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Developing a screening tool for offenders with intellectual disabilities – the RAPID

Salma Ali and Scott Galloway

Abstract

Purpose – The purpose of this paper is to outline and report on the initial development of a screening tool for offenders with suspected intellectual disability (ID) known as the rapid assessment of potential intellectual disability (RAPID).

Design/methodology/approach – This paper summarises the wider literature in relation to screening tools and methodology, indicating that quick and easy screening measures for this population are sparse. It outlines the processes involved in the early stages of developing an evidence-based screening tool for ID offenders, and an overall pathway approach to the identification, assessment and diagnosis of ID.

Findings – It is possible to develop a tool that can be used to identify potential ID with relative ease. The RAPID screening tool provided practitioners with a simple and easy measure to identify such individuals so that they may be referred for further specialist assessment. It has also demonstrated that it is an effective measure in identifying offenders with a possible ID.

Research limitations/implications – Formal statistical validation of this tool will serve to establish and measure its overall effectiveness and utility, further encouraging the timely identification of ID offenders.

Originality/value – This paper responds to current extensive literature about the variability of screening measures, and provides an effective solution to the identification of vulnerable offenders. Those who may benefit from an assessment of ID, and thereafter reasonable adjustments and alternatives to custodial sentencing are considered.

Keywords Assessment, Intellectual disability, Screening, Learning disability, Identification, Criminal justice

Paper type General review

Introduction

Offenders with mental health issues and intellectual disabilities (ID) often have difficulties navigating their journey through the criminal justice system (CJS), and may therefore be disadvantaged without specialist support (Gudjonsson and Joyce, 2011; Sondenaa et al., 2010; Talbot, 2008). Awareness of how mental health difficulty may contribute to offending behaviour is a relatively well understood and developed area. Services such as prison in-reach, and more recently the development and integration of police/court liaison and diversion schemes have been implemented to respond to the needs of such offenders. Schemes of this nature encourage better identification of mental health vulnerability, and in turn enables practitioners to consider appropriate support packages tailored to address individual need. The links between mental health, vulnerability and offending behaviour are well known and have been described within legislation such as the Police and Criminal Evidence Act (PACE), (1984). However in comparison, vulnerability with specific relevance to ID is much less well understood and acknowledged. Overall, research into ID, offending and screening for ID remains sparse (Barron et al., 2004; Pakes and Winstone, 2010).
The current paper reports on the development of what we have called the rapid assessment of potential intellectual disability (RAPID) screening tool; a 15-item questionnaire designed and piloted for use by all professionals working with adult offenders who may have an ID in both court and prison settings.

Literature review

The “No one knows” (Talbot and Riley, 2007) literature specifically explored how individuals with ID are treated in the CJS. It identified that approximately “20-30 per cent of prisoners have learning disabilities or difficulties that interfere with their ability to cope within the CJS” (Talbot, 2008, p. 1). A further 7 per cent of prisoners had an intelligence quotient (IQ) of below 70, and at least 25 per cent had an IQ of below 80 (Mottram, 2007). Overall it is generally accepted that between 5 and 10 per cent of adult offenders will have an ID (Talbot and Jacobson, 2010), compared to approximately 2 per cent of the general population (Department of Health, 2001).

Evidence indicates that offenders with ID are more vulnerable than their counterparts without ID. They are less likely to understand information about the police caution and are more likely to make decisions that would not protect their rights as suspects and defendants. They are also more likely to be acquiescent and suggestible (Clare, 2003), and more vulnerable in police interviews (Gudjonsson, 2003). Over half of offenders with ID have trouble making themselves understood in prison, two thirds have verbal comprehension difficulties and are more likely to act out aggressively in frustration. They are five times more likely to be restrained and are also three times more likely than other prisoners to suffer from anxiety or depression (Talbot, 2008). This group are at risk of re-offending due to their needs not being adequately, if at all, identified. Additionally, many of those with ID being arrested or detained are unlikely to have any obvious presenting features that make their ID easily identifiable. Consequently, those with “hidden disabilities” will have more difficulty coping (Petersilia, 1997) and are rendered more vulnerable within a system that appears to neither recognise nor support their needs (Loucks, 2007).

Encouragingly, the recent publication of the Bradley (2009) review has initiated much needed discussion in this area, and steps have been taken to improve the provision for ID offenders. How ID offenders are treated within the CJS is an area of real concern, and requires the integration and resourcing of a system that is currently ill-equipped to manage such individuals. Bradley (2009) recognised that there were many similarities between people with mental health issues and ID, but importantly acknowledged that there were also significant and definite differences between the two groups and subsequently each should be considered separately. Of the 82 recommendations outlined in the report, those central to this paper demanded greater and more robust screening for offenders with ID at the earliest point in the criminal justice pathway (Bradley, 2009). It also recognised that procedures for screening and identifying needs should be available at all points of the CJS. Adequate training of all criminal justice and healthcare professionals was recognised as a fundamental requirement to ensure successful identification, management and resettlement of ID offenders (Kvarfordt et al., 2005; Talbot and Jacobson, 2010; Talbot, 2012).

However, failure to identify individuals, early enough to make a meaningful difference to their progress through the system is a key issue (Bradley, 2009; Docherty, 2010; Douglas and Cuskey, 2011; McKenzie et al., 2012; Talbot and Jacobson, 2010). For example, Murphy and Clare (1998, p. 17) recognised the need to identify those individuals with ID early in order to assess their ability to “benefit from the due process of the law”. Ideally, they should be screened upon arrest (Mckenzie et al., 2012), and if not, at court. It is generally accepted that the formal assessment of ID should be undertaken by a qualified psychologist, using appropriately validated and standardised assessment measures (British Psychological Society (BPS), 2000), and although this information would prove essential in the appropriate determination of an ID, the need to expediently identify such individuals makes this type of assessment difficult to administer soon after arrest.

This problem has encouraged the greater use of routine screening measures in criminal justice proceedings (Bradley, 2009; McKenzie et al., 2012; Talbot, 2008), and an associated realisation
that there is a lack of screening and identification procedures specifically for this population (Hellenbach, 2012; Herrington et al., 2007; McKinnon and Grubin, 2012; Murphy and Clare, 1998; Young et al., 2013). Screening is a useful mechanism to identify those reasonable adjustments that require implementation by the CJS under the Equality Act (2010). However, the few services that do offer screening vary in consistency and delivery, which can obscure the complex nature of what is often a “hidden disability” (Talbot and Jacobson, 2010).

Screening is by no means an exact science, and tools generally rely heavily on self-report. Interviewees are often reluctant to disclose personal and sensitive information for fear of being stigmatised or labelled (Loucks, 2007; Talbot and Jacobson, 2010), particularly within the challenging environment of the prison. Such measures therefore rely on appropriate timing, a safe space and the establishment of a good relationship between interviewer and interviewee to achieve an honest appraisal at the screening stage (Hayes, 2004). The lack of an established relationship may have a significant impact on the number of individuals with ID who may be highlighted, as the absence of trust in such an evaluation is likely to lead to defensiveness and a lack of engagement. Consequently, the likelihood of failing to identify such offenders remains high, and in turn fails to meet the recommendations set out in the Bradley (2009) review.

Furthermore, many screening measures that are currently being used have not been adequately validated in criminal justice settings. For example, the authors of the learning disability screening questionnaire (McKenzie and Paxton, 2006) acknowledge that despite its use, it was originally standardised for use within community ID services and not with criminal justice populations, although recent steps have been taken to rectify this (McKenzie et al., 2012).

In contrast, the Hayes ability screening index (HASI) (Hayes, 2000), has been widely validated (Sondenaa et al., 2007, 2011), and evidence has suggested that it is a practical, quick and easy tool to administer within forensic settings (Robinson, 2005) to identify the presence of a possible ID. Additionally, it has been designed to be administered by all professionals, including those with no specialist training in ID or in the administration of specialist psychological instruments (Ford et al., 2008). It does, however, require more time and staff resources to deliver consistently to the large numbers of people passing through prison reception or courts.

It is therefore clear that a wider, quicker and more accessible set of screening processes at all points of the criminal justice pathway is required in order to inform decision-making. Whilst both police, court liaison and diversion schemes continue to develop screening processes, it seems that prison services are less well developed (Hayes et al., 2007) and may benefit from the creation and development of a robust reception screening pathway that is supported by the increase of ID awareness training for both healthcare staff and prison officers alike. This notion is supported by the literature (Bradley, 2009; Chappell et al., 2001; Talbot, 2008), in addition to practical advances in both policy and legislation. An effective screen upon prison reception therefore offers an opportunity to identify those with ID in order to ensure better provision for those who come into prison.

Design/methodology
The RAPID screening tool

The RAPID screening tool is a 15-item self-report questionnaire designed to identify adult offenders who may have difficulties with both intellectual and social and independent living skills. It is the first stage of a screening and assessment pathway, and scoring above a numerical threshold initiates a referral for a more comprehensive assessment. The principle aim is to provide practitioners with a quick and simple tool which seeks to identify whether an individual may have an ID or specific learning difficulty by obtaining an understanding of the difficulties they encounter on a day-to-day basis.

It is largely based on a screening tool developed by Lyall et al. (1995), who studied the incidence of individuals with ID detained in police custody in Cambridge. Out of a sample of 251 individuals detainted, 4.4 per cent had attended schools for individuals with moderate intellectual difficulties, whilst 0.4 per cent were reported to have attended schools for those with severe
intellectual difficulties. Furthermore, 10.4 per cent had attended schools for individuals with emotional and behavioural difficulties or had accessed a learning support environment within mainstream school.

However, whilst Lyall et al.’s (1995) questionnaire could be helpful in identifying those individuals who for example, require an appropriate adult under PACE (1984), it is by no means sufficient on its own as a reliable measure of identifying ID and vulnerability. It is well documented that individuals may be unwilling to disclose their disabilities due to the stigma attached (e.g. Loucks, 2007; Talbot and Jacobson, 2010), and it is possible that individuals fear the treatment they may receive from the police whilst in custody should they disclose any disability (Talbot, 2008). Consequently, a clinical interview was incorporated into the second stage of the RAPID screening pathway as well as the administration of the HASI (Hayes, 2000) to comprehensively explore the difficulties that an individual has encountered throughout their life, including education, employment, mental health difficulties, substance misuse and offending history.

The pathway has been designed in this way to address practical difficulties that may occur when screening an individual in custody. Administering cognitive tests in a busy court custody or prison reception environment is not always practical and can be potentially risky (Medford et al., 2000; Talbot, 2008). The RAPID screening tool accommodates these practical difficulties whilst simultaneously enabling the professional to obtain an understanding of an individual’s difficulties, and identifies the need for further assessment where appropriate (see Table I).

Development

The screening tool needed to include a number of elements. Given the time pressures within most criminal justice settings, the tool needed to be easily understood and quick and simple to administer. Additionally, all practitioners should be able to administer it regardless of qualifications, and with little training.

Decisions to include each of the questions were largely based on clinical experience of working within a service for people with ID – through general observation of individuals and their difficulties and by reading their collateral historical information, in addition to the relevant literature base. The screening questions should also encompass the three criteria used for a diagnosis of ID: significant impairment in cognitive functioning as measured by an IQ of less than 70; significant impairment in two or more areas of adaptive and social functioning; and onset before the age of 18 years (BPS, 2000).

Lyall et al.’s (1995) questionnaire was incorporated, but the question relating to “name of school” was omitted as the RAPID was originally devised for use in a local young offender’s institute (YOI) and a number of magistrates’ courts. Individuals being screened in the YOI and courts could originate from all over London and the UK, and so there seemed little mileage in asking for the name of their school at this point. This information could be obtained as part of the second stage screen and clinical interview process.

Often concerns are recorded about levels of engagement and educational ability, but few individuals are formally assessed following these concerns (e.g. Simonoff et al., 2007; Talbot and Jacobson, 2010; Talbot, 2012). As such, questions about historical diagnoses of dyslexia or attention deficit hyperactivity disorder (ADHD) were included. Dyslexia is typically seen as an underlying intellectual difficulty, and ADHD may also be seen to indicate the presence of intellectual difficulty (Simonoff et al., 2007). Features such as disruptive behaviour and poor concentration may in fact mask additional underlying and more global cognitive deficits that might otherwise be missed without an assessment of ID (Simonoff et al., 2007). Equally, disruptive behaviour which masks a generalised ID may be misdiagnosed as ADHD (Ageraniti-Belanger et al., 2012). Therefore, it was felt appropriate to include such questions within the screening tool.

Implementation

The screening tool was initially used in a YOI and court setting. Its use was later expanded into an adult female prison. It was administered by nurses across all sites, specifically, clinical nurse specialists from the court liaison and diversion team and primary care nurses at prison reception.
The scoring utilised a simple “1” or “0” system. “1” if the item was endorsed, and “0” if it was not. Each endorsed item was then totalled, and if it reached the cut-off score referral for specialist assessment was actioned. A total maximum score of 15 could be obtained.

There were some differences in the way the tool was administered which appeared to be largely dependent on context. All individuals who were identified as requiring a mental health assessment at court were also screened for ID. In comparison, all individuals received into each prison setting were automatically screened for ID as part of prison reception procedures. Consequently, the embedding of processes, permissions and ownership of data varied across sites.

**Cut-off score**

As the purpose of the screen is to identify possible ID and refer on for further assessment, each individual has to score above a certain threshold to initiate this. A “pilot assessment” approach was adopted, and the original cut-off score was set at 5. This was based on clinically informed experience, such as the types of screening questions that individuals with ID were likely to answer.

### Table I | The RAPID Screening Tool

<table>
<thead>
<tr>
<th>The Rapid Assessment of Possible Intellectual Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Score ‘1’ for each Yes and ‘0’ for each No answer. ‘Don’t Know’ answers should be scored ‘0’</td>
</tr>
<tr>
<td>1. Did you ever have any difficulties with classroom work or subjects at school?</td>
</tr>
<tr>
<td>2. Did you ever have a Statement of Special Educational needs, or your own classroom assistant?</td>
</tr>
<tr>
<td>3. Did you ever go to a special needs school or attend a special needs class?</td>
</tr>
<tr>
<td>4. Did you ever need or receive extra help with:</td>
</tr>
<tr>
<td>i. Reading</td>
</tr>
<tr>
<td>ii. Writing</td>
</tr>
<tr>
<td>iii. Maths</td>
</tr>
<tr>
<td>5. Do you need help now with any of the following?</td>
</tr>
<tr>
<td>i. Filling in Forms</td>
</tr>
<tr>
<td>ii. Household tasks</td>
</tr>
<tr>
<td>iii. Managing Money</td>
</tr>
<tr>
<td>iv. Using Public Transport</td>
</tr>
<tr>
<td>6. Have you ever been diagnosed with or has anyone ever said that you have:</td>
</tr>
<tr>
<td>i. Learning Disabilities</td>
</tr>
<tr>
<td>ii. Learning Difficulties</td>
</tr>
<tr>
<td>iii. Dyslexia</td>
</tr>
<tr>
<td>iv. ADHD</td>
</tr>
<tr>
<td>v. Autism</td>
</tr>
</tbody>
</table>

Yields a total score of 15, with a score of 3 being the threshold for further onward referral

Please note: The screening tool items are currently undergoing formal validation, and are strictly prohibited for use or reproduction without permission from the author.
positively as well as the issues highlighted in the literature. It was not at this (pilot) stage derived by way of statistical measure. After its introduction into the CJS, it transpired that the tool was not identifying the number of individuals initially anticipated, and was inconsistent with the figures reported in the literature on prevalence (e.g. Herrington et al., 2007). There were a number of possible explanations for this which were not accounted for initially, including self-report bias, the point at which the screening occurred, and administrator knowledge, training and commitment to appropriate administration or scoring. Taking these elements into consideration, and looking at the data collected, the cut-off score was revised and reduced to 3. This score seemed to better reflect the prevalence rates on adult offenders with ID, and later formal assessments seemed to suggest that a cut-off score of three typically produced a Wechsler Adult Intelligence Scale-UK Fourth Edition (Wechsler, 2008) full scale IQ (FSIQ) in the below 70 to borderline ranges. For example, a small sample of 22 assessments indicated that 17 individuals had a FSIQ of less than 70, and 5 had an FSIQ of 70-80. Of this sample, eight people had FSIQ’s of between 50 and 60, and seven people had FSIQ’s of 61-70. Albeit a very small sample, these figures do appear to demonstrate the utility of the RAPID using a cut-off score of 3 in identifying those people who may potentially have an ID.

However, given that the number of screens undertaken varied widely across services, data are currently being gathered to more formally evaluate the psychometric properties of the screening tool with a view to validating its use and compare its utility to other assessment/screening tools.

**Training and competency**

The screening tool has been designed for completion by any criminal justice or healthcare professional regardless of their specialist training or designation. However, following reports of variable practice by staff conducting the screen initially, and after much discussion and reflection on guidance and good practice, it was decided that all professionals using the tool should be trained in its administration by a specialist ID practitioner in order to maintain consistency of administration, and promote good practice. This is an area commonly reflected in the literature about the adequacy of training available to criminal justice staff (e.g. Bradley, 2009; Talbot, 2012). The training package considered three main areas. First, a general awareness of ID and the rationale for implementing a screening tool of this nature was introduced, providing information and promoting understanding about the wider diversion context; second, the importance of building rapport, considering the environment within which they were administering the screening tool, the importance of seeking additional information when necessary, and to support endorsed screening items was emphasised, and third, participants were trained on how to ask the separate questions, the importance of asking all the questions and the interview approaches that they may find useful. The training also had the added benefit of raising interest in and awareness of ID presentations and processes.

**Feedback**

Voluntary verbal feedback was provided by professionals using the screening tool at the different criminal justice sites within mental health team meetings, and liaison and diversion forums. All indicated that they found the tool to be an effective way of identifying ID and vulnerability, but it also allowed professionals to think about mental health and ID pathology in ways that they had not done previously. Their thinking had a unitary mental health focus, and little consideration had been given to how difficulties in cognitive functioning, understanding and communication may present as behaviours associated with mental ill-health.

**Discussion**

Existing literature raises important questions about the current level of screening procedures for offenders with ID, highlighting that screening is far from adequate with substantial variability in screening tools, procedures and service-delivery. It seems clear therefore that the presence of robust screening measures for ID offenders is necessary and overdue. The purpose of this paper was primarily to outline the process undertaken in the development of a simple screening tool for ID offenders, and to consider the practical and clinical issues that may arise in the development of such a measure.
The RAPID screening tool was designed to highlight the need for further cognitive evaluation, and initiate a specialist assessment pathway. Furthermore one of the intentions of this approach was to move one step beyond impressionistic, clinical or personal judgement to a more structured, but simple and effective screening tool to quantify and therefore justify and endorse referral for full assessment. Feedback from professionals has indicated that this simple but seemingly effective tool can appropriately identify an individual’s possible ID. It is by no means rigid and inflexible, and provides room for clinical judgement, which may pose both advantages and disadvantages. However, given the absence of well-established and validated screening measures for this population in general, this screening tool does seem to offer the promise of providing a consistent and robust framework for professionals to evaluate the potential presence of ID, and where indicated, make an informed referral for further specialist assessment.

The simplicity of this tool may suggest that little formal training is required for its use. However, throughout its development the authors recognised that the inclusion of a short training package about its use in addition to general ID awareness would be advantageous in promoting good practice and consistency. It is highly likely that despite professional training and knowledge, practitioners undertaking routine screening procedures will always require appropriate training around those measures.

Conclusions and future recommendations

The recent development of liaison and diversion services has led to an increase in the availability of staff who undertake screening, but there needs to be more consideration in terms of extending the delivery, consistency and reliability of screening, thereby also benefitting risk-management and increasing the availability of general clinical expertise both at court and in prison.

There may also be important practical differences that require consideration when implementing a screening measure for use in the CJS. For example, embedding a short screening measure has been demonstrated to be a relatively straightforward process in certain prison situations (e.g. Board et al., 2015). Management of risk and vulnerability may be easier, simply because more individuals are subject to screening and therefore likely to be identified easier. Legal and clinical systems in turn become more familiar with ID referrals, and therefore more responsive. Additionally, being in a contained environment, and having agencies such as prison in-reach and education, makes the identification process even more robust. If individuals negatively self-report at prison reception, it is possible that the aforementioned teams may identify individuals later.

The practical difficulties within a prison environment are slightly different to those at court. The need to process individuals expeditiously can mean that practitioners are under huge time pressures to screen people quickly. This has been alleviated somewhat by liaison and diversion services, but the number of people screened and identified overall remains unsatisfactory. This is of course in addition to other difficulties faced by individuals in custody affecting their ability to disclose vulnerability (Talbot, 2008). The absence of effective screening may mean those with ID are not afforded the reasonable adjustments as required by the Equality Act (2010) to assist vulnerable offenders and this may in turn have significant legal consequences.

Despite the many practical issues with screening procedures as a whole, it is hoped that this paper has added to the existing body of literature about screening for ID. Initial use of the RAPID has demonstrated that it is indeed possible to identify individuals who may have undiagnosed ID with relative ease, certainly to the extent where further referral for specialist assessment is evidenced. Positive feedback from practitioners working with this marginalised group have welcomed the introduction of this tool. It has allowed them to feel more confident in identifying ID, and advocate for further assessment, whilst also preventing those with possible ID being absorbed into the general mental health arena in the absence of any ID screen.

The screening tool forms the first and most important step in a pathway upon which individuals can be identified and assessed, as proposed by Lyall et al. (1995). It does not diagnose, but importantly highlights the potential for formal diagnosis on the basis of a series of questions, which in turn provide validation for onward referral. This in turn may compel specialist services to initiate formal assessments, and there after work with individuals in a manner that is specific and
appropriate to their level of functioning. By initiating effective assessment and identification of the person with ID, the screen offers a potentially significant contribution to reducing the risk of offending, and prevents criminalising behaviour which may actually be related to communication difficulties, limitations in understanding and associated vulnerability.

The consistency in providing screening for ID remains variable however, both with the tools that are adopted and the systemic procedures that are employed. Recommendations made in the wider literature have called for criminal justice professionals to be using properly validated screening tools to identify offenders with ID (Talbot, 2012). Given the apparent effectiveness of the RAPID screening tool, its utility, and the positive feedback received from professionals, it is now appropriate to conduct a more formal validation, and to evaluate the tool’s sensitivity, item specificity and overall effectiveness both as a clinical tool, and as a contribution to a criminal justice pathway. Statistical validation may encourage further dissemination into the CJS, particularly police custody, courts and prisons. This will continue to pave the way for effective and timely identification of ID offenders, who may benefit from reasonable adjustments and alternatives to custodial sentencing where appropriate.

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