Into the Unknown – A Discussion of Transforming Care

How will Transforming Care impact on the disposal and treatment outcomes of offenders with learning disability?

Andrew Taylor

University of Sheffield

Word Count: 4971
Introduction

“Winterbourne View: Abuse footage shocked nation”[1] was one BBC headline in the aftermath of the scandal at the infamous residential care home near Bristol. Although it has now been 7 years since BBC Panorama shone a light on the horrendous abuse taking place at Winterbourne View, the repercussions are still felt today. This essay will be a discussion of the Transforming Care agenda for people with learning disability and challenging behaviour, and its impact on the learning-disabled offender population. Beds are being closed and community plans are being made, but it remains to be seen whether services will satisfy public safety, as well as the patient population they are designed to serve. The priorities of the Ministry of Justice and courts are also important to consider in anticipating the outcomes of these new policies; it cannot be assumed that their motivations are perfectly aligned with those of NHS England. In this context, it is vital to examine the learning-disabled offender population themselves, including their needs and restrictions. The bed closures, and the ways these beds are utilised, will be discussed from both a care and legal perspective. The essay will conclude with some alternatives that may prove useful if hospital admission ceases to be an option.

The Inception

Winterbourne View Hospital

Winterbourne View hospital was an independent hospital opened in 2006, registered with the purpose of providing assessment, treatment and rehabilitation for individuals with learning disability.[2] Its closure in June 2011 followed the discovery of mistreatment and criminal abuse as part of a BBC Panorama programme in May 2011.[2] Many organisational and procedural failings were highlighted in the investigations that followed, alongside the realisation that there was a wider issue in the appropriateness of the services and care being provided for many learning-disabled individuals with challenging behaviour.[2] Various warning signs were missed at Winterbourne, including high rates of physical intervention and A&E attendance. Safeguarding alerts were made to South Gloucestershire Council on 40 occasions between January 2008 and May 2011; 27 were staff to patient assault allegations.[2]

No similar patterns of abuse were found in 150 other hospitals and care homes on CQC inspection.[2-3] It was decided however that too many patients were unnecessarily languishing in hospital, and that the current services were failing to meet patient needs. There was also a widespread failure to assess the quality of care and outcomes for patients in these hospitals.[2-3]

Transforming Care

The Department of Health published the Transforming Care report in December 2012 as a response to the Winterbourne View scandal.[2] Locally delivered, personalised, community-centred care were the principles that new services would be built around; emphasis was also placed on early intervention, quality of life, family support, regular reviews and early discharge planning.[2] This report stated that “all individuals should be receiving personalised care and support in appropriate community settings no later than 1st June 2014”. [2] The Transforming Care principles have their roots in the 1992 Reed report. Reed said that patients should be cared for close to home in the community if possible, or "under conditions of no greater security than is justified by the degree of danger they present to themselves or to others". [4-5] He also claimed that high-quality care should be provided by health and social care services, with the ultimate aim being rehabilitation and opportunities for independent living.[4-6]
Following stakeholder and political outcry at the government’s failure to deliver their promises by 2014, alongside claims that the situation had in fact worsened, the chief executive of the NHS made a new commitment to a 2-year learning disability hospital closure programme in 2015. This renewed national commitment, regarding individuals with learning disabilities and autism who display challenging behaviour, was detailed in the Building the Right Support plan. Overall, 35-50% of inpatient beds have been earmarked for closure, with low secure services expected to shoulder most of this reduction. The objective set for this bed reduction is now March 2019. Policy change because of public or political pressure, rather than well considered, credible evidence, can pose risks. In 1999, the government made a proposal concerning the management of individuals with dangerous and severe personality disorder (DSPD). The catalyst for this was the high-profile Michael Stone case. This was an individual with personality disorder, known to psychiatric services but considered ‘untreatable’, who killed a woman and her daughter, aged 6. The initial proposal would have allowed indeterminate detention for reasons of public protection, even for individuals who had committed no offence. This plan never came to fruition due to widespread criticism; it was suggested that 6 individuals would have to be detained to prevent one violent act, perhaps raising wider questions about the ‘number needed to detain’ in more general settings. Instead the treatability clause was removed from mental health legislation, making the availability of appropriate treatment the only necessity. It is estimated that £350-500 million was spent on developing services for DSPD to claim it as a success would be difficult. Admission processes were long-winded, patients did not know what to expect and delays were common. There was also a lack of consistency in treatment delivery and assessment, with no clear criteria for patient discharge, and a lack of services to receive patients. Hours in formal treatment were low despite high staff numbers, and there was even suggestion of deterioration in patients, with reports of increased self-harm and aggression. DSPD services have now been decommissioned.

The intentions of the Transforming Care agenda are admirable, and many patients will be better served in homes not hospitals. Development of robust and varied community services is also positive; if early identification of risky individuals does occur efficiently, the need for in-patient services could indeed be dramatically lowered. The eagerness to reduce bed numbers as quickly as possible is worrying however, and questions remain regarding the motivations for this; 164 inpatient beds closed in 2016/17 ahead of schedule. Do evidence-based reasons exist for these closures, or are they simply a quick way to demonstrate progress? Since 1987, the number of NHS learning disability beds has decreased from around 33,000 to between 2000-2500; 2,375 inpatients were in hospital at the end of August 2018. It could be argued that these remaining beds provide balance to a service with limited alternatives. Penrose’s law demonstrated an inverse relationship between mental hospital beds and prisoner population as early as 1939. Studies have shown that this theory still holds true, with additional associations to crime rate and police numbers. It remains to be seen whether the funding for community services will be enough to compensate, whether these services will be in place in time and whether they will sufficiently meet patient needs. There is good evidence for a balanced approach in the mental health service. Whilst resources and local area needs can dictate provision to a certain extent, both community and hospital services are necessary in all areas.

Transforming Care Partnerships (TCPs) are tasked with the implementation of innovative community housing, care and support solutions. They are comprised of clinical commissioning groups (CCGs), NHS England commissioners and local authorities, funded by up to £40 million of transformation funding from NHS England. A further £20 million in capital funding per year is also being made.
available to TCPs.\textsuperscript{[9,22]} The formation of these TCPs is designed to mitigate the weaknesses in existing commissioning arrangements. There have been difficulties in the past when stepping patients down from low secure care into either rehabilitation beds, or the community.\textsuperscript{[23]} This is because the patient is leaving the remit of NHS England, and the local CCG becomes responsible for them. Because CCGs are responsible for health care services across the board and have limited financial resources, the expensive care needs of offenders can be overlooked.\textsuperscript{[24]} Locked Rehabilitation services have come under fire in the Transforming Care era, with suggestions that they are often used as long-stay wards that institutionalise patients.\textsuperscript{[25]} It has also been claimed that they are used as an automatic option due to risk aversion and a lack of suitable alternatives.\textsuperscript{[26]} Nevertheless, it is accepted practice to use locked rehabilitation as an intermediary between hospital and the community;\textsuperscript{[23,27]} there is good evidence supporting their use for complex individuals.\textsuperscript{[28-29]}

New supervisory measures have also been introduced including care and treatment reviews\textsuperscript{[30]} and scrutiny panels to assess patient’s eligibility to move on. The author attended such a scrutiny panel and observed that the panel members were not at all familiar with the case, citing facts that were out of date and inconsistent with the current wishes of the patient. Panels discussing hundreds of people using identification numbers, never having met the individual, could be considered far removed from personalised and individualised care. Care and treatment reviews themselves could face similar issues, though independent review and discussion of patient care should be a positive influence, provided there are no ulterior motives and the best outcomes are achieved.

The Learning-Disabled Population

Learning disability and Challenging Behaviour

Learning disability is a markedly reduced capability to understand new or complex information or to learn new skills;\textsuperscript{[16]} an IQ below 70 is not enough for diagnosis and many people with a higher IQ may experience great difficulties.\textsuperscript{[16,31-32]} Learning disability starts before adulthood, leaving a lasting impact on development and the individual’s ability to manage independently.\textsuperscript{[16]}

Challenging behaviour in people with learning disability and/or autism is defined in new NHS service model documents. It is behaviour putting themselves or others at risk such as fire-setting, sexually inappropriate behaviour, self-injurious or aggressive behaviour not linked to other severe mental ill health.\textsuperscript{[33]} Severe challenging behaviour occurs in 10-15% of learning-disabled people known to services.\textsuperscript{[34]} The individuals targeted by Transforming Care often have severe learning disability or may be from disadvantaged backgrounds. Individual complexities mean that it is important to understand the many factors leading to an individual’s behaviour.\textsuperscript{[33]}

The Criminal Justice System

In 2007, it was estimated that 20-30% of offenders have learning difficulties or disabilities that interfere with their ability to cope in the criminal justice system and are unlikely to benefit from conventional programmes.\textsuperscript{[35]} Predictably, these difficulties largely relate to understanding the legal process, including poor understanding of cautions or rights and poor comprehension of written information.\textsuperscript{[36]} They are also more susceptible to suggestion and interrogation,\textsuperscript{[37]} misunderstand basic terminology such as ‘guilty’ and ‘not guilty’, and often presume that a false confession is reversible and transparent.\textsuperscript{[38]} The Bradley Report identifies early intervention as key in improving outcomes for people with learning disabilities, even as early as the first contact with the police. At all stages of the criminal justice system, psychiatric liaison and assessment is recommended to identify individuals with enhanced needs.\textsuperscript{[16]}
Prisons across England and Wales appear to be in crisis, with record numbers of self-harm incidents and violent attacks reported in 2018. In 2016, 122 of 354 deaths in English and Welsh prisons were self-inflicted; increasing yearly since 2011. In the 12 months to the end of June 2018 deaths in prison have been reported as 310, 77 of which were self-inflicted. The prison environment arguably encourages drug use, with the use of synthetic cannabinoids now rife amongst prison populations, partly due to its undetectability. Overcrowding has also been a key issue in prisons, meaning a higher proportion of prisoners to staff. Learning-disabled people in particular have problems understanding why they are in prison and adjusting to the prison regime. They are also vulnerable and at increased risk of victimisation; they are bullied and stigmatised for being different. Communication difficulties are also common, both with staff and fellow prisoners. Finally, there is a lack of staff training, time and resources to support the increased needs of these individuals.

The UK Offender Management Act 2007 requires the Secretary of State to take into consideration various aims in the provision of the probation purposes. This includes supervision and rehabilitation of charged or convicted individuals and assisting courts in determining appropriate sentencing. Their aims outlined in law are as follows: the protection of the public, the reduction of re-offending, the proper punishment of offenders, ensuring offenders' awareness of the effects of crime on victims and the public, and the rehabilitation of offenders. These priorities are multifaceted, concerned not only with best patient outcomes. There is already an over-reliance on remand to custody; reasons include public safety, unavailability of alternatives and lack of confidence in the safety and success of these alternatives.

It could be argued that public protection is not an appropriate objective for a hospital. The doctor’s principles make patient care the primary concern; introducing third-party motivations such as public protection is a departure from normal practice and requires justification. Nevertheless, forensic services do contribute significantly to public protection in many cases. The use of the Mental Health Act (MHA) and secure hospital beds as an assessment and disposal option for offenders is well-established. Secure hospital disposal appears to sufficiently meet the various sentencing priorities of the courts. The option to use restriction orders and have the final say on discharge and leave decisions may also give sentencers the confidence to direct offenders away from prison.

The Offender Population

Of 2375 patients residing in learning disability hospitals at the end of August 2018, 1155 (49%) were in secure settings; 675 were in low secure and 415 were in medium secure hospitals. Of the secure patients, 915 (79%) were detained under Part Three of the Mental Health Act, concerned with criminal proceedings or under sentence. Of these, 600 (66%) are restricted patients with Ministry of Justice involvement. The proportion of patients with a duration of stay greater than 2 years was 73% and 72% for low and medium secure services respectively.

The needs of individuals with learning disability and offending behaviour are distinct from the learning-disabled people displaying challenging behaviour. This group is arguably not the target population of Transforming Care. These forensic patients are often complex, with high rates of recidivism and psychiatric comorbidity; personality disorder prevalence is high, and schizophrenia is greatly overrepresented. In many cases they have only mild learning disability and are high-functioning intellectually relative to their peers; it could even be considered appropriate for such people to be charged and held accountable for their actions. These patients are perhaps one of the most stigmatised groups, labelled as psychiatric, disabled and offenders.
It is important to consider the background and offending characteristics of this group. A multicentre study was carried out in 2010; 477 individuals with learning disability were included across three study regions, all of whom had been referred for antisocial or offending behaviour.\(^{(56)}\) Forty-six percent of the referrals had presented with at least one ICD-10 categorised psychiatric disorder in adulthood; 24% was comprised of schizophrenia, bipolar affective disorder and other non-organic psychotic disorders. The same proportion had experienced anxiety and depression conditions and a significant number of individuals had multiple diagnoses.\(^{(56)}\)

Regarding offending behaviour, more than a third were referred for multiple incidents, defined in this study as greater than 5 instances of the index behaviour. Over three quarters had presented with the same index behaviour in the past, the majority not resulting in police involvement or action. The mean number of prior offences was 3.2, and 38% had been charged with at least one criminal offence.\(^{(56)}\) This arguably indicates deeply entrenched behavioural issues that need to be addressed. Most common were *offences against the person*, comprising 77% of all *offences* recorded. Verbal and physical aggression were most prevalent, occurring in 83% of individuals. Next most common were contact and non-contact sexual offences, occurring in 29%\(^{(56)}\), rates of greater than 50% for sexual offending have been reported in other studies.\(^{(57-58)}\) Damage to property was by far the most frequent form of non-person offence, present in 19% of patients. Fire-setting prevalence was notably low at 4%.\(^{(56)}\)

In a study of a medium secure service, fire-setting was found to have a prevalence of 22%, while verbal and person directed aggression occurred in greater than 90% of patients.\(^{(57)}\) Over a 6-year period, 138 patients were treated in this service. Seventy-seven were discharged, 90% of which were stepped down to a lower level of security; a further 36 were considered “difficult to discharge long stay” patients. A high level of psychiatric comorbidity was also apparent in this study.\(^{(57)}\)

To assume that the needs of the population described are consistent with the transformation agenda could be foolhardy. There is a high level of clinical complexity and forensic risk associated with these patients, and their treatment requires time.\(^{(51),(59)}\) They can demand prolonged periods of assessment and specialist involvement, the objective being to formulate new thinking styles, attitudes, emotional control strategies and lifestyles that are not conducive to offending behaviour.\(^{(59)}\) It is true that they should not be detained in hospital any longer than necessary, but the supposition that people with learning disability should always be routed away from hospital services could discriminate against these vulnerable individuals.\(^{(59)}\) Transitioning back into the community is highly challenging;\(^{(60)}\) if treatment benefits cannot be transferred effectively into community life, the patient could be at risk of not only reoffending, but exploitation and neglect.\(^{(59),(61)}\) If patients are rushed towards lower intensity interventions, they may find the disparity with hospital care more than they can handle.\(^{(62)}\) Limited access to inpatient treatment has also been associated with homelessness, violent crime and increased suicide risk.\(^{(63)}\) Rates of suicide are significantly higher in community patients managed by crisis teams, compared with in-patients; for many complex, vulnerable people, crisis resolution home treatment may be inappropriate.\(^{(54)}\)

It is wrong to assume that a home in the community and family support, as Transforming Care encourages, is always beneficial. For many patients with forensic needs, family and community are part of the problem, not the solution.\(^{(51)}\) Many cannot or do not want to return to the area of their index offence, resulting in commissioning issues.\(^{(2)}\) A history of abuse is also common in this group;\(^{(56),(63)}\) O’Brien et al. found that over a third of patients had documented histories of childhood abuse or neglect.\(^{(56)}\) Disabled people are often subject to abuse, aggression and violence in the community;\(^{(65)}\) this could be compounded by the reluctance of communities to welcome back individuals who have previously violently or sexually assaulted others, or damaged property.\(^{(51)}\)
Furthermore, history of substance abuse has been found to be more prevalent in forensic patients with learning disability and psychiatric disorder, compared with non-forensic patients.\textsuperscript{55} Returning to their previous community surroundings with lower levels of supervision and increased availability of substances could lead to patient difficulties.

**Bed Closure Impacts**

Due to diminishing availability of secure beds, many problems could arise. There has already been pressure, resulting from commissioner-led care and treatment reviews, to provide discharge dates for forensic patients who still carry high levels of risk.\textsuperscript{53} If community teams are not yet resourced to manage these individuals, an alternative is to transfer the patient to other hospital services. In July and August 2018 respectively, 21% and 22% of hospital departures were in fact transfers to other hospital services; a further 11% and 14% were unspecified.\textsuperscript{19} The mean community discharge percentage in 6 months from March to August 2018 was just 63%.\textsuperscript{19} The reasons for this are unclear, though it does provide evidence that many patients are being moved around in-patient services, possibly to exaggerate the rate of progress. When bed numbers drop below a certain threshold, transferring patients to services outside of the NHS could be the only option in many cases. Since Winterbourne View hospital was an independent hospital itself, it is concerning that more patients could now be faced with the prospect of being sent to independent institutions.\textsuperscript{51}

Once in the community, patients could be admitted more frequently to already-pressured acute general psychiatric services. The UK has seen a steady reduction in psychiatric bed numbers in recent years; between 2000-2014, beds have dropped from approximately 95 to less than 50 per 100,000 population.\textsuperscript{66} The evidence suggests that bed numbers are already insufficient.\textsuperscript{66-67} Patients are transferred far away from their local area and have inadequate lengths of stay.\textsuperscript{66} Involuntary admissions have also increased in concert with the reduction in provision of mental illness beds.\textsuperscript{68} Potential voluntary admissions may end up as involuntary admissions through repeated contact with crisis teams.\textsuperscript{66} Evidence is limited on the outcomes of learning-disabled people in general psychiatric services, but there is a suggestion that extra support is needed to achieve good outcomes for these patients.\textsuperscript{69} General inpatient units appear to offer opportunities for making friends,\textsuperscript{69} although there may also be a risk of exploitation by more able patients. Alcohol and drug use is also more common in general services.\textsuperscript{69} There is evidence of good treatment outcomes for patients with learning disability receiving offense-specific and other therapies in specialised secure units,\textsuperscript{69-70} particularly for personality-disordered individuals.\textsuperscript{70} In general settings, even a mildly low IQ may exclude patients from treatment programmes.\textsuperscript{70}

A higher number of learning-disabled offenders could also be sent to prison, due to sentencers having less confidence in the disposal options available to them, particularly when there is an element of culpability.\textsuperscript{16,47,49} Whether for reasons of punishment or public safety,\textsuperscript{47} there will most likely be reluctance to send offending individuals directly into the community. Furthermore, sentencers could be less likely to direct individuals to hospital beds, knowing that there is increased pressure to transition people into the community. They may harbour fears that people could be discharged to the community after a relatively short time, avoiding punishment. One possibility is that there could be an increase in the use of section 45A of the Mental Health Act.\textsuperscript{49-50} This is a specific type of hospital order known as a hybrid order; it allows direction to hospital, with the condition that once treatment is no longer necessary the patient can be taken to prison to serve the remainder of their sentence. Release decisions are then taken by the Parole Board rather than a Mental Health Review Tribunal.\textsuperscript{49-50} This could provide reassurance when making disposal decisions, but still relies on the availability of appropriate hospital beds.
As a comparison, the USA has significantly lower availability of publicly funded psychiatric beds; this has been associated with mass incarceration and homelessness of people with serious mental illness, increased suicide rates, lengthy delays for individuals who require services to restore their competency to stand trial and increased pressure on emergency departments.\cite{63,71}

**Beyond Hospital**

*Guardianship Orders*

If an individual is to be placed into the community, various legal options exist to aid their management. A guardianship order under the MHA can be used either for their own welfare or for the protection of others.\cite{50} The individual can be required to reside at a specified place and to attend at specified places and times for treatment, occupation, education or training.\cite{50} Access to the patient at any place of residence, to any medical practitioner or other specified person, is mandatory when it is deemed necessary.\cite{50} The guardianship order has limited power however, except to convey an individual back to their place of residence if they wander.

*Community Treatment Orders (CTOs)*

CTOs provide a potentially more useful option under the MHA. They can be used to manage treatment for discharged patients and protect the public; the responsible clinician has the power to recall the patient to hospital if conditions are not being met or if the patient needs hospital treatment.\cite{50} Most commonly, they are used to ensure medication compliance.\cite{72} It has also been suggested that CTOs are used inappropriately to alleviate bed management issues.\cite{72} CTOs have also sparked legal controversy, illustrated by 2 contrasting court appeals. One patient on a CTO was subject to conditions that amounted to deprivation of liberty, allowed by the Court of Appeals on the basis that the CTO was less restrictive than hospital.\cite{73-74} For another patient, the Court of Appeals ruled that a tribunal had no power to impose conditions on a CTO that deprived a patient of their liberty, even with the patient’s apparent consent. Permission to appeal in the Supreme Court was granted in both cases, highlighting the legal uncertainty regarding CTO conditions.\cite{73-74}

*Deprivation of Liberty*

The ‘acid test’ for deprivation of liberty consists of 2 questions; is the patient free to leave and is the patient under continuous supervision and control?\cite{75} Ordinarily, these deprivations are only acceptable where mental capacity is lacking in relation to the matter, and the arrangements are in the person’s best interests.\cite{76} In both the aforementioned cases, the patient had capacity.\cite{73-74} Deprivation of liberty comes under the remit of the Mental Capacity Act (MCA), not the MHA.\cite{76} It is also important to note that under the MCA, deprivation of liberty cannot be justified for reasons of public protection, only for the protection of the individual’s best interests.\cite{76} Where deprivation of liberty is occurring, it must be authorised either under the Deprivation of Liberty Safeguards (DoLS), by the Court of Protection, or under the MHA if applicable, which is where the conflict arises.\cite{76} It is unclear how it will be legally possible to achieve the supervision that complex individuals will demand in the community, particularly in cases where public protection is a major factor.

*Forensic Outreach Liaison Services (FOLS)*

The main aim of FOLS would be safe management of behaviour amongst learning-disabled people displaying challenging behaviour. Avoidance of contact with the criminal justice system, or admission to secure hospital is desirable.\cite{77} FOLS would provide forensic risk assessment and management in the community to ensure public and individual safety. Delivery of offence specific interventions would also be key, alongside case management of complex individuals. Support and training for day-
to-day support agencies would also be vital.\textsuperscript{(77)} At the core would be a dynamic register informing the commissioning of support services, as well as identifying individuals with risky behaviour.\textsuperscript{(77)} The main drawback of FOLS is that they are an add-on for existing community and social services. The problem therefore lies in the wide variability of community forensic mental health (CFMH) services across the UK, with complete absence of services in many areas.\textsuperscript{(78-80)} CFMH service provision is markedly different regionally and patchy even across boroughs in the same region.\textsuperscript{(78)} Variability has also been found in the treatments offered in different CFMH services, with few services offering offence-specific treatments.\textsuperscript{(79)} Development of consistent, countrywide CFMH services is a prerequisite for FOLS; developing this infrastructure and workforce\textsuperscript{(83)} will take time and financial investment. Services arguably will not be ready to receive patients in tandem with bed closures.

**PIPEs**

Psychologically Informed Planned Environments (PIPEs) are specially designed, contained environments where trained staff work with offenders in prison.\textsuperscript{(15,82)} A key feature of the model is the formation of safe and supportive relationships between staff and prisoners. Staff availability and respectful day-to-day interaction is vital. The staff team members should be clearly defined and committed, as well as sufficiently trained. Non-PIPE prisoners may undermine the potential of PIPE schemes, therefore special attention must be paid to the consequences if prisoners mix.\textsuperscript{(15,82)} Ideally, a separate population of PIPE prisoners should be created. PIPEs were created as part of a personality disorder strategy for offenders; they may be appropriate for learning-disabled offenders with personality disorder.\textsuperscript{(15,82)} While support exists for the development of PIPE schemes aimed specifically at learning disability, nothing has materialised yet. This is an area that could prove promising for the many learning-disabled individuals that go to prison.

**Conclusions**

“It ought to be remembered that there is nothing more difficult to take in hand, more perilous to conduct, or more uncertain in its success, than to take the lead in the introduction of a new order of things”\textsuperscript{(83)}

Forensic learning disability services are heading into uncharted territory. Transforming Care undoubtably has the best interests of the patient at its core, but it arguably does not make public protection a priority. The distinction between challenging behaviour and offending behaviour is important; many secure hospital patients display the latter, raising questions of the ongoing bed closure initiatives. There are many potential impacts on forensic individuals who may fall between the boundaries of different services. Individuals with learning disability, offending behaviour and often comorbid mental health problems make up a significant proportion of the patient population; bed closures and pressures for community care could discriminate against this group. It is questionable whether community care close to home is in the interest of these patients, or the public.

Whether it would always be legally possible to achieve required levels of community supervision is another issue that requires further clarity. Local services will need to develop a workforce that can manage forensically challenging people in social care settings; it is unclear whether this can be provided effectively 24 hours a day. The development of such a service necessitates time and investment, both of which appear limited. If the service does not meet the many complex needs of the population, there may be a paradoxical increase in admissions and adverse patient outcomes. With increased pressures on all parts of this already-strained service, there may also be less enthusiasm to work in this field. Consequently, quality of care across the board could decrease.
Another key factor will be who assumes responsibility for discharged patients – clinicians or the Ministry of Justice? The priorities of the Ministry of Justice are distinct, with a greater desire for punishment and public protection. In the absence of secure hospital beds, more people could be sent to prison. It has been shown that learning-disabled individuals do not cope well in prison or the criminal justice system, and it is inappropriate for them to be imprisoned due to a lack of safe alternatives.

It will be important to assess the outcomes of the Transforming Care agenda in the coming years. The number of patients discharged from secure settings who reoffend, or are readmitted to specialised, secure and general hospital settings will be of particular interest. Alongside community reoffending comes potentially avoidable victimisation, raising serious questions about community safety. A national learning disability programme should not impact on the outcomes of individuals with complex psychiatric needs, nor should it put the public at unnecessary risk.
References

15. Glynn K. Report for the October Meeting of the HOSC: Overview of PIPEs Service and Update on the Decommissioning of the DSPD Service at Rampton Hospital. NHS England Midlands and East; 2016. Available from: http://www.nottinghamshire.gov.uk/DMS/Document.ashx?czJkcaei5tUFL1DL2UE4zNRBoOShgo=buZHknBSowfddttQ%2BexgYi8Njihq%2BvF3%2FFjxL3rSO1YwPTATeCw%3D3%3D&rUzwRPF%2B7zrd4E7kn8Lwv%3D%3D=pwRE6AGJFLDNlh22SFS5QMaQWCPHwdsUFCZ%2FLUQzgA2uL5JNRG4jdQ%3D3D&mCTbCub5FFXsDGW9IXnlg%3D3D=hhfUudN3100%3D&kCx1An5S9%2FpWZ40DXFvdEw%3D3D=hhfUudN3100%3D&uJovDxwdjMPoYv%2BAJvYtyA%3D%


23. Kennedy M. Caught between Commissioners – the plight of forensic patients waiting for a rehabilitation bed. Mental Health and Court of Protection Department; 2017.


33. NHS England. Supporting people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition. NHS England;


