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Offenders with Intellectual and Developmental Disabilities: A commentary on psychological practice and legislation

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Executive summary

This paper reviews the literature on contemporary psychological practice and emerging legislation concerned with people with intellectual and developmental disabilities (IDD), identifies a number of emerging issues and makes recommendations for current practise and development work.

1 More precise use of nomenclature is necessary. Alongside intellectual disability, the term developmental disability would best reflect the heterogeneity of the patient population commonly served by forensic services in the UK.

2 Epidemiological questions are confounded by studies using different operational definitions and comparing heterogeneous populations. Prevalence figures may be further contaminated by prison deviation practices and a differential tolerance to people with IDD. The development of models depicting life trajectories and the contributory influences of vulnerability and resilience to risk will be especially welcome.

3 Specific and adapted assessment measures are emerging, including those for risk assessment. Considerable work remains in this crucial domain.

4 Whilst outcomes for interventions for specific offence groups lack radomised controlled trial (RCT) quality, there are positive preliminary findings for the efficacy of CBT-based work. The inevitable effect of intervention itself on identifying risk-needs and their management is a promising area for more process-directed models and enquiry. Generally, lengthier periods of intervention are associated with better outcomes, though briefer individual work directed at specific vectors like anger also demonstrates utility. Maintenance of treatment gains and the influence of protective scaffolds, like meaningful employment, require more direct examination.

5 Substance misuse issues may have particular salience for offenders with IDD, because of the 'hypersensitivity phenomenon' and the not uncommon issue of an underlying neuro-developmental disorder.

6 The comprehensive current revision of mental health and capacity law poses fascinating practical, ethical and political challenges for those working in this field.

7 There is a convincing and eminently practical body of knowledge emanating from in the field of jurisprudence and witnesses with IDD, which can be used to positively influence more equitable justice.

8 There is insufficient evidence about black and ethnic minority (BEM) groups within this population to make any definitive comment about whether BEM individuals are more represented than would be predicted from demographics.

1. Introduction

The aim of this briefing paper is to provide an overview of and commentary on the prevalence, assessment and treatment of offenders with intellectual and development disabilities (IDD).

It will be relevant for psychologists working within the forensic services, to those working in learning disability services and for some areas of CAMHS services, specifically Youth Offender Teams, though the emphasis is on adult forensic services. Cross-specialty areas such as family court work with parents who have IDD, capacity to care and allied risk assessment falls outside its scope.

It will be of value in providing an expert knowledge base for solicitors and others involved in the legal process and also for commissioners.

Until very recently, work with offenders with IDD was held to be very preliminary and at a stage where single case studies were encouraged (Clare & Murphy, 1998). There were mere beginnings of evidence that certain models, with known efficacy for other populations especially those described as challenging, may have applicability with the forensic IDD group. There has since been a blossoming of more sophisticated and rigorous clinical research that is increasingly able to guide practice. The document provides a summary of the evidence base for assessment and psychological interventions within this emergent area. A full bibliography is appended for those wishing to gain a more in-depth account of the field.

Particular issues of jurisprudence and the implications of emerging legislation pertaining to this population will also be considered. The paper will focus on the particular needs of this group of offenders, of witnesses with IDD, and on contemporary and unfolding best practice.

2. Understanding the use and influence of nomenclature

Whilst fashionably and descriptively more precise, or politically more correct, the use of rapidly changing terms and diagnoses has had a devastating effect on meaningful data. This trend has made comparative analysis methodologically problematic. Consider examples such as Asperger's syndrome and the 'autistic spectrum'; the more inclusive term 'developmental disability' and the narrower 'intellectual disability'; the unique to the UK 'learning disabled' rather than 'mentally retarded' (USA); with all these terms representing widely ranging deficits of cognition and social adaptation.

The inclusive term intellectual and developmental disability (IDD) is preferred in this paper as it better reflects the recipient populations in forensic services in the UK. It embraces and is broader than the equivalent terms of mental retardation, intellectual disability and learning disability.

For the purposes of this paper intellectual and developmental disability is defined as a severe, chronic, and enduring disability attributable to unitary or combinatory mental and/or physical impairments, manifesting before 22 years, which result in substantial multiple functional limitations in life activities, reflecting an associated need for supports and assistance. It includes conditions that do not necessarily involve significant sub-average intellectual functioning, such as autism.

It has been argued (e.g. Holland, 2004) that there are two broadly overlapping groups: those with an identifiable explanation for impaired brain development that is causally associated with IDD and those with a more idiopathic aetiology. Whilst the latter generally are associated with poorer socio-economic status, the former are randomly distributed across the social spectrum. It may therefore be that there are different, albeit complex and intertwined bio-psycho-social pathways leading to offending. The relative amenability to change of these groups remains debatable.

There is a dearth of studies differentiating male and female offenders (especially those with IDD) or exploring arguable gender differences. Where evidence exists, this will be commented upon, otherwise for offender assume male offender.

3. Epidemiology

The firm, historically forged, but false link between IDD and criminal predisposition continues to be a major challenge for psychologists and related professions interested in the management of offenders with IDD. Even the most recent legislated social policies in England and Wales betray a repressive control response (public order rather than health care) to an often ill-conceived risk to the public from people with mental health or IDD. (See section 8. Implications of new legislation.)

The long held belief in a causal association between IDD and criminality has, in the past, led to the inevitable institutionalisation of those seen as not responsible for their actions. The fathers of the IQ, like Terman and Darwin's own cousin Francis Galton, carry a decided responsibility for the causal conflation of disability with criminality, within the framework of Darwinian eugenics: '…not all criminals are feeble-minded but all feeble minded are at least potential criminals' (Terman, 1916, cited in Lindsay et al., 2004). Such preconceptions led to the preventative incarceration of many intellectually disabled men and women on the basis of presumptive criminality and moral depravity. Deinstitutionalisation, mostly in the last generation, has closed many of these hospital beds but has not really addressed the particular needs of this population which continues to have a limbo existence within the ill-defined rubric of challenging and offensive behaviour.

Given the marginalised social circumstances of people with IDD, having come into an often frankly abusive developmental world and having modest capacities for engaging knowledgably with it, the real surprise lies not in the frequency with which they offend, but in the equivocal evidence that the offence prevalence of people with IDD

exceeds in any way that of the population at large. The challenge for researchers lies in developing models that can tease out the complex pathways that lead individuals with IDD into lifestyles respectively more and less compatible with offending.

The main difficulty in establishing the relationship between IDD and offending is both definitional and contextual. People with IDD comprise heterogeneous intersecting clusters of need, measured intellect, syndromes and gender. Similarly, prevalence of offending falls along continua of filters in the criminal justice system (eg. is the data taken from the point of report, arrest, charge, conviction, or alternative disposal or deviation at any of these discretionary positions?). The context also needs to take account of the relative tolerance both of the response of the criminal justice system to reports of people with IDD who have offended and of the carers' propensity to report (Holland, 2004; Lindsay et al., 2004).

Although there is a well-established association between lower IQ and conviction, the relationship between intelligence and offending is not linear (Taylor, Lindsay & O'Brien, in press). A dual-process social learning model suggests that a proneness to aggressive behaviour may be accounted for by a failure to learn more complex and subtle interpersonal skills; conversely, the isolating and alienating effects of aggression itself may reduce effective educational opportunities, and a failure to optimise intellectual development.

Bearing these caveats in mind, the following broad conclusions can be drawn from the existing literature:

- 2–5 per cent of people with IDD are reported by social agencies to have had contact with the police. There is at least the issue of higher tolerance threshold here, involving both offender and victim who have IDD, that may explain this remarkably low rate (Lyall et al., 1995). A more recent prospective study reports 14.8 per cent having had contact with criminal justice agencies (Barron et al., 2004).
- 5–9 per cent of people interviewed by police have IDD (Gudjonsson et al., 1993).
- No studies have shown that there are more people with IDD in

prison in the UK than would proportionately be expected (Holland, 2004). Figures elsewhere in the world (Lindsay et al., 2004) are confirmatory. Diversion policies could of course contaminate these figures, rendering them less meaningful. A recent systematic (10 per cent sampling) prison survey in Eire (Carey, 2004) for instance came up with a proportion of 28 per cent of inmates with an IDD. That this is close to other estimates of prisoners with a broader (USA) definition of 'learning disability', may be telling. It may also be that this population reflects particular socio-educational issues in Eire. These men (hardly any women) were notably premature school-leavers.

- Large retrospective studies (e.g. Farrington, 2000) show that intellectual or educational disadvantage are strongly predictive of criminality, but it is difficult to extrapolate from this association to complex causal prediction.
- It seems likely from anecdotal reports (e.g. Lindsay et al., 2004) that a high proportion of people with IDD in the UK are being formally or informally managed in the community as a result of the de-institutionalising social policies. Similarly, it is generally acknowledged that both the police and the Crown Prosecution Service are reluctant to proceed against people who have identified IDD.
- Where deviation from prison is not a general practice (e.g. New South Wales in Australia) figures for prisoners with IDD rise to 12-13 per cent (cited by Shackell, 2004). This is close to the Barron et al. (2004) findings above. The inference could be drawn that the various deviations from the ordinary criminal justice and institutional processes is distorting available prevalence data. More precision than surmise is however required.
- Based on the limited data available, recidivism rates for offenders with IDD are not dissimilar to general offender populations (Taylor, et al., in press).

There is a subtle contrary development to the deinstitutionalisation of people with IDD. Institutions are being re-established, specifically for those who show challenging behaviour of the offensive variety (Sturmey, Taylor & Lindsay, 2004). There is a trend for local

commissioners to refer these patients to out-of-area regional secure services. This is reflected in the disproportionate number of such people detained under the Mental Health Act. Because these are often independent sector facilities there is in effect a re-institutionalisation by stealth. (See also 8. Implications of new legislation).

4. Assessment

4.1 General issues

There are several important considerations in the assessment of offenders with IDD. It is important that any assessment can be understood by the clients completing it. Since clients with IDD may have significant deficits in literary and comprehension skills, all assessments must be suitably adapted to simplify the language and concepts as lack of understanding is likely to lead to unreliable responding. Due to possible cognitive limitations, generally all assessment material will have to be read and explained to respondents. Thus, assessments take the form of a structured interview. Therefore, both the assessment instrument and the process require modification. Consequently it is important to establish that the psychometric properties of modified measures remain intact and that the integrity of the process is not undermined. These issues have been dealt with extensively elsewhere (e.g. Taylor & Novaco, 2005; Lindsay, 2008).

4.2 Risk Assessment

Assessment of risk for future offences has emerged as one of the most important fields in forensic psychology over the last 20 years. General principles of good practice in forensic risk assessment can be found in the recently published Faculty occasional briefing paper by O'Rourke and Bailes (2007). Recent studies suggest that risk prediction in the IDD forensic population, with suitably tailored risk assessments, may be as valid as it is for mainstream offenders.

Lindsay, Elliot and Astell (2004) conducted a study to review the predictive value of a range of previously identified variables in relation to recidivism for 52 male sex offenders with IDD. The significant variables to emerge from the study were similar to those which had been identified in mainstream studies. However, employment history, criminal lifestyle, criminal companions, diverse sexual crimes and deviant victim choice, which had been highly associated with recidivism in studies of mainstream offenders, did not emerge as predictor variables. On the other hand, variables related to staff behaviour and attitudes did emerge as strong predictors. These authors considered that this may be an indication of the way in which professionals developing assessments in this field should adjust their perceptions. For example, while few individuals with IDD have an employment history, they are likely to have alternative regimes of special educational placement, occupational placement and so on, which make up a weekly routine of engagement with society. Non-compliance with such regimes did emerge as a significant variable suggesting that individuals with IDD should be judged in relation to their peers. In another study of sexual offenders with IDD, Tough (2001) found that the Rapid Risk Assessment for Sex Offender Recidivism (RRASOR; Hanson, 1997) had a medium effect size in predicting recidivism for a cohort of 81 participants. Subsequently, Harris and Tough (2004) reported that they employed the RRASOR as a means of allocating sex offender referrals to their service and, by accepting referrals of only low or medium risk, they targeted limited resources on appropriate individuals.

Quinsey, Book and Skilling (2004) conducted a rigorous assessment of the Violence Risk Appraisal Guide (VRAG; Quinsey et al., 1998) in a 16-month follow-up of 58 participants with IDD. They found a significant predictive value with a medium effect size and that staff ratings of client behaviour significantly predicted antisocial incidents. Gray et al. (2007) conducted a more extensive investigation into the VRAG, HCR-20 (Webster, Douglas, Eaves & Hart, 1997) and the Psychopathy Checklist – Revised (PCL-R; Hare, 1991). They compared 145 patients with IDD and 996 mainstream patients all discharged from secure hospital having been admitted with serious

mental illness, IDD or personality disorder; and having been convicted of a criminal offence or having exhibited behaviour that might have led to a conviction in different circumstances. They found that all of the assessments predicted reconviction rates in the IDD sample with an effect size as large, or larger than the mainstream sample.

In a further risk assessment comparison study, Lindsay et al. (2008) employed a mixed group of 212 violent and sexual offenders with IDD. They followed up participants for one year and found that the VRAG was a reasonable predictor for future violent incidents, the Static-99 (Hanson & Thornton, 1999) was a reasonable predictor for future sexual incidents, and the Risk Matrix 2000 (RM2000; Thornton et al., 2003) predicted somewhat less well for violent and sexual incidents.

Employing the same study samples, Taylor et al. (2008) reviewed the psychometric properties and predictive validity of the HCR-20. They found that inter-rater reliability was acceptable for all scales, and internal consistency was satisfactory for the H Scale but low for the C and R Scales. Exploratory factor analysis found that the H Scale constituted three factors (delinquency, interpersonal functioning and personality disorder) while the C and R Scales made up distinct separate factors. They also found that the R Scale had the highest predictive value in relation to recorded incidents over a period of a year. They concluded that the HCR-20 was a robust instrument for guiding clinical judgement which would help clinicians to reach consistent and clinically defensible decisions.

All of these risk assessments (with the exception of the HCR-20 C and R scales) have focused on static/actuarial variables which are either immutable or difficult to change in the person's history. Quinsey, Book and Skilling (2004) also assessed the value of dynamic/proximal risk indicators. They found that in the month prior to a violent or sexual incident, dynamic indicators of antisociality were significantly higher than values recorded six months prior to the incident. This, they concluded, provided some evidence of the value of dynamic assessment since the increase in dynamic risk factors one month prior to the offence could not be

attributed to any bias in the light of an offence occurring. Employing a similar design, Lindsay et al. (2004a) tested the Dynamic Risk Assessment and Management System (DRAMS) on which staff made daily ratings of clients' mood, antisocial behaviour, aberrant thoughts, psychotic symptoms, self-regulation, therapeutic alliance, compliance with routine and renewal of emotional relationships. Ratings were compared between those taken on the day of the incident, the day prior to the incident and a further control day at least seven days before the incident. Although there were only five clients with full data sets on appropriate days, there were significant increases in ratings for the day prior to the incident for mood, antisocial behaviour, aberrant thoughts and DRAMS total score. Steptoe et al. (2008) conducted a larger study on the predictive utility of the DRAMS with 23 forensic patients in a high secure setting. Predictions were made against independently collected incident data and concurrent validity was assessed against the Ward Anger Rating Scale (WARS; Novaco & Taylor, 2004). The DRAMS mood, antisocial behaviour and intolerance/agreeableness ratings had significant predictive values with incidents and there were highly significant differences, with large effect sizes, between assessments taken one or two days prior to an incident and control assessments conducted at least seven days from an incident. Therefore, dynamic risk assessment appears to perform well both in terms of concurrent and predictive validity in relation to offenders with IDD.

Further developments have taken place recently concerning other measures. Hogue et al. (2007) evaluated the utility of the Emotional Problem Scale (EPS; Prout & Strohmer, 1991) with 172 offenders with IDD from a range of security settings. The EPS is generally considered to be a dynamic assessment of emotion and self-concept and these authors, using the assessment on only a single occasion, found that the derived scores successfully predicted recorded incidents over a period of a year with a medium to large effect size. Morrissey and her colleagues (Morrissey et al., 2005, 2007a, 2007b) have investigated the utility, discriminative validity and predictive validity of the PCL-R and found that it predicts both positive response to treatment and patient transfers from high to medium secure conditions, within two years of assessment. However, it did not

predict institutional violence at a better level than chance. In summary, there are a number of studies, using a range of assessments, some of which have been developed for this client group, which are promising in terms of utility and validity of risk prediction for offenders with IDD.

4.3 Sexual offending

Some work has been completed on knowledge and beliefs of sex offenders with IDD. With this client group, it is important not only to review cognitive distortions but to consider also the level of sexual knowledge an individual may have. Indeed, one of the first hypotheses put forward to account for inappropriate sexual behaviour in this group was that lack of sexual knowledge may lead the individual to attempt inappropriate sexual contact precisely because they are unaware of the means to establish appropriate interpersonal and sexual relationships. This hypothesis of 'counterfeit deviance' was first mentioned by Hingsburger, Griffiths and Quinsey (1991) and has been recently reviewed and revised to account for more recent research findings by Lindsay (2008). The term refers to behaviour which is undoubtedly deviant but may be precipitated by factors such as lack of sexual knowledge, poor social and heterosexual skills, limited opportunities to establish sexual relationships and sexual naivety rather than a preference or sexual drive towards inappropriate objects. Following this, remediation should focus on educational issues and developmental maturation rather than inappropriate sexuality.

In a review of variables associated with the perpetration of sexual offences in men with IDD, Lindsay (2005) noted that, surprisingly, there were no controlled studies of the counterfeit deviance hypothesis. There have now been two tests of this hypothesis. Michie et al. (2006) completed a test of counterfeit deviance by comparing the sexual knowledge of groups of sex offenders with IDD and matched control participants using the SSKAT (Wish, McCoombs & Edmondson, 1979; Griffiths & Lunsky, 2003). In the first comparison they found that of 13 SSKAT subscales, three (birth control, masturbation and sexually transmitted diseases) showed significant differences between the groups – in each case the sex offenders had

higher levels of sexual knowledge. In a second comparison, sex offenders were again compared with controls and significant differences between the groups were found on seven SSKAT scales – in each case the sex offenders showed a higher level of sexual knowledge. The authors presented two possible reasons for this finding. The first is that, by definition, the sex offender cohort has some experience of sexual interaction and they may have given some thought and attention to sexuality, at least in the period prior to the perpetration of the inappropriate sexual behaviour or sexual abuse. The second possibility is that the sex offenders might have a developmental history of increased sexual arousal which in turn may have led to selective attention and interest in sexual information gained from informal sources.

In a second, more detailed study, Lunsky et al. (2007) once again compared sexual offenders with controls but divided the sexual offenders into deviant persistent offenders (those who committed contact sexual offences and offences against children) and naïve offenders (public masturbation, indecent exposure). They found that the naïve offenders did indeed have a lower level of sexual knowledge than the deviant offenders, although the naïve offenders did not have poorer knowledge than the control group as might be expected from the counterfeit deviance hypothesis. However, the fact that they found differences in these subgroups of sexual offenders with IDD underlines the importance of assessment of sexual knowledge.

Although a number of assessments have been developed to assess cognitive distortions in sex offenders, as has been pointed out earlier, the language needs to be simplified considerably in order to be understood by individuals with IDD. Kolton, Boer and Boer (2001) employed the Abel and Becker Cognitions Scale and found that the four response options of the test needed to be simplified to a dichotomous system (agree/disagree) to reduce extremity bias in the sample. The revised assessment provided 'adequate' total score to item correlations and test re-retest reliability, and internal consistency was 'acceptable' (values not reported), and preserved the psychometric integrity of the assessment.

There have been a number of more recent developments specific to the assessment of sex offenders with IDD. Keeling, Rose and Beech (2007a) investigated the psychometric properties of simplified versions of a number of assessments relevant to this population. In order to assess validity and the integrity of their adapted measures, they compared these individuals with a wide range of IDD with mainstream sexual offenders. They found that the Social Intimacy Scale, the Criminal Sentiment Scale and the Victim Empathy Distortion Scale broadly retained their psychometric integrity after modification. One of the difficulties with this study is that it involved a convenience sample drawn from the Australian Correctional System and, as well as people with IDD, it included a diverse group of participants with borderline intelligence, low average IQ, significant literacy problems, and acquired brain injury.

Lindsay, Whitefield and Carson (2007) reported on the development of the Questionnaire on Attitudes Consistent with Sexual Offences (QACSO) which is designed to be suitable for offenders with IDD. The QACSO contains a series of scales which evaluate attitudes across a range of different offence types including: rape and attitudes to women, voyeurism, exhibitionism, dating abuse, homosexual assault, offences against children, and stalking. They compared sex offenders with IDD, non-sexual offenders with IDD, 30 non-offenders with IDD, and non-IDD controls who had not committed sexual offences. All items had an appropriate reading ease score and the response choices were dichotomous. The results of the study showed that six of the 7 QACSO scales were valid and reliable measures of cognitive distortions held by sex offenders with IDD (the exception was homosexual assault). Lindsay et al. (2006a) also found that the rape and offences against children scales in particular discriminated between offenders against adults and offenders against children in the hypothesised direction, with offenders against adults having higher scores on the rape scale and lower scores on the offences against children scale than child molesters. Therefore, it would appear that cognitive distortions in sex offenders with IDD can be assessed with some reliability and validity. However, changes in offence-related attitudes may reflect a number of processes such as suppression, influence by social desirability and even lying. The

authors recommended that post-treatment scores on the QACSO should be considered alongside a range of risk assessment factors including actuarial risk, socio-affective functioning, self-regulation abilities and observed behaviour.

4.4 Anger and aggression

Anger and aggression in individuals with IDD are areas which have attracted a reasonable amount of research when compared with other areas of socio-affective functioning. Studies by Benson and Ivins (1992) and Rose and West (1999) have indicated that a modified self-assessment measure of anger reactivity (the 'Anger Inventory') has some limited reliability and validity with people with IDD. Oliver et al. (2007) reported that the Modified Overt Aggression Scale (MOAS; Sorgi et al., 1991), an informant rated measure of the frequency and severity of aggression had high levels of inter-rater reliability when administered for a small number of people with IDD as part of a treatment outcome research study.

Novaco and Taylor (2004) evaluated the reliability and validity of several specially modified anger assessment measures with 129 detained male offenders with IDD. The Novaco Anger Scale (NAS; Novaco, 2003), the Spielberger State-Trait Anger Expression Inventory (STAXI; Spielberger, 1996), both self-report measures of anger disposition, and the Provocation Inventory (PI; Novaco, 2003), a self-report anger reactivity scale, along with the Ward Anger Rating Scale (WARS; Novaco, 1994) were evaluated. The modified anger self-report measures were found to have high internal consistency and less robust, but reasonable, test-retest reliability. The STAXI and NAS showed substantial intercorrelation providing evidence for the concurrent validity of these instruments. WARS staff ratings of patient anger were found to have high internal consistency and to correlate significantly with patient anger self-reports. Anger, self-reported by the patients, was significantly related to their record of assault behaviour in hospital. The NAS was found to be significantly predictive of whether the patient has physically assaulted others following admission to hospital and total number of physical assaults carried out.

In a further development, Taylor, Novaco, Guinan and Street (2004) developed the Imaginal Provocation Test (IPT) as an additional idiographic anger assessment procedure with people with IDD that taps key elements of the experience and expression of anger, is sensitive to change associated with anger treatment and is easily modifiable to be salient in a range of settings. The IPT produces four indices relevant to the individual client's experience of anger: anger reaction, behavioural reaction, a composite of anger and behavioural reaction, and anger regulation. They administered the IPT to 48 patients prior to beginning an anger treatment and showed that the indices had respectable internal reliabilities and reasonable concurrent validity when correlated with the STAXI and NAS. Therefore it would appear that there are rapid, flexible and sensitive idiographic assessments of anger among people with IDD.

Alder and Lindsay (2007) also produced an anger provocation inventory (the Dundee Provocation Inventory, DPI) which is easily accessible and easy to use. It is based on Novaco's (1975, 1994) analysis and construction of anger as an emotional problem. One of the facets of Novaco's analysis is that the individual may misconstrue internal and external stimulae and respond to a perception of threat. Alder and Lindsay (2007) found the DPI to be reliable. It correlated significantly with the NAS and highly significantly with the PI indicating that the DPI good convergence with established measures. They also found a five-factor structure consisting of threat to self-esteem, external locus of control, disappointment, frustration and resentment. The strongest factor was threat to self-esteem and this is consistent with Novaco's notion of anger being closely associated with threat.

Willner, Brace and Phillips (2005) developed the Profile of Anger Coping Skills (PACS) to assess the use by people with IDD of specific skills in managing angry situations. Informants are asked to rate client's use of eight anger management strategies in specific anger coping situations salient to that individual. The strategies assessed included use of relaxation skills, counting to 10, walking away calmly, requesting help, use of distraction activities, cognitive reframing, and being assertive. The PACS was found to have acceptable test, re-test and inter-rater reliability coefficients. It was also shown to be sensitive

to change associated with a community based anger management group – with participant's showing significant improvements in terms of cognitive reframing, assertiveness, walking away and asking for help.

4.5 Fire setting

Despite the importance of this issue in societal terms, there are relatively few published studies regarding the assessment and treatment of adult fire setters, and the literature concerning clinical practice with fire setters with IDD is even more limited. Murphy and Clare (1996) interviewed 10 fire setters with IDD concerning their cognitions and feelings prior to, and after setting fires using a newly developed Fire Setting Assessment Schedule (FSAS). Participants were also asked to rate their feelings in relation to a series of fire related situations described in a new 14-item Fire Interest Rating Scale (FIRS). The construction of the FSAS was guided by the functional analytical approach to fire setting proposed by Jackson, Glass and Hope (1987) in which it is proposed that fire setting is associated with a number of psychological functions including the need for peer approval, need for excitement, a need to alleviate or express sadness, mental illness, a wish for retribution and a need to reduce anxiety.

Murphy and Clare (1996) found that the participants in their study identified antecedents to fire setting with more reliability than consequences. The most frequently endorsed antecedents were anger, followed by being ignored and then feelings of depression. This assessment has proven to be clinically useful since its inception, but there has been little further research on its reliability and validity until Taylor, Thorne, Robertson and Avery (2002) used the FSAS in the assessment and treatment of a group of 14 people with IDD to review the effectiveness of a fire setting programme for this client group. Consistent with the results of Murphy and Clare (1996), Taylor et al. (2002) found that anger, being ignored and depression (in rank order) were the most frequently endorsed items on the FSAS in terms of antecedents to and consequences of participants' fire setting behaviour. In a further study on women with IDD who had set fires, Taylor et al. (2006) also found that anger and depression were the most frequently endorsed items in participants prior to fire raising incidents.

5. Treatment (especially criminogenic)

5.1 Sexual offending

Until relatively recently, behavioural management approaches dominated the field of intellectual disability and, as with interventions for aggression, the most common psychological treatments for management of sexual offending have been applied behavioural analysis (ABA)-type approaches (Plaud, Plaud, Colstowe & Orvedal, 2000).

Griffiths, Quinsey and Hingsburger (1989) developed a comprehensive behavioural management regime for sex offenders with IDD. Their programme included addressing deviant sexual behaviour through education, training social competence and improving relationship skills, reviewing relapse prevention through alerting support staff and training on issues of responsibility. In a review of 30 cases, they reported no re-offending and described a number of successful case studies to illustrate their methods. Others have also described similar positive outcomes with behavioural management approaches (Haaven, Little & Petre-Miller, 1990; Grubb-Blubaugh, Shire & Baulser, 1994). In their review, Plaud et al. (2000) described aversion therapy and masturbatory retraining techniques in some detail. Although there are few reports on the use of these methods with offenders with IDD, Lindsay (2004, 2008) has described the successful employment of imagined aversive events to control deviant sexual arousal and routines.

A major recent development in the use of psychological treatment for sex offenders with IDD has been the employment of cognitive and problem-solving techniques within therapy. These methods have been shown to result in significant reductions in recidivism rates with mainstream offenders (see Hanson et al., 2002 for a meta-analytic review). The essential assumption in cognitive therapy is that sex offenders may harbour cognitive distortions which support the perpetration of sexual offences. These distortions include mitigation of responsibility, denial of harm to the victim, thoughts of entitlement, complete denial that an offence occurred, etc.

Assessments described above represent attempts to evaluate the extent to which sex offender patients hold a range of cognitive distortions and the QACSO is specifically designed for this purpose in offenders with IDD.

Support for the centrality of cognitive distortions in sexually aggressive behaviour came from a qualitative study of nine male sex offenders with IDD by Courtney, Rose and Mason (2006), using grounded theory techniques. In the analysis of interviews with participants they concluded that all aspects of the offence process were linked to offender attitudes and beliefs such as denial of the offence, blaming others and seeing themselves as victims. Therefore a crucial aspect of treatment is to explore these issues of denial and other cognitive distortions. Lindsay et al. (1998a, b, c) reported on a series of case studies with offenders with IDD using a cognitive behavioural intervention in which various forms of denial and mitigation of the offence were challenged over treatment periods of up to three years. Across these studies, participants consistently reported positive changes in cognitions during treatment. This component of the intervention was evaluated using the QACSO (Lindsay, Whitefield & Carson, 2007). Reductions in the number of endorsements given to cognitive distortions were found following extended treatment periods and these improvements were maintained at one-year minimum follow-up. Further, longer follow-up of these cases (4 – 7 years) showed that none had re-offended following initial conviction.

Rose et al. (2002) reported on a 16-week group treatment for five men with IDD who had perpetrated sexual abuse. The group treatment included self-control procedures, consideration of the effects of offences on victims, emotional recognition and strategies for avoiding risky situations. Individuals were assessed using the QACSO attitudes scale, a measure of locus of control, a sexual behaviour and the law measure and a victim empathy scale. Significant differences from pre to post-treatment were found only on the locus of control scale. The authors noted that the length of treatment was somewhat short in comparison to the majority of sex offender treatment programmes, which usually last from 12–18 months. However, they reported that participants had not re-

offended at one-year follow-up. Rose et al. (2007) reported on a further six-month treatment group for sex offenders living in community settings. Basing part of their programme on the theoretical model expounded by Lindsay (2005), they made efforts to involve aspects of the offender's broader social life into treatment by inviting carers to accompany participants. They found significant improvements on the QACSO scale, positive changes in a locus, and no known re-offending at 12-month follow-up.

Although there are a number of treatment comparison studies evaluating the effects of sex offender treatment, they are quite limited methodologically. Lindsay and Smith (1998) compared seven individuals who had been in treatment for two or more years with another convenience group of seven clients who had been in treatment for less than one year. There were no significant differences between the groups in terms of severity or type of offence. The group that had been in treatment for less than one year showed significantly poorer progress and those in this group were more likely to re-offend than those treated for at least two years.

In a further series of comparisons, Lindsay and colleagues have compared individuals with IDD who have committed sexual offences with those who have committed other types of offences. Lindsay et al. (2004b) compared 106 men who had committed sexual offences of sexually abusive incidents with 78 men who had committed other types of offences or serious incidents. There was a significantly higher rate of re-offending in the non-sexual offender cohort (51 per cent) when compared to the sex offender cohort (19 per cent). In a subsequent, more comprehensive evaluation, Lindsay et al. (2006) compared 121 sex offenders with 105 other types of male offenders and 21 female offenders. Re-offending rates were reported for up to 12 years after the index offence. The differences in re-offending rates between the three groups was highly significant with rates of 23.9 per cent for male sex offenders, 19 per cent for female offenders and 59 per cent for other types of male offenders. The significant differences were evident for every year of follow-up except Year 1.

These authors also investigated harm reduction by following up the number of offences committed by recidivists and found that for those who had re-offended, the number of offences following treatment, up to 12 years, was a quarter to a third of those recorded before treatment, indicating a considerable amount of harm reduction as a result of intervention. Therefore, although these treatment comparisons have been less than satisfactory in terms of their experimental design, there are some indications that treatment interventions may significantly reduce recidivism rates in sex offenders with IDD.

Based on the limited evidence available, it is possible to conclude tentatively that in terms of treatment of sex offenders with IDD, psychologically informed and structured interventions appear to yield reasonable outcomes. Cognitive behavioural treatment may have a positive effect on offence related attitudes and cognitions and longer periods of treatment result in better outcomes that are maintained for longer periods.

5.2 Anger and aggression

There is a reasonable research base for interventions for aggression in the Applied Behavioural Analysis (ABA) field. Taylor and Novaco (2005) summarised the literature in this area, describing several extensive reviews, and concluding that ABA-type behavioural interventions that are generally applied to low functioning individuals in institutional settings, may not be as effective for anger and aggression problems observed in forensic IDD populations. These populations are relatively high functioning in intellectual terms, display low frequency but very serious aggression and violence, and live in relatively uncontrolled environments. The majority of research on interventions for aggression with offenders with IDD has evaluated the anger management treatment approach of Novaco (1975, 1994). In contrast to ABA-type treatments, anger management is a 'self-actualising' treatment that promotes generalised self-regulation of anger and aggression. The approach employs cognitive restructuring, arousal reduction and behavioural skills training. Importantly, anger management treatment incorporates Meichenbaum's (1985) stress inoculation paradigm.

Taylor (2002) and Taylor and Novaco (2005) reviewed a number of case series studies and uncontrolled group anger treatment studies involving individual and group therapy formats, incorporating combinations of cognitive behavioural techniques including relaxation and arousal reduction, skills training and self-monitoring. Generally they produced good outcomes in reducing anger and aggression and these were maintained at follow-up. Several case studies have reported successful outcomes in people with histories of aggressive behaviour in hospital and community settings (Murphy & Clare, 1991; Black & Novaco, 1993; Rose & West, 1999). There have also been a small number of studies of cognitive behavioural anger treatment involving offenders with IDD that have yielded positive outcomes. Allan, Lindsay, Macleod and Smith (2001) and Lindsay, Allan, Macleod, Smith and Smart (2003) reported on group behavioural anger interventions for a series of five women and six men with IDD respectively. The participants in these studies were living in community settings and they had all been referred following violent assaults resulting in criminal justice system involvement. In both studies, improvements were reported for all participants at the end of treatment that were maintained at 15 months' follow-up. Burns, Bird, Leach and Higgins (2003) reported on the results of a CBT framed group anger management intervention for three offenders with IDD residing in a specialist NHS medium secure unit. Using multiple assessment points to carry out time series analyses, the results for the participants were mixed in terms of self-reported anger and informant related aggression measures. The authors suggested that the relatively short length of the modified intervention and unstable baseline measures contributed to limited treatment effects observed.

More recently there have been a number of treatment trials involving people with IDD and offending histories that have shown the effectiveness of cognitive behavioural anger treatment over waiting list/no treatment control conditions. Lindsay et al. (2004) reported a controlled study of group cognitive behavioural anger treatment for individuals living in the community and referred by the court or criminal justice services. Several outcome measures were used including the DPI, provocation role plays and self-report diaries over

a follow-up period of 15 months. Aggressive incidents and re-offences were also recorded for both the treatment group and the waiting list control group. There were significant improvements in anger control on all measures with significant differences between the treatment and control groups. In addition, the treatment group recorded significantly fewer incidents of assault and violence at the post-treatment assessment point (14 per cent compared with 45 per cent). There was evidence that anger management treatment had a significant impact on the number of aggressive incidents recorded in these participants in addition to improvements in the assessed psychological variables.

Taylor, Novaco, Gillmer and Thorne (2002), Taylor, Novaco, Guinan and Street (2004) and Taylor, Novaco, Gillmer, Robertson and Thorne (2005) have evaluated individual cognitive behavioural anger treatment with detained male patients with mild borderline IDD and significant violent, sexual and fire raising histories in a series of waiting list controlled studies. The 18 session treatment is based on individual formulation of each participant's anger problems and needs, that follows the classical cognitive behavioural stages of cognitive preparation, skills acquisition, skills rehearsal and then practise in vivo. These studies showed significant improvements on self-reported measures of anger disposition, anger reactivity and behavioural reaction indices following intervention in the treatment groups compared with scores for the control groups, and these differences were maintained for up to four months following treatment. Staff ratings of study participants' anger disposition conferred with patients' reports but did not reach statistical significance.

In summary, an emerging evidence base suggests that cognitive behavioural interventions can be effective for this population with regard to its self-report and informant anger measures and socially valid indices of the number of incidents carried out by offenders with IDD following treatment.

5.3 Fire setting

A number of case studies have been reported on the treatment of fire-setters with IDD. Rice and Chaplin (1979) conducted an early study that involved social skills training for two groups of five fire-setters in a high security psychiatric facility in North America. One of the groups was reported to be functioning in the mild-borderline IDD range. Following treatment, both groups improved significantly on a reliable observation scale of role played assertive behaviour. At the time of reporting, eight out of the ten patients treated in the study had been discharged for around 12 months with no reconviction or suspected fire setting.

Clare, Murphy, Cox and Chaplin (1992) reported a case study involving a man with mild ID who had been admitted to a secure hospital following convictions for two offences of arson. He had a prior history of arson and making hoax calls to the fire service. Following his transfer to a specialist in-patient unit, using a comprehensive treatment package, including social skills and assertiveness training, development of coping strategies, covert sensitisation and facial surgery (for a significant facial disfigurement), significant clinical improvements were observed in targeted areas. The client was discharged to a community setting and had not engaged in any fire related offending behaviour at 30 months follow-up.

Taylor, Thorne and Slavkin (2004) reported a case series of four detained men with IDD and convictions for arson offences. They received a cognitive behavioural, 40 session group based intervention that involved work on offence cycles, education about the costs associated with setting fires, training skills to enhance future coping with emotional problems associated with previous fire setting behaviour and work on personalised plans to prevent relapse. The treatment successfully engaged these patients, all of whom completed the programme delivered over a period of four months. Despite their intellectual and cognitive limitations, all participants showed high levels of motivation and commitment that was reflected in generally improved attitudes with regard to personal responsibility,

victim issues and awareness of risk factors associated with their fire setting behaviour.

In a further series of case studies on six women with mild-borderline IDD and histories of fire setting, Taylor et al. (2006) also employed the same group intervention as reported by Taylor, Thorne and Slavkin (2004). The intervention successfully engaged participants in the therapy process, all completed the programme and scores on measures related to fire treatment targets generally improved following the intervention. All but one of the treatment group participants had been discharged to community placements at two year follow-up and there had been no reports of participants setting any fires or engaging in fire risk related behaviour.

Using the same assessment and treatment approach as that used by Taylor, Thorne et al. (2004), Taylor, Thorne, Robertson and Avery (2002) investigated the outcomes for 14 men and women with IDD and arson convictions. Study participants were assessed pre- and post-treatment on a number of fire-specific, anger, self-esteem and depression measures. Following treatment significant improvements were found in all areas assessed, except for depression.

The results of these small and methodologically weak pilot studies do provide some limited encouragement and guidance to practitioners concerning the utility of group-based, cognitive-behaviourally orientated interventions for fire setting behaviour by people with IDD.

5.4 Recidivism

Follow-up studies of offenders with IDD have reported recidivism rates of up to 72 per cent (Lund, 1990). However, as for prevalence studies involving people with IDD, reported recidivism rates vary a great deal for many of the same methodological reasons. These issues notwithstanding, in a US study involving 252 offenders with IDD subject to a case management community programme, Linhorst et al. (2003) found that 25 per cent of programme completers were re-arrested within six months of finishing the programme, compared with 43 per cent of those who dropped out of the programme. While there is a dearth of controlled studies comparing recidivism rates for

offenders with IDD and non-IDD offenders, in another US study 43 per cent of 79,000 general offenders on probation were re-arrested (Langan & Cunnliff, 2002). In a more recent UK study, Gray et al. (2007) conducted a two-year follow-up of 145 offenders with IDD and 996 offenders without IDD all discharged from independent sector hospitals. The IDD group had a lower rate of reconviction for violent offences after two years (4.8 per cent) than the non-IDD group (11.2 per cent). This trend also held true for general offences (9.7 per cent for the IDD group and 18.7 per cent for the non IDD group). Thus, based on the limited data available to date, it is not clear that recidivism rates for offenders with IDD are very different to those for general offenders.

Setting aside the methodological vexations of comparing those with IDD and other studies of offenders, with specific reference to IDD offenders, shorter duration of both institutional as well as community-based treatments is associated with poorer progress and greater likelihood of reconviction. A period of at least two years of active treatment appears to be indicated for more successful outcome. High rates of recidivism also suggest that there is a problem of generalisation of treatment effects across treatment settings. Institutional treatment needs to be planned and contiguous with contemplated community settings and cannot be left to chance or as an addendum (Lindsay, 2004).

Most offenders with IDD do not have jobs. Meaningful employment has been anecdotally described as the single strongest predictor of not re-offending. The notion of the offender with IDD as the archetypal 'fall-guy/doll' is another appealing empirical conjecture in search of confirmation.

6. Substance misuse

People with learning disabilities are less likely to misuse substances but those who do experience the same problems as other misuse populations. The level of abstinence is higher, and the level of problematic use is low; however, for those who do use alcohol, a higher proportion is prone to misuse. The relatively small group of people with IDD who use substances are hard to manage because they tend to fall between services and are prone to engage in generally high-risk behaviours before they offend significantly and as a result receive attention (Sturmey, Reyer & Lee et al., 2003). There is a pressing need for interactive crossover services to develop pathways of clinical care for these vulnerable at-risk people who currently face admission barriers. These often take the form of bureaucratically driven diagnostic gateways. It may be that only when the person with IDD hits some forensic threshold that associated or even causal substance misuse gets addressed, if at all.

In terms of learning disability there may be a secondary or concurrent diagnosis of substance misuse that adversely affects mental health and level of functioning. Withers and Hodge's occasional briefing paper (unpublished) highlights a 'hypersensitivity phenomenon' for people with IDD. This may be especially true those who fall within the group identified by Holland (2004) as having a neuro-developmental aetiology. Certainly patients with IDD demonstrate a much lower threshold to psychotropic medication (O'Brien, 2002).

It appears that offenders with IDD characteristically use larger quantities of substances more frequently than non-offending cohorts and half of such offenders are under the influence of substances at the time of the commission of the offence (McGillivray & Moore, 2001). Anecdotally, this is true of the experience of many in working with this population. There are similar early predictors, like difficult temperament, aggression and hyperactivity during childhood, for both substance misuse and offending, particularly violent offending, across the lifespan. Those children who show early behavioural problems and progress to conduct disorder are most likely to persist

with antisocial behaviours, and to substance misuse (Withers & Hodge, unpublished). The link is so strong, that it has been suggested that traits of impulsivity and aggressiveness possibly underpin both substance misuse and antisocial and borderline personality disorders.

In forensic services in general, the contribution of substance misuse to risk is often understated or ignored. It is not known whether this risk link extends to IDD to the same extent, yet it is difficult to escape the conclusion that substance abuse is a major risk factor contributing to offending and re-offending. Many studies that Withers and Hodge cite indicate the much higher prevalence of substance misuse in prison populations than in the general population; the contribution of substance use to crime, particularly violent crime; the proportion of offenders who were intoxicated or had used substances at the time of the offence in high secure hospital populations. Indeed, the single most reliable predictor of re-offending in people discharged from Special Hospitals is the existence of an alcohol problem prior to their admission. The authors imply that treatment of substance abuse alone may be effective in reducing offending, particularly violent offending and challenge the view that the best way of reducing risk is to deliver offence-focussed programmes.

The nature of the relationship between mental disorders and substance misuse is complex. Within forensic settings it is important to assess co-morbid mental disorder and substance use and PTSD symptomatology. The following areas need to be examined: mental illness, personality disorder, learning disability, mood disorders, the misuse of alcohol, the misuse of illicit drugs, and the interrelationships among these (McMurran, Blair & Egan, 2002) as well as PTSD. However a thorough assessment cannot be completed while significant substance misuse continues. How substance use impacts on the assessment of risk of violence and self harm requires further consideration, and a formulation which includes a functional analysis of the substance use and its impact on risk behaviours needs to be developed.

There is relatively little specific literature on people with IDD and substance misuse problems. Treatments are less well developed and tend to be cognitively simpler, more behavioural, less confrontative, more directive, more educational, of longer duration, and more likely to include the person's family.

7. Co-morbidity

People with IDD have a high prevalence (20 per cent) of mental disorder, pervasive developmental disorder and a range of neuro-psychiatric disorders arising from inherent brain damage (Taylor, et al., in press). This is also true of the offender sub-population which carries major implications for treatment and management by the multi-disciplinary team. The interaction of autism with offending is complex, because of obsessive fixations, misunderstanding by others of their motivations and panic-induced aggression. Epilepsy figures highly with poor control, behavioural disturbance, aggression and irritability. The prompt assessment, diagnosis and treatment through every stage of a programme is crucial to optimise engagement in and progress in treatment and maintenance of treatment effects.

8. Implications of new legislation

Relevant legislation affecting work with offenders with IDD, or those at risk of offending, includes the following:

- Mental Capacity Act (2005)
- Amendments to Mental Health Act (1983/2007)
- Sexual Offences Act (2003)
- Criminal Justice Act (2003)
- Disability Discrimination Bill (2004)
- Relevant Scottish legislation (especially Mental Health (Care and Treatment) (Scotland) Act 2003)

- Relevant amending and ancillary legislation in Wales (MHA Code of Practice) and Northern Ireland (Mental Health (Amendment) (Northern Ireland) Order 2004).

The mental health legislation, in its confused emergence, must be approached as a composite raft of political opinion about and toward people with putative IDD. Most of these documents do not actually mention IDD specifically so it is necessary to pick one's way carefully through the collectively most significant mental health law reform in 50 years.

The emphasis is on English legislation as it is there that extended roles for psychologists are most promising. The Bamford review in Northern Ireland indicates that mental capacity and mental heath provisions will be encompassed in a single piece of legislation. Within that there are considerations, but no more, of a widening of professional roles. As yet, in Scotland, the primary responsibility for detained patients remains an exclusively medical domain.

The clearest indication, in England and Wales, of a reactive legislative groundswell away from public order toward care lies in the pre-legislative concession that the final draft of the 'Incapacity' Bill would be entitled the Mental Capacity Act (MCA), with the emphasis on day to day respectful actualising of a variably able person's decision-making. A functional approach is adopted regarding each decision, with defined 'best interests' and the trusting relationship of the carer to the disabled being foregrounded over formal judicial process.

The principles of the MCA guide the process of assessment and of decision-making:

- A person is assumed to have capacity.
- All practical steps must be taken to aid decision-making.
- Unwise decisions do not equate to incapacity.
- Decisions made on behalf of a person who lacks capacity must be made in their best interests.
- The least restrictive alternative must be considered to attain the specified goal.

There is a clear interface between the Mental Capacity and Mental Health Acts reflected in the deprivation of liberty safeguards appearing through the promulgation of the Mental Health Act (2007), which closes the so-called 'Bournewood gap', whereby patients who lack capacity can no longer be informally detained without an explicit and complex legal process.

This Mental Capacity Act (MCA) should now set the tone for the interpretation and practice of the Mental Health Act (2007) (MHA). There was never much prospect that the amended MHA would be influenced by its Scottish counterpart, particularly with regard to 'significantly impaired decision-making'. However, what is certain is that the MCA, MHA and related legislation must dovetail. The Sexual Offences Act (2003), for example, proscribes sexual activity with a person with any mental disorder (including IDD) that in any way affects that person's capacity to exercise choice. A mental disorder that affects ability to choose, as defined in this Act, must be compatible with the MCA's requirement for adequate knowledge of, meaning of, and consequence of a sexual act, and with the ability to communicate choice. Care workers helping service users to exercise some advocated or perceived sexual choice need to be mindful of the risk of in good faith, but unlawfully, inducing a person who lacks that capacity to embark on an intervention that may arguably be 'politically motivated' in the interests of 'right to choose'. Policies will need to be developed to reflect the delicate balance required between advocacy of choice and management of risk in sexual relationships between people where at least one has a IDD.

The proposed Disability Discrimination Bill is similar in scope and intent to the Race Relations Act and obliges local authorities to make provision for positive non-discrimination of people with disabilities. There are particular challenges for those concerned with the rights of offenders with IDD to be appropriately and safely housed and to be provided with meaningful employment to underpin the attainment of a lifestyle less compatible with offending.

The MHA (2007) came into effect on 3 November 2008. It has major implications for applied psychologists in England and Wales, particularly in the extension of the professional role of the former

Responsible Medical Officer to non-medical health professionals, who possess the relevant competencies, in appropriate cases. Once they are Approved Clinicians (ACs), such psychologists can be appointed as the Responsible Clinician (RC) and may lead the care of a particular patient. It is now Department of Health policy that the patient's RC should be the available AC with the most appropriate expertise to meet the patient's main treatment needs (National Institute for Mental Health in England, 2008). When psychological therapies are the main treatment it may be appropriate for a psychologist to lead the team as the RC in the management of that patient's care. It is through clinical leadership, by the assumption of these functions and roles and the implicit shift in power from psychiatry that psychologists can in future effect strategic changes to current practice in forensic settings. Offenders with IDD and who are detained are likely to be among the most appropriate patients for non-medical RCs, especially when medication is not a major part of treatment. Forensic IDD services are in the vanguard of the field trial sites for early implementation (Gillmer & Taylor, 2008) and already clinical psychologists have been deployed as RCs.

Although the definition of mental disorder has been considerably widened and categories removed, 'learning disability' (which falls within the rubric of IDD) is included where it is associated with abnormally aggressive or seriously irresponsible conduct. In March 2006, 1098 patients were detained under the MHA (2003) within the mental impairment categories (7.5 per cent of 14,625) (Taylor et al., 2007, in press). Proportionately, far more of those detained under criminal orders were categorised as mentally impaired than those under civil orders. Assuming a normal distribution, more than double the expected number of people with impaired intellectual functioning are being detained in NHS facilities, whilst in the independent sector one in six patients have mental impairment. The drift to forensic institutionalisation is striking. As prospective RCs this will become a direct concern for psychologists.

There is a new provision for Supervised Community Treatment (SCT), which is initiated by a Community Treatment Order (CTO). Such Orders can specify behavioural requirements (like not going into pubs unaccompanied) that are devised to prevent readmission.

Whilst there is concern that CTOs will herald an incontinence of newly restricted persons, the proper application of such powers has the potential to provide pro-active pathways of care for at-risk people with IDD with complex needs who have offended or are very likely to do so. The declared intent of these powers is for the 'revolving door' patient, who is well known to services and who could be helped to retain a precarious hold on community life by the prosthetic of well managed, statutorily imposed non-residential care.

There are far reaching implications for psychologists in forensic practice. The British Psychological Society has been at the forefront of the development of approvals processes, training requirements, and employer guidelines (National Institute for Mental Health in England, 2008). Guidance, supplementary to the *Code of Practice* and especially though not exclusively intended for psychologists seeking approval, is available (British Psychological Society, 2009). There is, however, no nationally agreed or recommended training course for non-medical professionals to develop their competencies in preparation for AC approval. In order to demonstrate the full range of AC/RC competencies, psychologists may need to acquire additional skills, knowledge and experience through CPD and access to appropriate specific training. This need will vary for individual psychologists seeking approval. Some preparatory training programmes (for example, Northumbria University's Professional Practice in Law (Mental Health)) are being piloted through early implementer field test sites. Most recently the BPS's own Mental Health Act Working Party has set up a pre-approval scrutiny panel to support and guide psychologist applicants and employers of non-medical approved clinicians (BPS, 2010).

9. Jurisprudence and IDD

9.1 Competence and consent

Gudjonsson's pioneering work (Gudjonsson et al., 2000) showed that people with IDD are disadvantaged during interrogative interview, especially if under-represented from the earliest stages of an investigation. This disadvantage may extend even to simplified cautions (Hayes, 1996). However, Beail (2002) questioned the applicability of suggestibility scales in real-life settings. Concerns about competency are important because evidence based on a confession has to be voluntary, knowing and intelligent (Baroff, Gunn & Hayes, 2004). These authors provide a thorough account of the difference between assessing competence (to stand trial) and responsibility (for one's acts). Knowing that an act is criminally wrong is quite distinct from being fully responsible for its commission (Baroff, 1996). Previously there was a global judgement that people with significant IDD were incapable of forming intent and thus being responsible for their actions. Modern English jurisprudence has moved to the individual case (Baroff et al., 2004). The presence of IDD, whilst not necessarily an excuse, may provide a basis for a more reasoned explanation for an act and for an appropriate judicial disposal (see 5.2 Fire setting: 'only viable alternative' theory as an example).

9.2 Witnesses

There is small but respected body of knowledge in the professional research literature that is concerned with adaptations that can be made to court proceedings in order to improve the probity of the evidence of witnesses with IDD (especially Kebbell, Hatton & associates 1999-2004).

People with IDD, when they are witnesses, generally believe that:

- they must provide a definite answer;
- they should know the answer to the question; and
- they are expected to know the answer and to be able to provide it. (Gudjonsson & Clark, 1986).

It may be most helpful at the outset of the proceedings and from time to time to correct such misconceptions.

The accuracy and completeness of testimony by people with learning disabilities can be appreciably enhanced by suitable questioning strategies:

- The most accurate answers are provided to open, free recall questions (i.e. what the defendant spontaneously remembers). Such information is generally not especially complete. It tends to be limited in extent, which does not necessarily equate to withholding information. People with IDD simply recall fewer details.
- As questions become more focussed and closed, accuracy proportionately decreases (i.e. what the questioner wants the witness to remember).
- People with IDD are generally more suggestible to leading questions, especially when the witness is unsure about the facts.

Research indicates that witness evidence is especially enhanced when those with IDD are asked to reinstate the context regarding the incident.

The court interview procedures have a direct influence on IDD witnesses' performance. In direct examination, due to its generally open ended nature, people with IDD usually provide fairly accurate though often incomplete accounts. However, during cross examination, which is often directed to discrediting their evidence, such accuracy may diminish, particularly with the use of:

- complex legal language and syntax (especially negatives and multi-part questions);
- many closed questions;
- leading questions in particular; and
- focus on peripheral information as opposed to the central details.

In practice it has been found (Kebbel et al., 2004) that the court's actual questioning of witnesses with IDD is virtually identical to that of witnesses from the general population. Similar to the above finding for solicitors (Kelly et al., 2003 and based on Crown Court

records), judges themselves do not generally intervene in any differential way when dealing with witnesses who have IDD. As a result, witnesses with IDD, who are potentially capable of providing good evidence in court, are effectively prevented from doing so by inflexible barrister techniques and judges who do not use their discretion to intervene on the witnesses' behalf in the interests of clarification of language or simplification of procedure (as they would, for example, with a child).Yet the evidence is clear that officers of the court can help to substantially improve the probity of such evidence by the basic means of:

- simplifying question and style;
- calling breaks;
- suggesting methods by which witnesses can reply; and
- preventing oppression of witnesses and when necessary asking counsel to move on.

10. Recommendations for best practice

10.1 Nomenclature

The term intellectual and developmental disability (IDD) best captures the breadth of this population and should be adopted routinely. Within this construct specific diagnoses or syndromes should be used.

10.2 Epidemiology

The relationship between IDD and offending remains uncertain. There is a need to guard against any assumption that people with IDD have a particular propensity to offend, although they may have particular criminogenic pathways. People with IDD are at higher risk of detention under the MHA. It is recommended that models depicting life trajectories and the contributory influences of vulnerability and resilience to risk become a focus of theoretical development.

10.3 Assessment

A number of adapted measures are achieving satisfactory levels of validity and reliability. There is no systematic information on risk assessment, though preliminary studies show that similar historical and especially dynamic risk factors apply to offenders with IDD; this is particularly true for violent and sexual offenders.

Considerable work needs to be done on the development of tools for this offending population. Pooling of locally developed adaptations and norms is urged. Greater use of behavioural observation and informant data is recommended.

10.4 Intervention

General

Intervention programmes with the greatest prospect for success are:

- structured;
- have good arrangements for ensuring treatment fidelity and integrity;

- have a clear underpinning model with a theoretical base;
- are guided by a protocol; and
- are adapted from proven methods for the IDD population.

Sexual offending

Treatment programmes which show most promise

- extend to two years and beyond;
- have a strong CBT underpinning;
- are group based; and
- emphasise the confrontation of cognitive distortion and development of risk management.

Better evaluation of outcomes is required, bearing in mind the complementary value of empirical process research.

Anger and aggression

Individual CBT, for both men and women, adapting Novaco's anger model, is showing positive preliminary findings. Such short-term interventions should be regarded as ancillary to longer specific criminogenic programmes. Anger treatment is distinct from management, being formulated and less educational.

Fire setting

Group interventions for both men and women fire-setters (who are an over-represented sub-group) have been developed, though studies lack methodological rigour. The emphasis should be on developing adaptive empowerment via more effective communication. Individual formulations are necessary.

10.5 Recidivism

Active treatment exceeding two years is associated with better outcome, whether community- or institution-based. The transition from hospital to residential setting needs seamless collaborative planning. Meaningful employment and the maintenance of an established lifestyle that is less compatible with offending are strongly associated with lower recidivism, irrespective of earlier interventions.

10.6 Substance misuse

Because of a propensity for hypersensitivity to alcohol and drugs, and the frequent association of misuse and offending, this may be the most overlooked and important risk area for offenders with IDD. This may be particularly true of violent offenders. It is recommended that offence-focussed programmes incorporate substance misuse within the individual formulation.

10.7 New legislation

There are enormous practical, ethical, and political challenges in emerging legislation. These will have implications for training, policy and new professional roles. It is recommended that every practitioner working in the field ensures they remain up to date with this as part of their CPD.

10.8 Jurisprudence

There are a range of simple adaptations that can be made to improve the probity of evidence provided by witnesses with an IDD. Practitioners should see it as their role and responsibility to advise courts and officers to adopt these where appropriate.

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References are arranged by relevant heading for convenience.
A supplementary reading list is appended

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