



UNIVERSITY OF LEEDS

BEHAVIOUR THAT CHALLENGES:

Planning services for people with learning disabilities and/or autism who sexually offend

DR ANDREA HOLLOMOTZ (University of Leeds) and **JENNY TALBOT** (Prison Reform Trust)
with **ELLIE GORDON** (Independent Clinical Advisor),
CLARE HUGHES (National Autistic Society),
DAVID HARLING (NHS Improvement)

PUBLISHED APRIL 2018

This work was supported by the Economic and Social Research Council
[grant number ES/L010534/1]

E·S·R·C
ECONOMIC
& SOCIAL
RESEARCH
COUNCIL

PRISON
REFORM
TRUST

With support from:

NHS
Improvement


The National
Autistic Society

ACKNOWLEDGEMENTS

Many people contributed to the success of our seminar day, held in May 2017, and to this briefing paper. We are especially grateful to Lord Bradley for providing the seminar opening address and for writing one of the two forewords to this briefing paper; to Niles for sharing his personal story in his presentation and foreword; to all the other important contributors who made seminar presentations (Janette McCormick, Kate Davies OBE, Joe Rafferty, Janice Grant, Danielle Kenney, Monika Egli-Alge, Paul Jennings, Ben Hughes); and to the table chairs (Glynis Murphy, Kerensa Hocken, Alison Giraud-Saunders), seminar note takers (Zoe Burton, Karina Hepworth, Caroline Allnutt, Kimmet Edgar, Les Smith) and other seminar delegates, many of whom shared case studies and other material to inform the seminar and this briefing paper.

We are obliged to our critical readers, Kerensa Hocken, Alison Giraud-Saunders, Salma Ali, Pam Mount with Michelle Anwyl, Prof Anna Lawson and Dr Lisa Buckner. We would also like to thank the many helpful people who have answered our questions whilst we were writing this briefing paper, including James Haaven, Phil Jarvis, John Hutchinson, Richard Curen, Chris Bath, Rachel Riddy, Tania Tancred; and all those who helped to write and review their case study text boxes. Special thanks go to the Economic & Social Research Council and the Leeds Social Sciences Institute, without whose support neither the seminar nor this briefing paper would have occurred.

CONTENTS

FOREWORDS

The Rt Hon Lord Bradley.....	1
Niles, service user representative.....	2

1. INTRODUCTION..... 3

1.1 About this briefing paper.....	3
1.2 About our seminar.....	3
1.3 Structure of the briefing paper.....	3
1.4 Methods and reflections on the process of writing this paper.....	3

2. BACKGROUND..... 5

2.1 Key definitions.....	5
2.2 Prevalence of learning disability and autism, and behaviour that challenges.....	5
2.3 Prevalence of sexual offending.....	6
2.4 Psychological treatment for sex offenders with learning disabilities and/or autism.....	7
2.5 Different pathways for people with learning disabilities and/or autism.....	9

3. LEGISLATIVE AND POLICY FRAMEWORK..... 11

3.1 The Mental Health Act 1983.....	11
3.2 Transforming Care.....	11
3.3 Criminal justice responses.....	12

4. THE CASE FOR CHANGE..... 14

5. OUR EVENT - ACHIEVING IMPROVED OUTCOMES..... 15

5.1 Prevention.....	15
5.2 Early intervention.....	15
5.3 Criminal justice responses and different routes of incarceration.....	17
5.4 Community support and treatment.....	18
5.5 Settling into a community home after prison or hospital.....	18
5.6 Workforce development.....	21

6. RECOMMENDATIONS..... 23

Prevention and early intervention.....	23
Contact with criminal justice services.....	25
Further research.....	26

REFERENCES..... 26

LEGISLATION..... 28

APPENDECES..... 29

Appendix 1: Seminar Day Programme.....	29
Appendix 2: List of seminar day delegates.....	31
Appendix 3: A brief overview of the Autism Act 2009.....	33

FOREWORD



The Rt Hon Lord Bradley

Compared to the general population, offenders have disproportionately higher burdens of health and social care needs and people with a learning disability and/or autism can face even greater burdens.

They frequently experience disadvantage and discrimination alongside a multitude of pressures, such as poor housing, hate crime, financial exploitation, and difficulties in developing friendships and relationships; while many will struggle to cope, more generally, with the demands of daily living.

They may also experience poor physical and mental health and problems with alcohol and drugs misuse. Some will have experienced poor parenting as a child and had a limited or inadequate education, including sex education. Their needs are often multiple and complex, requiring professional services to provide a highly responsive, well-coordinated approach, which can be hard to deliver. Collaborative working across health, social care and justice agencies is essential to better understand how to improve outcomes for people with a learning disability and/or autism who sexually offend.

Joint training between health, social care and justice agencies can help identify shared priorities and break down some of the barriers and misunderstandings that often exist between different professional groups and sectors. For example, having a shared understanding of 'risk' and the factors that can impede positive risk taking, are especially pertinent.

Timely access to care at times of distress or crisis in a person's life, as well as care that fosters independence, are important in developing an integrated framework of support. Proactive and preventative approaches to service provision can greatly reduce the likelihood of an offence occurring and help keep our communities safe. However, should a person come to the attention of the police, liaison and diversion services are a good example of an early intervention model that can help coalesce support around the individual and help to inform criminal justice decision making.

Holding individuals to account for their behaviour by supporting them to learn new and adaptive skills, and to understand the implications of their behaviour, is an important principle in improving outcomes for people with learning disabilities and/or autism who sexually offend, and in enabling them to live full, valued, and meaningful lives.

Building on a seminar held in May 2017, this briefing paper provides a stimulus for further discussion. It brings to the fore the plight of an especially marginalised group of people, and the challenges they face, describes positive practice examples and proposes recommendations for improved outcomes.

The Rt Hon Lord Keith Bradley

A handwritten signature in black ink that reads "Keith Bradley". The signature is written in a cursive style with a long horizontal flourish at the end.

FOREWORD

Niles has been convicted of a serious sexual offence. He is a young man with learning disabilities and autism who attended our event and shared his story. This is not his real name.

After being arrested and being in prison I was in hospital for 4 years. After completing treatment, it was agreed I was ready for discharge. After a lot planning and bridging I was discharged. It took nearly 2 years!

I now live in my own house (I am the tenant). I currently have staff support with me all the time. I also get support from my forensic nurse, responsible clinician (psychiatrist), social worker and the police monitoring officer (Sex Offender Management Unit). My dreams for the future are to have a decent job, a decent car, to work towards living on my own, with no service (or just a little bit of support) and to keep out of trouble.

The following four things, I feel, have helped me to stay out of trouble, increased my confidence and understand things:

- The sex offender treatment I did in hospital made me look at life in a different way and understand where I went wrong. It gave me tools to use, such as cards and code words to help me not to reoffend. I still use these tools today.
- The help I get from my support service (a specialist forensic supported living service) helps me enjoy life. My staff are always there to listen to any problems and they help me work through them. They support me with my daily life and help me find new activities to do. They also remind me about how to stay safe and stay out of trouble. If I put myself in a difficult situation, my staff will help me work out a way out of it.
- I need to keep busy, so I don't get bored. This helps me keep safe. Being busy helps me not to think about the bad side of things. Things I do to keep busy include going to college, cycling, socialising, visiting the library and cinema.
- My family is very important to me. I look forward to weekly visits to mum's home and mum visiting me at my home. I am very protective over my mum because she stood by me when I kept getting in trouble.

I am very grateful for the support I have and I think other people like me should be given a chance. The most important thing for me is having someone who is always there when I need them to listen to any problem I may have and help me work through them. If I could tell the Prime Minister one thing about what I would like to see done better, it would be to get people out of hospital quicker. Often too much time passes from when a person is ready to leave to actually leaving. This is often to do with legal stuff and sections.

Signature withheld



Niles, Service User Representative

1. INTRODUCTION

1.1 ABOUT THIS BRIEFING PAPER

There are people with learning disabilities and/or autism in every community, some of whom will engage in sexually offending and risky behaviour.

Already a highly marginalised group, many will themselves be at risk of exploitation and abuse. Several local, regional and national authorities and multi-agency partnerships have overlapping responsibilities for their health and wellbeing – whether as a statutory duty or because supporting people who are vulnerable is integral to their role.

The array of support agencies can be confusing and hard to access – both for individuals with learning disabilities and/or autism and family members seeking help on their behalf. Early intervention and support can improve outcomes for the individuals themselves, make communities safer and reduce the number of victims, and lessen the high cost of crisis intervention.

This briefing paper sets out the case for change: it draws on presentations and discussions from a seminar we held in May 2017. It includes practice examples and suggests practical ways forward and makes recommendations to improve outcomes for some of the most vulnerable citizens in our society.

1.2 ABOUT OUR SEMINAR

The seminar was led by the University of Leeds, in collaboration with the Prison Reform Trust, The National Autistic Society and NHS Improvement. Our seminar was divided into two parts: first, we considered health and justice pathways for people with learning disabilities and/or autism who display sexually offending behaviour and we heard about some of the challenges and possible solutions from the perspective of national leaders.

Second, we focussed on practice within service design and delivery, including practical examples and a ‘whole system’ approach. Two structured group discussions provided the opportunity for delegates to share practice ideas, raise concerns, and to explore solutions. The seminar programme is shown in Appendix 1, and the list of delegates is in Appendix 2.

1.3 STRUCTURE OF THE BRIEFING PAPER

Chapter 2 provides background information. Learning disabilities and autism, challenging behaviour and sexual offending are defined and an estimate of the number of people with learning disabilities and/or autism who are currently known to have committed sexual offences is given.

Psychological treatment that is currently offered to this population is briefly described and different pathways that they may take, through the criminal justice, forensic or social care systems, are outlined.

Chapter 3 provides more detailed background information of the legislative and policy framework that underpins these pathways, including how the Mental Health Act 1983 and the Transforming Care agenda shape current forensic pathways and responses, as well as criminal justice responses. In chapter 4 we pause for a moment to reflect on these current frameworks and practices and we briefly consider the case for change.

Chapter 5 summarises the substance of what was discussed at our event. Just like the event itself, this focuses on solutions and avoids a rehearsal of the difficulties we have summarised in chapter 4. The discussion follows the ‘journey’ that a person with learning disabilities and/or autism may take once they have been identified as at risk of sexually offending.

We begin by considering how we can move beyond crisis driven responses to sexually offending behaviour and working to prevent such behaviour from occurring. Next, we consider criminal justice responses to alleged sexual offences by health and social care services, and police discretion. We discuss diversion into inpatient settings. Delegates were in agreement that community support and treatment can have positive outcomes, but there were mixed views about the availability of interventions and treatment options. We highlight some of the positive examples delegates discussed. The following section highlights some of the difficulties that people with learning disabilities and/or autism face when settling back into the community after they leave prison or inpatient care and it provides a number of creative examples of ways in which different types of support have helped them. The subsequent section offers some brief reflections on workforce development, including opportunities for sharing practice.

Chapter 6 features our 13 key recommendations arising from the day. These relate specifically to prevention and early intervention, contact with criminal justice services and further research.

1.4 METHODS AND REFLECTIONS ON THE PROCESS OF WRITING THIS PAPER

This paper was written collaboratively by Dr Andrea Hollomotz and Jenny Talbot OBE. Ellie Gordon, Clare Hughes and David Harling helped to organise and facilitate the seminar and offered further input into this paper on their specific areas of expertise. In writing this paper, we were guided by the materials we gathered at our seminar and from our delegates. This includes the PowerPoint presentations from the speakers, notes taken during those presentations, any materials that delegates have sent to us about their work prior to and

following the event, and detailed table discussion notes. Each table had an allocated note taker who recorded the two table discussions (note takers were: Zoe Burton, Karina Hepworth, Caroline Allnutt, Kimmie Edgar, Les Smith). The first table discussion gave delegates the opportunity to get things 'off their chest'. We were looking for brickbats (uncomplimentary remarks), bugbears (causes of annoyance), and bright ideas.

We encouraged this debate because most of us will have ideas about the cause of the 'problem' and pet ideas about what would help to solve that problem and we wanted to get these out in the open, not least because others present in the room might be perceived as being part of the problem (so we needed to hear their perspective) or the solution. The brickbats and bugbears are reflected in chapter 4, the case for change. Many brickbats and bugbears were caused by contextual factors and the notes therefore also guided us in terms of what to include in the background and legislative policy framework sections.

The second table discussion focussed on 'achieving best outcomes'. The idea was to capture and present relevant legislation, policy levers, good practice, and ideas/solutions for overcoming challenges, as part of a 'seamless' whole. Many of the findings from this discussion are captured in chapter 5 but, as with the first discussion, the pointers provided by delegates also helped us decide what to include in the literature and policy review.

Hence, in the writing of this paper, we worked back and forth from data to literature as we needed to insert precise information to set the context, to enable the reader to make full sense of the discussions that have informed chapters 4 and 5. Moreover, the literature we used throughout the paper features materials produced or recommended by our seminar delegates, along with further sources that help to elucidate or contextualise points that were raised on the day.

During our event we structured the speaker contributions so that they reflected the 'journey' a person with learning disabilities and/or autism who has committed a sexual offence may take from being arrested, through to going to court and then prison, or being diverted into inpatient care and then release into the community. This structure guided us in organising the debates in chapter 5. However, the reader will note that there are vastly different perspectives represented within each section.

Delegates did not always agree and offered different perspectives that reflected their professional role and positioning along the 'journey'. We attempted to capture this diversity and have incorporated the points noted by the scribes into this briefing paper. In other words, we decided that all of the data that note takers recorded on the day would go into the briefing paper. Whilst this means that note takers had some control in prioritising what contributions to write down during table discussions, once they had made the decision to

note it, we would ensure that the information was used. Where this was useful, Hollomotz brought in further examples to elucidate points made by delegates from her current research project, which asks: 'what works, for whom and under what circumstances, on treatment programmes for sex offenders with learning disabilities?'

Once we had produced a full draft, our critical readers (Kerensa Hocken, Alison Giraud-Saunders, Salma Ali, Pam Mount, Michelle Anwyl, Prof Anna Lawson, and Dr Lisa Buckner) pointed to any issues within the paper that needed clarifying. They helped to draw out and develop our list of recommendations and further points were added to the substance of the discussion.

We aimed for a ten-page paper and to spend a week or so writing this. After several discussions over the summer, Hollomotz and Talbot worked on the paper for four months in between other commitments (November 2017 to February 2018). At times we worked separately on different sections and at times we worked together on the whole draft.

There were more than forty different versions of this paper before we arrived at this version, a vast number of e-mails exchanged, many phone calls and one face-to-face meeting. What this reflects is that we did not realise when we started writing just how detailed the notes by our excellent scribes were, which reflected the thoughtful comments by our enthused and talkative delegates, much to the credit of the table chairs who facilitated these discussions (Glynis Murphy, Kerensa Hocken, Alison Giraud-Saunders, Ellie Gordon, and Clare Hughes).

It also indicates that, even though we realised that this was a complex area of practice, we did not appreciate the full extent of this complexity and how much care needed to be taken to reflect the vast range of issues to be considered when planning services for people with learning disabilities and/or autism who sexually offend. (We have covered many, but we are not claiming that we have covered all of them.) We were at times left unsure and had to seek further clarifications. Again, this shows just how complex this area of practice is; if even we, the so-called 'experts', are left puzzled at times.

To conclude, this paper had to end up this long, because we are bringing together such vastly different sectors of practice and we believe that all the points found herein will be useful in some way when services are being planned for people with learning disabilities and/or autism who sexually offend.

We hope that this paper puts an end to some of the confusions that were reported by our delegates and that it can inspire more creativity and real improvements for individual cases, at local and at national level.

2. BACKGROUND

2.1 KEY DEFINITIONS

The World Health Organisation (WHO, 2018) defines **learning disabilities**¹ as:

'a significantly reduced ability to understand new or complex information and to learn and apply new skills (impaired intelligence). This results in a reduced ability to cope independently (impaired social functioning), and begins before adulthood, with a lasting effect on development.'

However, thresholds to qualify for support vary and sometimes people with a diagnosis of learning disabilities are excluded. Our paper is about all those people with learning disabilities to whom the WHO definition above can be applied, regardless of whether they meet thresholds for local services. As we will argue throughout this paper, even and perhaps especially those people with learning disabilities and/or autism who are not known to services need personalised and specialist interventions at certain times in their lives.

In many policy documents that mention learning disabilities and autism in a criminal justice context, autism, learning disabilities and, at times, specific learning difficulties² and even mental health are conflated, which is unhelpful and there is a risk that the issues that affect those with a specific condition are not always clearly distinguished. This paper is about both learning disabilities and autism.

We adopt the National Autistic Society's (2016) definition of autism, which is a lifelong, developmental disability that affects how people perceive the world and interact with others. Autistic people see, hear and feel the world differently to other people. Autism is a spectrum condition. All autistic people share certain difficulties, but being autistic will affect them in different ways. Some autistic people also have learning disabilities, mental health issues or other conditions, meaning people need different kinds of support. The statutory rights of people with autism to receive support to meet their needs within health, criminal justice and social care settings are further enshrined and protected through the Autism Act 2009.

This does two things: It places a duty on the Government to produce a strategy for autism and to underpin the strategy with statutory guidance for councils and the NHS which resulted in several key outputs in this area (Department of Health, 2010, 2014, 2015, 2016). The criminal justice system actions within the Think Autism strategy and statutory guidance are summarised in appendix 3.

2.2 PREVALENCE OF LEARNING DISABILITY AND AUTISM, AND BEHAVIOUR THAT CHALLENGES

The National Autistic Society (2016) state that: *'there are around 700,000 autistic people in the UK - that's more than 1 in 100'*.

It is furthermore estimated that between 44-52% of people with autism also have learning disabilities. An estimated 1.2 million people in England have learning disabilities, which is about 2-3% of the general population (children and adults). Administrative prevalence (i.e. the number of individuals known to services as having learning disabilities) drops significantly from around 2.5% among children in education, to around 0.6% among adults aged 20-29 years. It is estimated that only 21% of adults with learning disabilities are known to services (Emerson et al., 2012). According to Public Health England (2016, pp. 13-14), there are a number of likely reasons for this:

- an increased threshold used for health/disability identification and surveillance by post-education health and social care agencies;
- the operation of eligibility criteria to access specialised social care supports for adults with learning disabilities;
- the stigma associated with learning disabilities leading to an unwillingness to use specialised services or self-identify;
- the less obvious impact of the intellectual impairments associated with learning disabilities in non-educational settings.

Behaviour that challenges is generally understood to be exhibited by 10-15% of adults with learning disabilities known to services, peaking between the ages of 20-49 (Emerson et al. 2001, cited in NHS England, 2017a, p. 12). It is noteworthy that:

'Many of those people who are admitted to secure inpatient settings may not have previously been known to adult services prior to their contact with the criminal justice system, and may not have received a formal diagnosis of learning disability and/or autism until admission to hospital.' (NHS England, 2017a, p. 26).

A report by the Royal College of Psychiatrists, British Psychological Society, and Royal College of Speech and Language Therapists (2007, p. 10) said that:

'Behaviour can be described as challenging when it is of such an intensity, frequency or duration as to threaten the quality of life and/or physical safety of the individual or others and is likely to lead to responses that are restrictive, adverse or result in exclusion.'

Sexual offending covers a range of behaviour, and includes a person exposing their genitals, if they intend that someone else will see them and if they intend to cause 'alarm or distress'; viewing abusive images, touching someone with sexual intent, if the other person has not consented to such touching; sexual assault by penetration; and rape (which can only be committed by a man).

1: WHO use the term 'intellectual disability'. In the UK, the term 'learning disabilities' is more commonly used than 'intellectual disability', but it applies to the same condition. Learning disabilities will therefore be used throughout this briefing paper.

2. Specific Learning Difficulties affect the way information is learned and processed. It is an umbrella term used to cover a range of difficulties, including Dyslexia, Dyspraxia and A.D.H.D. (British Dyslexia Association, 2018)

BOX 2.2: CASE STUDY OF AN AUTISTIC SEX OFFENDER

Peter (not his real name) is an individual with circumscribed interest in, and sensory need for, children's garments, their dimensions and fabrics. As a child Peter lived in a children's home and he used to take the other children's clothes and collected them. He used this as a coping strategy and it became his special interest. As he became a young adult and no longer lived with children, he started to become captivated by children in public wearing specific coloured, textured and sized clothing. As he did not have the money to buy such clothes, he decided to stop children with their parents and ask them for their clothes (theory of mind and context blindness contributing³). The parents understandably reacted very strongly to this and threatened to call the police. Peter therefore decided to seek children on their own to ask for their clothes. They would run away or struggle away when he tried to pull their clothing. He then decided to abduct children and hit them until they stopped struggling, in order to take their clothes. Each step in the escalation was a practical step further to literally overcome the last hurdle.

When arrested and charged Peter could not understand why the police thought his actions were sexually motivated. He was not interested in the children, just their clothing. He received his autism diagnosis in prison, after the offence. His behaviours have only been seen in the context of his autism since then and probably only because the person who carried out his diagnostic assessment drew attention to it.

Contact: Clare Hughes, Criminal Justice Manager, National Autistic Society, clare.hughes@nas.org.uk

There are several reasons why people with learning disabilities and/or autism may get into trouble over an alleged sexual offence. At times their actions may be influenced by factors that are similar to those affecting non-disabled offenders, such as lack of empathy, poor impulse control, attachment problems and cognitive distortions (Lindsay, 2009; Marshall, Anderson, & Fernandez, 1999). Some of these issues can be caused by a person's own experiences of being victimised and people with learning disabilities have a significantly increased risk to of such experiences (Fisher, Baird, Currey, & Hodapp, 2016).

Other reasons that are particular to the experiences of people with learning disabilities and/or autism may include a lack of opportunities for appropriate sexual expression, limited knowledge about sex and sexuality (Griffiths, Hingsburger, Hoath, & Ioannou, 2013) or a poor understanding of the social sanctions attached to sexual offending. These difficulties are often linked to a lack of early learning and education about sex and relationships, but they may also be linked to a person's impairment.

For instance, autistic people often have difficulty recognising or understanding the feelings and intentions of others and as a consequence they may appear 'to be insensitive' or to behave 'strangely' or in ways thought to be socially inappropriate (National Autistic Society, 2016). Box 2.2 discusses the case of a man whose invasive behaviours had not been understood in the context of his autism and this meant that opportunities to intervene early were missed and behaviour escalated.

2.3 PREVALENCE OF SEXUAL OFFENDING

In the year ending March 2015, there was a 37% increase of police recorded sexual offences compared with the previous year. This 'should be seen in the context of a number of high profile reports and inquiries which are thought to have resulted

in police forces reviewing and improving their recording practices' (Office for National Statistics, 2016, p. 12). Moreover, the number of people sentenced to custody for sexual offences has risen by 54% over the last decade. In September 2017, 13,456 people were serving a custodial sentence for a sexual offence – 18% of the sentenced prison population (Ministry of Justice, 2017c).

The vast majority are men, accounting for 99% of people currently serving a custodial sentence for a sexual offence (Ministry of Justice, 2017a). On average, people in prison for sexual offences serve longer custodial sentences than any other offence group, with the exception of murder which carries a mandatory life sentence (Ministry of Justice, 2017a). On 31 March 2017, there were 55,236 registered sexual offenders in England and Wales eligible for MAPPA⁴ arrangements in the community, some of whom are individuals with learning disabilities and/or autism. This number marks an increase of 82% within the last decade.⁵ This reflects:

'sentencing trends, in which the number of people convicted of sexual offences is increasing. Additionally, many sexual offenders are required to register for long periods of time, with some registering for life.' This has a cumulative effect on the total number of offenders required to register at any one time (Ministry of Justice, 2017b, p.8).

The vast majority of people managed by MAPPA (99%) are under Level 1 supervision, the lowest level (Ministry of Justice, 2017b). The number of people with learning disabilities and/or autism who are known to be convicted of a sexual offence and serving either a prison sentence or under supervision in the community is shown at Table 2.3. The figures have been taken from the National Probation Service (NPS) case record system, which records information on learning disabilities and autism based on self-reporting. Some reasons that will inevitably lead to low

3: Theory of Mind is the ability to put yourself in someone else's shoes, to understand what other people think, feel and believe and to predict behaviour and outcomes based on those thoughts, feelings and beliefs. Context blindness is the inability to adjust behaviours or perception based on the context. This meant that he was unable to predict what the response of the parents would be and what the outcomes could be for him.
4. Multi-Agency Public Protection Arrangements (MAPPA) are a set of statutory arrangements to assess and manage the risk posed by certain sexual and violent offenders (Ministry of Justice, 2017b, p. 1).
5. A rise from 30,416 to 55,236 between 2006/07 and 2016/17 (Ministry of Justice, 2017b, p. 7).

TABLE 2.3: TOTAL NUMBER OF SEX OFFENDERS FOR WHOM THERE IS NPS INVOLVEMENT AS AT 30 JUNE 2017⁶

	Autism Spectrum	Learning Disability	Learning Difficulties	Total Sex Offenders
In Community	37	12	823	14,820
In Custody	22	21	615	13,324*
Total	59	33	1,438	28,144

These figures have been taken from the National Probation Service case record system as of 30 June 2017, with the exception of the one marked with *, which was taken from the Ministry of Justice (2017d) Statistics bulletin that captured the same date.⁷ This information is in response to a written parliamentary question asked by Lord Bradley on 6 December 2017, and was answered by Lord Keen on 19 December 2017; reference: HL3929⁸

levels of self-reporting were discussed in section 2.2. The data, therefore, cannot be taken to give a complete picture of the prevalence of individuals with learning disabilities and/or autism amongst sex offenders in custody or supervised by NPS in the community.

We know that this population is vastly over-represented in prisons. Between 20-30% of offenders are estimated to have learning disabilities or difficulties that interfere with their ability to cope within the criminal justice system (Loucks, 2007). It would seem, however, that many individuals with learning disabilities and/or autism are not identified and do not, therefore, receive the necessary support to meet either their social or offending behaviour needs.

This implies that whatever examples of good practice we will highlight later on in this paper, these accommodations are likely to be available to only a small number of sex offenders with learning disabilities and/or autism for whom there is NPS involvement. It is important to emphasise here that there is currently no conclusive evidence that there is a higher rate of sexual offending amongst people with learning disabilities (Craig, Stringer, & Sanders, 2012), compared to the non-disabled population. Rather, it has been suggested that this population may conduct their offences with less sophistication than those without learning disabilities, causing higher rates of detection (Craig & Hutchinson, 2005) and this in turn explains their assumed overrepresentation amongst the population of sex offenders in prison.

In other words, there are not proportionally more sex offenders with learning disabilities and/or autism represented in our society per se, but from the population of people who have committed sexual offences those with learning disabilities and/or autism are more likely to be detected and thus to end up in prison.

2.4 PSYCHOLOGICAL TREATMENT FOR SEX OFFENDERS WITH LEARNING DISABILITIES AND/OR AUTISM

Group cognitive behavioural therapy-based sex offender treatment has been developed to meet the needs of men with what are considered to be mild learning disabilities, which is usually defined by IQ scores ranging between 60 and 80. The main purpose of these programmes is the prevention of future sexual offending. The key objective is therefore to change a participant's thoughts and actions in such a way that they will not offend again.

A current ESRC funded study by one of the authors⁹ seeks to establish what works, for whom and under what circumstances on these programmes. Preliminary findings suggest that best outcomes are achieved by a whole system approach, whereby the whole support system that works with an individual collaborates to develop individualised pro-social daily routines and puts in place support structures that help a person to stay safe. This approach is standard practice in a community based Swiss programme; see Box 2.4A.

There are two available routes into group treatment in the UK. It is available either in select prison or probation trusts (Williams & Mann, 2010) or within community based or forensic healthcare settings (e.g. Hordell et al., 2008; SOTSEC-ID, 2018). HMPPS run three relatively new accredited programmes for men with learning disabilities, which are available in both custody and community. These are:

- New Me Strengths
- Becoming New Me Plus
- Living as New Me

The programmes have been designed to be responsive to the communication styles and abilities of people with learning disabilities. 'Becoming New Me Plus' is for offenders who have been convicted of a sexual, intimate partner violence,

6. The reader will note the difference between the figures cited in table 2.3 and the 55,236 MAPPA registered sexual offenders (Ministry of Justice, 2017b) cited earlier. The MAPPA figures are inflated as these include people who are not necessarily under supervision/licence by the NPS. Thus, there are people still registered as MAPPA Category 1, but who are not actively serving a sentence or licence period with NPS involvement.
7. This figure applies to 30 June 2017 and with this it differs from the 13,456 cited earlier on in this section, as that referred to the most recent statistics from 30 September 2017.
8. <http://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Lords/2017-12-06/HL3929/>
9. For further information contact Dr Hollomotz: A.Hollomotz@leeds.ac.uk
10. James Haaven was interviewed by Dr Hollomotz for her current study and has given permission to be named in this paper.

BOX 2.4A: FORIO'S SUPERVISION AND SOCIAL CARE NETWORK

Forio is a forensic healthcare provider in the north-east of Switzerland. They deliver outpatient group therapy for young men with learning disabilities who have sexually offended. The Forio therapists work closely with the supervision and social care network of the men in their treatment programmes. This includes the referrer (generally the prosecution service), parents or other family carers, key workers (for instance from their home or workplace), as well as any further persons that are involved in planning and delivering supervision or care. The network makes recommendations on personalising treatment, jointly monitors progress, helps to reinforce lessons learned and supports individuals in putting these into practice and in identifying potentially risky situations. They will also work to ensure that any community sentence requirements are met. The network meets before treatment commences and then at regular intervals throughout. How often these meetings are held is determined on a case-by-case basis and varies between monthly and every 6-8 months. Additional meetings are arranged on an ad hoc basis in response to major issues, such as a breach of community sentence requirements. Contact within the network is maintained via e-mails and phone calls and information shared whenever this is deemed necessary.

After treatment completion, participants and their network are offered aftercare in the form of risk-circles. These are not to be confused with circles of support (see box 5.5c). The Forio risk-circles are principally a continuation of an active information exchange between all members of the supervision and social care network. The standard format is to offer this for one year after treatment concluded and to hold meetings every three months. Central to risk-cycle discussions is the transfer of lead risk management responsibilities to social care.

Contact: lic. phil. I Monika Egli-Alge, Director, Forio, monika.egli-alge@forio.ch

or general violent offence, and have been assessed as high or very high risk. 'Living as New Me' is a skills maintenance programme, or 'booster' for people who have already completed 'New Me Strengths' or 'Living as New Me'.

A screening tool has been developed to assess a person's suitability for the programmes. This is made up of information from the Offender Assessment System (OASys), the Adaptive Functioning Checklist – Revised (AFC-R), and clinical observation. The assessments are not designed to diagnose learning disabilities, but to provide indicators of the presence of cognitive and adaptive functioning deficits, typically found in populations with learning disabilities.

There is currently no accredited group programme available for men with autism and some attend groups designed for men with learning disabilities, although these have not been developed with autism in mind. James Haaven¹⁰, a key originator of modern group treatment (e.g. Haaven, 2006; Haaven, Little, & Petre-Miller, 1990) believes that the needs of men with autism cannot be fully met by these groups because intellectually they are generally functioning at a higher level, and the specific issues they need to address through treatment are often different.

For instance, on rare occasions, the criminal actions of people with autism can be misunderstood and are in fact not sexually motivated, as illustrated in box 2.2 (case study of an autistic sex offender). James Haaven¹¹ further advises:

'There needs to be caution in using group therapy with people with autism since they may have significant problems in

processing and sharing information in a group setting. In addition, they may filter information in a group process very differently from what the intent of the information was for. Because of a myriad of issues, individual therapy is generally a more appropriate therapy modality, especially, during the initial stages of therapy. Clearly, there needs to be a comprehensive assessment done on such an individual prior to any consideration for placing them in a group therapy setting.'

BOX 2.4B: MEN WITH A DUAL DIAGNOSIS OF LEARNING DISABILITIES AND AUTISM IN GROUP TREATMENT

Men with autism are assessed for their ability to function in group settings by attending non-offence related group activities. We work on victim awareness, not empathy¹², as we have found these topics to be difficult for most of our men, especially those with autism or personality disorder.

The Good Lives Model of Offender Rehabilitation¹³ works for some men with autism, especially around the forging of new identities and healthy narratives that go with them. Unlearning old rules can be tricky for men who have rigid thought processes, but equally new rules for life help to contain anxiety when lack of knowledge and lack of social understanding provokes high levels of uncertainty.

Contact: Pam Mount, clinical nurse specialist, Mersey Care, pamela.mount@merseycare.nhs.uk

11. Personal communication 14-12-2017.

12. Victim empathy refers to 'a cognitive and emotional understanding by a sexual offender of the experience of the victim of his or her sexual offense, resulting in a compassionate and respectful emotional response to that person' (Mann & Barnett, 2013, p. 284). Victim awareness is thought to be a precondition to empathy and focusses on enabling 'group members to understand the harm they are likely to have caused to the victim' (Williams & Mann, 2010, p. 303). They will also consider consequences for themselves and their own families.

13. This is discussed later on, in section 5.4.



Unsurprisingly, higher recidivism rates are reported amongst men with autism who completed these treatments, compared to those without (Heaton & Murphy, 2013). However, case studies such as Niles (see foreword) demonstrate that some men with a dual diagnosis of autism and learning disabilities can benefit from group programmes written for men with learning disabilities. Box 2.4B features some observations on supporting their participation.

Like men with autism, for whom groups designed for non-disabled men or men with learning disabilities are not suitable, female sex offenders with learning disabilities and/or autism are only able to access individual therapies, as numbers are generally considered too low to make groups viable. For instance, Respond¹⁴ offer individualised and psychodynamically informed therapies to outpatients. They have treated a small number of female sex offenders (8 in the last 15 years). HM Prison and Probation Service uses the Women Sex Offender (WSO) Framework:

*'The WSO Framework provides a step-by-step guide on how to assess, manage and develop work and treatment plans for WSOs in a manner and style that is likely to enhance the woman's motivation and co-operation and reduce shame-led resistance. It outlines a relational approach to developing an effective working alliance between the WSO and the practitioner, which encourages openness and disclosure, thereby promoting pro-social behaviour.'*¹⁵

Resources for working with female sex offenders are available from the Lucy Faithful foundation¹⁶. Due to low numbers less is known about women who sexually offend. More research is necessary to understand the needs of this group.

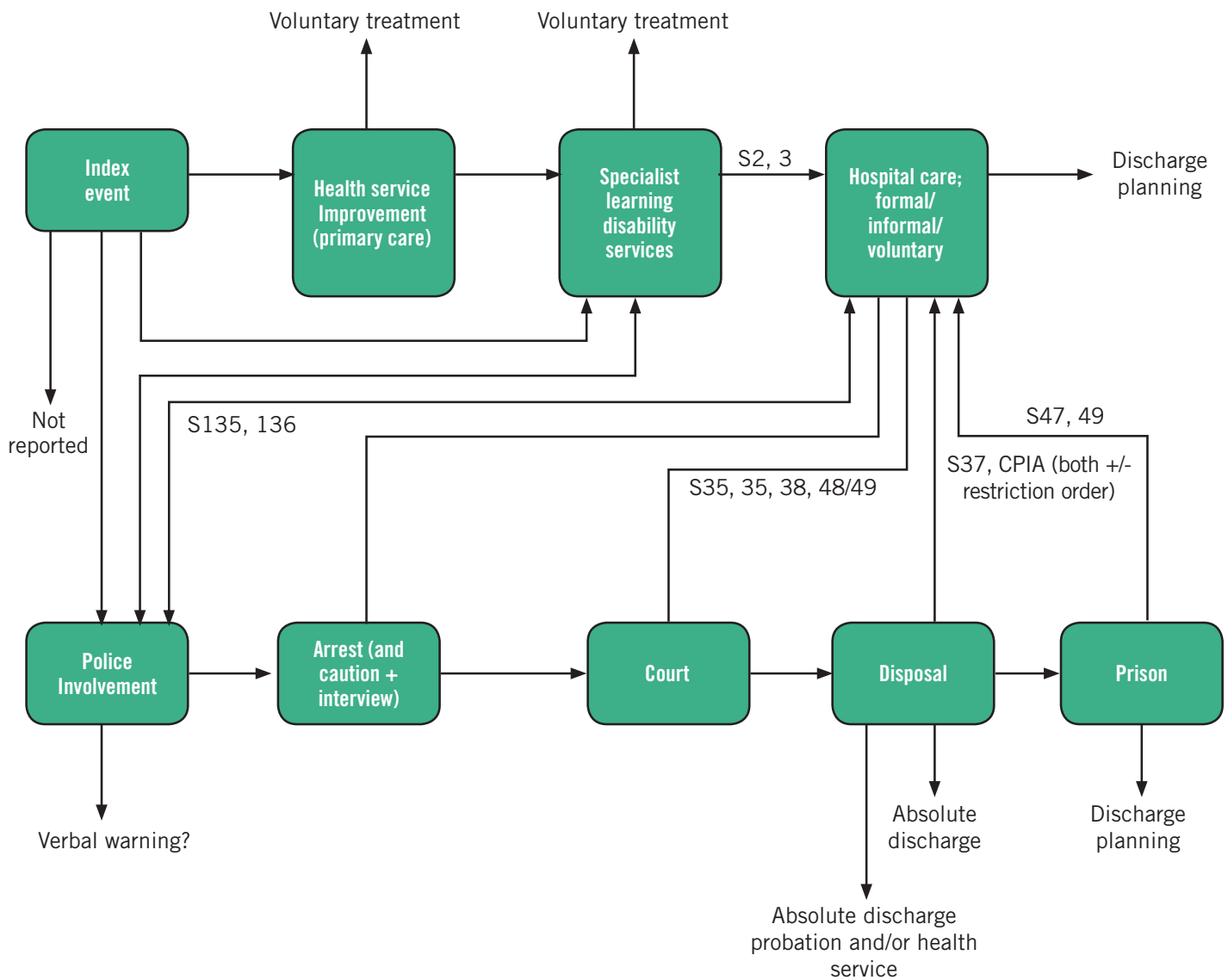
2.5 DIFFERENT PATHWAYS FOR PEOPLE WITH LEARNING DISABILITIES AND/OR AUTISM

Figure 2.5 displays the 'bewildering sequence of events' (Royal College of Psychiatrists, 2014, p. 18) that a person with learning disabilities and/or autism may be subject to following contact with the police due to an allegation of sexually offending behaviour. It shows that they may be treated and managed within health and social care, dealt with through the criminal justice system, or a combination of both.

How a person is dealt with, and what pathway is followed, can differ according to who the victim is, with offences towards male child victims having the highest chance of being reported (Green, Gray, & Willner, 2002), and where the alleged offence took place, with incidents within specialist disability services and towards victims with learning disabilities being less likely to be referred (McBrien & Murphy, 2006). It also differs depending on what services are already working with a person at the time of the offence (Wheeler et al., 2009).

This, in turn, can have profound implications for the person concerned. For example, evidence demonstrates that people

FIGURE 2.5: PATHWAY OF AN OFFENDER WITH LEARNING DISABILITIES THROUGH THE CRIMINAL JUSTICE SYSTEM
 (reprinted with minor edits from Royal College of Psychiatrists, 2014, p. 18)¹⁷



with learning disabilities and/or autism are frequently discriminated against and failed by the criminal justice system (HM Inspectorate of Probation, 2015; Talbot, 2008). A specialist services route, on the other hand, can deny the person the opportunity to defend themselves in a court of law, and can commit them to an indeterminate time spent in secure healthcare.

Inclusion in society of people with disabilities is an important principle.¹⁸ It means that people with disabilities should, with the necessary reasonable adjustments and wherever possible, be able to participate in society in much the same way as people without disabilities including, in the context of this paper, the criminal justice process.

In 2016, after a thorough consultation and review on Unfitness to Plead, the Law Commission said:

'At the heart of our recommendations lies our belief that the normal criminal trial is the optimum process where a defendant faces an allegation in our criminal justice system. We consider that full trial is best not just for the defendant, but also for those affected by an offence and society more generally.

This is because the full criminal process engages fair trial guarantees for all those involved... [and] offers the broadest range of outcomes in terms of sentence and other ancillary orders' (Law Commission, 2016, p. 4).

17. Abbreviations used in figure 2.5:
 S, Section (of the Mental Health Act 1983).
 a. Appropriate adult (Police and Criminal Evidence Act 1984).
 b. Special measures (Youth Justice and Criminal Evidence Act 1999).
 c. Criminal Procedure (Insanity) Act 1964, Criminal Procedure (Insanity and Unfitness to Plead) Act 1991 (CPIA).
 18. See Equality Act 2010 and UN Convention on the Rights of Persons with Disabilities (United Nations, 2006).

3. LEGISLATIVE AND POLICY FRAMEWORK

3.1 THE MENTAL HEALTH ACT 1983

Part III of the Mental Health Act allows ‘mentally disordered’ defendants to be diverted from the criminal justice system into compulsory treatment by the healthcare system either before or after conviction. The Act defines a ‘mental disorder’ as ‘any disorder or disability of the mind’ and specifies that a person with learning disabilities should not be considered mentally disordered unless the ‘disability is associated with abnormally aggressive or seriously irresponsible conduct on his part’. Key disposals under the Mental Health Act 1983 for ‘mentally disordered’ defendants are shown in Box 3.1.

Some people who have been detained under the Mental Health Act are entitled to support under section 117 after they leave hospital; this is sometimes referred to as ‘section 117 aftercare’ (MIND, 2017). This can cover health and social care, and supported accommodation. Aftercare services are intended to meet needs that arise from or relate to a person’s mental health problem, and to reduce the risk of mental conditions getting worse, resulting in the person having to return to hospital. Clinical Commissioning Groups and the local social services authority are responsible for providing aftercare services, or for arranging for them to be provided.

In May 2017, an independent review of mental health legislation was announced by the Prime Minister¹⁹. In his opening address to our seminar, Lord Bradley welcomed the review, and highlighted the opportunity to ensure that people with learning disabilities and/or autism who display behaviour that challenges were properly included in forthcoming discussions.

3.2 TRANSFORMING CARE

The Transforming Care agenda was initiated as a response to events at Winterbourne View hospital, where patients suffered serious systematic abuse by staff (Department of Health, 2012). It aims to deliver a culture change to ensure people with learning disabilities and/or autism who display behaviours that challenge receive the necessary care and support.

A significant part of this work has been to alter traditional practice of placing people many miles away from home, in institutional settings for many years, with little or no evidence of beneficial outcomes for the person or their family. This practice is to be replaced by care and support that is delivered locally, person centred and responsive to individual’s needs and wants, thereby reducing the reliance and need for inpatient services (NHS England, Local Government Association, & Association of Directors of Adult Social Services, 2015a).

The Transforming Care Service Model for Commissioners of Health and Social Care Services (NHS England, Local Government Association, & Association of Directors of Adult Social Services, 2015b, p. 8) highlights people with learning disabilities and/or autism whose behaviour places them at risk of contact with the police as a distinct group whose ‘specific needs have not always been recognised’.

Two years later this was followed by the service specification for community-based forensic support (NHS England, 2017a), which provides a useful guide for commissioners in developing service specifications to meet their local area needs, including what an ‘active caseload’ of individuals might be. It describes

BOX 3.1: KEY DISPOSALS FOR ‘MENTALLY DISORDERED’ DEFENDANTS, MENTAL HEALTH ACT 1983

- A hospital order permits the court to order the defendant’s admission to hospital if the mental disorder makes detention for medical treatment appropriate, and if suitable treatment is available (section 37). The order can be made by a magistrates’ court or the crown court following conviction for an imprisonable offence, or by a magistrates’ court without a conviction if the court is satisfied that the defendant committed the act/omission with which he was charged. A hospital order can be for up to six months’ duration in the first instance, but it can be renewed; thus, unlike most criminal justice disposals, it is essentially indeterminate.
- Under a guardianship order, the defendant is placed under the responsibility of a local authority or a person approved by the local authority (s. 37). Like a hospital order, this can be made by a Magistrates’ Court or the Crown Court following conviction, or by a Magistrates’ Court without a conviction if the court is satisfied that the defendant committed the act/omission.
- An interim hospital order can be made, by the Crown Court or a Magistrates’ Court, after conviction, when the court needs more time to decide whether to impose a hospital order or to use an alternative disposal (s.38).
- A restriction order can be imposed by the Crown Court alongside a hospital order, where this is deemed necessary by the court to protect the public from ‘serious harm’ (s.41). The order places limits on the individual’s discharge from hospital.

(Jacobson with Talbot 2009, p. 23)

the core functions that need to be delivered locally to provide effective specialist community-based forensic support to meet the needs of adults who meet the following criteria²⁰:

- They have a learning disability and/or autism;
- They display behaviours that present an active and high risk to others or themselves;
- This behaviour has led to contact with the criminal justice system, or there is risk of this.

Even though the framework, described in box 3.2, predates these recent policy initiatives, it helps to illustrate what the community-based forensic support envisaged by Transforming Care can look like. It also shows that developing such effective practices takes commitment over time.

Transforming Care promotes preventative and supportive mechanisms, demonstrated by the principle of ‘no wrong door’²⁴, which complements duties under the Care Act 2014 (part 1, section 2(1a)) that require local authorities to:

‘provide or arrange for the provision of services, facilities or resources, or take other steps, which it considers will contribute towards preventing or delaying the development by adults in its area of needs for care and support.’

Some local authorities have developed a ‘whole system approach’ to working with specific population groups, such as women, which aims to provide holistic support when a person comes into contact with criminal justice services. This is achieved through greater cohesion between policy, commissioning, and service delivery across and between justice, health, social care, housing and other community services. At an operational level this means greater collaboration between local services to ensure individuals are offered necessary support at the point of arrest and along the justice pathway (see box 5.2: Working together for person centred care in a whole system approach).

3.3 CRIMINAL JUSTICE RESPONSES

Following arrest, and depending on the seriousness of the alleged offence, the police will decide between possible courses of action (see Box 3.3); this applies to all people, not only those with disabilities or accused of a sexual offence.

The police can exercise a degree of discretion in how they proceed and a person’s disability may, but does not necessarily, impact on the decision taken. Where liaison and diversion services exist, their assessment of the accused will help to inform criminal justice decision making, alongside referrals into local services, as needed.

BOX 3.2: PEOPLE WITH LEARNING DISABILITIES ON A FORENSIC PATHWAY IN CUMBRIA

Back in 2006 Cumbria Partnership NHS Foundation Trust (CPFT) started an initiative they called ‘Breaking the Cycle’ where they monitored people who were placed out of county to look at whether they were placed appropriately within services that met their identified needs and to plan for transition back to Cumbria when appropriate. In autumn 2017 the last of approximately 16 individuals with a primary diagnosis of learning disabilities and forensic backgrounds from South Cumbria, who had been placed out of area within a specialist forensic (Mersey Care) hospital, moved back into a community-based setting.

Whilst ‘Breaking the Cycle’ meetings no longer occur, CPFT still has monitoring arrangements in place of all individuals placed out of County²¹ or who may be at risk of being placed out of county, through local clinical commissioning groups. This now also includes child cases to try to ensure a smooth transition from child to adult services. The specialist community learning disability nurse –forensic pathway lead coordinates the therapeutic work for all the individuals with learning disabilities who are on a forensic pathway. CPFT lead on multi-agency risk evaluations (MARE)²² for individuals with learning disabilities, who are deemed to present a high risk but who may not have a criminal conviction or meet the criteria for MAPPA. Other individuals who are eligible, and/or were previously supervised through MAPPA, may transfer into the MARE process and then into a Multi-Disciplinary Team (MDT). In all these cases the specialist community learning disability nurse works closely with other agencies involved. This includes the Liaison and Diversion teams, which work within Police Custody and Adult Social Care.

CPFT work closely with the public protection unit within the police, which has identified officers who manage MAPPA/MARE cases. CPFT employs the Development Officer for Mentally Disordered Offenders, who leads on all MAPPA/MARE cases and development work around offenders with learning disabilities and/ or autism²³. The specialist nurse has a good relationship with the police officers and may jointly see individuals. The public protection unit officers do not wear uniforms; therefore, they do not draw attention when visiting offenders.

Contact: Kay Lynas, Forensic and Mental Health Lead, South Cumbria kay.lynas@cumbria.nhs.uk

22. For further information, see Cumbria’s MAPPA/MARE Pathway Policy (Cumbria Partnership NHS Foundation Trust, Cumbria Constabulary, Cumbria Probation Trust, & Cumbria County Council Adult Social Care, 2017).

23. Currently the specialist nurse would only work with individuals with Autism if they have a diagnosis of learning disabilities. The MARE process would still cover Autism without involving the specialist nurse. In addition, the local commissioning group monitor out of county placements for individuals with Autism.

24. The ‘no wrong door’ principle acknowledges that integrated service delivery is challenging and can only be achieved if front line workers are supported with clear guidance and opportunities to build effective inter-agency relationships to improve outcomes for service users.



The more serious the alleged offence, the more likely the decision to proceed either to charge or to divert away from criminal justice into an inpatient setting. Conversely, the less serious the alleged offence, the more likely the decision to discontinue in the public interest, to issue a formal caution, or for the Crown Prosecution Service to issue a conditional caution.

The Equality Act 2010 requires reasonable adjustments to be anticipated and put in place for people with disabilities, so enabling them to participate in society on an equal basis with others without disabilities, including within the criminal justice system. In police custody, the role of the Appropriate Adult safeguards the rights and welfare of adults whom the police consider to be **'mentally disordered or mentally vulnerable'**.

While good progress has been made in enabling effective participation in justice proceedings for people with disabilities, the accused are mostly excluded from 'special measures' contained in the Youth Justice and Criminal Evidence Act 1999.

Case law, guidance and training have, however, encouraged reasonable adjustments in police and court proceedings, and assessments by liaison and diversion services highlight the need for such provision.

That said, evidence shows that across the criminal justice system – police, courts, prison and probation – there remains much work to be done to ensure people with learning disabilities and/or autism²⁶ are routinely identified when they first come into contact with the police, and are adequately supported throughout the criminal justice process (HM Inspectorate of Probation Criminal Justice Joint Inspection, 2014, 2015; Talbot, 2008).

'The main factor that probation and prison leaders, both nationally and locally, appear to miss is that they have a statutory duty to make reasonable adjustments to the services they provide to make them accessible to all offenders with disabilities' (HMI Probation & HMI Prisons, 2015, p. 11).

BOX 3.3: POLICE OPTIONS FOLLOWING ARREST

The major options available to the police are:

- To discontinue the investigation because of a lack of evidence or because prosecution would not be in the public interest,
- Release on police bail pending further investigation,
- To issue a formal caution²⁵ if the suspect admits the offence and gives informed consent to a caution and the offence is not serious;
- Proceed to charge (as an alternative, the Crown Prosecution Service have the option of issuing a 'conditional caution', to which restorative or rehabilitative conditions are attached);
- Engage with local health and social care services for the purpose of diverting the suspect into treatment or support, in view of their particular psychological or psychiatric needs

(Jacobson, 2008, p. 23).

25. The use of cautions for 'mentally disordered' suspects can be difficult because of the requirement that the offence is admitted, and the suspect agrees to the caution and understands its implications. If there are doubts about a suspect's level of understanding or truthfulness of their admissions, a caution is inappropriate.

26. While most of the evidence relates to people with learning disabilities, this would include people with both learning disabilities and autism.

4. THE CASE FOR CHANGE

An effective response to people with learning disabilities and/or autism who sexually offend requires professional health, social care and justice services to integrate support around the individual, and a focus on prevention and early intervention, which can be hard to deliver. Cultural and organisational factors can mitigate against joined up working and it is often only at the point of crisis that services intervene. Poor recognition of individuals with learning disabilities and/or autism is compounded by limited understanding of how best their needs can be met, the stigma of sexual offending, and fear of sexual risk.

Most adults with learning disabilities and/or autism are not known to services, and those with conditions considered mild often find it hard to access support – either from specialist learning disability services because they are deemed ‘too able’ and do not meet thresholds for support, or because they find it hard to access mainstream services because of their disability.

Under-identified and frequently underserved by local services, people with learning disabilities and/or autism are over-represented in the criminal justice system. Here, they are made vulnerable if this system does not recognise nor support their needs (Talbot, 2008). There is a lack of reasonable adjustments, including a lack of access to adapted programmes. According to the Equality Act 2010 this can constitute unlawful disability discrimination.

For those admitted to hospital there may be no therapeutic benefit from admission, which can lead to people being trapped for years, with concomitant risks of institutionalisation and loss of hope. People with learning disabilities and/or autism often find it difficult to transfer learning from an artificial hospital environment to the real world.

There are examples where the release of prisoners is generating a police response to ‘gate detain’ under s136 of the Mental Health Act. The practice, variously referred to as ‘gate arrest’ or ‘gate detention’, is highly objectionable and should be stopped. If assessment or transfer to hospital is necessary, this should be undertaken within the period of detention and not as the person prepares to leave prison, in the belief that they will soon be free to return home.

Different responses by local health and justice services can result in a post code lottery of outcomes, ranging from ‘no further action’, through to a prison sentence, or detention under the Mental Health Act 1983, with no opportunity to defend themselves in a court of law. In many areas there is a lack of skilled community services that have the confidence of courts; and courts often feel that they have very few options.

The Transforming Care programme, and local Transforming Care Partnerships, are central to improving outcomes for people with learning disabilities and/or autism who sexually offend. Progress, however, can only be made with the full engagement of a range of local services.

Good practice does exist. This briefing paper, and the event upon which it draws, describes ways of working and treatment options that can help to reduce risk and improve outcomes for individuals with learning disabilities and/or autism who display behaviours that challenge. This, in turn, can help to reduce numbers of victims, and make our communities safer.



5. OUR EVENT - ACHIEVING IMPROVED OUTCOMES

This section draws together main points from our seminar, providing additional information to describe the wider context, and practice examples. Perhaps unsurprisingly, some of the main points that emerged are generic and well-rehearsed, such as improved information sharing and collaborative working; some relate generally to individuals with learning disabilities and/or autism; and some to individuals with learning disabilities and/or autism who sexually offend.

Many different views were expressed during our seminar; at times delegates were in agreement and at other times views differed. What follows, therefore, is neither representative of all delegates nor of the authors of this briefing paper.

5.1 PREVENTION

Prevention was a major theme during our seminar - moving beyond crisis driven responses to sexually offending behaviour and working to prevent such behaviour from occurring. One of our seminar delegates, Karina Hepworth, described her work to support a young man who was displaying sexually inappropriate behaviour; see Box 5.1.

Sex education for children with learning disabilities and/or autism, or who are attending schools for children with additional needs was considered important by delegates. Sexualised content is readily available and distorted perceptions of what is 'normal' sexual behaviour can bring

children into contact with justice services without them realising that they have done anything wrong.

Creating opportunities for early intervention and support can be hard to deliver. For example, most adults with learning disabilities and/or autism are not known to services. Poor transition arrangements between children and adult services may in some part account for this. Thresholds to access community support have risen, and the array of support services can be hard to navigate (see, for example National Audit Office, 2017).

The combined impact of these factors can make it hard for more able individuals with learning disabilities and/or autism to benefit from the preventative/ supportive mechanisms of Transforming Care and the Care Act 2014. Several delegates spoke of the need for specialist forensic services that work with local community services to promote and encourage preventative working, with built in referral routes back into specialist forensic services when concerns were raised. Integral to this approach is support based on need, and access to support for individuals with conditions some may consider mild.

5.2 EARLY INTERVENTION

The first meaningful contact a person has when they are in crisis is often with the police. This can pose difficulties for the police, who have limited specialist knowledge of learning

BOX 5.1: ILLUSTRATIVE STUDY

Sam [not his real name] came to the attention of the Youth Offending Service (YOS) following a police interview for a series of 'sexting' incidences to a female student in the same school. There had been a two-year history of Sam using inappropriate sexual language to teachers, and incidents of sexual behaviour, such as touching girls' bottoms. The YOS police officer considered a Youth Conditional Caution (YCC) for Sam but, because he was attending a school for young people with additional needs, it was decided to approach the school to explore a way forward that took into consideration his level of ability and whether a YCC was appropriate. The YOS police officer and YOS senior nurse specialist in learning disabilities met with the school's head teacher and Sam's head of year, neither of whom were aware of the extent of concern about Sam's behaviour – Sam having been transferred from another school only a few weeks before.

Sam has significant difficulties with his level of understanding, and it was agreed that the formality of a YCC was not the best course of action. It was agreed that the YOS would work with Sam in a supervisory capacity, with the school leading in the delivery of the work. This approach also helped the school to increase their confidence and skills in delivering sex education. The YOS police officer and senior nurse specialist met fortnightly with Sam's teacher to discuss progress, consider possible motivations for Sam's behaviour, and agree next steps. A school risk and safety plan was put in place to reduce the risk of further incidents and harm to other children. Sam's social worker contacted his mum to gather information about his development and health needs, familial factors and behaviour outside school. Plans are now in place to reduce risk, the family are on board, and there is a clear plan of work. Staff in school feel supported and much more confident to approach a piece of work that they were unsure of. Sam has said that, while he finds all the following him about difficult, he knows why it is necessary and wants to learn how to approach things in a different way, so he doesn't get in trouble.

Contact: Karina Hepworth, Queen's Nurse, Behaviour Therapist & Senior Nurse Specialist, Learning Disabilities, South West Yorkshire Partnership NHS Trust & Kirklees Youth Offending Team Karina.Hepworth@kirklees.gov.uk

disabilities and/or autism. However, where liaison and diversion services exist, contact with the police can provide opportunities to access support. In addition, many delegates highlighted the need for better identification (and information sharing) across the criminal justice process. Transforming Care Partnerships, and the development of whole system approaches for these individuals should help to encourage opportunities for learning disability and autism awareness training, leading to better recognition and referral routes into necessary support.

At our seminar we heard from Sergeant Paul Jennings about the Hampshire High Intensity Network, which seeks to co-ordinate interagency working between emergency and healthcare teams to better support people struggling with highly intensive patterns of mental illness and behavioural disorders. The High Intensity Network uses the Serenity Integrated Mentoring²⁷ model of care, which combines mental health nursing and policing to form a specialist support team that intensively manages the needs and behaviours of high intensity mental health service users.

Now a national programme, the 55 NHS Mental Health Trusts that provide crisis care across England and Wales will be able to train together, share best practice, and develop new national standards of care for some of our most vulnerable and high-risk service users.²⁸

Liaison and diversion services operate in police custody and the criminal courts. They help to identify individuals with specific needs, including learning disabilities and autism; they make referrals into local services, as necessary; and inform criminal justice decision making – including the need for reasonable

adjustments to support a person through the justice process, or diversion away from criminal justice into healthcare. An important feature of liaison and diversion services is their role in identifying unmet need when a person first comes into contact with criminal justice services, and to make referrals accordingly. Referrals can, however, only be made into services that exist. According to the Transforming Care Model Service Specifications and highlighted during our seminar – people with learning disabilities and/or autism who come into contact with criminal justice services, or are at risk of doing so, are:

'...often excluded from mainstream mental health or forensic services because of their learning disability and/or autism, and excluded from learning disability services because they are considered too able or too high risk, or because they have autism but do not have a learning disability' (NHS England, 2017a, p. 25).

The conundrum for many individuals with learning disabilities and/or autism is that they can appear too able to access learning disability services, but are not sufficiently able to access and maintain contact with mainstream mental health or forensic services.

Differing needs are frequently addressed by different services, each with their own 'threshold' criteria for support. Thus, many fall through the gaps in service provision, which places them at greater risk of entry into criminal justice and secure inpatient systems. In response to this, and other concerns, Essex County Council has developed a whole system approach. The model was presented at our seminar by Ben Hughes, and is described in Box 5.2.

BOX 5.2: WORKING TOGETHER FOR PERSON CENTRED CARE IN A WHOLE SYSTEM APPROACH

Essex County Council has recently completed a procurement process to deliver an integrated Criminal Justice Health and Care service linked to existing offender support provision, which will go live on 1 April 2018. It links street triage, liaison and diversion, and police custody healthcare provision. The work has brought together seven clinical commissioning groups, NHS England, The Office of the Police, Fire and Crime Commissioner and Essex police, HMP Chelmsford, Community Rehabilitation Company and National Probation services, the County Council's own Public Health, learning disability and mental health commissioners, and local Unitary Councils at a Criminal Justice Commissioning Group; and good links have been made with the Transforming Care Board. The overall aim is to reduce crime and reoffending, and improve health and well-being by providing support to historically underserved individuals, their families and carers. The development of this single service and joined up planning and accountability enables more effective integration of specific local structures and functions to develop a truly joined-up system at the various points of delivery. Operating within a single framework, and with a common agenda, multiple partners are better able to collaborate effectively to ensure a client centred system of care and support.

Specific areas being addressed include a greater focus on early intervention and diversion, peer support and mutual aid, and engagement with service users and their families and carers; and processes are being further developed for identifying and supporting previously under identified and underserved groups of individuals engaged with criminal justice services, such as those with learning disabilities and autism.

Contact: Ben Hughes, Head of Commissioning: Public Health and Wellbeing, Essex County Council: ben.hughes@essex.gov.uk

27. For further information, see: <http://wessexahsn.org.uk/projects/128/serenity-integrated-mentoring-sim>
28. For further information, see: <https://www.highintensitynetwork.org/>

The function of a whole system approach is reliant on interdependence across local areas, which according to one of our speakers, can make it hard to maintain a person-centred approach, especially when the focus is on reducing risk. Supporting people in the community requires a balance to be struck between allowing people to take risks (within an evidence-based risk management structure), while ensuring that the individual is also protected from harm, alongside members of the community in which they live.

The stigma of sexual offending, and fear of sexual risk, heightened by the recent high volume of historic sexual offence cases and media coverage, can complicate buy-in from partners, and management of individuals in the community. Another benefit of a whole system approach is that it can help to remove what one of our delegates described as a 'takeaway service' – meaning that some professionals and practitioners try hard to find ways to move a 'difficult' client into another service, and away from theirs.

5.3 CRIMINAL JUSTICE RESPONSES AND DIFFERENT ROUTES OF INCARCERATION

Local responses to alleged sexual offences by health and social care services, and police discretion can lead to a 'postcode lottery' of outcomes. For example, delegates spoke about alleged offences taking place in health settings that were not reported, low level offences being 'let off' with the risk of escalation when behaviour is left unchecked, and individuals being 'randomly' diverted into healthcare or processed through the criminal justice system.

One delegate noted that reports that could usefully inform the decision to prosecute (especially for cases when public interest might be relevant) are not always available before trial. Several delegates raised the need for more and better community sentence treatment requirements which, it was felt, had greater potential to produce more effective engagement, learning and outcomes than a prison sentence or hospital admission. The point was made that a court ordered sentence that required joint working between health, social care and justice, and compliance by the offender, could help to ensure improved working relationships between the respective agencies and ongoing engagement with the individual concerned.

Clearly a sensitive area, and not wishing to deflect or underestimate the distress felt by victims, questions were raised during our seminar about the continuum of behaviour and threshold for criminalising sexually inappropriate behaviour by individuals who may have reduced mental capacity.

Notwithstanding the principle of inclusion in society of people with disabilities (see section 2.5), there will be times when a person with learning disabilities and/or autism is diverted away from the criminal justice process into an inpatient

setting (i.e. a secure hospital). For example, in his presentation at our seminar, Joe Rafferty, Chief Executive of Mersey Care NHS Foundation Trust, noted that on 1st July 2016²⁹ between 50% and 75% of people detained under the Mental Health Act at Calderstones Hospital³⁰ had sexually offended or had sex offending risks. There were mixed views about the most appropriate route for a person with learning disabilities and/or autism when they are accused of a crime – whether they continue through the criminal justice process (with reasonable adjustments, as necessary), or are diverted into hospital care – and these were explored during our seminar.

There is little doubt that the 'harms of imprisonment' are greater for people with learning disabilities than they are for people without such disabilities (Talbot, 2008). Despite improvements and pockets of good practice, reasonable adjustments are often lacking throughout the criminal justice process (HM Inspectorate of Probation Criminal Justice Joint Inspection, 2014, 2015).

Those who argue in favour of the criminal justice route frequently point to a person's fundamental right to be able to defend themselves in a court of law, where they may be found innocent of any crime; or, if found guilty and a custodial sentence is given, it will generally be for a fixed term – neither of which applies if a person is diverted into healthcare. On the other hand, it is perhaps reasonable to expect that an inpatient setting is more conducive to managing challenging and sexually offending behaviour, and better able to provide the necessary care and support.

During our seminar, however, concerns were raised about people with learning disabilities and/or autism becoming 'stuck' in hospital settings long after the initial therapeutic purpose of their admission has been exhausted. Transfer back into the community, especially for individuals with sexually offending forensic histories, can be challenging – see, for example, the foreword to this report by Niles and Box 5.5a (developing self-protective narratives). This reflects the difficulties experienced, more generally, in reducing the number of people with learning disabilities and/or autism in secure settings (National Audit Office, 2017).

What came to the fore during our seminar is that it often is not a question of either/or – justice or healthcare – what is needed is a hybrid, combining the best of each, alongside social care, within a whole system, person-centred framework. Properly handled, contact with the police can help individuals to understand the gravity of their behaviour, and provide a marker to review levels of support given and/or to encourage engagement with services (and vice versa). Liaison and diversion services in police custody are well placed to identify when a person might need support, and to make referrals accordingly. The challenge here is for local areas to ensure community services exist that can respond in a timely way to the multiple needs individuals frequently present with. The

29. The date Mersey Care NHS Foundation Trust acquired Calderstones Partnership NHS Foundation Trust. Also see: NHS England et al. (2015a, p. 14f).

30. This site at Whalley in Lancashire is now called Mersey Care's specialist learning disability division. Earlier in 2017 NHS England announced that they will cease commissioning learning disability services at this site and Mersey Care are currently consulting with commissioners on a new clinical model, see: <http://www.merseycare.nhs.uk/about-us/news/statement-on-specialist-learning-disability-site-in-whalley/>

Essex model (Box 5.2: Working together for person-centred care in a whole system approach) is an example of where efforts are being made to secure community services for people who have historically been under identified and underserved. See also NHS England (2017a, pp. 24-39).

5.4 COMMUNITY SUPPORT AND TREATMENT

There were mixed views at our seminar about the availability of interventions and treatment options to meet the specific needs of people with learning disabilities and/or autism who sexually offend, which may reflect differences in local practice. Little information, however, appeared to be available to sentencers about what interventions for offenders were available locally and what might, in theory, be possible. Delegates who work with young people spoke highly of the AIM project, which has developed a range of tools and training for assessment and intervention with children and young people who display sexually harmful behaviour³¹, including young people with learning disabilities. Delegates working with adults spoke highly of the Good Lives Model of Offender Rehabilitation (GLM), which is used in a number of jurisdictions, including the UK, and has been used as a framework for sex offender treatment programmes. Ward and Stewart (2003, p. 356) describe this as ‘essentially a capabilities or strength-based approach’. ‘According to the GLM, individuals commit criminal offences because they lack the opportunities and/or the capabilities to realise valued outcomes in socially acceptable ways’ (Lindsay, Ward, Morgan, & Wilson, 2007, p. 48).

SOTSEC-ID³² have demonstrated the effectiveness of cognitive-behavioural treatment groups for men with learning disabilities who have sexually offended (Heaton & Murphy, 2013; SOTSEC-ID, 2010). More recently, and in response to little in the way of provision for young people with intellectual learning disabilities who display sexually harmful behaviours, they have developed a sub-group, ySOTSEC-ID, to share knowledge and experience of working with children and young people with learning disabilities, and to develop a similar intervention protocol for evaluation (Malovic, Rossiter, & Murphy, 2018)³³.

Delegates wondered whether it would be helpful to have standardised programmes across health and justice settings and, while some were supportive of this approach, others felt that personalised responses would be lost. One experienced learning disability nurse described how she ‘mixes and matches’ from a range of resources to ensure the particular needs of each client are met. This approach helps to adapt trauma informed working where it is required. This is recommended as high numbers of individuals who commit sexual offences have themselves been victims of abuse.

Individuals with learning disabilities and/or autism who sexually offend are a minority group, within which there are smaller minority groups of individuals. During our seminar, delegates

highlighted the need to better understand the specific needs of women, individuals from black and minority ethnic groups, and those with autism.

The need for improved data about interventions and treatment options was highlighted. It is important to be able to say, with confidence and underpinned by robust evidence that, ‘this is what getting it right’ looks like.

Similar concerns were raised for individuals upon release from prison, as were raised during our discussions on prevention and early intervention – namely, difficulties in accessing community support. A recent study by Murphy et al. (2017), which followed up 38 men with learning disabilities who were leaving prison in England, found they received little support in the community, despite high rates of clinically significant anxiety and depression, and many had been re-interviewed by police.

This lack of support is also reflected in a recent inspection report on ‘Through the Gate Resettlement Services for Prisoners Serving 12 Months or More’. This said:

‘There were great hopes for Through the Gate, but none of these have been realised. Staff working for Through the Gate services in prisons are keen and committed, but they are making little real difference to people’s life chances as they leave prison’ (HM Inspectorate of Probation and HM Inspectorate of Prisons, 2017).

In the study by Murphy et al. (2017), more than half the men had a probation officer, who they tended to see once a week or once a fortnight, and half had a care manager/social worker. Twenty-two had contacts with specialist health professionals, including learning disability services.

Although the sample size was small, it is noteworthy that contact with specialist health professionals was associated with a significantly reduced likelihood of contact with the police – which makes it all the more disappointing that it was not unusual for probation officers involved in the study to:

‘...complain that they had referred the men to the community [learning disability] teams but had been told they were not eligible for support’ (Murphy et al., 2017, p. 965).

5.5 SETTLING INTO A COMMUNITY HOME AFTER PRISON OR HOSPITAL

Deprivation of Liberty and Deprivation of Liberty Safeguards³⁴ (DoLS) were discussed by some delegates in two different contexts: to support discharge planning from secure inpatient settings, and as a way of providing structured support and risk management for individuals in the community who are in contact with criminal justice services, such as those released on bail and sentenced to a community order.

31. Established in 1999 by ten Youth Offending Teams and Social Service Departments, NSPCC, the police, education, health and G-map (G-map provides services for young people who have sexually abused, and their families), AIM has developed a range of tools and training for assessment and intervention with children and young people who display sexually harmful behaviour. For more information, see <http://aimproject.org.uk/>

32. Sex Offender Treatment Services Collaborative – Intellectual Disabilities.

33. For more information, see: <https://www.kent.ac.uk/tizard/sotsec/ySOTSEC/About%20ySOTSEC.html>

BOX 5.5A: DEVELOPING SELF-PROTECTIVE NARRATIVES

Jonathan [not his real name] is managed through MAPPA. He pleaded guilty to indecent assault of pubescent boys. He has spent over twenty years in hospital on section 37/41 of the Mental Health Act and is currently being prepared for community discharge. During one of his outings to his new community he went to the barber's. His forensic support worker reflects:

'People talk while they're having their hair cut, and barbers are very good at eliciting information from people: 'I haven't seen you before. Who are you? Where have you come from?' Because Jonathan had been in an institution, that gave him a dilemma. He couldn't exactly say: 'I spent the last twenty-odd years there because I sexually offended against young boys.' With it being a small community, it would have completely ostracised him. So, we did lots of role-play for him to work out what kind of replies he would need to give to some of these questions and he developed a narrative around having recovered from illness.'

Sexual offences are never forgotten, and they stay with both the victim and the offender, for life. The strong prejudices and emotions that people have towards those who are labelled as sex offenders make those whose histories become known vulnerable. This role play intervention was pivotal in enabling Jonathan to settle into the community. It helped him 'to build his resilience and his practical skills in protecting the things about his past that he needs to protect'.

Contact: Pam Mount, clinical nurse specialist, Mersey Care, pamela.mount@merseycare.nhs.uk

Depriving a person of their liberty is a serious undertaking. The issue in question focused on the extent to which depriving or restricting a person's liberty in the community was a preferred option to their being detained in prison or a secure in-patient setting.

The Mental Capacity Act allows restrictions and restraint to be used in a person's support, but only if they are in the best interests of a person who lacks capacity to make the decision themselves. DoLS apply when a person lacks capacity to make the decision about their care and accommodation when the person is in hospital or a care home. In other settings, including in supported living or their own home, the person who lacks capacity to make the decision about their care and accommodation may be deprived of their liberty in their best interests via an application to the Court of Protection (Social Care Institute for Excellence, 2017).

There was a view that more creative working between health, social care and justice agencies could help to ensure a better understanding of risk and how it could be mitigated, leading to more effective support and risk management strategies for individuals with learning disabilities and/or autism who sexually offend. Concerns about DoLS have resulted in proposed amendments to the Mental Capacity Act (Law Commission, 2017). Amongst other things, the amendments strengthen people's rights in areas such as best interest decisions, and incorporates a new scheme, the Liberty Protection Safeguards, which would replace DoLS.³⁵

One delegate recommended that digital technology should be explored, specifically whether an 'app' can be developed that individuals can themselves use to manage their own risk, and that professionals and practitioners can access to provide support.

It was recognised during our seminar that within society generally, and in particular within local communities, there is a *'powerful fear of sexual risk, which can complicate its management'*. In the context of our seminar, and of this briefing paper, 'risk' is often compounded by poor understanding of learning disabilities and autism and the prejudice frequently shown towards individuals with such disabilities. This demands specific and often creative responses by professionals and practitioners, personalised to suit the individual and their circumstances.

Keeping communities safe is important; so too is support for individuals with learning disabilities and/or autism, enabling them to live productive lives, free from harm within a risk management framework. One example shared at our seminar was about developing self-protective narratives as an integral part of preparing for release from a secure inpatient setting; see Box 5.5A. Whether leaving prison or an in-patient setting, delegates said that finding suitable accommodation was difficult. Guidance for commissioners of health and social care says that people with learning disabilities and/or autism who display behaviour that challenges:

'should have choice about where they live and who they live with', and goes on to say that 'Inappropriate housing arrangements increase the likelihood of people displaying behaviours that challenge, which can lead to placement breakdown and an avoidable admission or readmission to hospital' (NHS England, Local Government Association, & Association of Directors of Adult Social Services, 2016, p. 4).

Transforming Care Partnerships³⁶ are encouraged to develop a housing strategy, and to engage with housing providers, to accommodate the estimated 2,400 people who will require new living arrangements upon discharge from inpatient care by March 2019.

34. Footnote deleted

35. For further information, see: <https://www.lawcom.gov.uk/project/mental-capacity-and-deprivation-of-liberty/>

36. In England there are 48 Transforming Care Partnerships made up of clinical commissioning groups, NHS England's specialised commissioners and local authorities. They work with people with a learning disability and/or autism, and their families and carers; <https://www.england.nhs.uk/learning-disabilities/tcp/>

BOX 5.5B: CREATIVE RISK MANAGEMENT PLANNING

Gary (not his real name) was 17 when he raped a female child. Initially found unfit to stand trial, he was later convicted and given a custodial sentence of two years. During his trial he was found to have an IQ of 59. In prison, there was little planning to identify and respond to his needs, and Gary described being bullied and assaulted when the nature of his offending became known. He wasn't considered for an adapted Sex Offender Treatment Programme because of his 'short' sentence.

Gary's release from prison was planned under MAPPA³⁷ due to his status as a registered sex offender. He was not keen to return home (his home was later assessed as unsuitable), and he was released to a Probation Hostel. Gary was unable to understand the conditions of his licence, and quickly breached rules. He was assessed as being unsuitable for support from adult social care and, due to continued breach of his licence, was recalled to custody. Driven by an inability to determine a suitable community risk management plan, Gary was escalated to MAPPA level 3. It was agreed that Gary's social functioning should again be assessed, which confirmed he was eligible for financial support, and supported housing was recommended. It was further agreed that the local learning disability service would work with Gary to help him prepare for re-release, and to adapt the written instructions of his licence conditions to help him understand what was expected of him. Despite a robust search, a suitable address for Gary could not be found. A manager from the learning disability service suggested a Shared Lives³⁸ placement, which involves placing adults with special needs into households with 'foster carers'. A suitable placement was found with a couple who had many years of experience of working with learning disabled men and managing inappropriate sexual behaviour.

To prepare for Gary's arrival, they received training from probation staff, MAPPA and SOPO³⁹ briefings, and their home was visited by police, probation and learning disability services. Finally, Gary was released by the Parole Board to the Shared Lives address. He engaged well in his new environment and began to flourish. He developed self-care skills and, for the first time, was able to undertake basic cooking and cleaning tasks without instruction. He developed positive relationships with a forensic psychologist and a speech and language therapist, and their joint work helped to improve his confidence and behaviour management. Gary successfully completed his licence.

REFLECTION AND COLLABORATION:

Following Gary's situation, all the agencies involved met to reflect on their learning, and two main factors were identified: there was no process to enable probation practitioners to seek timely guidance and support from learning disability services, and agencies knew little about each other's roles and responsibilities. As a result, the following was put in place:

- A package of training was developed and delivered jointly to all probation staff;
- A pathway for referral into learning disability services for probation clients was established at all stages of the criminal justice process;
- A Criminal Justice Learning Disability Champions Group was established, which comprises justice, health and social care agencies, including learning disability and social care services, police, probation (NPS and CRC)⁴⁰, youth offending service, HMCTS⁴¹, and G4S⁴². The Group meets quarterly, participate in shared training sessions, and feedback learning to their respective organisations.
- A learning disability nurse provides a dedicated one day per week for the assessment of probation clients, and several adult offenders have been diagnosed with learning disabilities and/or autism since June 2016, when the role commenced.

Contact: Danielle Kenny, Senior Probation Officer, National Probation Service: Danielle.Kenny@probation.gsi.gov.uk

These arrangements, however, are unlikely to include individuals leaving prison and those at risk of contact with the criminal justice system. Many delegates said that support for independent living for people with learning disabilities and/or autism was increasingly hard to get, and some individuals were losing support as thresholds were raised; and this, in turn, led to an increased risk of contact with the police. When thinking about what a 'home' in the community may look like, we need to consider the

social care and support needs of the individual, as well how best to manage risks. At our seminar, Senior Probation Officer Danielle Kenny described how necessity led to a creative approach to risk management planning for a man with learning disabilities convicted of a sex offence, which in turn led to the development of a pathway for referral into learning disability services by probation staff, and a multiagency network of Learning Disability Champions; see Box 5.5B.

37. Multi-agency Public Protection Arrangements.

38. The Shared Lives scheme offers accommodation and support within approved family homes for people aged 18 and over who rely on the help and support of others to maximise their potential and maintain a sense of independence; Derbyshire County Council website, accessed 18/12/17: https://www.derbyshire.gov.uk/social_health/adult_care_and_wellbeing/disability_support/learning_disabilities/support_living/default.asp

39. Sexual Offences Prevention Order.

40. Community Rehabilitation Company

41. Her Majesty's Courts & Tribunals Service

42. G4S is a secure outsourcing company.

BOX 5.5C: ADAPTED CIRCLES OF SUPPORT AND ACCOUNTABILITY

D was referred to Circles South East's Adapted Pilot through the local Health Trust. He completed the adapted sexual offender treatment programme when resident at a secure hospital. At the end of his treatment he left hospital quite quickly and with little support, as he was no longer able to get support under Section 117 of the Mental Health Act. Circles South East assessed D at the end of his treatment and accepted him. He was found a bedsit on release and had limited contact with Social Services. Circles South East provided D with a counsellor to address childhood trauma and behaviours emerging from this. He had no additional support at this time and was very low. He attempted to overdose twice before he was moved to a more structured and supportive environment.

After three months in the community a Circle of volunteers was set up to support him and to help him to use the counselling support in a more formal and structured way. D has now been in a Circle for nearly a year. Sometimes his diagnosis of Borderline Personality Disorder and learning disabilities has meant that he has been misunderstood by agencies. The Circle has advocated on his behalf regarding engagement with Social Services, support in gaining Mental Health support and linking with the Police.

He has now lost 5 stone of excess weight, is engaged actively in his local community with appropriate pursuits, is completing courses with a local charity and has re-established contact with family members. His depressive episodes are now irregular, and he seeks help before they overwhelm him. The Circle still has a further year to run and is now focusing on helping him to practice his social skills in a less formal environment. The risk he presents is linked to development of intimate relationships and therefore it is important for him to engage with appropriate contacts in the community and practice his safety plans before making more permanent connections in the community.

For further information, email info@circlessoutheast.org.uk

Even if a person is settled in their physical home environment and has no further social care needs, they may find it difficult to become 'at home' in the community, in other words to find meaningful things to do and make social contacts. To remind the reader, the Good Lives Model assumes that assisting individuals to achieve positive life goals via non-offending methods 'may function to eliminate or reduce the need for offending' (Ward & Maruna, 2007, p. 108).

As a follow up to our seminar, Dr Tania Tancred (Senior Forensic Psychologist, National Probation Service) circulated information about Adapted Circles of Support and Accountability, run by Circles South East.⁴³

The standard Circles model was originally designed for high-risk sex offenders on their release from prison (Wilson, McWhinnie, Picheca, Prinzo, & Cortoni, 2007). More recently (since 2013), an Adapted Circles model has been developed specifically to support individuals with learning disabilities and/or autism. An illustrative study showing how the adapted Circles model worked for one man is shown in Box 5.5C.

5.6 WORKFORCE DEVELOPMENT

The need for better information sharing is well rehearsed and isn't repeated in detail here – other than to say that inadequate information sharing makes effective outcomes harder to achieve and improvements are long overdue. One solution we discussed was the idea of a key worker 'Holding the story'.

This means that a single (or small number) of staff should understand a person's situation, history and aspirations for the future so that they, and/or their family member are not constantly having to repeat themselves.

Many delegates felt strongly that positive outcomes largely depended on local availability of 'good' professionals and practitioners (the 'post code lottery'). As in many events such as ours, the question of workforce development, or rather lack of it, including opportunities for sharing practice, was raised. At a local level, a 'champions network' comprising health, social care and justice agencies, including members of the judiciary, can support shared work-based learning and a better understanding of the respective roles and responsibilities of each agency, alongside opportunities to explore collaborative working and common agendas; and the 'reflection and collaboration' example in Box 5.5B is a good example of this. The different terminology used by different sectors, and understanding of 'risk' can be problematic, and is perhaps best explored within local areas.

The need for a formal process, at a national level, for sharing practice, transferring skills and learning from the experiences of others was considered important. Being able to capture the knowledge and experience of staff working in specialist inpatient settings, as these reduce in number and community models of care and support are established, was especially highlighted. A proposal was made to develop a national standard that would collate the statutory functions of respective agencies as they relate to people with learning disabilities and/or autism who

43. This model is not exclusive to Circles South East. Adapted circles are also offered by the Safer Living Foundation Circles project in the Midlands and also by the circles project in Manchester. Circles UK are currently working to make sure this model is available in all areas.

display challenging behaviour, including inappropriate sexual and sexually offending behaviour. This would be used to create minimum standards, while a national network for shared learning would encourage creativity and best practice.

It was further suggested that by incorporating specificity for people with learning disabilities and/or autism into health and justice commissioning frameworks, rather than a blanket requirement to meet duties under the Equality Act, greater attention would be given to ensuring necessary reasonable adjustments for these individuals, and training for members of staff working with them. A number of delegates said there was a need for awareness training for health and justice personnel, including Appropriate Adults, that addressed sexually offending behaviour through the lens of learning disability and autism.

Ensuring a skilled workforce is in place was highlighted as important, and concerns were expressed at apparent falling numbers of learning disability nurses, but it was also felt that in addition to nurses we need a wider range of appropriately qualified individuals experienced in working with people with learning disabilities and/or autism. It is essential that these individuals receive appropriate support.

People with learning disabilities and/or autism who have sexually offended often have high levels of emotional demand and many have histories of exposure to child sexual abuse.

The needs of staff working with them need to be attended to by the support of a good occupational health structure, regular clinical supervision and timely access to psychological treatment for counselling or other therapies required when faced with working with the abused and the abusers on a daily basis.

While training was seen as important by most delegates, others were more sceptical and said that training was often hailed as a solution, when what was needed was a culture shift and more effective 'policing' to ensure what should happen, such as reasonable adjustments for people with disabilities, actually did happen.

Whatever changes may arise in terms of workforce development, but also the issues outlined in previous sections, delegates highlighted the importance of ensuring that people with learning disabilities and/or autism are involved in designing their own care and support and in helping local services to develop new and improved responses. Working with individuals with direct experience to design and deliver services that meet their needs, and builds upon their strengths, is likely to be more effective and efficient than services designed without their unique insight and experiences.

Many delegates said how valuable they had found our event and hoped there would be opportunities for follow up.



6. RECOMMENDATIONS

PREVENTION AND EARLY INTERVENTION

This report has attempted to tackle a significant and challenging topic, encompassing legislation, and national and local policy and practice. After our event, on 10 May 2017, Lord Bradley said:

'Some of the main points to come out of the day were that services must be planned and commissioned in an integrated way, involving a wide range of partners. Integration must include robust information sharing protocols backed up by effective enhancement of technology. Crucially, all partner organisations should commit to joint training to bring expertise together, and to break down cultural and organisational barriers.'

These points – along with others made by delegates at our event – are reflected in the recommendations that follow. While our recommendations seek to address individuals with learning disabilities and/or autism who sexually offend, some of what we say refers also to all individuals with learning disabilities and/or autism who find themselves in contact with, or on the edges of, the criminal justice system.

- 1. Education and learning about sex and relationships** for children with learning disabilities and/or autism should be included in the curriculum from a young age, and reinforced throughout their statutory education. Education and learning should address relationships, sexually (in)appropriate behaviours, how to stay safe, how to prevent unwelcome sexual behaviour, and what to do if you are a victim of unwelcome sexual behaviour.
 - a. A recent government consultation on changes to the teaching of sex and relationship education, and PSHE⁴⁴ closed on 12 February 2018. Delegates from our event responded, highlighting the importance of sex education for children with learning disabilities and/or autism attending mainstream schools and schools for children with additional needs. Sexualised content is freely accessible on social media, and distorted perceptions of what is 'normal' sexual behaviour can bring children into contact with justice services without them realising they have done anything wrong.
- 2. Local Transforming Care Partnerships and community-based forensic support:** We agree with the Transforming Care Model Service Specifications that effective specialist community-based forensic support should be delivered to meet the needs of people:
 - a. With a learning disability and/or autism;
 - b. Who display behaviours that can be described as challenging;
 - c. Where this behaviour has led to contact with the criminal justice system, or where there is risk of this [happening in the future]' (NHS England, 2017a, p. 24).

The cited specifications found in recommendation 2 are aimed at adults and we welcome the additional guidance on working with children and young people (NHS England, 2017b). We further agree with the threshold criteria proposed by Transforming Care, as shown in Box 6. To ensure timely referrals from criminal justice agencies, local Transforming Care Partnerships should establish positive working relationships and referral routes with liaison and diversion services, and vice versa; see recommendation 9.

- 3. Involvement of family members:** Family members frequently provide much needed support for relatives with learning disabilities and/or autism. The difficulties they can face in securing the additional support they feel is needed is well rehearsed. Family members may also have concerns about sexually inappropriate behaviour displayed by their relative, but may be reluctant to raise these for fear of a punitive response for their relative and/or being blamed themselves for not preventing or even 'creating' that behaviour. The involvement of family members should, where appropriate and with the consent of the individual concerned, be supported. This should include, for example, information about topics that family members may feel reluctant to raise, such as sexual relationships, sexual behaviour, and sexually inappropriate behaviour.

Transforming Care Partnerships, Adult Autism Strategy arrangements and Education Authorities are well placed to support this work, and to take a lead role where services do not exist. NICE⁴⁵ (2015) guideline [NG11] considers environmental interventions in section 1.7, such as parent-training programmes for parents or carers of children who are at risk of developing, behaviour that challenges and these could offer a safe space for discussion.

44. <https://www.gov.uk/government/consultations/changes-to-teaching-of-sex-and-relationship-education-and-pshe>

45. National Institute for Health and Care Excellence

BOX 6: EXCLUSION CRITERIA AND THRESHOLDS FOR COMMUNITY-BASED FORENSIC SUPPORT (NHS ENGLAND, 2017A, PP. 36-37)

Support should be provided for adults with:

- A confirmed diagnosis of learning disability; and/or
- A confirmed diagnosis of autism; or
- in the absence of a confirmed diagnosis of either a learning disability or autism, evidence that on the balance of probability such a condition may be present.

AND who either:

- Have a conviction for an offence;
- Have had an allegation of offending made against them;
- Are considered to be at significant risk of offending, and/or present a risk of serious harm to the public.

NB. “At risk of offending” means that an individual has exhibited behaviours which could be construed as an offence (such as assault) or have carried out activities which may be viewed as pre-cursors to more serious offending behaviours. The provider should take referrals from a wide range of sources, including housing, criminal justice system agencies and health and social care services. It should also establish mechanisms for self-referral and from families and carers. The service should accept referrals on the basis of need, rather than being restricted purely to diagnosis.

- 4. A ‘whole system approach’** is one that recognises the contribution that all partners, including service users, make to the delivery of care and support. Whole system working does not have restrictive service boundaries – it puts the individual at the centre of service provision and responds to their particular needs. A system-wide strategy should sit with the **Health and Wellbeing Board**, which should assure itself that the overall strategy and operational activity involves appropriate partners. This could be done by allocating the task to existing relevant partnerships, such as the **Adult Autism Strategy**⁴⁶ and **Transforming Care Partnership**.⁴⁷ Activities undertaken within the overall strategy could include:
 - a. A shared, multi-agency **directory of services**, including voluntary sector support;
 - b. Multi-agency **awareness training**, involving individuals with learning disability and/or autism;
 - c. **Opportunities for shared learning across the ‘whole system’**, which is important for front line practitioners unused to dealing with individuals with learning disabilities and/ or autism, especially those who display sexually inappropriate behaviour. Opportunities should include: recognising and responding to sexually inappropriate behaviour, sharing good practice and concerns, and effective joint working across the whole system.
- 5. Equal partners:** Working with people with learning disabilities and/or autism to design and deliver services that meet their needs and builds upon their strengths is likely to be more effective and efficient than services designed without their unique insight and experiences. Opportunities for involvement include:
 - a. Awareness training;
 - b. Designing their own care and support packages;
 - c. Informing the design and ongoing development and review of services;
 - d. Research.
- Recent years have seen improved **interventions, treatment options and outcome data** for individuals with learning disabilities and/or autism who sexually offend. Health and justice agencies should collaborate to agree a suite of shared, evidence-based interventions and treatment options for use in the community, and in secure and custodial settings. Data should be shared to inform ongoing development. It is important to be able to say, ‘this is what getting it right looks like’, taking into consideration the need to balance supporting the individual to take risks within a supportive, evidence-based risk management structure, while ensuring they are protected from potential harm and the community is kept safe.
 - a. **A national digitally driven network** should be developed to help ensure shared learning and dissemination of best and evolving practice across health, social care and justice.

46: Statutory guidance for Local Authorities and NHS organisations to support the implementation of the Adult Autism Strategy states that the responsible authorities (local authorities, police, probation, Clinical Commissioning Groups, and the fire and rescue authority) are under a statutory duty to work together to reduce reoffending, tackle crime and disorder, tackle anti-social behaviour, tackle alcohol and substance misuse, and any other behaviour which has a negative effect on the local environment.

47: The Transforming Care programme is scheduled to end in March 2019, and a whole system approach for this group should be developed and extend beyond this time period.

CONTACT WITH CRIMINAL JUSTICE SERVICES

7. Principle of inclusion in society of persons with disabilities: We agree with the report on the Law Commission's review into Unfitness to Plead, which looked at how defendants who lack sufficient ability to participate meaningfully in trial should be dealt with in the criminal courts. Following a lengthy and comprehensive consultation, the Law Commission based its recommendations on the belief that:

'...the normal criminal trial is the optimum process where a defendant faces an allegation in our criminal justice system. We consider that full trial is best not just for the defendant, but also for those affected by an offence and society more generally. This is because the full criminal process engages fair trial guarantees for all involved... [and] offers the broadest range of outcomes... Removing any defendant from the full trial process should, we consider, only be undertaken as a last resort' (Law Commission, 2016, p. 4).

This reflects the principle of inclusion in society of persons with disabilities, legislated for in the Equality Act 2010, and promoted by the United Nations Convention on the Rights of People with Disabilities (UNCRPD) 2006, which was ratified by the UK government in 2009.

- 8. Mental Health Act independent review:** People with learning disabilities and/or autism who commit offences should not be treated less favourably by the combined criminal justice, health and social care systems. There are currently people detained in hospital for longer periods than they would have spent in prison, with no discernible clinical purpose or therapeutic benefit. Specific sentencing options should be developed for offenders with learning disabilities and/or autism. See recommendation 12.
- 9. Identification of support needs:** The planned roll out of **liaison and diversion services** to all police custody suites and youth justice and criminal courts by 2020/21 is welcomed. Commissioners of liaison and diversion services, working together with the police, should ensure that all suspects are screened for learning disability and autism. Assessment reports by liaison and diversion services should provide information on the need for **reasonable adjustments** to ensure a person's effective participation in criminal justice proceedings, and provide guidance on ways in which adjustments can be made (see also Talbot, 2012).
- a. Liaison and diversion services should develop positive working relationships with community-based forensic support within local Transforming Care Partnerships to ensure timely referrals, and vice versa. See recommendation 2.
- 10. Appropriate Adults⁴⁸:** We agree with the National Appropriate Adult Network that a statutory entitlement to assistance from an appropriate adult should be accorded to the adult suspects, where necessary. There should be a national framework for funding and quality assurance of appropriate adults. Accountability should ensure independent provision for all adults in need of support.
- 11. Intermediaries:** We agree with the Law Commission that a statutory entitlement to assistance from an intermediary should be accorded to the accused, where necessary (Law Commission, 2016, p.9). We agree with Justice (2017) that intermediaries should be accessible at the police station and in court through a duty scheme (see also Talbot, 2012). The Ministry of Justice should review arrangements for intermediaries to ensure that suspects and defendants are able to access support from an intermediary during the investigation stage, pre-trial and in court.
- 12. Community sentences:** The Community Sentence Treatment Requirement (CSTR) trial sites are welcomed. Specific CSTRs should be developed for offenders with learning disabilities and/or autism, including for those convicted of sexual offences. Health, social care and justice agencies should collaborate to agree a suite of shared, evidence-based interventions and treatment options for use in the community settings; see recommendation 6.

⁴⁸. Personal correspondence with Chris Bath, chief executive, National Appropriate Adult Network: 14 February 2018.

FURTHER RESEARCH

13. The last 20 years has witnessed great progress in research into sex offenders with learning disabilities (Craig, 2017). Most advances were made in explaining why offending happens (see section 2.2) and in discussing specific practice issues in treatment, such as the debate about victim empathy work (compare to box 2.4B and footnote 12).
- a. Less attention has thus far been paid to exploring the social context in which treatment takes place and the impact this has on treatment outcomes. Further research is needed in this area.
 - b. Murphy et al.'s (2017) study on offenders with learning disabilities leaving prison (see section 5.4) provided fascinating insights and more research of this kind is needed to expose what happens, and needs to happen, when a person is released after their prison sentence or detention has finished.
 - c. Further research is needed to better understand the vulnerability and criminogenic factors of:
 - i. Individuals with autism who display inappropriate sexual behaviour and sexually offending behaviour, including sensory needs, levels of anxiety, and general autism profile;
 - ii. Minority groups within learning disability and autism communities, such as women and individuals from black and minority ethnic groups.

REFERENCES

British Dyslexia Association. (2018). *What are Specific Learning Difficulties?* Retrieved from <http://www.bdadyslexia.org.uk/educator/what-are-specific-learning-difficulties>

Craig, L.A. 2017. *Working with sexual offenders with intellectual developmental disabilities.* In: Wilcox, D., et al. eds. *Working with Sex Offenders: A Guide for Practitioners.* London: Routledge, pp.136-161.

Craig, L. A., & Hutchinson, R. B. (2005). *Sexual offenders with learning disabilities: risk, recidivism and treatment.* *Journal of Sexual Aggression*, 11(3), 289-304.

Craig, L. A., Stringer, I., & Sanders, C. E. (2012). *Treating sexual offenders with intellectual limitations in the community.* *The British Journal of Forensic Practice*, 14(1), 5-20.

Cumbria Partnership NHS Foundation Trust, Cumbria Constabulary, Cumbria Probation Trust, & Cumbria County Council Adult Social Care. (2017). *Multi-Agency Public Protection Arrangements/Multi-Agency Risk Evaluation (MAPPA/MARE) Pathway Policy (POL/001/005/020).* Retrieved from https://cdn.cumbriapartnership.nhs.uk/uploads/policy-documents/MAPPA_Multi_Agency_Risk_Policy_POL-001-005-020.pdf

Department of Health. (2010). *Implementing "Fulfilling and Rewarding Lives".* London: Department of Health.

Department of Health. (2012). *Transforming care: A national response to Winterbourne View Hospital.* London: Department of Health.

Department of Health. (2014). *Think Autism. Fulfilling and Rewarding Lives, the Strategy for Adults with Autism in England: An Update.* London: Department of Health.

Department of Health. (2015). *Adult autism strategy: statutory guidance.* London: Department of Health.

Department of Health. (2016). *Progress Report on Think Autism: the updated strategy for adults with autism in England.* London: Department of Health.

Emerson, E., Hatton, C., Robertson, J., Roberts, H., Baines, S., Evison, F., & Glover, G. (2012). *People with Learning Disabilities in England 2011.* Stockton on Tees: Improving Health and Lives: Learning Disabilities Observatory.

Fisher, M. H., Baird, J. V., Currey, A. D., & Hodapp, R. M. (2016). *Victimisation and Social Vulnerability of Adults with Intellectual Disability: A Review of Research Extending beyond Wilson and Brewer.* *Australian Psychologist*, 51(2), 114-127.

Green, G., Gray, N. S., & Willner, P. (2002). *Factors associated with criminal convictions for sexually inappropriate behaviour in men with learning disabilities.* *Journal of Forensic Psychiatry & Psychology*, 13(3), 578 - 607.

Griffiths, D., Hingsburger, D., Hoath, J., & Ioannou, S. (2013). *'Counterfeit Deviance' Revisited.* *Journal of Applied Research in Intellectual Disabilities*, 26(5), 471-480.

Haaven, J. L. (2006). Suggested treatment outline using the Old Me/ New Me model. In G. D. Blasingame (Ed.), *Practical treatment strategies for persons with intellectual disabilities: Working with forensic clients with severe and sexual behavior problems* (pp. 85-114). Brandon, VT: Safer Society Press.

- Haaven, J. L., Little, R., & Petre-Miller, D. (1990).** *Treating intellectually disabled sex offenders: A model residential programme.* Orwell, V.T.: Safer Society Press.
- Heaton, K. M., & Murphy, G. H. (2013).** *Men with Intellectual Disabilities who have Attended Sex Offender Treatment Groups: A Follow-Up.* *Journal of Applied Research in Intellectual Disabilities*, 26(5), 489-500.
- HM Inspectorate of Probation. (2015).** *Annual Report 2014–15.* Manchester: HM Inspectorate of Probation for England and Wales.
- HM Inspectorate of Probation and HM Inspectorate of Prisons. (2017).** *An Inspection of Through the Gate Resettlement Services for Prisoners Serving 12 Months or More.* Retrieved from <https://www.justiceinspectorates.gov.uk/hmiprobation/throughthegate2/>
- HM Inspectorate of Probation Criminal Justice Joint Inspection. (2014).** *A joint inspection of the treatment of offenders with learning disabilities within the criminal justice system – phase one from arrest to sentence.* London: HM Inspectorate of Probation.
- HM Inspectorate of Probation Criminal Justice Joint Inspection. (2015).** *A joint inspection of the treatment of offenders with learning disabilities within the criminal justice system – phase two in custody and the community.* London: HM Inspectorate of Probation.
- HMI Probation, & HMI Prisons. (2015).** *A joint inspection of the treatment of offenders with learning disabilities within the criminal justice system – phase two in custody and the community.* Manchester: Her Majesty's Inspectorate of Probation.
- Hordell, A., Robinson, D., Rees, J., Forshaw, N., Chandler, C., Dhaliwal, R., & Murphy, N. (2008).** *Brooklands Sex Offender Treatment Programme Treatment Manual – For Male Offenders with Learning Disabilities.* Birmingham: Coventry and Warwickshire Partnership.
- Jacobson, J. with Talbot, J. (2009).** *Vulnerable defendants in the criminal courts: a review of provision for adults and children.* London: Prison Reform Trust.
- Jacobson, J. (2008).** *Police responses to suspects with learning disabilities and learning difficulties: a review of policy and practice.* London: Prison Reform Trust.
- Justice. (2017).** *Mental health and fair trial: a report by Justice.* London: Justice.
- Law Commission. (2016).** *Unfitness to Plead Summary.* London: Law Commission.
- Law Commission. (2017).** *Mental Capacity and Deprivation of Liberty.* London: Law Commission.
- Lindsay, W. R. (2009).** *The treatment of sex offenders with developmental disabilities: a practice workbook.* Chichester: Wiley-Blackwell.
- Lindsay, W. R., Ward, T., Morgan, T., & Wilson, I. (2007).** *Self-regulation of sex offending, future pathways and the Good Lives Model: Applications and problems.* *Journal of Sexual Aggression*, 13(1), 37-50.
- Loucks, N. (2007).** *Prisoners with learning difficulties and learning disabilities – review of prevalence and associated needs.* London: Prison ReformTrust.
- Mann, R. E., & Barnett, G. D. (2013).** *Victim Empathy Intervention With Sexual Offenders: Rehabilitation, Punishment, or Correctional Quackery? Sexual Abuse: A Journal of Research and Treatment*, 25(3), 282-301.
- Malovic, A., Rossiter, R., & Murphy, G. (2018).** *Keep Safe: the development of a manualised group CBT intervention for adolescents with ID who display harmful sexual behaviours.* *Journal of Intellectual Disabilities and Offending Behaviour*, <https://doi.org/10.1108/JIDOB-1110-2017-0023>.
- Marshall, W. L., Anderson, D., & Fernandez, Y. (1999).** *Cognitive-Behavioural Treatment of Sex Offenders.* Chichester: Wiley.
- McBrien, J., & Murphy, G. (2006).** *Police and carers' views on reporting alleged offences by people with intellectual disabilities.* *Psychology, Crime & Law*, 12(2), 127-144.
- MIND. (2017).** *Section 117 aftercare.* Retrieved from <https://www.mind.org.uk/information-support/legal-rights/leaving-hospital/section-117-aftercare/#.WkzXdt9l-Ul>
- Ministry of Justice. (2017a).** *Criminal justice system statistics quarterly: June 2017.* London: Ministry of Justice.
- Ministry of Justice. (2017b).** *Multi-Agency Public Protection Arrangements (MAPPA) annual report 2016 to 2017.* London: Ministry of Justice Statistics Bulletin.
- Ministry of Justice. (2017c).** *Offender Management statistics quarterly, England and Wales, Quarter: April to June 2017, Prison population: 30 September 2017.* London: Ministry of Justice Statistics Bulletin.
- Ministry of Justice. (2017d).** *Offender Management statistics quarterly, England and Wales, Quarter: January to March 2017, Prison population: 30 June 2017.* London: Ministry of Justice Statistics Bulletin.
- Murphy, G. H., Chiu, P., Triantafyllopoulou, P., Barnoux, M., Blake, E., Cooke, J.,...Beecham, J. K. (2017).** *Offenders with intellectual disabilities in prison: What happens when they leave?* *Journal of Intellectual Disability Research*, 61(10), 957-968.
- National Audit Office. (2017).** *Local support for people with a learning disability.* London: National Audit Office.
- National Autistic Society. (2016).** *What is autism?* Retrieved from <http://www.autism.org.uk/about/what-is/asd.aspx>
- NHS England. (2017a).** *Transforming Care: Model Service Specifications.* Leeds: NHS England.
- NHS England. (2017b).** *Developing support and services for children and young people with a learning disability, autism or both.* Leeds: NHS England.

NHS England, Local Government Association, & Association of Directors of Adult Social Services. (2015a). *Building the Right Support*. Retrieved from: <https://www.england.nhs.uk/wp-content/uploads/2015/10/ld-nat-imp-plan-oct15.pdf>

NHS England, Local Government Association, & Association of Directors of Adult Social Services. (2015b). *Supporting people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition*. Retrieved from <https://www.england.nhs.uk/wp-content/uploads/2015/10/service-model-291015.pdf>

NHS England, Local Government Association, & Association of Directors of Adult Social Services. (2016). *Building the Right Home*. Retrieved from <https://www.england.nhs.uk/learningdisabilities/wp-content/uploads/sites/34/2015/11/building-right-home-guidance-housing.pdf>

NICE. (2015). [NG11]: *Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges*. Retrieved from <https://www.nice.org.uk/guidance/ng11>

Office for National Statistics. (2016, 11-02). *Overview of violent crime and sexual offences*. Retrieved from <https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/compendium/focusonviolentcrimeandsexualoffencesyearendingmarch2015/chapter1overviewofviolentcrimeandsexualoffences#sexual-offences>

Public Health England. (2016). *Learning Disabilities Observatory: People with learning disabilities in England 2015*. London: Public Health England.

Royal College of Psychiatrists. (2014). *Forensic care pathways for adults with intellectual disability involved with the criminal justice system*. London: Royal College of Psychiatrists.

Royal College of Psychiatrists, British Psychological Society, & Royal College of Speech and Language Therapists. (2007). *Challenging Behaviour: A Unified Approach (CR144)*. London: Royal College of Psychiatrists.

Social Care Institute for Excellence. (2017). *Deprivation of Liberty Safeguards (DoLS)*. Retrieved from <https://www.scie.org.uk/mca/dols/at-a-glance>

SOTSEC-ID. (2010). *Effectiveness of Group Cognitive-Behavioural Treatment for Men with Intellectual Disabilities at Risk of Sexual Offending*. *Journal of Applied Research in Intellectual Disabilities*, 23(6), 537-551.

SOTSEC-ID. (2018). *Welcome to the SOTSEC-ID website*. Retrieved from <https://www.kent.ac.uk/tizard/sotsec/index.html>

Talbot, J. (2008). *No One Knows: Experiences of the criminal justice system by prisoners with learning disabilities and difficulties*. London: Prison Reform Trust.

Talbot, J. (2012). *Fair Access to Justice? Support for vulnerable defendants in the criminal courts*. London: Prison Reform Trust.

United Nations. (2006). *United Nations Convention on the Rights of Persons with Disabilities*. New York: United Nations General Assembly.

Ward, T., & Maruna, S. (2007). *Rehabilitation: beyond the risk paradigm*. London: Routledge.

Ward, T., & Stewart, C. A. (2003). *The treatment of sex offenders: Risk management and good lives*. *Professional Psychology: Research and Practice*, 34(4), 353-360.

Wheeler, J. R., Holland, A. J., Bambrick, M., Lindsay, W. R., Carson, D., Steptoe, L.,...O'Brien, G. (2009). *Community services and people with intellectual disabilities who engage in anti-social or offending behaviour: referral rates, characteristics, and care pathways*. *The Journal of Forensic Psychiatry & Psychology*, 20(5), 717-740.

Williams, F., & Mann, R. E. (2010). *The Treatment of Intellectually Disabled Sexual Offenders in the National Offender Management Service: The Adapted Sex Offender Treatment Programmes*. In L. A. Craig, W. R. Lindsay, & K. D. Browne (Eds.), *Assessment and Treatment of Sexual Offenders with Intellectual Disabilities* (pp. 293-315). Chichester: John Wiley & Sons, Ltd.

Wilson, R. J., McWhinnie, A., Picheca, J. E., Prinzo, M., & Cortoni, F. (2007). *Circles of Support and Accountability: Engaging Community Volunteers in the Management of High-Risk Sexual Offenders*. *The Howard Journal of Crime and Justice*, 46(1), 1-15.

World Health Organisation. (2018). Definition: intellectual disability. Retrieved from <http://www.euro.who.int/en/health-topics/noncommunicable-diseases/mental-health/news/news/2010/15/childrens-right-to-family-life/definition-intellectual-disability>

LEGISLATION

Autism Act 2009

Care Act 2014

Criminal Procedure (Insanity and Unfitness to Plead) Act 1991 (CPIA)

Criminal Procedure (Insanity) Act 1964

Equality Act 2010

Mental Capacity Act 2005

Mental Health Act 1983

Police and Criminal Evidence Act 1984

Youth Justice and Criminal Evidence Act 1999

APPENDICES

APPENDIX 1: SEMINAR DAY PROGRAMME

Behaviour that challenges: planning services for people with learning disabilities and/or autism who sexually offend

MORNING THEME: THE BIGGER PICTURE

09:30	Registration, tea/ coffee
10:00	Welcome Andrea Hollomotz (lecturer, University of Leeds) Jenny Talbot (Director, Care not Custody, Prison Reform Trust)
10:05	Opening plenary Lord Bradley
10:20	Keynote panel: health and justice pathways for individuals with learning disabilities and/or autism Lord Bradley (chair) Police response Janette McCormick (Disability Lead for the National Police Chief's Council) Health and justice response: liaison and diversion services Kate Davies OBE, Director of Health & Justice, Armed Forces and Sexual Assault Services Commissioning, NHS England Community forensic services response Joe Rafferty, Chief Executive Mersey Care NHS Trust Adult social care response Janice Grant, ADASS care and justice network and social care health and wellbeing directorate, Kent County Council
11:25	Table discussions: 3Bs Jenny Talbot (chair)
11:55	The NHS Learning Disability policy context: beyond the magic ingredient David Harling (NHS improvement) Ellie Gordon (Independent clinical advisor)
12:15	Lunch

AFTERNOON THEME: DISCUSSING PRACTICE EXAMPLES AND FINDING SOLUTIONS

13:00	<p>Towards best outcomes: practice examples</p> <p>Jenny Talbot (chair)</p> <p>Through the gate example XXX (XXX) Niles (Service user, XXX)</p> <p>A community placement in adult foster care Danielle Kenney (Senior Probation Officer, National Probation Service)</p> <p>Overview of the ESRC project and inter-agency working in a Swiss adapted sex offender treatment programme Andrea Hollomotz (lecturer, University of Leeds) Monika Egli-Alge (forensic psychologist & psychotherapist, Forio, Switzerland)</p> <p>Crisis driven behaviour – meeting ‘their’ needs (not our own) Paul Jennings (Mental Health Police Sergeant, Hampshire police)</p>
14:05	<p>Pooling budgets for person-centred, rather than service-specific delivery Ben Hughes (Head of Commissioning: Public Health and Wellbeing, Essex County Council)</p>
14:30	<p>Table discussions: Achieving best outcomes Jenny Talbot (chair)</p> <p>Table chairs: Clare Hughes (Criminal Justice Manager, National Autistic Society) with Sheila Nagy (Practice Manager, National Probation Service) Prof Glynis Murphy (co-chair, SOTSEC-ID) Kerensa Hocken (Cluster Lead Psychologist for Sexual Offending Strategy, NOMS) Alison Giraud Saunders (independent consultant) Annie Norman (RCN Professional Nurse Adviser for Learning Disability and Nursing in Criminal Justice Services)</p>
15:45	<p>Final comments/ next steps Andrea Hollomotz & Jenny Talbot</p>
16:00	<p>Drinks reception</p>
16:30	<p>Close</p>

APPENDIX 2: LIST OF SEMINAR DAY DELEGATES

Behaviour that challenges: planning services for people with learning disabilities and/or autism who sexually offend

Surname	Name	Job title/ organisation
	Niles	Service user
Alexander Dr	Regi	Consultant Psychiatrist, PiC LD Services, St John's House, Diss, Norfolk
Ali	Salma	Specialist Liaison & Diversion Practitioner - Intellectual Disabilities
Allnutt	Caroline	PRT volunteer
Anwyl	Michelle	Clinical nurse specialist, Mersey Care
Anderson	Julia	Clinical Nurse Manager, Mersey Care
Barnes DJ	Barbara	District Judge (Magistrates' Court)
Boer Dr	Harm	Consultant Forensic Psychiatrist for People with Learning Disability, Forensic Service, Brooklands, Coventry and Warwickshire Partnership NHS trust
Lord Bradley	Keith	
Brufal	Tabitha	Deputy Director, Early Interventions, Women and Vulnerable Offender Policy
Burns	Mick	Head of Mental Health (Interim)/ Co-Commissioner PD Offender Pathway (North), NHS England
Burton	Zoe	Office Manager, PRT
Byrne-Watts	Irene	Director of community services, Mersey Care
Curen Dr	Richard	Consultant Forensic Psychotherapist, Respond
Davies OBE	Kate	Director of Health & Justice, Armed Forces and Sexual Assault Services Commissioning, NHS England
Easton	Jo	Director of Policy and Research, Magistrates' Association
Edgar	Kimmett	Head of Research, PRT
Egli-Alge	Monika	Director, Forio (Switzerland)
Flavelle	Eileen	Clinical Director, Michael Batt Foundation (Plymouth)
Fletcher	Mick	Specialist Behavioural Nurse, Hull and East Riding for Humber NHS Foundation Trust
Gayler	Paul	Strategic Housing Manager, Maldon District Council
Giraud-Saunders	Alison	independent consultant
Gordon	Ellie	Independent clinical advisor
Graham	Anne	Director, Resolve Care
Grant	Janice	ADASS care and justice network and social care health and wellbeing directorate, Kent County Council
Hagem	Birgitte	Specialist Prosecutor, DLA Team, Crown Prosecution Service
Hammond	Tracy	Operations Director, Learning Disability England

Surname	Name	Job title/ organisation
Harling	David	Head of Learning Disability, Mental Health Team - Nursing Directorate, NHS Improvement
Hepworth	Jonathan	Senior Mental Health Supplier Manager
Hepworth	Karina	Queen's Nurse, Behaviour Therapist & Senior Nurse Specialist, Learning Disabilities, South West Yorkshire Partnership NHS Trust & Kirklees Youth Offending Team
Higgins	Laura	Board Certified Behaviour Analyst/ Service Manager, BILD
Hocken Dr	Kerensa	Cluster Lead Psychologist for Sexual Offending Strategy - Midlands, NOMS
Hollomotz Dr	Andrea	Lecturer, University of Leeds
Hughes	Ben	Head of Commissioning, Public Health and Wellbeing, Essex County Council
Hughes	Clare	Criminal Justice Manager, National Autistic Society
Hutchinson	John	Director, New Focus Preston
Inett	Andy	Consultant Forensic Psychologist, Psychology lead for low secure services (LD and mental health), Kent and Medway NHS and Social Care Partnership Trust
Jennings	Paul	Mental Health Police Sergeant, Hampshire police
Kenny	Danielle	Senior Probation Officer, North Offender Management Unit, National Probation Service
King	David	Director, Resolve Care
Lockett	Karen	Regional Head of Transforming Care (Midlands & East)
McConnell	Elaine	Chief Executive, Lucy Faithful Foundation
McCormick DCC	Janette	Cheshire Deputy Chief Constable
Mount	Pam	Clinical nurse specialist, Mersey Care
Murphy Prof	Glynis	Professor of Clinical Psychology & Disability, University of Kent; co-chair, SOTSEC-ID
Nagy	Sheila	Practice Manager, Lancs/Cumbria Sex Offender Resource Team, National Probation Service NW Division
Nicholls	Shelley	Association of YOT Managers, (Nottingham YOT)
Norman	Ann	RCN Professional Nurse Adviser for Learning Disability and Nursing in Criminal Justice Services
Rafferty	Joe	Chief Executive, Mersey Care NHS Foundation Trust
Sinclair Dr	Neil	Clinical Psychologist, Co-chair, SOTSEC-ID.
Smith	Les	PRT volunteer
Stewart	Zandrea	Director, SOLVE Social Care and Health, and ADASS associate
Talbot OBE	Jenny	Director, Care not Custody, Prison Reform Trust
Tancred	Tania	Senior Forensic Psychologist, NPS OPD Lead Kent, Surrey & Sussex
Walker	Chris	Editor, Learning Disability Practice, RCNi
Williams	Matt	Senior Project Worker, New Focus Preston

APPENDIX 3: A BRIEF OVERVIEW OF THE AUTISM ACT 2009

Written by Clare Hughes, Criminal Justice Manager, National Autistic Society

The Autism Act 2009 was the first disability-specific law in England, and it did two things:

- It placed a duty on the Government to produce a strategy for autistic people;
- It placed a duty on the Government to underpin the strategy with statutory guidance for councils and the NHS

Both must be kept under review.

- 2010 – Fulfilling & Rewarding Lives (1st strategy and statutory guidance was produced)
- 2014 – Think Autism 2nd (strategy was produced)
- 2015 - Updated statutory guidance
- 2016 – Progress Report on Think Autism

CJS ACTIONS WITHIN THINK AUTISM STRATEGY

• Ministry of Justice:

Establish a Cross-Government Group to consider and take forward issues to do with autism and the criminal justice system and report on progress to the Autism Programme Board, including issues such as training and awareness, screening, reasonable adjustments, and the use of IT systems to better support people with autism. Consider whether autism awareness training can be built into the work of the new Institute of Probation, and, where appropriate look to place relevant information in to the Transforming Rehabilitation data room.

The group has been meeting since 2014 and has a good representation from the different Government departments. The Institute of Probation held several regional training events, delivered in partnership with Key-Ring. In addition, the Institute held an equality and diversity conference in Bristol in 2015, which featured a workshop on addressing the needs of autistic people.

• Home Office:

Work with the College of Policing to update and add to their mental health e-learning training which includes autism training for new police officers, look at evidence-based advice for managing autism within justice settings, and whether the markers on local police force systems used for offenders with mental health or learning difficulties can be extended for those with autism.

The College of Policing launched their Mental Health Approved Professional Practice (APP) in 2016, which includes information about autism and learning disabilities. Discussions are still taking place about the use of a marker,

which will cover a range of vulnerabilities, including autism. The disability lead for the National Police Chief's Council has set up and oversees the ongoing work of the autism Community of Practice. In February 2017, a joint DH, MoJ and National Autistic Society (NAS) event was held to share best practice in relation to autism and policing. In May 2017, the NAS launched an autism guide for police officers and staff funded by DH and supported by MoJ.

• National Offender Management Service (now Her Majesty's Prison and Probation Service) -

Examine and share good practice in prisons towards prisoners with autism. Report back to the Autism Programme Board on the impact that the mandatory assessment of functional skills for all prisoners from August 2014 has had on identifying prisoners with autism.

The NAS have been working with a number of criminal justice agencies to develop Autism Accreditation standards. HMYOI Feltham became the first prison to achieve accredited status in 2015. The former Minister for Prisons, Probation, Rehabilitation and Sentencing, Andrew Selous, visited Feltham in March 2015 and subsequently wrote to all prison governors and directors to encourage them to consider working towards Autism Accreditation. A number of prisons are now working towards Autism Accreditation and pilots exist in probation, police forces and forensic support services. Autism and learning difficulties are covered under the refreshed Young Offender Institution training on working with young people in custody.

• Crown Prosecution Service

Develop an aide-memoire and support material for prosecutors, highlighting key issues, implications for the prosecution process and sources of support for people with autism.

The CPS launched their 'autism checklist for prosecutors' in 2015. The Checklist provides basic information and signposting in relation to issues arising from a victim's, witness's or defendant's perspective. (Publicly available on their website)

CJS ACTIONS WITHIN THINK AUTISM STATUTORY GUIDANCE

Local Authorities must:

- Under the Care Act, from April 2015, assess the care and support needs of adults (including those with autism) who may have such needs in prisons or other forms of detention in their local area, and meet those needs which are eligible;
- Work with prisons and other local authorities to ensure that individuals in custody with care and support needs have continuity of care when moving to another custodial setting or where they are being released from prison and back into the community.

It would be good practice for local authorities, in partnership with NHS bodies and NHS Foundation Trusts:

- As the Liaison and Diversion approach is rolled out, to connect with the local authority autism lead, relevant community care assessment team(s), and local preventative services with local Liaison and Diversion services.

NHS bodies and NHS Foundation Trusts should:

- Ensure that Liaison and Diversion services have a clear process in place to communicate the needs of an offender with autism to the relevant prison or probation provider;
- Ensure that in commissioning health services for persons in prison and other forms of detention, prisoners are able to access autism diagnosis in a timely way;
- and healthcare, including mental health support, that takes account of the needs of people with autism.

Local Authorities, NHS bodies and NHS Foundation Trusts should:

- Seek to engage with local police forces, criminal justice agencies and prisons to the training on autism that is available in the local area; and
- Consider undertaking some joint training with police forces and criminal justice services working with people with autism.

Local authorities also have to complete an autism self-assessment framework (SAF) every 18 months and rate themselves red, amber or green. The SAF covers a range of issues including criminal justice.

The questions relating to their links and work with criminal justice agencies are:

- Do staff in the local police/court/probation services engage in autism awareness training?
- Are the Criminal Justice Services (police, probation and, if relevant, court services) engaged with you as key partners in planning for adults with autism?
- Is access to an appropriate adult service available for people on the Autistic Spectrum in custody suites and nominated 'places of safety'?

This is still a challenge for many Local Authorities. Only 11% of councils reported good joint working with CJS agencies (almost two thirds had some discussions and had CJS agencies attending their autism partnership board). Only 22% said that appropriate adults were available and trained in autism.





UNIVERSITY OF LEEDS

University of Leeds
Leeds, United Kingdom
LS2 9JT