Offenders with Intellectual Disabilities – *Roots, Risks and Remedies in the Transforming Care Policy Context*

Bergen International Conference on Forensic Psychiatry
Bergen, Norway, 22 October 2018

John L Taylor
Northumbria University/
Northumberland, Tyne & Wear NHS Foundation Trust

Offenders with Intellectual Disabilities: *Roots, Risks & Remedies*

- Transforming Care Policy Context
  - Hospital detention and its impact
- Risk Assessment
- Treatment and Management of Offenders with ID
  - Sex offending
  - Firesetting
  - Anger/Aggression
- Transforming Care Programme Outcomes
- Summary and Conclusions

Transforming Care for People with LD (NHS-England)

Transforming Care for People with LD (NHS-England)

- ***Building The Right Support: (LGA/ADASS/NHS-E, October 2015)***
  - **Currently there are 2,600 inpatient beds**
  - **Reduce this number by 35-50%**
  - **Aim for 1,300-1,700 beds**
  - **Within 3 years**
  - **This is a “starting point”**
  - **Money saved will be re-invested in community services**

Crime and People with Intellectual Disabilities

- Historically, crime and ID have been firmly linked (*Hirschi & Hindelang, 1977; Trent, 1994; Wilson & Hernstein, 1985*)
- "… there is no investigator who denies the fearful role of mental deficiency in the production of vice, crime and delinquency … not all criminals are feeble-minded but all feeble-minded are at least potential criminals." (*Terman, 1911*)
- There is robust evidence that there is a inverse relationship between low IQ and offending
- However, the relationship is not simple or linear; particularly when considering individuals ≤ 1.5 standard deviations below the average IQ

Bivariate Relationship between IQ and Offending

from Mears & Cochran (Criminal Justice & Behr, 2013)

N = 3,253 cases from the National Longitudinal Survey of Youth (MLSY) concerning self-reported offending

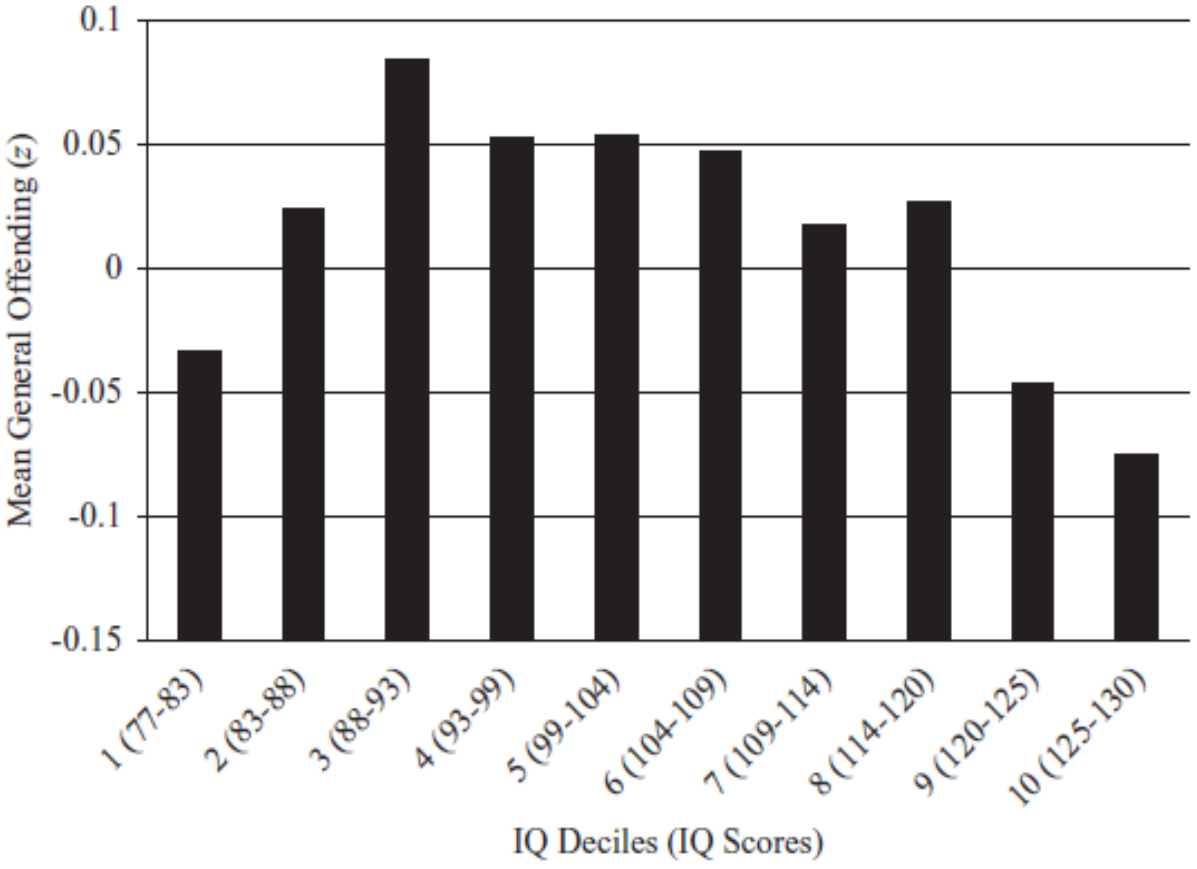


Figure 1: Bivariate Relationship Between IQ and Offending

Prevalence of Offending and People with ID

- **Prevalence studies involving people with ID report large variations in rates of offending**
- **The evidence base is poor with regard to epidemiological studies - in particular there is dearth of well-controlled studies including non-disability comparison groups *(Lindsay & Taylor, 2018)***
- **It is not clear, therefore, whether people with ID are over- or under-represented in the offender population**
- **Similarly, it is unclear whether offending is more prevalent amongst people with ID than those in the general population**

MHA 1983 Detention of People with ID

- **Proportion of people in general population with IQ scores <70 is approx. 2.5% (assuming normal distribution)**

- **Census data shows that a disproportionate number of people with impaired intellectual functioning are being detained under MHA 1983, as at 31st March 2014 (i.e. 1,405 out of 18,166)**

  - ***More than three times the expected number overall (7.7%; or 1 in 13)***
  - ***More than double the expected number in NHS hospitals (5.6%; or 1 in 18)***
  - ***More than five times the expected number in independent hospitals (13.1%; or 1 in 8)***

Source: ***The Health & Social Care Information Centre (2014)***

Impact of Hospital Admission on People with ID

- On 31st March 2010 there were 3,642 people with ID residing in inpatient services in England and Wales
- The *median length of stay* for men with ID was x5 greater than that for male mental health inpatients (31 vs 5.8 months)
- and x11 greater for women with ID (31 vs 2.5 months)
- Over a 3-month period
  - more ID inpatients had been subject to one or more *physical assaults* compared inpatients in mental health services (28% vs 11%)
  - *restraint* (30% vs 12%)
  - *self-harm* (22% vs 8%)

Source: *Care Quality Commission (April 2011)*

Detention Under the MHA 1983 – Learning Disabilities

- People with learning disabilities can be detained under the MHA 1983 (as amended by the MHA 2007)
- Detention is required for the person's health and safety or for the protection of others
- Learning disability is defined as "a state of arrested development of the mind which includes significant impairment of intelligence and social functioning"
- Hospital detention on the basis of learning disability must be qualified by either:
  - ***Abnormally aggressive behaviour**, or:*
  - ***Seriously irresponsible conduct***

LD Offender Pathway Study – *antisocial and offending behaviour (N = 477)*

- *Ref*: *O'Brien, Taylor, Lindsay, Holland et al. (2010)*. *JofLD&OB*

Index Antisocial/Offending Bhr	Frequency (%)
Offences against the person	
Physical aggression	238 (50)
Verbal aggression	158 (33)
Inappropriate sexual - contact	69 (15)
Inappropriate sexual – non-contact	67 (14)
Cruelty/neglect of children	28 (6)
Stalking behaviour	9 (2)
Non-person offences	
Damage to property	91 (19)
Substance misuse	28 (6)
Theft	27 (6)
Fire-setting	20 (4)
Traffic offences	6 (1)

Northgate Hospital Forensic Services: Male Patient Offending Histories *(N = 129)*

Ref: Novaco & Taylor (2004). Psychological Assessment

- 36% (46) had convictions for violent behaviour
- 38% (49) had documented histories of violence
- 47% (59) physically violent post-admission
- 43% (55) had convictions for sexual aggression
- 20% (26) had convictions for arson
- 53% (68) had convictions for property related offences

History, Clinical and Risk Management (HCR) - 20

(Webster, Eaves, Douglas & Wintrup, 1995)

- **HCR-20 predictive power has been extensively tested across a range of client groups and cultures, but not offenders with ID**

- **Made up of:**
  - **10-item *Historical* scale, e.g. 'early maladjustment'**
  - **5-item *Clinical* scale, 'negative attitudes'**
  - **5-item future *Risk* scale, 'plans lack feasibility'**
  - **All 20 items yield a *Total* score**

- **Each item is rated on a 3-point scale with 0 = 'absence'; 1 = 'possible presence'; and 2 = 'definite presence' of the factor**

HCR-20 and Offender with ID -- *Study Aim*

- **To evaluate the reliability, validity and utility of the HCR-20 with offenders with ID across a range of forensic service settings and levels of security**

- **Part of a Home Office funded study on *'The Applicability of Personality Disorder and Risk Assessment (DSPD) Measures in a Sample of Intellectual Disability Offenders'* Grant No. RDS/01/247**

- **Ref: *Lindsay, Hogue, Taylor, et al. (2008).* Risk assessment in offenders with intellectual disability. *International Journal of Offender Therapy and Comparative Criminology.***

Study Sites

212 men with IDD and offending and offending-type histories from 3 sites:

1. Rampton Hospital, Nottinghamshire (High Security)
   N = 73

2. Northgate Hospital, Northumberland (Medium & Low Security)
   N = 70

3. Tayside, Scotland (Community Forensic Service)
   N = 69

HCR-20 Scales, *Reliability Analyses*

	N	Mean (*SD*)	Cronbach Alpha	Interrater Reliability*
HCR-20 Historical	184	12.1 (4.4)	.75	89.4%
HCR-20 Clinical	205	4.4 (2.4)	.59	93.1%
HCR-20 Risk Managt.	203	3.0 (1.8)	.59	82.7%
HCR-20 Total	182	19.5 (6.4)	.75	

**IRR = number of agreed ratings divided by the number of agreements plus disagreements, expressed as a percentage. IRR calculation involved 30 cases.*

Correlations between *HCR-20* and Other Risk Measures and Violent Incidents

	HCR-20		
	Historical	Clinical	Risk Managt.
VRAG	.65*	.23*	.22*
Short Dynamic Risk Scale	.39*	.42*	.27*
Total Violent Incidents	.28*	.28*	.20*

Note. * $p < .01$. All correlations are Spearman Rho, two-tailed tests. $N = 151 – 203$.

Correlations between *HCR-20* and selected *EPS* Scales

	HCR-20		
	Historical	Clinical	Risk Managt.
EPS Scales			
Physical Aggression	.32*	.35*	.23*
Verbal Aggression	.30*	.37*	.19
Anxiety	.12	.18	.15
Withdrawal	.17	.13	.03

Note. * $p < .01$. All correlations are Spearman Rho, two-tailed tests. $N = 154 – 171$.

Mean *HCR-20* Scores, *Grouped According to Violent/Aggressive Incidents*

	Violent Incidents			
	No Incident (*n* = 139)	Incident (*n* = 65)	*t*	*p*
HCR-20 Historical	11.2 (4.6)	13.9 (3.4)	-4.01	.000
HCR-20 Clinical	3.9 (2.5)	5.3 (1.9)	-3.8	.000
HCR-20 Risk Managt.	2.8 (1.8)	3.5 (1.7)	-2.4	.017

Note: Standard deviations are given in parentheses.

HCR-20 Scales, *Receiver Operator Characteristics (ROC) Analysis* (Lindsay, Taylor et al. 2008)

	AUC	*p*
HCR-20 Historical	.68	.000
HCR-20 Clinical	.67	.000
HCR-20 Risk Managt.	.62	.02
HCR-20 Total	.72	.000

Note: Dependent Measure is recorded aggressive and sexually aggressive incidents in 6-month period. AUC = Area Under Curve. *N* = 154 – 171

HCR-20 Scales, *Receiver Operator Characteristics (ROC) Analysis* (Gray et al., 2007)

	AUC	*p*
HCR-20 Historical	.81	<.05
HCR-20 Clinical	.71	<.05
HCR-20 Risk Managt.	.64	<.05
HCR-20 Total	.79	<.05

Note: Dependent Measure is recorded violence over a 5-year period following discharge from medium secure services. AUC = Area Under Curve. *N* = 106-107

Implications – *for Practice and Research*

- **The HCR-20 is a robust instrument for *guiding structured clinical judgments* concerning risk of violence amongst males with ID and forensic histories**
- **This approach enables clinicians (and teams) to reach clinically defensible decisions, drawing on historical and clinical data, that are transparent and so accountable**
- **The utility of this instrument needs to be tested in routine clinical settings**
- **The predictive validity of the HCR-20 requires further evaluation in prospective studies**

Sex Offenders with ID - Courtney, J. & Rose, J. (2004). *Journal of Sexual Aggression*

Reviewed 31 published studies post-1990

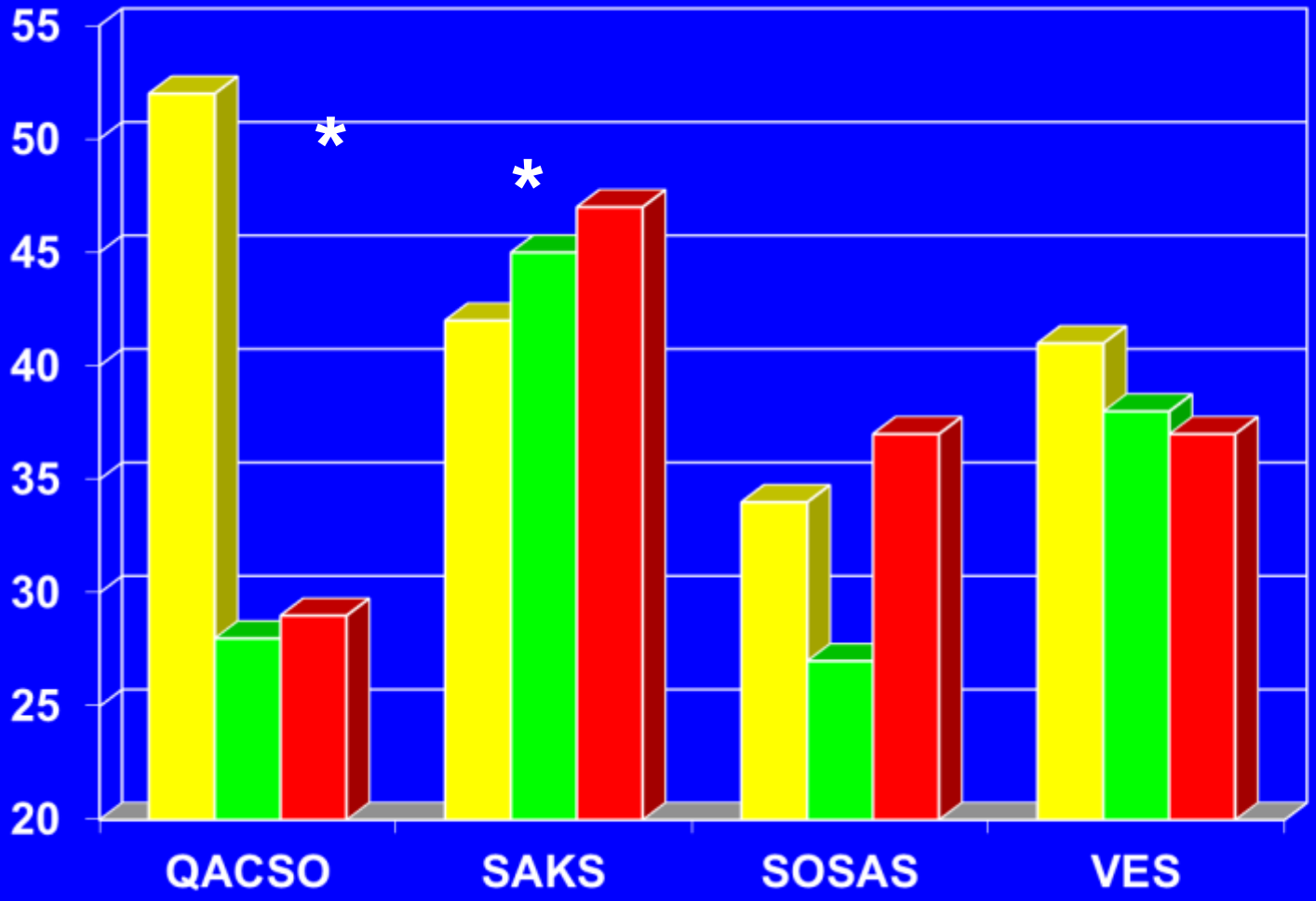
- **11 Case Study/Small Case Series Reports**
  - **4 drug therapy**
  - **7 psychological interventions (behavioural, CBT, individ., group)**
  - **Generally good outcomes, but poor methodology and reporting**

- **8 'Larger' Studies**
  - **1 drug therapy; 3 service/management interventions**
  - **5 psychological interventions (behavioural, CBT, individ., group)**
  - **Outcomes for psychological interventions appear better but variable**

- **8 Group Therapy Interventions**
  - **Mixed outcomes – reported recidivism rates 0% - 40%**

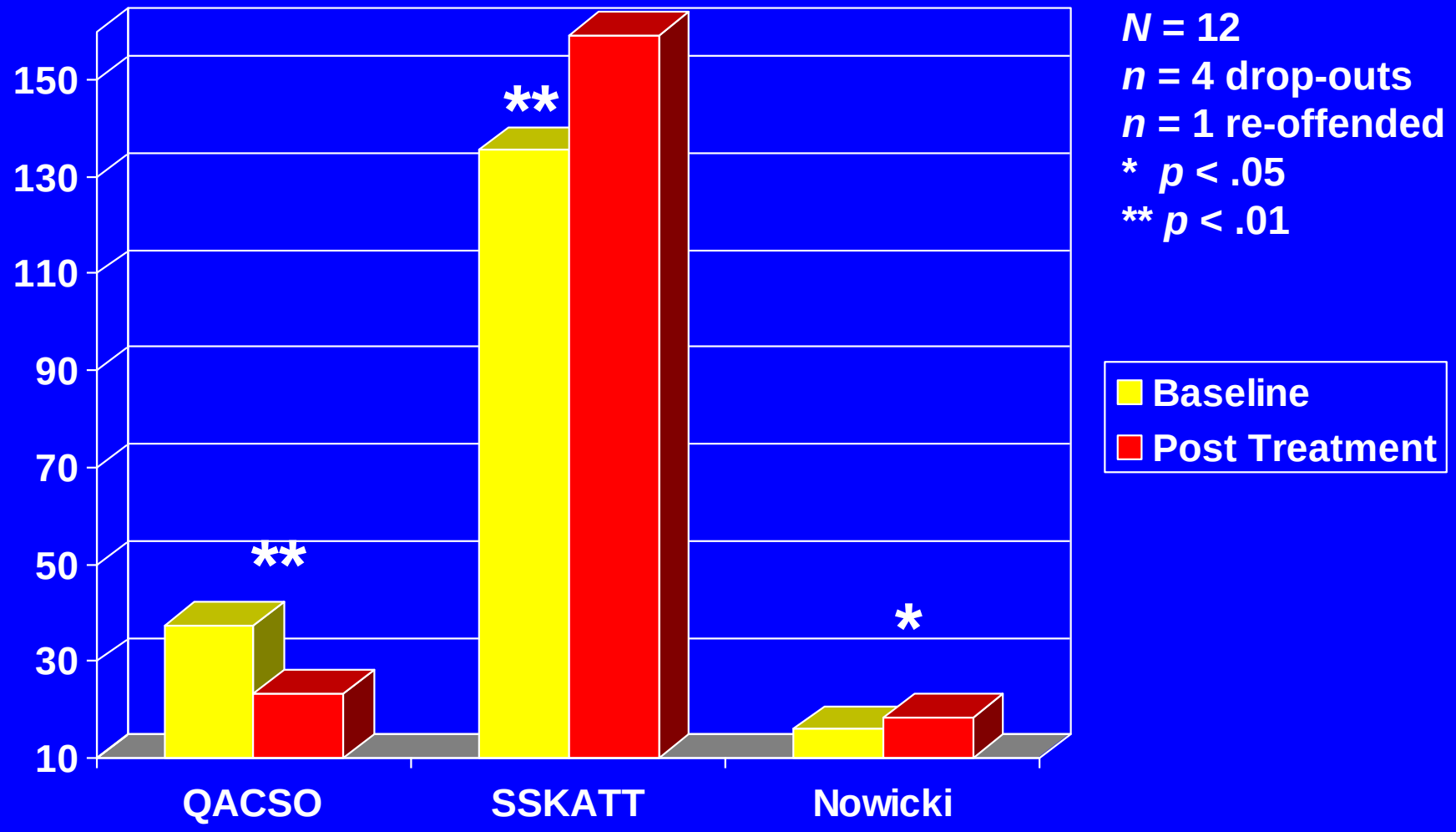
Sex Offender Treatment Services Collaborative (SOTSEC) ID Study

Murphy et al. (2010) JARID



***N* = 46**
9% re-offending at 6-months follow-up

Rose et al. (2012) *J. Forensic Practice*



N = 12
n = 4 drop-outs
n = 1 re-offended
* *p* < .05
** *p* < .01

Lindsay et al. (2006). *Legal & Criminological Psychology*

- 247 consecutive referrals to a specialist community forensic ID service
  - 121 referred for sexual offences/inappropriate sexual behaviour
  - 105 referred for other offences

- 13-year follow-up
  - 24% recidivism (sex offenders)
  - 59% recidivism (other offences)

- 70% harm reduction effect for sexual recidivists
  - 235 offences over 2 years pre-referral
  - 68 offences upto 12 years post-referral

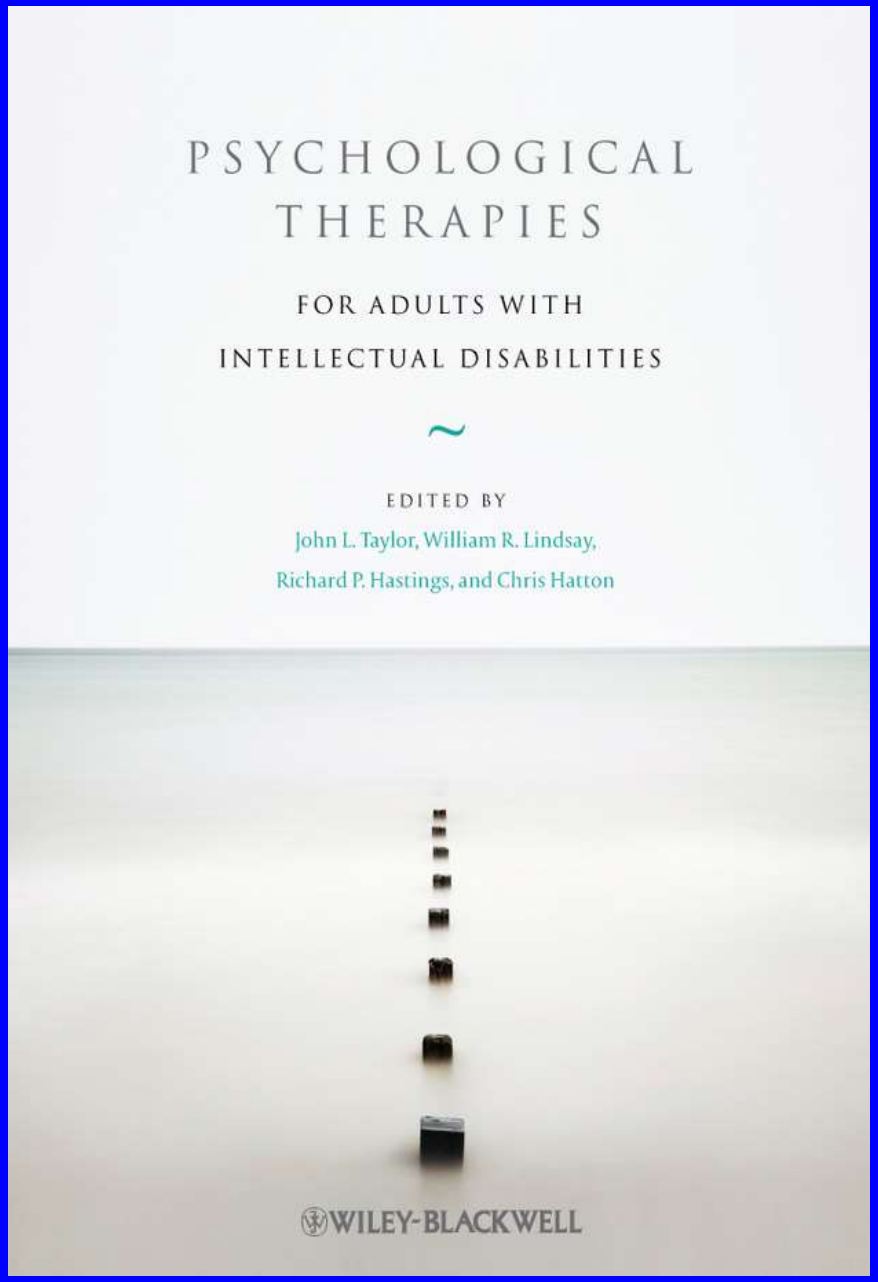
Sex Offenders with ID – *Summary and Conclusions*

- **Studies to date are quite limited: no control conditions; small and heterogeneous samples**
- **Psychologically informed and structured interventions result in better outcomes than drug, counselling or regime-based interventions**
- **There is some evidence that psycho-sexual knowledge, cognitions/attitudes towards offending and offending rates can be improved following treatment (e.g. Lindsay et al. 1998, 2006; Patterson, 2018; Rose et al. 2002)**
- **Longer length of treatment produces better outcomes that last longer (e.g. Haaven et al. 1990; Patterson, 2018; Lindsay & Smith 1998)**

Chapter 11

W.R. Lindsay (2013)

- ***Cognitive-behavioural treatment for inappropriate sexual behaviour in men with intellectual disabilities***



Fire-Setting Behaviour

- **Despite the unknown scale of the problem, people with ID and histories of fire-setting behaviour present significant risks and difficulties**

- **Services working with this client group need to develop effective methods for intervention and management**

- **In our own service, in a hospital-wide study of male forensic inpatients with ID 20% (i.e. 26 out of 129) had convictions for arson prior to admission *(Novaco & Taylor, 2004)***

Interventions for Fire-Setting by People with ID

- *Rice & Chaplin (1979)*
  - Treated 5 fire-setters in “mild/borderline range of mental retardation” in a maximum security psychiatric facility in the USA
  - Improved significantly on a reliable observational scale of role-played assertive behaviour
  - 12-months post-discharge, no re-convictions for or suspicions of setting fires

- *Clare et al. (1992)*
  - Single case study of a man with mild ID admitted to a secure hospital for 2 convictions of arson + history of hoax calls to the fire services.
  - Received comprehensive treatment package
  - Significant clinical improvements observed and no evidence of re-offending at 30-month follow-up.

Content of the Northgate Fire-Setters Treatment Programme

Comprises seven (7) modules delivered in approx. 40 sessions:

1) **Group establishment**
2) **Group cohesion**
3) **Information and education**
   - ***concerning the dangers and costs of setting fires***
4) **Offence cycle analysis**
   - ***antecedents, triggers, behaviour/emotions, consequences***
5) **Family and relationship issues**
6) **Alternative skills training**
   - ***enhance future coping with emotional/interpersonal problems***
7) **Risk management and reduction**
   - ***personalised plans that detail coping skills, and support systems that can be utilised when risks increase***

Interventions for Fire-Setting by People with ID *cont*.

- *Taylor et al. (2004) in 'Offenders with Develop. Disabilities'*
  - Case series of 4 men
  - Little change on fire specific measures, but marked changes in anger and self-esteem scores

- *Taylor et al. (2006) J. of Applied Rsch. In Intell. Disabilities*
  - Case series of 6 women
  - Marked improvements on fire specific and clinical measures (anger, self-esteem and depression)
  - No fires or risk of fire-setting observed at 2-year follow-up (4/6 discharged)

- *Taylor et al. (2002) Criminal Behaviour & Mental Health*
  - 14 detained men and women
  - Significant pre-post treatment improvements on fire specific and clinical measures (anger and self-esteem)
  - Significant improvements on staff-rated Goal Attainment Scales for 'victim issues', 'emotional expression', and 'understanding of risks'

Follow-Up of Treatment Completers 1

- **Collected follow-up data for 24 treatment completers; 16 men and 8 women**

- **Length of time since completing treatment:**
  - ***Mean = 8.10 yrs (4 yrs – 12.9 yrs)***

- **20/24 discharged from hospital**
  - ***Mean time since discharge = 6.8 yrs (3 mths – 12.7 yrs)***

- **Current living circumstances:**
  - ***17/24 living in community settings***
  - ***4/24 in hospital settings***
  - ***1/24 in prison***
  - ***2/24 deceased (both women)***

Follow-Up of Treatment Completers 2

- 0/24 patients set fires following completion of treatment
- There are suspicions that 1/24 might have set minor fires
- File data available for 17 treatment completers shows that pre-treatment they set a total of 425 fires:
  - Mean = 25
- Between 4.0 and 12.5 years after completing treatment just 2 suspected fires have been set by this group of 17 patients

Fire-Setters with ID – *Conclusions*

- **Broadly cognitive-behavioural group interventions for arsonists with mild/borderline ID have resulted in improvements on: i) fire-specific measures; ii) clinical outcome measures; and iii) a marked harm reduction effect at long-term follow-up**

- **The format and content of these interventions were acceptable to participants**

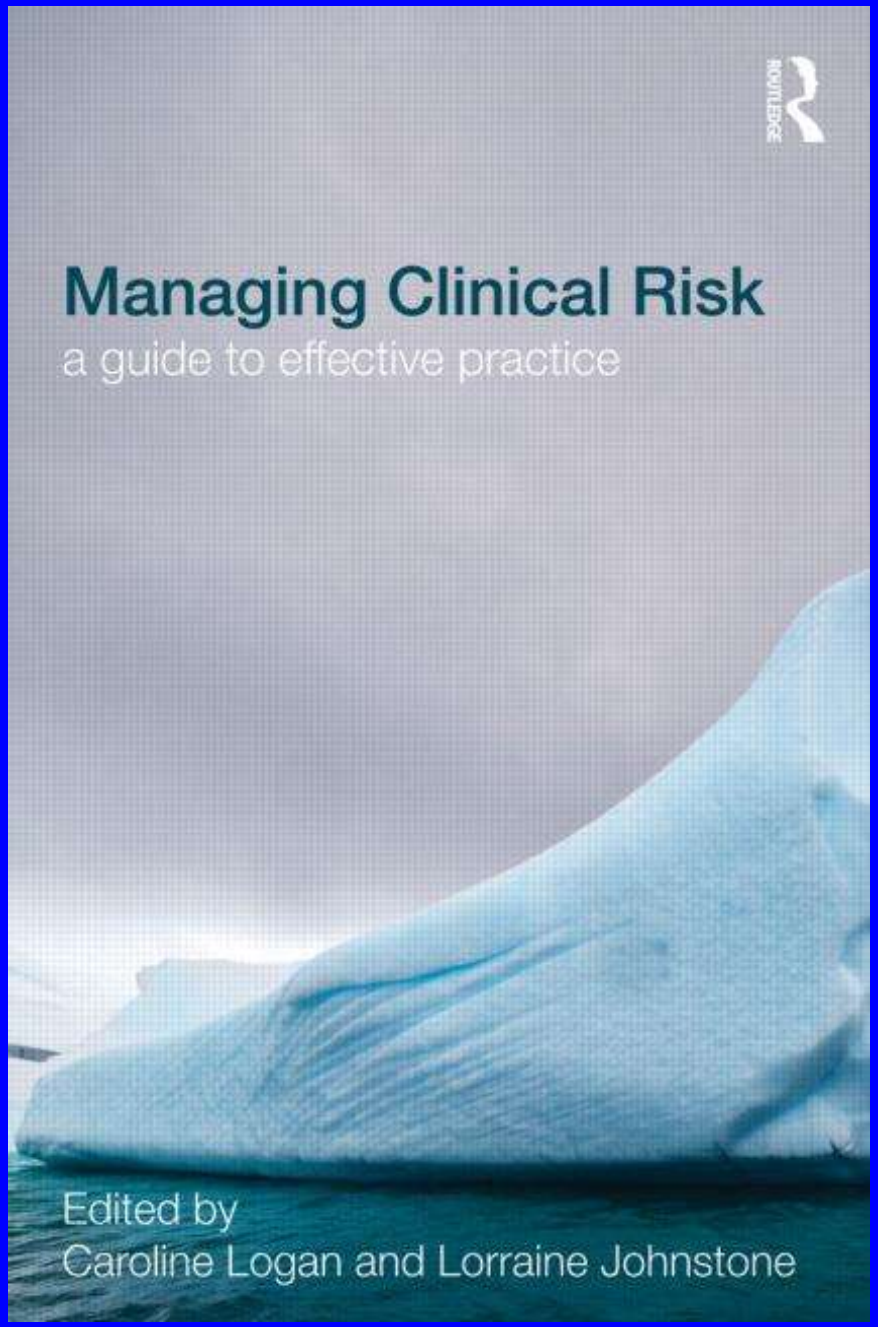
- **Study designs are quite limited in a number of important ways, so results obtained need to be viewed cautiously**

- **However, they provide encouragement to practitioners working with this client group using similar interventions for fire-setting behaviour**

Chapter 6

J.L. Taylor & I. Thorne (2013)

- ***Pathological Firesetting by Adults: Assessing and Managing Risk within a Functional Analytical Framework***



Prevalence of Aggression in People with ID

- **Aggression is a common feature of populations of people with IDD**
- **Studies across 3 continents using broadly similar interview and survey methodologies have yielded similar results**

  (e.g. Deb et al., 2001; Hill & Bruininks, 1984; Sigafoos et al., 1994; Smith et al., 1996; Taylor et al., 2004)
- **Prevalence of *serious* aggression in the UK IDD *community* population is 12-22%**
- **Prevalence of aggression in hospital settings is significantly higher than in community settings**

Prevalence of Aggression in People with IDD –
Ref: Taylor & Novaco (2013)

			Prevalence (%)		
Study	*Location*	*n*	*Community*	*Institution*	*Forensic*
Taylor et al. (2008)	England	782	12	-	-
Tyrer et al. (2006)	England	3065	16	-	-
Hill & Bruininks (1984)	USA	2491	16	37	-
Harris (1993)	England	1362	11	38	-
Sigafoos et al. (1994)	Australia	2412	10	35	-
Smith et al. (1996)	England	2202	-	40	-
McMillan et al. (2004)	England	124	-	-	47
Taylor et al. (2004)	England	129	-	-	47

Impact of Aggression in People with ID

- **Aggression is the 1° reason for people with ID to be prescribed antipsychotic medication *(Aman et al., 1987; Robertson et al., 2000)***
- **Aggression is the 1° reason for people with ID to be (re)admitted to institutional care (*Lakin et al., 1983)***
- **Physical violence has a significant negative impact on the rehabilitation of offenders with ID**
- **Physical violence has significant costs for institutional and forensic ID services *(Jenkins et al., 1997; Kiely & Pankhurst, 1998)***
- **Anger is a significant activator of, and is predictive of violence in psychiatric, forensic and ID populations *(Novaco, 1994; Novaco & Renwick, 2002; Novaco & Taylor, 2004)***

Cognitive-Behavioural Treatment of Anger for People with ID – *Summary of Evidence*

- **Post-1985 36 studies been have published on the effectiveness of psychotherapeutic anger interventions for people with ID**
  (see Taylor & Novaco, 2013 for review)

- **There are 13 reports on small anger CBT outcome studies with ID clients that involved comparison groups**
  (Benson et al., 1986; Hagiliassis et al., 2005; Lindsay et al., 2004; Rose et al., 2000, 2005, 2008, 2009; Taylor et al., 2002, 2004, 2005; Willner et al., 2002, 2005, 2013)

- **There are also a number of reports in the literature of CBT for anger in offenders with ID**
  - ***Allen et al., 2001***
  - ***Burns et al., 2003***
  - ***Lindsay et al., 2003, 2004***
  - ***Taylor et al., 2002, 2004, 2005, 2009***
  - ***Singh et al., 2008***

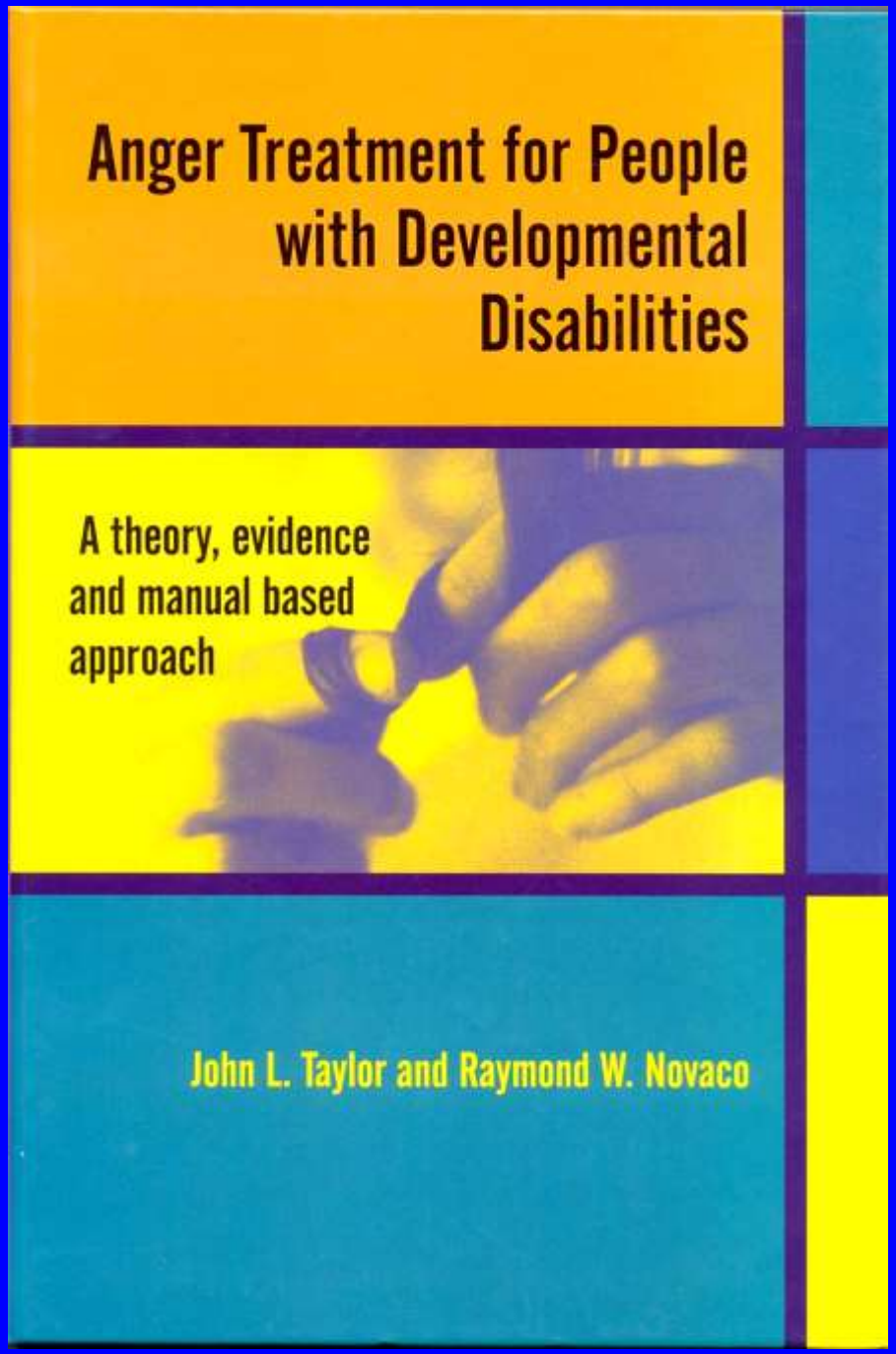
Cognitive-Behavioural Treatment of Anger for People with ID – *Summary of Evidence II*

Ref. Nicoll, Beail & Saxon (2013). JARID

- **Systematic Review and meta-analysis of CBT for anger in adults with ID**
- **12 studies published between 1999-2011 met the inclusion criteria (10 UK; 2 Australia)**
- **All studies utilised the Novaco CBT approach**
- **Overall large uncontrolled ES = 0.88; 6 group treatment studies ES = 0.84; 3 individual treatment studies ES = 1.01**
- **Review reveals an 'emerging evidence base' for CB anger interventions for adults with ID; studies show 'a good level of methodological rigour'**

Anger Treatment for ID Offenders

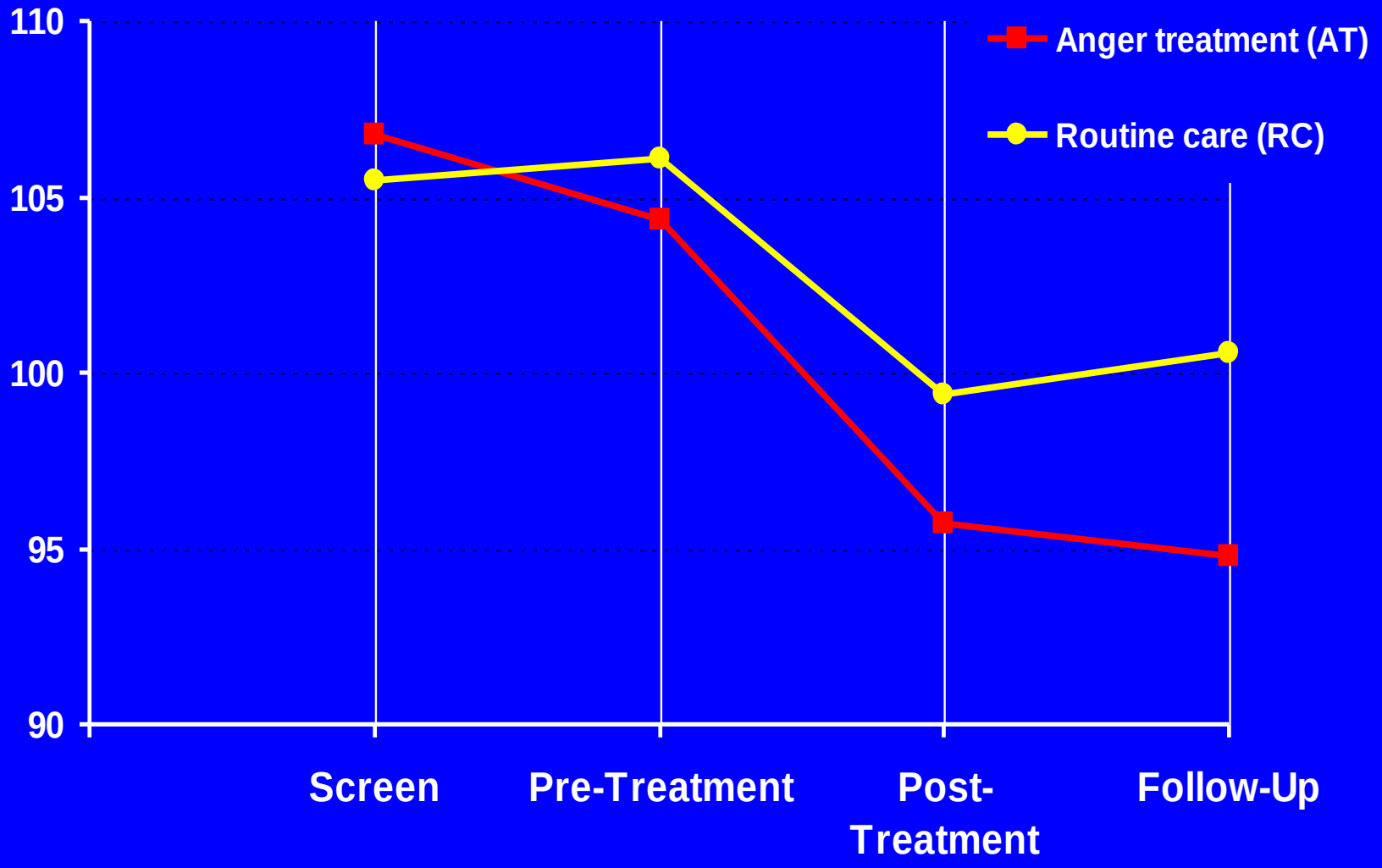
- Modification of Novaco's (1993) treatment protocol
- The treatment is based on the 'Stress Inoculation' paradigm *(Meichenbaum, 1985)*
- Emphasises collaboration, personal responsibility, self-control & the legitimacy of anger
- Utilises a range of assessment, educational & training materials adapted to help patients with LD engage in the treatment process
- Treatment is delivered individually by a qualified psychologist over 18 sessions (twice weekly)
  - 6 session preparatory phase (psycho-educational)
  - 12 sessions of treatment 'proper' (cognitive re-structuring, arousal reduction & skills training)


Anger Treatment for People with Developmental Disabilities
A theory, evidence and manual based approach
John L. Taylor and Raymond W. Novaco

Mean Novaco Anger Scale (NAS) Total scores over Time

ANCOVA (WAIS-R IQ as covariate) $F(1,33) = 4.74$. $p < .05$, $r = .35$

Taylor et al. (2005). Brit. J. of Clinical Psychology



Impact of CBT Anger Treatment on Aggressive Behaviour and Violence

- There is very limited evidence – small case studies and series and small group studies – that CBT anger treatment reduces aggressive behaviour/violence

Impact of CBT Anger Treatment on Aggressive Behaviour and Violence – *study aims and methods*

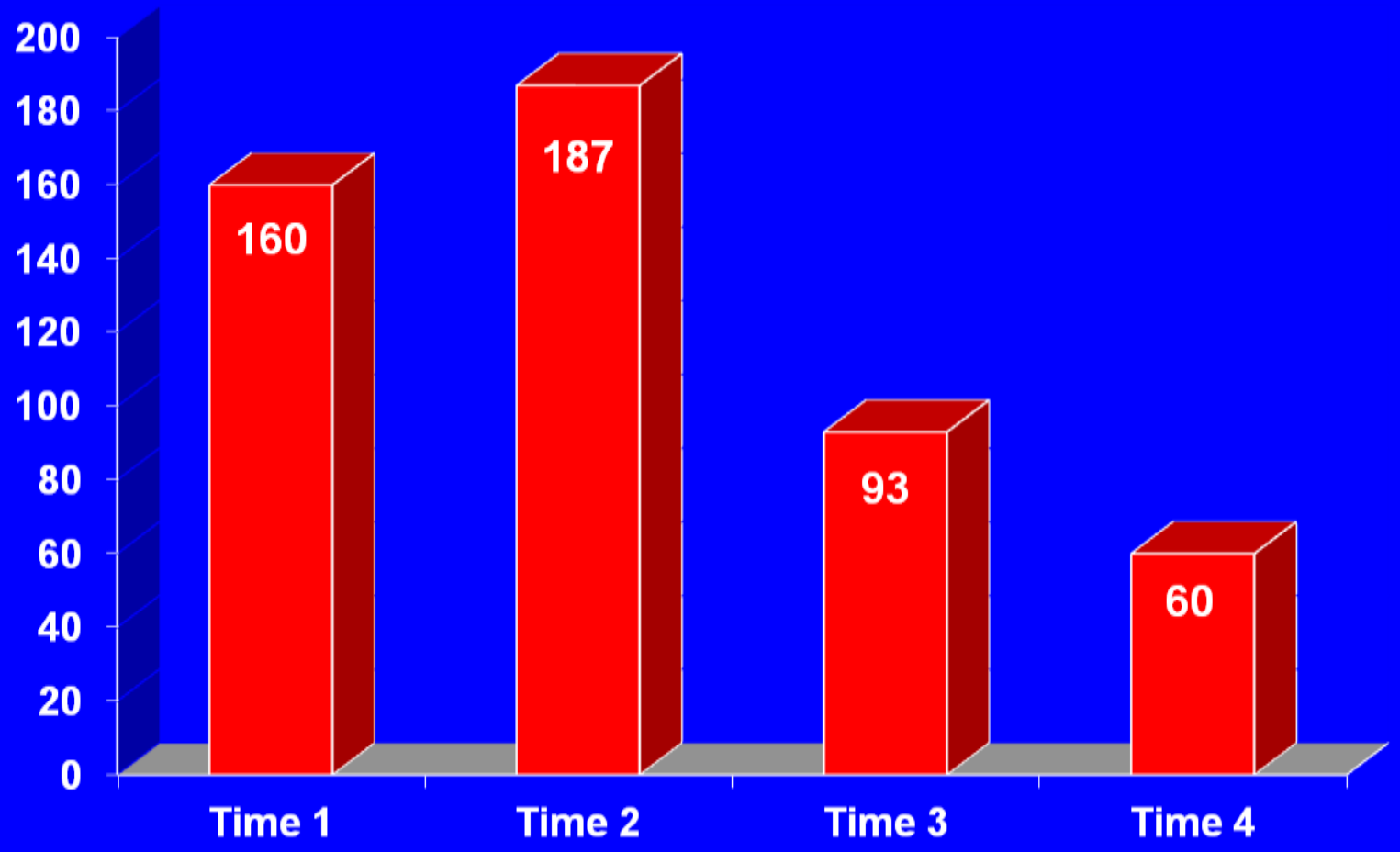
Study Aim:

- **To evaluate the impact of CBT anger treatment on aggressive and violent behaviour by offenders with ID in a secure forensic hospital setting**

- **Incident data collected retrospectively over a 24-month period:**
  - **Time 1 – 7-12 months pre-treatment**
  - **Time 2 – 0-6 months pre-treatment**
  - **Time 3 – 0-6 months post-treatment**
  - **Time 4 – 7-12 months post-treatment**

Total Physical Attacks Over 24 Months: *Pre- and Post-Treatment (N = 50) Ref: Taylor et al. (2016). JIDR*

Pre-treatment = 347; Post-treatment = 153



Reduction in Physical Assaults as Associated with Anger Change Scores – *hierarchical regression*

(Novaco & Taylor, 2015, BRAT)

- **Reductions in physical assaults, controlling for IQ, are related to pre-treatment minus post-treatment improvement in anger disposition (NAS Total scores)**

- **Reductions in physical assaults are also related to pre-treatment minus post-treatment improvements in:**

  - **Outwardly directed anger (STAXI anger-out)**
  - **Anger control (NAS anger regulation)**
  - **Staff-rated patient anger (WARS anger attributes)**

Summary – Anger Treatment

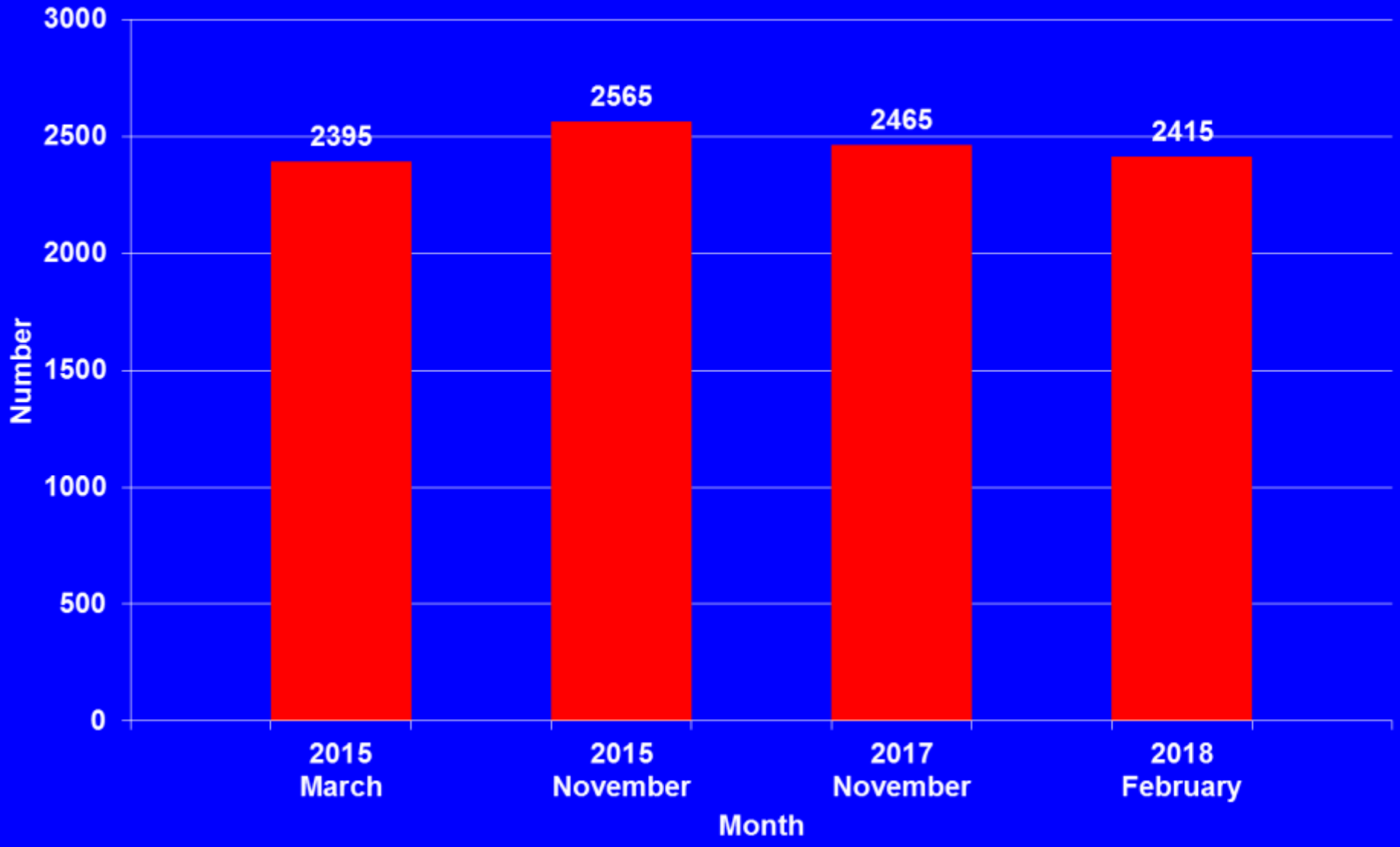
- Patients with significant histories of offending, and recent in-patient violence, are amenable to and benefit from an individual cognitive-behavioural anger treatment programme
- Significant reductions in aggression and violence are observed following completion of anger treatment
- Reductions in aggression and violence were strongly associated with improvements in patient anger following treatment
- This harm reduction effect is likely to result in significant benefits for individual patients and care staff, as well as cost improvements for services

Transforming Care for People with LD (NHS-England)

- *DoH Winterbourne View Review (December 2012) Concordat*
  - **Commitment to ensure that: "all people with challenging behaviour in inpatient assessment and treatment services are appropriately placed and safe, and if not make alternative arrangements for them as soon as possible."**

- *Building The Right Support: (LGA/ADASS/NHS-E, October 2015)*
  - **Currently there are 2,600 inpatient beds**
  - **Reduce this number by 35-50%**
  - **Aim for 1,300-1,700 beds**
  - **Within 3 years**
  - **This is a "starting point"**
  - **Money saved will be re-invested in community services**

Learning Disability Patients Receiving Inpatient Care -
NHS Digital (February 2018)



NICE Guideline 11: Challenging Behaviour and LD (May 2015) – *PBS*

- ***"The reviews did not find any evidence on the effectiveness of PBS."*** **(p. 206)**

- ***"Low-quality evidence from 3 pilot studies indicates that there is wide variation in costs associated with provision of PBS programmes in the UK."*** **(p 254)**

cRCT of Staff Training in PBS to Reduce Challenging Behaviour – Hassiotis et al. (2018) Brit J Psychiatry

- **No significant differences between PBS and TAU arms on ABC Total or ABC domain scores (N = 245)**
- **No significant differences on secondary outcome measures (mental health and community participation/activity)**
- **No reductions in use of psychotropic medications**
- **“Offering training in PBS … does not provide added benefits in reducing CB, use of psychotropic medication, or community engagement.” (p.166)**

NICE Guideline 11: Challenging Behaviour and LD (May 2015) – *CBT*

Review question:

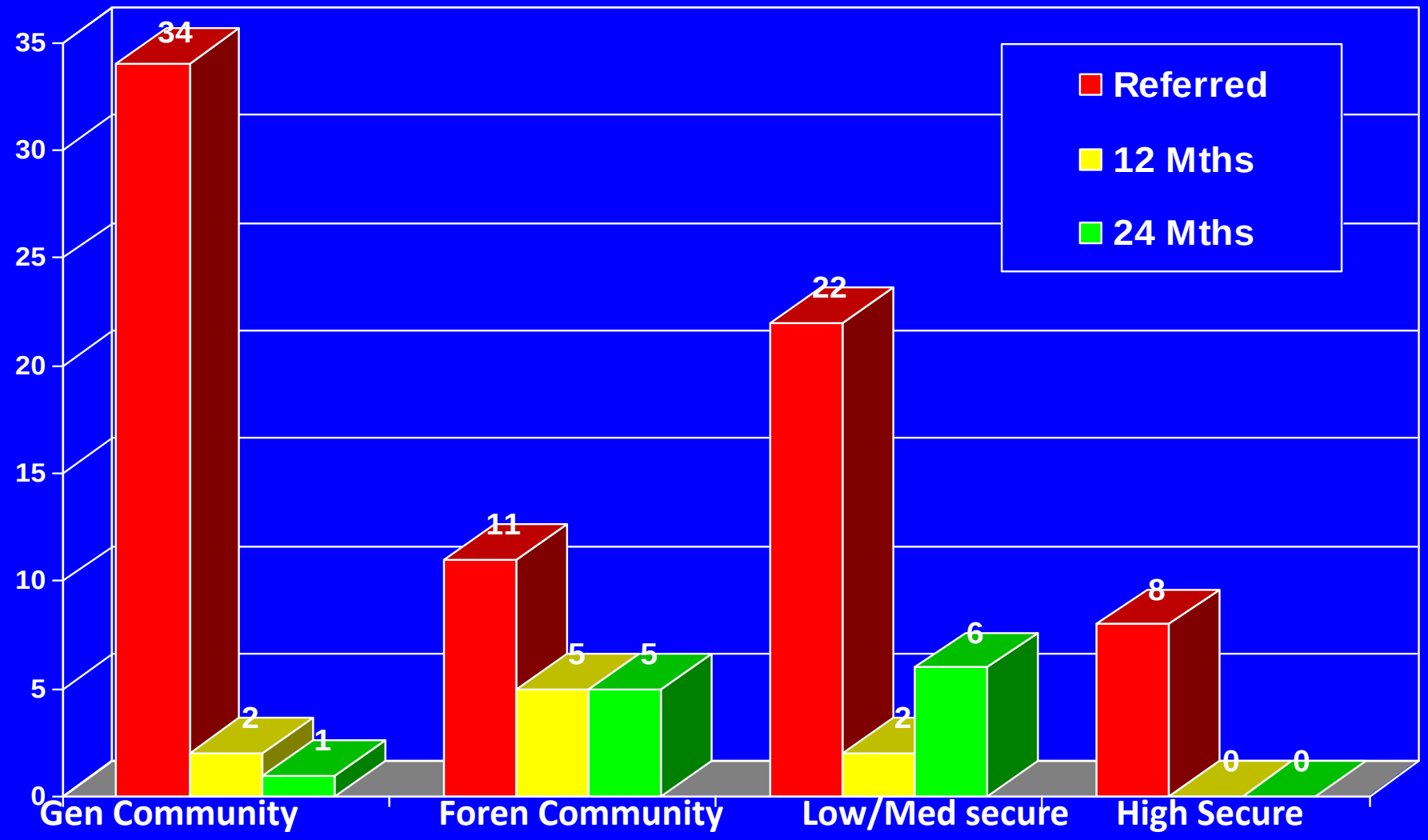
- ***In people with a learning disability and behaviour that challenges, what are the benefits and potential harms associated with psychosocial interventions aimed at reducing and managing behaviour that challenges?***

Recommendation 43

'Consider individual psychological interventions for adults with an anger management problem. These interventions should be based on cognitive-behavioural principles and delivered individually or in groups over 15–20 hours.'

Treatment Over 24 Months – Violent Index Offences

Lindsay et al. (2012) Psychiatry, Psychology & Law



Anger Maintenance Programme

Typically anger maintenance sessions will take place on a weekly basis with the named nurse and will include:

a) weekly review and discussion of patients completed anger logs

b) cognitive re-framing of situations (from anger logs) that appear to have been misinterpreted

c) rehearsal of awareness, self-instructional and behavioural coping strategies as set down in the client's personal reminder sheet

d) either prompts to use arousal reduction techniques regularly or practice of abbreviated relaxation exercises in the session

Thus patients are not simply going over material covered in the standard treatment sessions, but are building on the techniques acquired by drawing on here-and-now events in order to consolidate the skills learnt in treatment

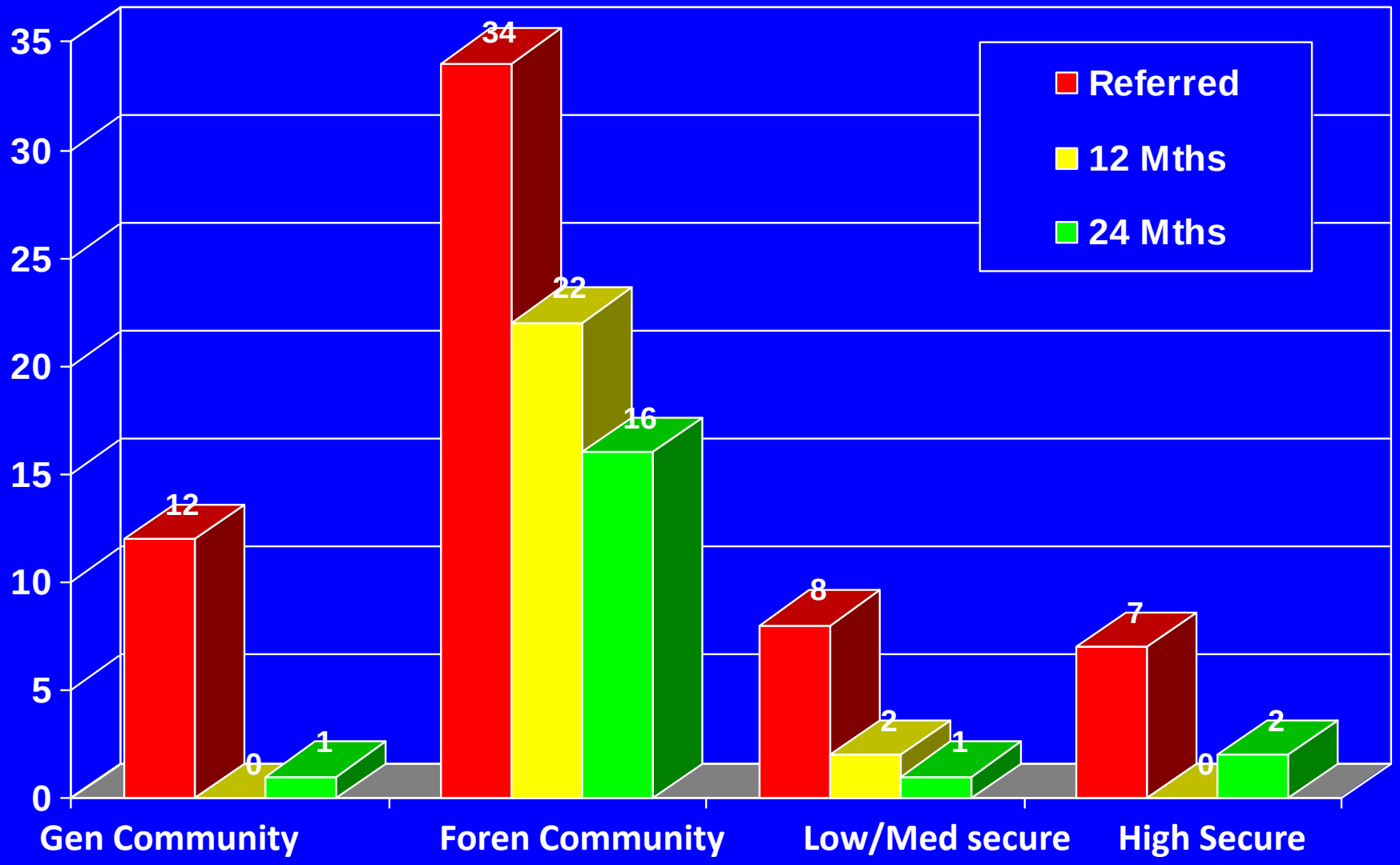
Anger Treatment Maintenance – *Audit*

Taylor & Novaco, 2010

- **70 patients completed treatment through the Northgate Anger Treatment Project**
- **At audit point, 47 of these treatment completers remained in hospital**
- **Audit showed that just under 25% (11) of these 47 patients were receiving anger treatment maintenance sessions -- although just one of this group was recorded as having declined this input**

Treatment Over 24 Months – Sexual Offences

Lindsay et al. (2012) Psychiatry, Psychology & Law



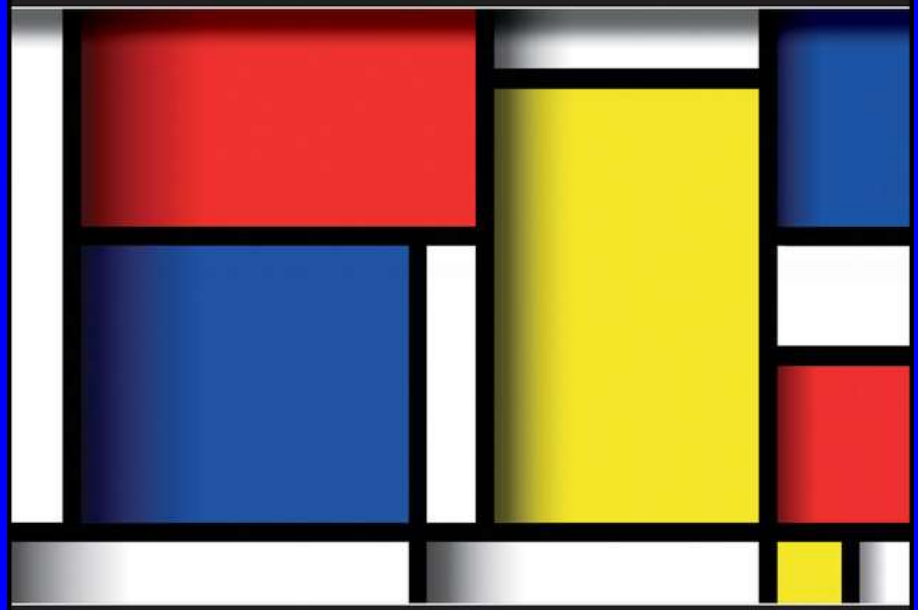
General Summary

- It is not clear whether people with ID are over- or under-represented in the offender population
- Disproportionate numbers of people with ID are detained in hospital under the MHA
- Good progress is being made in developing actuarial and clinical assessments of forensic risk
- The evidence for the effectiveness of interventions for violent, sexually aggressive and fire-setting behaviour is limited but building and requires further development
- Services are not providing and/or supporting evidence-based interventions that can be effective in reducing offending
- A national policy to reduce the number of people with ID in hospital is failing

Future Directions

- Further development and evaluation of assessment and interventions for people with ID and forensic needs
- Investigation of the barriers to implementation of evidence-based interventions – organisational, training & leadership
- An independent evaluation of the impact of Transforming Care - with lessons learnt applied
- Refinement of what is understood by PBS and a realistic appraisal of its utility (as a national policy facilitator)
- Future policy development based on critical analysis of needs and evidence-based interventions


Euskaltel
Euskad



Edited by
William R Lindsay and John L Taylor

THE WILEY HANDBOOK OF

Offenders with Intellectual and Developmental Disabilities

Research, Training and Practice

WILEY Blackwell

john2.taylor@northumbria.ac.uk