

SPECIAL NOTE

Following the consultation period during 2004, and at the request of the Forensic Network Advisory Board, Prof Bill Lindsay, Dr Steve Young and Dr Fergus Douds reviewed this report paying particular attention to in-patient facilities. This resulted in a paper being presented to the Advisory Board on 11 March 2005. The Advisory Board agreed that this paper should be added to this report as an addendum and it can be found at page 24 of this report.

**FORENSIC MENTAL HEALTH SERVICES
MANAGED CARE NETWORK
REPORT FOR THE LEARNING DISABILITIES SERVICE
WORKING GROUP**

Forensic Mental Health Services
Managed Care Network

Report for the Learning Disabilities Service Working Group

Background

The group is multi-professional with representation from both social work and health service staff. Membership is taken from across Scotland, helping to provide the group with an overview of forensic learning disability services in the country. The group met on November 3rd 2003 and January 14th 2004 in order to address the following remit.

Group Remit

- Propose opinions on best configuration of services for forensic learning disability cases
- Address any requirements for high security
- Estimate the size of the population in Scotland
- Consider how these services will fit in to an overall national plan
- Consider any gaps in the working group membership
- Provide costing plans if possible
- Work within a timescale of SIX months

The timescale has been very short. However, group members have contributed time and expertise to the report. Dr Karen Moody has provided excellent support for the working group. It is expected that committee members will wish to amend sections of the draft report in the light of local comments and comments from the Forensic Mental Health Services Managed Care Network Advisory Board.

Membership of Learning Disabilities Services Working Group

Chair: Professor Bill Lindsay	Consultant Forensic Clinical Psychologist	The State Hospital / NHS Tayside Primary Care Trust
Facilitator: Dr Karen Moody	Clinical Effectiveness Facilitator	The State Hospital
Dr Fergus Douds	Consultant Psychiatrist	Royal Edinburgh Hospital /Lynebank Hospital, Fife
Alex Davidson	Head of Adult Services	South Lanarkshire Social Work
Dr Steve Young	Consultant Psychiatrist	The State Hospital
Dr Anne Smith	Consultant Psychiatrist	Learning Disabilities Service Carseview Centre
Beth Wilson	Project Manager - Learning Disabilities	Forth Valley Primary Care Trust
Dr Bruce Kidd	Head of Learning Disabilities Psychology Department	Dumfries and Galloway Health Board
Dr Margaret Whoriskey	Advisor (Disability Services)	NHS Quality Improvement Scotland
Donellen MacKenzie	Senior Social Worker	Highland Council
Gail Crawford	Service Manager - Mental Health	Dundee City Council
Janice Turnbull	Senior Nurse - Training & Development	Greater Glasgow Primary Care Trust Leverndale Hospital
Maria Dawson	Chartered Clinical Psychologist	Community Learning Disability Team , Elgin
Mark Ashby	Formerly Acting Head of Occupational Therapy	The State Hospital
Dr Louise Ramsay	Consultant Psychiatrist	Greater Glasgow Primary Care Trust Leverndale Hospital
Sheila Gillies	Principal Officer Adult Services	Renfrewshire Council
Mike Tait		People First Scotland
Fiona Wallace		People First Scotland
Cindy Wallis	Service General Manager, Learning Disabilities	NHS Argyll and Clyde

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1. EXECUTIVE SUMMARY OF RECOMMENDATIONS

- 1.1 Hospital closures have increased the need for robust, flexible forensic learning disability services.
- 1.2 There is an urgent requirement for the spread of good practice and establishment of assessment, treatment and support services to allow equal access across Scotland.
- 1.3 Service development should be focused primarily in the community
- 1.4 Services should be underpinned by multi-agency risk assessment/management groups, identifying and targeting resources at the individuals presenting with the most significant levels of risk.
- 1.5 There is an urgent need for NHS Boards and local authorities to commission robust community services, including specialist residential placements.
- 1.6 There should be a move towards there being specialist care providers working in the community in this challenging field.
- 1.7 There should be linkage across and between all secure facilities, i.e. in both community and in-patient settings.
- 1.8 There is probably an adequate number of secure learning disability in-patient beds in Scotland, but an overweighting of beds at the high secure end of the spectrum. Regional planning groupings are required to develop close supervision/enhanced low secure facilities. Limited access to regional medium secure beds will occasionally be required for assessment/treatment.
- 1.9 All regions should develop specialist multi-agency forensic learning disability teams. There should be emphasis on the development of necessary links with criminal justice services, including specialist input into police stations, courts and prisons.
- 1.10 Early identification and intervention for young people is required; too often specialist therapeutic interventions are not available for young people with learning disabilities.
- 1.11 Provision should be made within Learning Disability services for the small number of learning disabled women who have forensic needs.
- 1.12 There should be access to advocacy across all services.

2. INTRODUCTION

2.1 National Policy Context

The needs of people with learning disabilities and the way services are provided is part of the wider policy and legislative framework governing services in Scotland. *Joint Future*¹ provides the organisational arrangements to ensure that health and social work services work together. From April 2004 learning disability services will be part of the Joint Future framework.

*The Same As You*² was published in May 2000 and sets the national policy for health and social care services for children and adults with learning disabilities in Scotland. *The Same As You?* makes reference to the need to ensure that services are in place for people with complex needs and this includes people with offending behaviour. It states that **..all long stay hospitals for people with learning disabilities should close by 2005 and that there requires to be a new structure to assess and support people in different settings, predominantly in the community. Health Boards should aim to reduce their assessment and treatment places specifically for people with learning disabilities to four for every hundred thousand population across the country as a whole. Health Boards should plan for appropriate community services to avoid inpatient assessment and treatment (recommendation 13).**

The Same As You? recognises that there will require to be assessment and treatment in-patient services for people with specialised or complex health assessment/treatment needs which cannot be met in the community. This includes people on statutory orders. It is recognised that a small number of people are detained under the Mental Health (Scotland) Act because of offending and other seriously irresponsible behaviour. *The Same As You?* recommends that... **"Health Boards and Local Authorities should make sure that there are local professionals with expertise in working with offenders with learning disabilities. Services should make sure an appropriate risk assessment is carried out and that treatment and ongoing support are provided as far as possible within the community. Health Boards should make sure that secure accommodation is provided for the small number of people who need this. There should be links between secure settings and less secure forms of accommodation in the community. There should be enough properly planned after care, including access to a range of rehabilitation and training facilities and opportunities"**. *The Same As You?* also made a recommendation for research into the number of people with learning disabilities in prison or in secure accommodation. The Scottish Development Centre was commissioned to undertake this research and a report is due to be published shortly.

While *The Same As You?* sets out the broad policy objectives for health and social care services - *Promoting health, supporting inclusion*³ focuses specifically on the contribution of nurses to the care and support of people with learning disabilities. A five tier model of care is set out:

- tier 0 - community, public health and strategic approaches to care
- tier 1 - primary care and directly accessed health services
- tier 2 - health services accessed via primary care
- tier 3 - specialist locality health services
- tier 4 - specialist area health services

Services for people with offending behaviour could be provided across all these tiers with specialist provision being located within tiers 3 and 4, but with consultation/liaison being provided across the model. A number of the recommendations in *Promoting health, supporting inclusion* are relevant to the needs of people with learning disabilities who engage in offending behaviour.

¹ Scottish Executive (2000) Community Care: A joint Future

² Scottish Executive (May 2000) *The Same As You?* A review of services for people with learning disabilities.

³ Scottish Executive (July 2002) *Promoting health, supporting inclusion* – a review of the contribution of all nurses to the care and support of people with learning disabilities.

An NHS Health Scotland Learning Disability Needs Assessment Report has just been published. This report builds on the five tier model identified in *Promoting health supporting inclusion* and recognises the need for a spectrum of services for people with complex needs including those with offending behaviour. The needs assessment report reviews the research relating to people with learning disabilities who engage in offending behaviour. It states that there is “**growing consensus that research should move away from prevalence studies to developing and evaluating effective interventions and services for this group**”.

A recent report published by the Scottish Executive - *Home at Last?*⁴ relates to progress with hospital closure and service re-provision and sets out a range of actions for the Scottish Executive, NHS Boards, Local Authorities and other organisations. The recommendations address, in particular, the need to ensure that the range of robust community services are in place and that there is access to specialist inpatient services as required for people with learning disabilities in particular for those mental health needs, offending behaviour and challenging behaviour. It emphasises the need to develop local capacity and confidence in community services. The report does not identify a strategy for preventing the increasing number of ‘delayed discharges’ across the preprovided in-patient services.

2.2 Legislative Framework

The *Adults with Incapacity (Scotland) Act 2000* provides a legal framework for gaining consent or acting on a persons behalf when the person does not have capacity to give or withhold consent. The new *Mental Health (Care and Treatment) Scotland Act 2003* will be implemented from April 2005 and this places a range of new duties on NHS Boards and Local Authorities. People with mental disorders, including those with learning disabilities, are afforded new rights by the Act, with a significant development being the right of access to independent advocacy. Of particular relevance to people with learning disabilities who engage in offending behaviour is the right to appeal against excessive security.

The Regulation of Care (Scotland) Act 2001 set up the Scottish Commission for the Regulation of Care. The Care Commission registers and inspects the services listed in the Act, taking account of the National Care Standards published by Scottish Ministers. The Care Commission is responsible to Scottish Ministers.

Legislation regarding the prevention of discrimination is relevant to people with learning disabilities including the *Disability Discrimination Act 1995*, the *Race Relations (Amendment) Act 2000* and the overarching *Human Rights Act (2000)*. Such legislation provides a framework for the delivery of services that are culturally competent, free from discrimination and recognise individual rights. The *Community Care and Health (Scotland) Act 2002* provides statutory framework for joint working arrangements. Such arrangements may provide alternatives to hospital admission.

It is important to make reference to the current consultation on Vulnerable Adults Bill. There is a commitment from the Scottish Executive to consider the place of learning disabilities within Mental Health Legislation, following on from a recommendation in the Millan Report. This is particularly relevant for people with learning disabilities who do not have a mental illness, but may be eligible for detention under the current Mental Health Act due to ‘mental impairment’.

2.3 Prevalence Research

Studies have investigated prevalence in high security hospitals (Walker and McCabe 1973), prisons (MacEachron 1979), Criminal Justice Services (Mason and Murphy 2002), appearance at court (Messinger and Apfelberg 1961) and appearance at police stations (Lyll et al 1995). These studies have found considerable variation in the prevalence of offenders across these highly differing settings. Walker and McCabe (1973) in a study of individuals in special Hospitals, found that 35%

⁴ Scottish Executive (January 2004) Home at last? The Same As You implementation group – report of the sub group on progress with hospital closure and service re-provision.

were diagnosed as having learning disabilities (LD). On the other hand, Messinger and Apfelberg (1961) in their study of approximately 57,000 individuals assessed for the Courts in New York, found that about 2.5% had LD. MacEachron (1979) reviewed the literature on prevalence rates for offenders with LD studied in Prison. She found a range from 2.6% to 39.6%. In her own more carefully controlled study, employing recognised intelligence tests, she found prevalence rates of LD of about 0.6% to 2.3%. There is little relationship between these various populations although they are all subsumed under the heading of studies on prevalence of people with LD in the criminal population. Three studies investigating forensic LD populations in Scotland will be discussed below.

3. OVERVIEW OF CURRENT SERVICE PROVISION

3.1 Community Services and Issues

The context for community services is shifting markedly following the publication of 'The Same as You', with an emphasis on person centred approaches in inclusive services.

Within forensic services there are a number of areas of practice and service development which continue to require attention.

It is necessary to ensure partnership working in relation to early intervention and the provision of appropriate services. The current framework for this is likely to be through the Adults with Incapacity Act although there is some evidence that people may fall between the current Mental Health and the Adults with Incapacity Legislation and that there may need to be a strengthening of focus on vulnerable adults to achieve appropriate intervention.

Additionally there is some evidence that, during the transition stage from school to adult services, some young people with learning disabilities struggle in community settings, and there is a need to ensure that behaviour tariffs applied in forensic or anti-social behaviour activity does not inappropriately target these individuals.

While practice guidance is developing in relation to the anti-social behaviour activity, arising from the Executive's policies it is clear that there could be issues for a small number of people with learning disabilities in the community who for various reasons draw attention to themselves because of lifestyle, vulnerability or abuse. Main issues are likely to arise for individuals and families where there is no statutory involvement and it is recognised therefore that numbers would be small.

The emphasis requires to be on individual housing and care and for support to those service users given that traditional routes to Hospital as a disposal from the Courts is less of an option given the closure programme. Robust local services which can tackle such immediate problems require to be developed involving both social care, health and housing agencies. Good practice with Housing Departments and their Housing policies and strategies, especially homeless practice, require attention. The range of housing and support options which can protect individuals with behaviours which require appropriate support or close supervision, require to be developed and modelled. Key activities would require:

- Comprehensive needs assessment (through Single Shared Assessments)
- Referral protocols between agencies including integrated care and support pathways and including the SPS
- Tenancy support services working within a care management framework and in multi disciplinary teams for complex cases
- A range of specialist support for people with high needs
- The availability of high standard accommodation with appropriate support services
- Reduction of exclusion of people from social housing through the provision of support and measures to ensure compliance with tenancy conditions (AWI/Vulnerable Adults)
- Need to develop a range of housing options including floating support and medium stay supported housing. Evidence suggest that homeless people with multiple needs often have

poor contact with health and community care services, and result in being offered inconsistent support

- Robust individual and community risk assessment and management

The use of Appropriate Adult Schemes to support individuals in forensic needs to be reinforced through multi-agency activity, both for victims and offenders with a learning disability.

3.2 The Impact of Hospital Closures

There has been a significant reduction in learning disability hospital beds from over 7 thousand in 1980 to less than 900 in 2003. The traditional route of using the hospital bed as the means of providing respite, short term intervention, assessment and a holding ground for a range of community issues including inappropriate sexual behaviour, challenging behaviours, chaotic lifestyles and people with decreased capacity for decision making. Sheriffs have been content to use this option to allow 'observation' and provide time for service planning.

With the hospital closure programme being also completed, there now requires to be a focus on community services. The framework for this activity is contained in "Promoting Health Supporting Inclusion" and requires to be multi-agency involving Social Care Agencies, Social Work, Housing and Health, and the development of services at primary care level, and for good specialist support.

Models of risk assessment such as developed in Fife; or robust services as developed in the City of Glasgow; interagency protocols on Vulnerable Adults; and Single Shared Assessment arising from Joint Future activity, should assist the process of identifying how appropriate services in the community can be structured. There is a need for further development of the "What Works" agenda in relation to close supervision in community settings.

3.3 Learning Disability Admissions to The State Hospital (JANUARY 1987 to DECEMBER 1996)

Introduction

The State Hospital at Carstairs, midway between Glasgow and Edinburgh, is the "special" hospital for Scotland and Northern Ireland. It provides a maximum security environment for mentally ill and / or mentally impaired (learning disabled) patients "who require treatment under conditions of special security on account of their dangerous, violent or criminal propensities" (Section 90, Mental Health (Scotland) Act 1984).

Method

The Information and Statistics Division (ISD) of the Scottish Health Service was asked to provide a list of all patients admitted to the State Hospital with a diagnosis of "mental retardation" (ICD 9) between 1st January 1987 to 31st December 1996, i.e. a ten year period.

Results

68 admission episodes were identified for the 10 year period, accounted for by 48 male patients (55 episodes) and 11 females (13 episodes). 1 male patient was admitted 3 times during the study period and 5 men twice. 2 female patients were admitted on 2 occasions during the study period. The mean age on admission for males was 28 years (range 16 - 52) and for females was 27 years (range 17 - 44 years).

29% of male patients had been sent to an approved or residential school at some point during their education. 37% of all patients had documented histories of childhood sexual abuse (73% of the female patients and 29% of the male). 58% of male and 64% of female patients had no documented history of either alcohol or illicit substance misuse. Substance misuse was felt to have been a significant factor in 25% of admission episodes.

Past Psychiatric History

30% of patients had been in contact with child and adolescent services. 51% had a history of contact and admission with general adult psychiatric services. 78% had a history of contact and admissions with learning disability services. 29% of all patients had been "long stay" (admissions of

10 years or more) patients in learning disability hospitals. 26% of patients had previously been admitted to the State Hospital. 46% had a history of self harm (73% of the female patients and 40% of the male).

I.Q. / Aetiology of Learning Disability

Full scale I.Q. scores were not generally documented in the medical case records and instead I.Q. bands were detailed in psychology reports. 27% of patients were documented as having "borderline mental retardation" (I.Q. 70 -84, ICD9 Code 319.9), 65% "mild" (I.Q. 50 - 69, ICD9 Code 317) and 8% "moderate" (I.Q. 35 - 49, ICD9 Code 318.0).

52% of patients had no documented aetiology for their learning disability. 25% were described as perinatal, e.g. birth injury / asphyxia; 14% attributed to childhood illness (2 cases of meningitis and 2 measles encephalitis) and 4 cases attributed to head injury. 2 patients were described as having "cerebral palsy". Only 1 patient had a specific syndromal diagnosis noted (Fragile X).

Past Medical History

32% were recorded as having either active or inactive epilepsy (1 patient died during admission from status epilepticus). 12% had a history of serious head injury. 15% had histories of other neurological problems, including 3 patients with either hearing or visual impairment and one patient with a past history of a stroke.

27% were noted to have specific communication difficulties, including stutters, dysarthria and 1 patient with marked echolalia.

Admission and Diagnoses

Psychiatric diagnoses were obtained from the narrative of the medical case notes and were not subject to review by a diagnostic classification system.

55% of patients had a diagnosis of learning disability per se. 16% had dual diagnoses of learning disability and schizophrenia. 15% had dual diagnoses of learning disability and other mental illnesses (9 cases of "paranoid psychoses" and 1 case of schizo affective disorder). 10% had dual diagnoses of learning disability and specific personality disorder (5 female patients, 2 male). 4% had dual diagnoses of learning disability and pervasive developmental disorders.

Legal Status at Time of Admission

40% of patients were detained under the Mental Health (Scotland) Act, 1984 and 60% of patients were detained under the Criminal Procedures (Scotland) Act, 1975.

Table 1 Reason for Admission

Fire Raising	13
Sexual Offences	6
Culpable Homicide	3
Murder	1
Attempted Murder	7
Absconding from Local Hospital	4 (2 = restricted patients)
Severe Aggression / Behavioural Disturbance	
In Hospital Setting	17
In Prison Setting	19

It can be seen that the majority of patients were admitted as a result of severe aggression / behavioural disturbance from hospital and prison settings (Table 1). Some of the aggression in hospital settings was very serious, but did not necessarily result in criminal charges being pressed. In both hospital and prison settings poorly controlled (or undiagnosed) mental illness was often a contributing factor to the aggressive and other forms of behavioural disturbance, which included

severe deliberate self harm. A number of individuals were transferred from prison settings as a result of failing to cope in a penal setting.

13 individuals were admitted as a result of fire raising (1 also charged with attempted murder) and another 6 following serious sexual offences. However it should be noted that a number of other patients (5) did have histories of convictions for either fire raising or serious sexual offences.

Previous Convictions

40% of patients had no history of previous criminal convictions.

Table 2 Previous Summary Convictions

No. Of summary convictions	No. of patients
1 - 5	22
6 - 10	2
11 - 20	7
21 - 30	2
31 +	5

Previous Solemn Convictions

12 men had a history of solemn (1 had 3, 1 had 6, 10 had 1). 24% of patients had appeared before the Children's' Panel.

Summary

This study only provides a description of the characteristics of individuals admitted with a diagnosis of "mental retardation" to Scotland and Northern Ireland Maximum Security Hospital over a ten year period. As such it only provides a "snap shot" of this population and cannot support generalisations about people with learning disabilities who may offend. In common with other studies, there was an integral flaw in the definition of "mental retardations", i.e. 27% of patients admitted were actually defined as functioning in the "borderline" I.Q. range, i.e. probably did not have learning disabilities.

3.4 A Community Learning Disability Service in Tayside Region

Tayside Region began a community forensic LD service in 1990 and three major review publications have emerged from detailed clinical evaluations (Lindsay et al 2002, 2004a,b). Between 1990 and 2001, 202 individuals were referred for offences or offence related behaviour (e.g. un-prosecuted sexual abuse). There were 184 males and 18 females. Of the males referred to the service, there were 106 who had committed sex offences or sexually abusive incidents and 78 who had committed other types of offences and serious incidents.

Demographic Information

Characteristics of referrals can be seen in Table 3

Table 3: Characteristics and Referral Details expressed as a percentage of each group

Characteristic	SO (male)	OO (male)	Women
Age	38.14	34.82	28.8
IQ	64.3	65.4	67.1
Mental Illness	33	34	67
Psychotropic Medication	42	36	66
Community referral	39	11	27.5
Criminal Justice referral	48	29	44
Other referral	13	60	38.5

Key:

SO = Sex Offender

OO = Other Offender

As can be seen the women in this cohort were slightly younger than the men although this is not statistically significant. Around two thirds of the referrals fell in to the range of mild LD while about one quarter fell in the range of borderline intelligence. All of those individuals with borderline intelligence had an IQ of less than 75 which takes into account the standard error of an IQ = 70 and is a generally acceptable criterion for LD services. Around 5% fell in the range of moderate ID (IQ less than 50). Around one third of the men and two thirds of the women were diagnosed as having a mental illness. Criminal Justice referrals were more frequent in sex offenders and women while other referral sources (predominantly psychiatrists) were more frequent with non-sexual male offenders.

Problems Identified in Referrals

Table 4 shows the range of problems identified to this community forensic LD service.

Table 4: Problems identified expressed as a percentage of each group

Problem	SO (male)	OO (male)	Women
Anger/aggression	27	52	61
Sexual and relationship	52	24	44.5
Anxiety	10	18	33
Alcohol	9	22	33
Daily living problems	25	10	16.5
Sexual Abuse	38.2	17.7	61
Physical Abuse	16.1	13.4	38.5

As can be seen in Table 4, anger and aggression featured significantly amongst the women and other types of offenders, sexual and relationship problems featured significantly among the women and sexual offenders, anxiety was recorded more often in the women and other types of offenders as was alcohol abuse. Daily living problems were more pro-dominant in the sex offenders cohort. Sexual abuse in childhood was significantly more frequent in the women and in the male sex offenders while physical abuse in childhood was significantly more frequent amongst the women and non-sexual offenders

Criminal Justice Details

Table 5 shows the percentage of each cohort falling into four alternative disposals.

Table 5: Criminal Justice details expressed as a percentage in each group.

	SO (male)	OO (male)	Women
Formal disposal	44	29	44.5
No action	20	34	11
Diversion	27	29	38.3
High security/prison	9	8	5.5
Re-offending	19	51	22

Formal disposal is normally probation with Court ordered treatment but can include deferment for up to 2 years. Other types of offenders had a lower rate of formal disposal although this was not statistically significant. The other types of offenders had a significantly higher rate of no action taken following the index incident with no significant differences in the rates of diversion from the criminal justice system or referral to high security settings including prison. Although re-offending rates seem high in the other types of offenders, Lindsay et al (2004a) reported significantly lower numbers of re-offending incidents up to 7 years following referral.

Estimates of Prevalence

Across the years 1990-2001, Tayside has had a population of approximately 400,000. 202 forensic LD referrals represents around 0.05% of the population. Extrapolated to the population of Scotland, this would suggest that there are approximately 2,500 individuals with learning disability and forensic problems, who might require the services of a managed care network from forensic out-patient and day patient services through to prison and secure facilities. This figure would be proportionate across the regions of Scotland.

This would represent between 5% and 10% of the identified individuals with LD within each local authority area ⁵

3.5 The Prevalence of People with Learning disability in Secure Forensic and other Specialist Settings ⁶

A recent report ⁵ has reviewed the prevalence of individuals with LD in Scottish Prisons and secure settings. A self-completion, pro-format was distributed to secure settings and respondents were asked to indicate the numbers of people currently accommodated in their establishments who had been formally assessed or diagnosed as having a learning disability and/or autistic spectrum disorder. 19 individuals were identified with these disorders residing in the 16 Scottish Prisons (average daily prisoner population 6475) totalling around 0.3% of the present population. This figure is comparable with that of 0.4% found in the English Prison Service (Gunn et al 1991) and consistent with the figure of 0.4% prevalence of people with LD in some Scottish Prisons. Some commentators have expressed surprise at these prevalence rates but they are consistent across the UK and with figures reported elsewhere (e.g. MacEachron 1979). Lambrick (2003) reported a study of the Australian population which indicated a prevalence of between 1.4 and 1.8% at any given time. Therefore prevalence studies of LD in the prison population consistently provide figures of less than 2%. It is likely that commentators doubts about these figures are influenced by the larger number of individuals in the prison service who have borderline intelligence (above the ranges of learning disability but below the ranges of average intellectual ability).

3.6 Out of Area Forensic Placements (as of 1st March 2004)

The information we have on out of area forensic placements is not consistent across the regions of Scotland. Appendix X has a section for each area indicating out of area placements. The information on Glasgow Forensic Services includes patients who have been referred to the area but not patients who have been referred from the area. Therefore this information should be treated with the utmost caution.

Borders - 1 individual with forensic needs is placed out of the area in an NHS placement.

Lothian - 7 patients in The State Hospital. No other out of area forensic placements

Fife - 2 out of area forensic placements both in NHS units In Scotland. Four patients in The State Hospital

Forth Valley - 4 out of area forensic placements, one in NHS care (England), 3 with private provider (One in England).

Lanarkshire - not known

Argyll and Clyde - Only 1 forensic LD out of area placement identified. It is noted that NHS Argyll and Clyde has, in the past, shown a willingness to make use of out of area placements.

Dumfries and Galloway - 2 out of area placements: one in The State Hospital and 1 in Northumberland.

Grampian - 1 individual from Grampian at The State Hospital. Several out of area placements specifically associated with challenging behaviour rather than forensic issues.

⁵ Scottish Executive National Statistics Publication (2003) Statistics release: adults with learning disabilities implementation of "The Same As You". This figure is consistent with that found by Hayes (1991) in her study of offenders in New South Wales, Australia. Using intelligence tests and assessment of social and adapted skills, she reported that around 13% of people known the LD services had been convicted of offences or had committed acts which had been diverted from the Criminal Justice System.

⁶ Scottish Office Central Research Unit (2003) on the borderline? People with learning disabilities and/or autistic spectrum disorders in secure, forensic and other specialist settings

Highlands - 1 individual in The State Hospital and several additional out of area placements associated with challenging behaviour rather than forensic issues.

Tayside -2 patients in The State Hospital. 3 out of area placement with private providers (1 health funded and 2 local authority funded)

Glasgow - 1 patient in out of area placement (no information regarding this).

Ayrshire and Arran - 1 patient in out of area placement (no information regarding this).

The information contained in this section is inconsistent. Tayside is the only area which specifically notes those out of area placements funded by local authority and NHS. It is possible that the actual numbers of out of area placements are higher than those reported here.

As detailed above, there are many individuals in Scotland currently placed in expensive out of area placements (usually in the private sector) by local authorities and/or health boards. These expensive out of area placements detract from the ability of local authorities and health boards to increase their own capacity and develop appropriate services locally/regionally. A worrying trend in England and Wales has been the development and proliferation of private hospital groups, providing secure care for people with learning disabilities and forensic needs. To put this in context, 5% of general forensic provision is within the private sector in England and Wales, while the figure for learning disabilities is 30%.

3.7 Service Overviews

Appendix X shows the service overviews for the regions of Scotland. They are summarised in this section.

Greater Glasgow

Previous service located in Lennox Castle Hospital was re-provided on to the Leverndale site with 7 locked male beds. There is a small out-patient and day patient service consisting of Consultant Forensic Psychiatrist and 2 Community Forensic LD Nurses. There are informal working relationships between agencies with some organised day activities and occupational activities. There is limited access to a forensic day service project.

Fife

Fife is part of the South East area Learning disabilities Managed Care Network, comprising Lothian, Forth Valley, Borders and Fife Regions. The Forensic working group of the MCN is in the process of developing organisational structures. Fife has a low secure forensic unit of 12 beds based in Lynebank Hospital. A regional close supervision unit (low secure) associated with the MCN may be sited at Lynebank Hospital.

The Hospital has a day service department employing a forensic occupational therapist with a small number of day placements for assessment purposes. There is an integrated community forensic learning disability team comprising 2 social workers, social inclusion worker, a forensic psychologist, a community forensic learning disability nurse, an occupational therapist and a psychiatrist. The social work department and Richmond Fellowship both provide specialised community placements for individuals with forensic needs. The majority are supported and supervised 24 hours a day. There is a rolling programme of training/professional development being developed for care staff. There are links with the criminal justice services. All forensic practice in Fife is overseen by the significant risk advisory group (SRAG) which is a multi-agency and multi-professional group that critically appraises and underwrites risk assessment and management of patients with forensic needs. Full details of services can be seen in Appendix X.

Borders

There are no specific secure beds and no day services for forensic patients. The current in-patient service would struggle to manage any in-patient presenting with significant challenges or forensic needs. There are no health professionals within the community learning disability team who have a

specific forensic remit. There are however established links with the social work department and joint working arrangements. Full details in Appendix X.

Forth Valley

There are no designated forensic beds but if necessary, a limited number of beds can be used for this purpose. Forensic cases are seen at routine out-patients clinics or domiciliary visits by psychiatrist, psychologists and community nurses. There are no designated day services. Where appropriate, there is close liaison both with the social work department and the social work criminal justice workers. Full details in Appendix X

Lothian

There is a 6 bedded semi-secure assessment and treatment facility in the William Fraser Centre. There is also a 7 bedded semi-secure "Health Care House". Forensic out-patients are seen within the generic community learning disability teams and 1 consultant psychiatrist has a small case load of forensic out-patients. 1 consultant psychologist is appointed to work with forensic out-patients. Formal links are being established between the health and social services and there are links with the probation services. The William Fraser Centre has a day Hospital providing specialist multi-disciplinary forensic assessment and treatment services 2 days per week. Approximately 8 to 10 out-patients can attend at any one time. Full details in Appendix X.

Lanarkshire

Work is progressing in Lanarkshire to reach the position on Hospital closure. There are plans for a small assessment unit supported by robust community services. Single tenancy arrangements are being organised where possible for all people being discharged from Hospital. Social work services have recently appointed a forensic social worker in Court settings across Lanarkshire to ensure early intervention is gained at the point of contact with the Criminal Justice Services. Single shared assessment has been progressed in both local authority areas within Lanarkshire. Criminal Justice Services have developed risk management activity to support community based staff. Details in Appendix X.

Argyll and Clyde

There are plans to develop a Community Forensic Service which, at present, is at the stage of a board wide needs assessment exercise. Learning disability out-patients with forensic needs are seen within the LD service. 2 clinical psychologists have a particular interest in forensic issues. Referrals are received from the Courts and a small number from Solicitors. Forensic cases requiring assessment are admitted to the learning disability admission unit of the IPCU at Dykebar Hospital. It is considered that the forensic learning disability service requires considerable development at present. Full details in Appendix X

Dumfries and Galloway

There is no specialist supervision for forensic learning disability cases. There are informal services for sex offenders and some other offenders. There is no formal risk assessment system.

Grampian

Bracken Close Supervision Unit, 12 male beds, has recently been commissioned. There are on-going security and staffing issues. There is no specific LD forensic provisions for out-patients or day-patients other than clinical psychology. There are some good professional links between health and social work professionals. There are also some links with adult forensic psychiatry. Care management for forensic cases is done through the normal LD care management service. Some specific forensic care packages have been set up through these channels. It is considered that more focused risk assessment is required. Full details in Appendix X.

Highlands

Work is progressing in the decommissioning of 32 long stay beds and the development of services in support of an 8 place assessment and treatment in-patient unit. There are no specific forensic out-patient or day-patient services. However, there are some good interagency professional working arrangements between health and social work. Currently there are no full-time psychiatrists for

learning disabilities. Care management is conducted through two learning disabilities support teams and social workers working within the broader community care teams

Tayside

There is 1 low secure 8 bedded unit for forensic male patients. There is another open unit with 10 beds which is the hub of the forensic learning disability services in Tayside. There are assessment/treatment day places for up to 30 patients. Out-patients are seen in the three localities of Perth and Kinross, Dundee and Angus. There is a recently established forensic community nursing team providing close liaison between specialist services and locality based services. Care packages for forensic learning disability cases are somewhat adhoc and opportunistic. They include NHS and voluntary sector placements with up to 24 hour staffing. Care management, liaison with social work services and liaison with criminal justice probation services has been on-going for several years and is at a fairly mature stage. Multi-disciplinary risk assessments are at the core of planning. Assessment and treatment services are multi-disciplinary across health and social work. Full details in Appendix X.

Summary

Looking across the regional descriptions, it is clear that services are very uneven in Scotland. There are some excellent examples of good practice including joint risk assessments between all the relevant agencies, comprehensive day-patient and out-patient assessment/treatment services joint working between individual social work, NHS and voluntary staff, forensic learning disability teams and newly commissioned purpose built units for forensic cases. However, there are clearly major deficits in large areas of Scotland including in some regions, lack of psychiatric services, lack of in-patient services, few allocated staff and no clear arrangements for joint working between health and social work. From the descriptions provided, services in Fife and Tayside would appear to provide some examples for the discussion of good practice.

4. OTHER ISSUES

4.1 Financial Framework/Funding streams

Part of our remit was to cost any proposals made. It soon became apparent that even if we had had the time to do this, we lacked the information and the expertise.

4.2 Clinical Effectiveness and Quality Indicators

Quality Assurance

NHS Quality Improvement Scotland (NHS QIS) was established as a special health board on 1 January 2003 as a result of bringing together the Clinical Resources and Audit group (CRAG), Clinical Standards Board for Scotland (CSBS), Health Technology Board for Scotland (HTBS), Nursing and Midwifery Practice Development Unit (NMPDU) and the Scottish Health Advisory Service (SHAS).

The purpose of NHS Quality Improvement Scotland is to improve the quality of health care in Scotland by setting standards/quality indicators and monitoring performance, and by providing NHS Scotland with advice, guidance and support in effective clinical practice and service improvement.

A part of this remit is to develop and run a national system of quality assurance of clinical services. Working in partnership with healthcare professionals, users, carers, members of the public, NHS Quality Improvement Scotland sets quality indicators and standards for health services, assesses performance throughout NHS Scotland against these quality indicators and standards and publishes the findings.

SHAS published learning disability quality indicators in May 2000. Since then these quality indicators have been used to assess the quality of health services available to children and adults

with learning disabilities in Scotland. A revised set of quality indicators⁷ has now been published by NHS Quality Improvement Scotland reflecting developments in policy, legislation, research and practice. The revised quality indicators for learning disabilities focus on 6 key elements which impact on the quality of care a person with learning disability receives. They provide a robust framework of aspirational targets, which set achievable challenges for services. While focussing on the role and contribution of health services, the quality indicators also provide a foundation for the development of joint indicators and standards in due course. There is a specific quality indicator identified for services for people with offending behaviour.

The "Home at Last?" report recommended that NHS QIS with others would undertake a progress review of the development of effective community services for people with complex needs in order to achieve hospital closures. A programme of visits will be undertaken between September 2004 and July 2005 to all NHS board areas in Scotland. The needs of people with offending behaviour and the required services will be looked at over the course of the reviews.

The Care Commission has responsibility for regulating social care. National Care standards have been set relevant to a range of services. They are based on a set of principles which reflect the recognised rights of all citizens. The Standards are used to monitor the quality of care services and their compliance with the Regulation of Care (Scotland) Act 2001. In this context Care Standards relating to care homes for people with learning disabilities and for people in criminal justice supported accommodation, including secure settings, are of particular relevance.

Social Work Services Inspectorate have responsibility for inspecting aspects of professional/social work practice in Scotland. In recent years visits have been undertaken to each local authority area with the publication of local and reports and national overviews.

4.3 Criminal Justice Inspection

Some authorities, e.g. Fife are using assessment tools and suchlike that are for LD offenders. A criminal inspection programme is being undertaken at the moment and this involves looking at practice across the essential types of statutory supervision. The inspection method involves:

- analysing available statistical data;
- reading a sample of case files
- interviewing staff and managers;
- observing practice

This work leads to the publication of a report. An example of this can be found on the Scottish Executive website: <http://www.scotland.gov.uk/library5/social/picjsw-00.asp>⁸

Through the prism of the most common types of order we examine all issues about practice, including issues about discrimination and stigma affecting offenders.

4.4 Social Work - Social Work Inspectorate

Following the publication of the SWSI and Mental Welfare Commission Reports into the case of a woman with learning disabilities in the Borders, the Executive have announced a programme of joint inspections relating to services for people with learning disabilities (no further information is available at this stage).

5. PROPOSED SERVICE PROVISION

5.1 Multi Agency Risk Assessment / Management

An infrastructure is required to bind Health / Social Work / Criminal Justice Services in order that all areas can establish arrangements for the management of significant risks, i.e. of serious sexual / violent offenders. The Significant Risk Advisory Group (SRAG) established in Fife is an example of

⁷ NHS Quality Improvement Scotland (February 2004)– Learning Disability Quality Indicators (Revised)

⁸Social Work Services Inspectorate: Performance Inspection of Criminal Justice Social Work Services- Report on Argyll, Bute and the Dunbartonshires' Criminal Justice Social Work Partnership (June 2004)

such a model. The English Multi Agency Public Protection Panels (MAPP) provide a model of national good practice. Information relating to SRAG and MAPP is included Appendix W.

Multi agency risk management groups need to have clear lines of accountability and effective communication systems. One of the most difficult tasks is to identify and target resources at the individuals presenting with the most significant levels of risk. Good practice will necessitate the sharing of all relevant information in order to properly assess and manage risk. Moving towards a uniformity of risk assessment / management tools would be desirable. Senior management need to be involved from all agencies.

The workings of such groups should be transparent and underpinned by a philosophy of defensible decision making.

5.2 Inpatient Services

In England and Wales there are approximately fifteen hundred secure (high, medium, low, semi secure) beds for people with learning disabilities and forensic needs.

The review of services across Scotland has indicated that service provision is uneven from region to region. Certain regions appear to have examples of good practice while other regions have relatively impoverished services. This suggests that there is unequal access to services from region to region. It is important that each region in Scotland has access to in-patient forensic learning disability services as well as integrated community services for this client group.

It is thought that there are probably an adequate number of secure beds in Scotland, but there is an over weighting of beds at the high secure end of the spectrum (The State Hospital). Many of the learning disabled patients detained in the State Hospital are recognised as being “delayed discharges”, i.e. are waiting to move to less secure placements (usually health) in their home areas. It is also considered that, of those admitted to conditions of special security at The State Hospital the majority could have been dealt with locally had robust, secure health facilities been available in their home area.

Across Scotland there are a number of “entrapped” patients/“delayed discharges” in low secure settings and admission units. This is certainly true in Tayside, Grampian, Fife and Lothian. Were there to be appropriately commissioned community facilities, these individuals could move on freeing up a certain number of low secure places which would be appropriate both for acute admissions and some delayed discharges from The State Hospital. They may also be appropriate for the repatriation of out of area placements. However, other areas in Scotland e.g. Highland region, Argyll and Clyde and Dumfries and Galloway have no specific provision and require commissioning. This might be done on an interregional basis through a Managed Care Network with local community facilities. It should be remembered that without appropriate community placements, any low secure assessment and treatment unit will soon become full with no avenues for discharging individuals on to community facilities. This has already happened in the Bracken Unit in Grampian. We will emphasise more than once throughout this section that although there is a need the development of close supervision units (enhanced low secure facilities) in the 4 regional planning areas, the most pressing requirement for functional forensic learning disability services through the foreseeable future is for robust community facilities.

With regard to inpatient care, the level of security provided should be commensurate with the level of risk and clinical need of individuals. Clearly there should a balance between the demand for adequate security and the need for the development of a therapeutic/least restrictive environment. As stated, this balance does not currently exist for many individuals detained in secure health settings throughout Scotland. Within regions clear patient pathways (multi-agency) should be developed, ensuring that individuals can move smoothly from one level of security to another, across and within community and inpatient services, as appropriate. There is currently a dearth of “joined up” planning and management systems between Health and Local Authorities throughout Scotland to facilitate such patient pathways. “Delayed discharges” (individuals who are ready to move to robust community settings) in local area secure health units, result in it being

impossible to accept back “delayed discharges” from the State Hospital. This situation is a serious concern in terms of defensible, ethical practice and will need to be resolved by April 2006, when patients in the State Hospital (and potentially other hospitals) will have the right to appeal against “excessive security” under The Mental Health (Care and Treatment)(Scotland) Act, 2003 (Part 17, Chapter 3).

As stated, there is currently a clinical need for the regional planning areas to commission close supervision units (enhanced low secure care). This would provide robust facilities ensuring that patients, who do not require to be managed in conditions of “special” security, are not transferred to the State Hospital. At the same time, the working group recognise that there will continue to be a small number of patients who will require care within the State Hospital clearly, no attempt should be made to reduce the number of learning disability beds in the State Hospital, until more robust facilities are available. It would be helpful for there to be consistent policies regarding the admission criteria for the 4 planned medium secure units. It is considered that on occasion it may be necessary to admit people with learning disabilities to these units for periods of assessment/treatment, with involvement from learning disability clinicians, as required/agreed.

5.3 Community Developments

The working group consider that the majority of individuals with forensic needs can be managed in robust community settings. However, such care packages are often more expensive than the provision of inpatient hospital care. There is currently inadequate robust community provision for individuals with forensic needs and this capacity has to be increased, before any attempt is made to reduce inpatient bed numbers. These expensive out of area placements detract from the ability of local authorities and Health Boards to increase their own capacity and develop appropriate services.

It should also be remembered that there will be a continued requirement for inpatient assessment/treatment services for people with learning disabilities living in the community who have forensic needs.

5.4 Forensic Learning Disability Teams

These should be multi agency and community focussed. Good links with all agencies need to be established, particularly with housing and criminal justice services. Relationships with the voluntary sector are also important, especially with regard to establishing social / recreational / occupational opportunities for individuals within community settings, promoting the social inclusion agenda.

Teams will be multi professional and will focus predominantly on individuals presenting with the most significant levels of risk. Ideally, case management numbers will be small and instead such teams will provide more widespread consultation liaison support to other agencies and provide training / other support.

Clearly teams will deliver and provide appropriate therapeutic interventions (both for individuals and in group settings). There should be a focus on early interventions and all regions should attempt to provide services which respond to the needs of children and adolescents (see transition services).

The work of multi agency forensic learning disability teams could be overseen and under written by local multi agency risk assessment and management groups, e.g. SRAG / MAPP models.

5.5 Transition Services

Young people with learning disabilities struggle in community settings and behavioural tariffs applied through anti social behaviour activity often inappropriately targets these individuals. There is a national void of robust services for young people with learning disabilities who present with significant challenging behaviours, particularly offending behaviours. Many learning disability

teams will not pick up referrals until individuals are aged 16 or 18 years old. There is evidence from SHAS/NHS QJS reports and other publication that many children and young people with learning disabilities do not get access to appropriate mental health services. As a rule, there is poor communication between youth justice services and adult service. Specialist therapeutic interventions for young people with learning disabilities are often not available within mainstream youth justice services. Early identification and intervention with such young people is required.

In many Scottish local authorities difficult young people are sent to out of area schools and other placements, as there is a lack of robust local / regional services. Many of these young people end up in secure facilities in adulthood, particularly in hospital care.

There is a need for “joined up” care straddling child and adult services. At a regional level, it would be beneficial to have professionals developing experience and skills working with young people with learning disabilities and forensic needs. Ideally, these professionals would also work within adult multi agency forensic learning disability services.

5.6 Specialist Input into Police Stations and Courts

Appropriate adult schemes are well established throughout Scotland. There should be links developed between such schemes and forensic learning disability services, ensuring that individuals with forensic needs do become known to services. Targeted input to police stations and courts in the form, for example, of Mental Health Officers (a Fife development) could be of benefit in terms of increasing the identification of individuals with learning disabilities coming into contact with Criminal Justice Services. In Glasgow there is daily involvement of forensic service professions (learning disability and Mental health) at court to identify and assess people with mental disorder.

It would be helpful for there to be formal links between Criminal Justice Teams and Forensic Learning Disability Teams. There is a need to develop, and put into practice, screening tools to more accurately identify people with learning disabilities within Criminal Justice Services. However, there requires to be an acceptance that an increased level of detection will, almost certainly, lead to there being an increased demand for services. The potential funding implications in terms of service capacities needs to be recognised.

5.7 Links with Prison

In Scotland (and in the UK) there is evidence to suggest that there may only be small numbers of people with learning disabilities detained in prisons. However although the numbers may be small, it may be the case that such individuals, by definition, constitute a high risk group within the prison population. It is suggested that at the pre-sentencing stage, where there is any doubt about intellectual ability (concern that an individual may have a learning disability), attempts should be made to support the individual through the criminal justice process, and, where appropriate, make suitable post conviction arrangements. There is evidence in some areas (e.g. Tayside) that Court systems can become sensitive to the needs of individuals with learning disabilities. If an individual is then identified as potentially having a learning disability, specialised psychological and psychiatric input could be requested to carry out thorough evaluation. Specialist reports can be and are commissioned from forensic learning disability services, making recommendations for appropriate disposal.

Within prisons an attempt should be made, where appropriate, for learning disabled individuals to have access to adapted treatment programmes. A policy for learning disabled individuals not to have unnecessary moves from one prison to another would be commendable, as would access to advocacy services. It is proposed that there should be clear links between prisons (for example through care teams / health centres) and forensic learning disability teams. Forensic learning disability teams should be involved in pre-release planning.

5.8 People First (Scotland)

Representatives from People First (Scotland) were members of the committee and submitted their views on forensic learning disability services. These can be seen in Appendix Z. They emphasise that professionals should make considerable efforts to discover the reasons why people with learning disabilities commit crimes. Using the example of sexuality, they note that individuals with learning disabilities may not have the same opportunities for appropriate sexual development and behaviour. They also note that sexual abuse in childhood and adulthood is more common amongst people with learning difficulties than in the general population. Such considerations are important when making assessments of sexual offending in an individual with learning disabilities.

They also make the point that these considerations may be true in other kinds of offences such as fire setting and aggression. The learning disabilities working group discussed the use of the Mental Health Act sections and guardianship orders in relation to offenders with learning disability. People First (Scotland) express surprise at the use of statutory orders in order to supervise people with learning disabilities and indeed are opposed to such orders being used as a convenience to cover gaps in services. They do not believe that secure group accommodation of any kind will help the individual with learning disabilities and feel that individuals should not be abused or mistreated, segregated, denied experience, suppressed, ridiculed, disrespected, dismissed or devalued at any age. People with learning disabilities who commit offences require support to build and sustain relationships, develop an identity, develop self-worth, become secure and valued citizens in their communities and to learn socially accepted behaviours. The full report can be seen in Appendix Z.

5.9 Training for Provider Organisations

It is suggested that there should perhaps be a move towards there being specialist care providers working in this challenging field. Care providers do need to be able to deliver the care plans that have been drawn up by multi agency forensic learning disability teams. Deviations from agreed care plans often occur as a result of there being conflict with the service providers' own philosophy of care, particularly relating to the rights, choices and autonomy of individuals.

Before addressing training as a specific issue, organisations need to look at recruitment strategies, ensuring that there is an emphasis on employing individuals with the right attitudes and aptitude.

There is often a high turnover of staff in social care settings and as a result there need to be rolling programmes of training. Induction periods should include core training which will preferably be developed between care providers and multi agency forensic learning disability teams. Core training should focus on skills, not only knowledge. Skills training may include role playing, interpersonal skills, active listening and negotiation.

Core training for care staff should be developed around best practice and include knowledge / developing skills including:

- appropriate risk assessment and management
- appropriate staff-resident relationships
- anger management including appropriate de-escalation strategies
- anxiety management, including learning basic relaxation techniques
- social problem solving skills
- knowledge and skills regarding relationships and sexuality issues
- knowledge of mental health disorders

Care packages and training programmes should be centred around values, respect, be demonstrably therapeutic and again strive to promote social inclusion.

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7.0 APPENDICES

Appendix W	Fife Primary Care NHS Trust Significant Risk Advisory Group (SRAG) Constitution
Appendix X	People First (Scotland) view of Forensic services
Appendix Y	STAFF TRAINING AND LEVELS OF COMPETENCE
Appendix Z	Regional Planning Groups Service Overviews

Special Addendum

(As agreed at the Forensic Network Advisory Board Meeting 11 March 2005)

Written by: Prof Bill Lindsey, Dr Fergus Douds and Dr Steve Young

1. SERVICES FOR LEARNING DISABLED REPORT

1. Secure Inpatient Bed Provision

The draft report from the National Forensic Managed Care Network Learning Disabilities Working Group clearly identifies the priority for service development is in the community and by necessity this involves joint health and local authority planning and resource. Appropriate area joint futures initiatives should support such working. Forensic learning disability is more closely linked to generic learning disability than forensic psychiatry. Since most forensic community learning disability services will be carried out by generic community multidisciplinary learning disability teams or community forensic learning disability teams, it is crucial that strong linkage needs to be supported between any medium secure services and local community learning disability services.

Given this background, the Learning Disabilities Working Group has been asked to give further consideration to the future configuration of secure beds for people with learning disabilities in Scotland. The group has, in particular, been asked to consider the provision of medium security. After further discussion, it was considered that secure inpatient facilities for people with learning disabilities should probably be mapped to the matrix of security, attempting to align secure learning disabilities facilities with general forensic facilities. Using the common forensic definitions may be advantageous in terms of the right of patients in the future to challenge detention in conditions of "excessive" security.

2. Proposed Tiers for Scottish Secure Learning Disabilities Inpatient Facilities

High Secure Care

There are currently a group of patients who require and benefit from the high secure environment at The State Hospital. This group benefit from the ability to have unescorted leave, something very important which enhances their quality of life. Within medium or low security it would not be envisaged that these individuals would graduate to unescorted ground leave, something the individuals themselves may find difficult to understand and tolerate.

It is proposed that there is a future need for 12 high secure beds within The State Hospital for people with learning disabilities, possibly in one unit comprising three, four bedded areas for assessment, treatment and rehabilitation.

Medium Secure Care

It is proposed that medium secure provision would primarily exist for assessment purposes. Stand alone units built to medium secure specification would almost certainly be uneconomical. It is suggested that there could be learning disability pods attached to the regional medium secure units. In terms of population needs,

there should perhaps be one West Coast and one East Coast unit, the location to be determined by regional planning groups. The learning disability pods could have six to eight beds each, subject to further discussion/planning.

Low Secure Provision

Most areas in Scotland have low secure provision though the “robustness” of the units varies significantly. It is suggested that all areas should be familiar with the matrix of security (see appendix) in order to improve the consistency of service provision across Scotland, in terms of defining the tiers of secure care. On balance, it is considered that the units currently termed “close supervision” are probably robust low secure, rather than medium secure units.

3. Other Forensic Provision

The group still consider that robust services should be weighted towards the community and that if there is no linkage then throughput will continue to be problematic. The development of regional multi-agency risk management groups is still supported in terms of developing the multi-agency risk governance that is required to maintain “joined up” services.