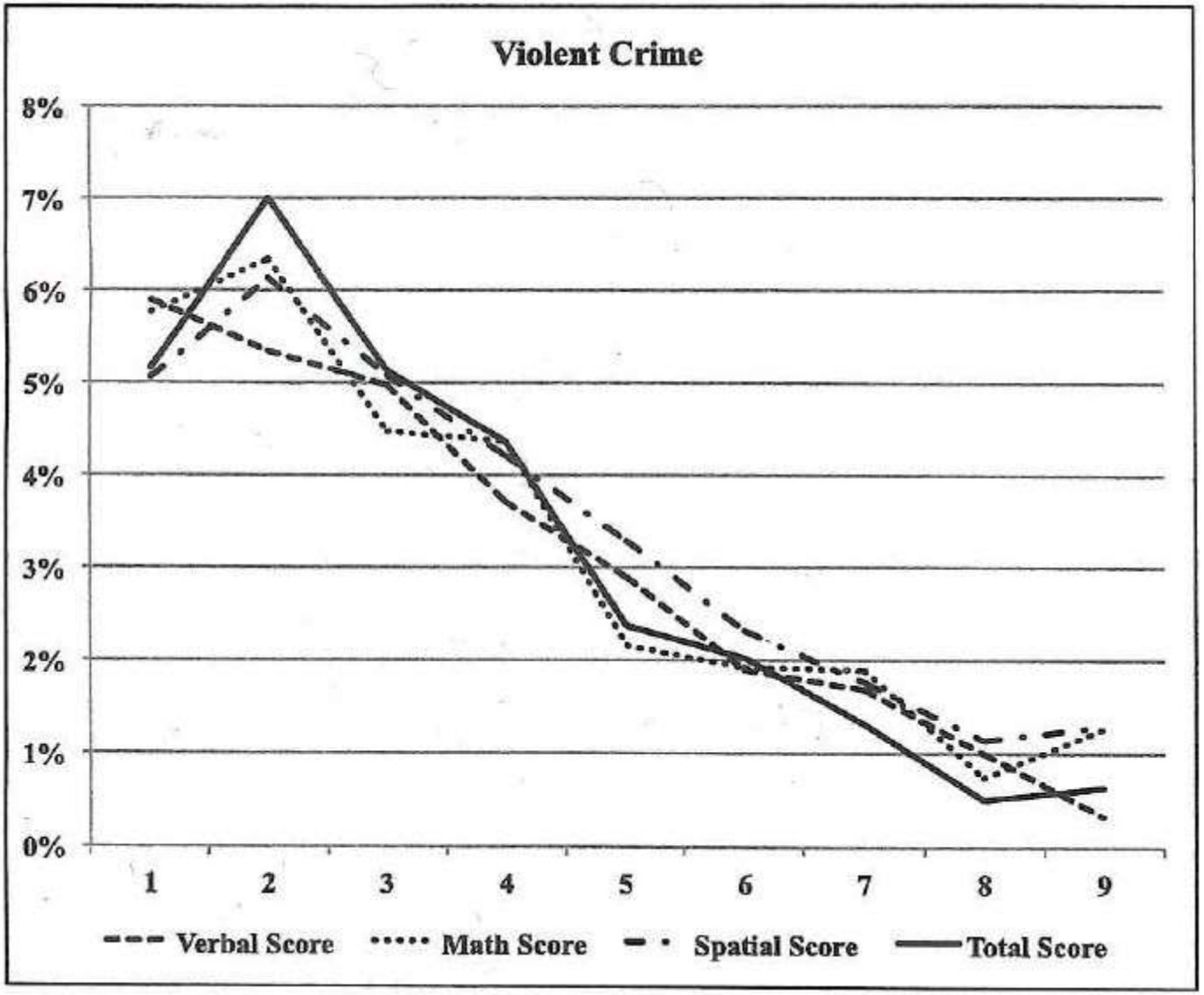

0.10
0.05
0.00
-0.05
-0.10
-0.15
Predicted Offending (z)
Upper Bound of
Confidence Interval
Lower Bound of
Confidence Interval
0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
IQ Percentiles

Relationship between IQ-ID and offending

- **Schwarz et al (2015)**
- Birth cohort of 60,000 males born Finland 1987
- Wide range of intelligence and offending indicators (20k)
- Consistent evidence of **linear patterns**, for all types of offending and intelligence
- But slight increase between lowest and second lowest category - curvilinear at this lower range
- Although lowest category still high levels of criminal behaviour
- However:

  -military service cognitive assessments (?ID)

  -officially recorded crime


Violent Crime
8%
7%
6%
5%
4%
3%
2%
1%
0%
1
2
3
4
5
6
7
8
9
Verbal Score
Math Score
Spatial Score
Total Score

Relationship between IQ-ID and offending

- Those with the most severe ID do not come into contact with the CJS (Clare et al., 2002)
- > supervised
- < opportunity to offend
- > tolerance/protectiveness
- < likelihood of charge/conviction
- true to a lesser degree, even in mild ID
- But in the main the population we are considering fall in the upper end of the mild range (60-70)

Relationship between IQ-ID and offending

- Mechanism much debated, poorly researched
- Aspects of lower cognitive ability :

- < self control > impulsivity
- < planning/executive functioning
- < understanding of consequences
- < verbal comprehension
- > misunderstanding, inaccurate social judgements
- < moral reasoning (Langdon et al, 2011)

Relationship between IQ-ID and offending

Other established correlates of lower IQ and ID:

- < Educational performance
- > Socio-economic deprivation (Hatton & Emerson; 2007)
- < Employment opportunities
- > Relationship problems
- > Risk for mental illness (Deb et al., 2001)
- > Early trauma, neglect and abuse (ACE's) (Emerson; 2003, 2012)

- All of which are established static/predisposing risk factors for offending (see HCR-20 V3)

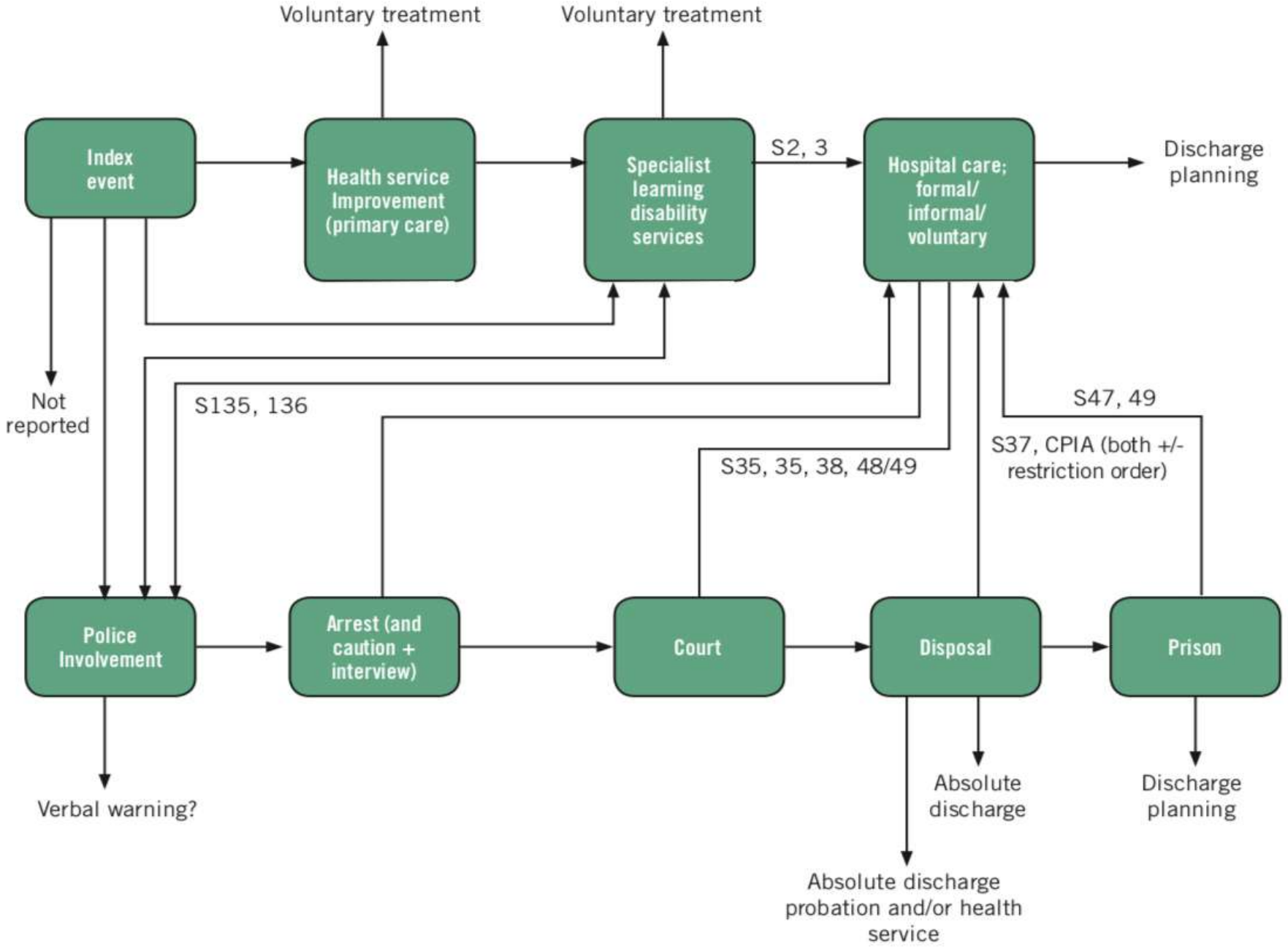
ID in stages of the Criminal Justice System (England & Wales)

Disadvantages at various stages of the CJ process

Royal College of Psychiatrists (2014), Chester (2018)

- *Communication (expressive)*
- *Comprehension issues (receptive)*
- *Acquiesence/suggestibility*

- Arrest & interview –(*Appropriate Adult*; Liaison and Diversion Services)
- Court – fitness to plead, mens rea (independent *Registered Intermediary* as support)
- Sentencing, imprisonment and release; Parole Board hearings etc. (no formal support provided)


Voluntary treatment
Voluntary treatment
Index event
Health service Improvement (primary care)
Specialist learning disability services
S2, 3
Hospital care; formal/ informal/ voluntary
Discharge planning
Not reported
S135, 136
S47, 49
S37, CPIA (both +/- restriction order)
S35, 35, 38, 48/49
Police Involvement
Arrest (and caution + interview)
Court
Disposal
Prison
Verbal warning?
Absolute discharge
Discharge planning
Absolute discharge probation and/or health service

ID in stages of the CJS (England & Wales)

Same behaviour can lead to a ‘lottery of outcomes’:

- No further action
- Managed within health and social care – changes to care
- Prison sentence
- Detention under the Mental Health Act (forensic or civil section)
- Community order (with or without treatment component - CSTR/MHTR)
- …is it ‘behaviour that challenges’ or ‘offending’

Liaison and diversion services

Diversion

- "*a process whereby people are assessed and their needs identified as early as possible in the offender pathway (including prevention and early intervention), thus informing subsequent decisions about where an individual is best placed to receive treatment, taking into account public safety, safety of the individual and punishment of an offence*"

Liaison and Diversion

- Provision of support may help overcome offending related problems

BUT

- Failure to arrest and prosecute carries its own risks

…may not appreciate seriousness

…reinforcement of behaviour

…further offences/victims

- Diversion to health and social care problematic
- Too intellectually disabled for forensic and too forensic (and not disabled enough) for ID services

Two clinical cases

‘Jack’

- FS IQ 67
- Significant adaptive deficits, unable to live independently
- Grew up in a dysfunctional family; not in care
- Quasi psychotic symptoms (‘voice’); self harm
- Mainstream school, dropped out age 13
- No adult ID service involvement
- Firesetting x 1. Set fire to a factory
- Charged and convicted arson aged 23
- 6 year prison sentence
- Bullied in prison, attempt ligation
- No intervention or learning disability support
- Hospital transfer considered but not pursued
- Released on licence to a mainstream probation hostel
- Recalled within 2 days

‘Jimmy’

- FS IQ 68
- Significant adaptive deficits, unable to live independently
- Grew up in a dysfunctional family; not in care
- ADHD diagnosis
- School for children with ID
- Numerous fire setting incidents, primarily cars but also a fairground
- Charged but charges dropped once sectioned at age 21
- Section 3 (civil section) In rehabilitation hospital for PWID for 3 years
- Rehabilitation and psychological intervention
- Move to community supported living
- Continued to offend but not charged

ID in prison: prevalence

- Hard to establish and disputed
- Diagnostic variations/ difference in assessment methods/representative samples
- Last 10 years some better conducted studies
- **Fazel et al (2008)**

- Systematic review
- 4 countries, 12000 prisoners
- From 0 % to 9% Norway (Sondenaa et al 2008)
- Concluded typically **0.5% to 1.5 %** have ID

ID in prison: prevalence

- **Hassiotis et al (2011)**

- Over 3000 prisoners sampled from 131 prisons UK
- Quick Test score (<65 IQ)plus poor educ. attainment
- **4.7%** <65 (9.0% <70)
- Mean IQ was 84 – 25 % in borderline range
- ID: Significantly higher prevalence of probable psychosis & attempted suicide

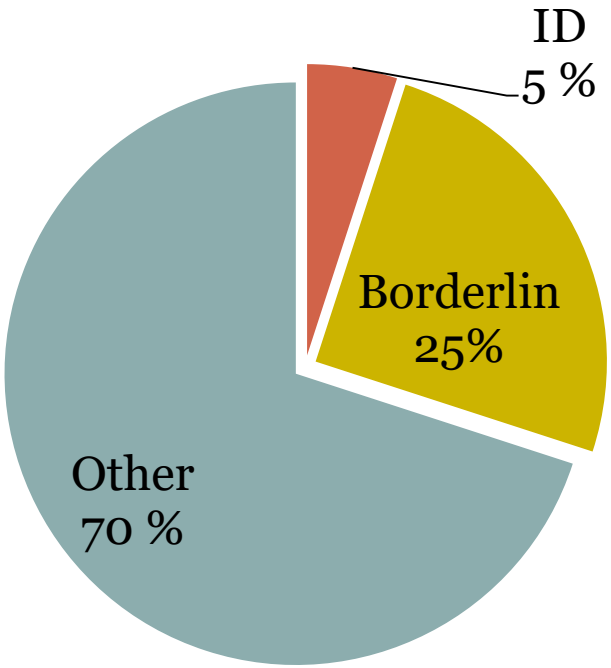
ID in prison: prevalence

- **Murphy et al (2015)**

- Screened 3000 prison admissions in three English prisons using the LDSQ (no formal IQ or adaptive functioning measure)
- **6.9%** screened positive
- Although may be over inclusive for diagnosable ID, those individuals needed adjustments

Overrepresented?

- E&W Prison population is 83000 (2000 women)



ID in prison: needs

- **Prison Reform Trust** (2008) & **Bradley Report** (2009)
- Have identified needs of this group and made recommendations
- PRT – Interviewed n=170 PWID in prison
- 3x more likely to have been subject to **control and restraint**
- 5x more likely to have been **segregated**
- 3x more likley to suffer from **anxiety/ depression**

Recommendations (*10 years on…)*

- **Routine Screening** – *not mandatory and not routine in all prisons*
- **Reasonable Adjustments** (legally necessary under the Equalities Act 2014) – simplified communication, easy read leaflets, additional support, training of staff, employment of ID nurses in prison healthcare, provision of adapted programmes/regimes (*patchy*)
- *Care Act 2014:* social care have to consider the care and support needs of a person in prison (*Responsible social workers appointed)*
- Establishment of **Liaison and Diversion Teams** (*83% coverage by 2108, 100% by 2020)*

Prison interventions for ID

- Prisons in E&W early to adopt adapted programmes
- 1999 Adapted Sex Offender Treatment Programme (IQ 60-80) - *Becoming New Me*
- Treated 100s of offenders- psychometric outcome data (Williams & Mann,2014)
- 2017 - Evolved into a suite addressing violence/other offending :
- *Becoming New Me* + (High/very high risk
- *New Me Strengths* (medium risk)
- *Living as new me* (booster/maintenance
- Individual needs – I packs; skills practice

Key tools

The Great Eight Tactics

Prison interventions for ID

- ID Therapeutic Communities – *TC+ (2013+)*
- 3 prisons, 52 beds
- For men with ID and personality disorder
- 'Whole environment' intervention fostering positive relationships, taking of responsibility
- Evidence from mainstream TCs and adapted TCs in secure hospitals (Morrissey, Taylor & Bennett, 2012)

- Need exceeds demand

Outcomes prisoners with ID

- Few studies
- **Murphy et al 2017**
- Ambitious study following men leaving prison in England
- Outcomes poor…
- Hard to contact..n=38 at 1 month follow up
- 59% above cut off for depression
- 21% were in a low or medium secure hospital
- 10% back in prison
- More than 50% had been in contact with police

Outcomes prisoners with ID

- Grossly underoccupied
- Poor social networks
- Although 15% were in supported living, in general little contact social care and community teams
- Likely to compare unfavourably with men who have been in hospital

- Need further studies of studies with men with ID on probation

Outcomes prisoners with ID

- Move from prison to hospital (MHA detention)
- Strong indications numbers are decreasing for ID
- Of those with ID in hospital % from prison

  2015- 16%

  2018- 11% (NHS England)
- Prison coping better with needs or other factors?


Anxiety/ depression
Psychosis
Personality Disorder
Delayed release
Vulnerable
Segregation
Self harm/ Suicide

Offenders with ID in forensic mental health settings

- Policy context (England) 'Transforming Care' 2012
- Reduction of inpatient ID hospital beds:
- 2014 – 3000
- 2018 - 2400 (<20%)
- 73% male
- Half (1200) are in forensic - secure beds
- High secure 5%; Medium Secure 37%;Low secure 58%

- 'Expected' numbers (based on non-ID inpatient bed numbers) much lower than this

ID inpatients: Length of stay

- Length of stay existing inpatients: August 2018 (NHS England)

  > 2 years - 59%

  > 5 years - 33%

- Again, higher than mental health patients without ID

- Length of stay is a complex calculation- ideally use admission cohort

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Researching outcomes from forensic services for people with intellectual or developmental disabilities: a systematic review, evidence synthesis and expert and patient/carer consultation

Catrin Morrissey, Nicole Geach, Regi Alexander, Verity Chester, John Devapriam, Conor Duggan, Peter E Langdon, Bill Lindsay, Jane McCarthy and Dawn-Marie Walker

Length of stay- ID systematic review

- **Morrissey et al (2017)**
- 22 studies from secure ID services had **length of stay** as an outcome measure
- Measured in different ways

Mean lengths of stay (discharges):

- High secure - 9 years
- Medium secure – 3 years
- Low secure – 1 year

Outcomes - reoffending

- 20 studies have reoffending as outcome measure
- Generally single settings
- **Gray et al** (2007) – medium secure cohort
- 5% offended within 2 years vs 12% non ID
- **Alexander** et al (2012)
- 58% discharged had 'offending like' behaviour within 5 years
- Need to have measures of 'offending-like' behaviour as well as charges /convictions

Why are people with ID over represented in forensic hospitals and have longer lengths of stay, especially if (some) studies suggest that they are less likely to offend?

Complex historical and systemic reasons but…

Forensic ID inpatients – risk research

As compared to their non-ID counterparts:

- ID inpatients are assessed as higher risk (using standard risk frameworks)
- ID inpatients have a higher number of violent incidents in hospital (behavioural indicators)
- ID 'long stay' patients have similar offence profiles
- ID inpatients have a high level of psychiatric complexity/co-morbidity

ID inpatients are assessed as higher risk

HCR20 studies

- Gray et al (2007) (medium secure)
- Morrissey, Beeley & Milton (2014) (high secure)
- Chester et al (2018) (long stay patients – med/high)

- **All find significantly higher risk ratings in ID than in comparable non -ID samples**
- **And less likely in longitudinal studies to show change**

- *Historical* – ID associated with predisposing risk factors (ACEs; employment; relationships)
- *Clinical* – less likely to be responsive to treatment
- *Risk management* – less likely to have appropriately robust future management plans

ID have a higher number of risk incidents

- **Chester et al (2018)** (long stay study)

Levels of serious incidents (assaults, self harm, absconding attempts and weapons incidents) were significantly higher among the ID group

- **Dickens et al (2013)**

Comparatively higher violent incidents in ID group

- **Uppal & McMurran** (2009) (high secure)

Violent incidents highest in ID (and women's) service

Offence severity

Chester et al (2018) –Long Stay ID Inpatients

- Representative sample roughly 10% highest length of stay psychiatric inpatients (medium and high secure)
- ID oversampled compared with those without ID
- Overall inpatient stay - non ID patients significantly higher (162 months vs 132 months)
- **No difference** in category of offences; offence severity; though fewer 'forensic' sections
- So have greater number of serious incidents for which they are unconvicted

ID inpatients have a high level of psychiatric complexity/co-morbidity

- Many experts in the field point to a high degree of psychiatric complexity in forensic ID (RCP, 2014)
- Co -morbid diagnoses of ASD; Mental illness; Personality disorder; Substance misuse disorders (Alexander et al 2010)
- Comparative studies of personality disorder indicate higher scores on assessment measures and high levels of co-morbid diagnosis (PCL:SV: Gray et al 2007 ; Alexander et al 2010;)
- This may lead to slower treatment change

Conclusions

- Likely that those with ID in secure settings are detained in hospital for reasons of risk/public safety, any treatment changes are slow, and may they not easily be managed in the community (hence difficulty in discharge)
- Transforming Care bed reduction - unintended consequence more people with mild ID going to prison
- MHA detentions to hospital from prison already seem to be reducing

- Improved prison ID pathways
- Improved robust forensically informed community care and treatment options

‘Jack’ – recalled prisoner

After a lot of work and collaboration is:

- well supported
- in a community supported living placement
- joint working between community forensic team and ID community team and probation service
- 6 months – no recall

Conclusions

- This is an heterogeneous, and complex and under-researched group
- Need more outcome research across representative samples, particularly comparing them with comparable groups without ID
- In prisons, inpatient and community
- Cohort study tracking individuals over time
- With appropriate complexity indicators and treatment outcome indicators
- Preliminary work on outcome domains and measures has been completed

(Morrissey, Geach, Alexander, Chester, Devapriam, Duggan, Langdon, Lindsay & Walker, 2017)

Thank you

- Contact

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