Assessing the prevalence of learning disability among young adult offenders in Feltham

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Disclaimer: The views in this report reflect the views of the authors alone and do not necessarily reflect the views of Hounslow NHS PCT.
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## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acknowledgements</td>
<td>ii</td>
</tr>
<tr>
<td>Foreword</td>
<td>iv</td>
</tr>
<tr>
<td>Summary</td>
<td>vi</td>
</tr>
<tr>
<td>Chapter 1: Introduction</td>
<td>1</td>
</tr>
<tr>
<td>Chapter 2: Methodology</td>
<td>9</td>
</tr>
<tr>
<td>Chapter 3: Learning disability in Feltham YOI</td>
<td>14</td>
</tr>
<tr>
<td>Chapter 4: Healthcare in Feltham YOI</td>
<td>29</td>
</tr>
<tr>
<td>Chapter 5: Summary and recommendations</td>
<td>33</td>
</tr>
<tr>
<td>References</td>
<td>39</td>
</tr>
<tr>
<td>Appendices</td>
<td>43</td>
</tr>
</tbody>
</table>
Foreword

In April 2004 responsibility for commissioning healthcare services in Feltham Young Offenders Institution (Feltham YOI) was transferred to Hounslow Primary Care Trust (Hounslow PCT). This was the first wave of the national programme designed to help deliver a comparable health service to inmates as that available through the National Health Service (NHS) in the community. This involved 18 PCTs covering a total of 34 prisons in England and Wales.

In October 2003, Hounslow PCT, under the leadership of the Nurse Consultant in Learning Disabilities (Susan Harvey), considered the implications of this move for learning disability services. A clinical team from the PCT developed an outline proposal to assess the prevalence of learning disability (LD) in Feltham YOI, and approached the Institute for Criminal Policy Research (ICPR) at King’s College London to discuss how this could be progressed. Funding of approximately £31,000 was secured from Hounslow PCT.

The ICPR conducted a feasibility study to assess what was already known about the prevalence of LD in the criminal justice system, the measures in place to manage offenders with a LD, and the practicalities involved in an assessment of LD prevalence in Feltham YOI (see Herrington et al., 2004). This involved discussions with staff from the West London Mental Health Trust and Feltham YOI.

In identifying a methodology for the prevalence study, discussions were held with Phil Shackell at the Cumbria and Lancashire (NHS) Specialised Services Commissioning Team and Associate Professor Susan Hayes at the University of Sydney. They were developing a similar research project to assess the prevalence of LD in an adult prison in the North West of England. The Cumbria and Lancashire team provided a further £10,000 funding to the project, allowing the ICPR to engage the services of Dr. Christopher Bennett and his team at the Eric Shepherd Unit, part of the Hertfordshire Partnership Trust. Specifically, these funds paid for the training and supervision of the research team from a Consultant Clinical Psychologist experienced in forensic LD.

Ethical approval for this work was obtained from three committees (NHS, King’s College London, HM Prison Service) and NHS Research Governance permissions.
were granted through Hounslow PCT. This report is the product of a collaboration between the ICPR, Hounslow PCT, Hertfordshire Partnership Trust, Cumbria and Lancashire Specialised Services Commissioning Team, Associate Professor Susan Hayes and Feltham YOI.
Summary

This research was commissioned by Hounslow Primary Care Trust (Hounslow PCT) in order to establish the prevalence of learning disability (LD) among inmates aged 18 to 21 years in Feltham Young Offenders Institution (Feltham YOI).

LD is characterised by significant impairments in both intelligence and adaptive behaviour (i.e. difficulty coping with the daily demands of a normal social environment). It is a developmental disability which generally manifests itself in early childhood (and before the age of 18 years). Cognitive and adaptive behaviour difficulties as a result of head injury are not classified as a LD. Likewise LD is not a mental health issue per se, and it is different to specific learning difficulties such as dyslexia.

There has been considerable discussion surrounding the prevalence of LD in the criminal justice system, and the implications of this for service providers, although results from previous studies have been mixed. This report presents findings of a prevalence study conducted in Feltham YOI. It hopes to provide Hounslow PCT with evidence on which to base decisions about the commissioning of specialist learning disability services within the prison.

Key findings from the research are:

- Most participants (93 per cent) scored below average (i.e. below 100) on a standardised measure of intelligence (or IQ) indicating a generally low level of cognitive performance amongst this group.

- Ten per cent of participants had an IQ composite score of 69 or less on this measure of intelligence, indicating a significant cognitive impairment.

- A further 13 per cent had IQ composite scores ranging between 70 and 74; and 16 per cent had scores between 75 and 79. This indicates a considerable cognitive impairment, and these individuals may also benefit from additional help. In total then, 39 per cent of participants had an IQ composite score of 79 or less.
Eighty-four per cent of participants scored below average (i.e. a score below 100) on a standardised measure of adaptive behaviour, indicating difficulties in areas such as self-care, communication, involvement in the community, leisure and work. For 17 per cent, scores were sufficiently low to indicate that this impairment was significant (that is, a score of 79 or less).

Five per cent of participants scored sufficiently low on measures of both IQ (i.e. a score of 69 or less) and adaptive behaviour (i.e. a score of 79 or less) to fulfil the broad diagnostic criteria for LD. In other words, seven (out of 137) interviewees could be regarded as LD.

This is an estimate based on a sample, and the estimate is subject to sampling error. The true value may lie anywhere between 1.3 and 8.7 per cent. At the lower end of this range this represents a level comparable with the wider community. At the upper end of this range, this represents approximately four times the prevalence of LD in the wider community.

A further seven per cent of participants (10) had IQ and adaptive behaviour scores low enough to be regarded as having a borderline LD indicating some impairment that might benefit from specialist LD service provision (i.e. an IQ score between 70 and 79, and an adaptive behaviour score of less than 79).

Based on these measurements then, we estimate that 12 per cent (17) of participants exhibited signs of a mild or borderline learning disability. This estimate is subject to sampling error, and the true value may lie anywhere between 6.4 and 17.6 per cent.

The Hayes Ability Screening Index (HASI) (a screening tool designed to identify the need for a further assessment for LD), was also administered to participants. The limited data collected precludes a formal assessment of the accuracy of the HASI as a screening tool. That said, in 32 per cent of our cases the HASI identified LD where there was none (referred to in this report as false positives), or failed to identify LD where this was the case (false negatives). Given the small samples involved, additional research is required before any conclusions about the use of the HASI with young offenders in England.
• A greater proportion of the LD group reported having previous convictions in all offence categories except fraud and other offences (which typically encompassed possession of an offensive weapon). There were no significant differences between the groups in terms of reported frequency and/or nature of contact with the criminal justice system.

• Reported contact with healthcare services was largely similar across the two groups, although there seemed a greater degree of self-reported pro-activity in terms of accessing health services in prison among non-LD participants.

• Reported alcohol consumption was significantly less prevalent among the LD sample in the month prior to imprisonment. There was no significant difference between the groups in terms of their reported use of other substances.

**Recommendations**

The prevalence of LD found in this research is considerably lower than was expected through the initial scoping study, where interviewees suggested prevalence might be as high as 50 per cent (Herrington et al., 2004). Based on our data, there may not appear to be a strong case for developing specialist LD services in Feltham YOI. That said, the PCT does have a responsibility to provide equitable care for these individuals and failure to do so may result in the PCT and the Feltham YOI being regarded neglectful under the DDA (1995; 2005). Two key recommendations can be made.

1. There is a need to develop a reliable screening system for LD in the criminal justice system. This should be a two-pronged approach, involving development of a reliable non-specialist screening tool (such as the HASI) which could be used at all stages of the criminal justice system; and increasing the awareness of LD among criminal justice workers to facilitate the sharing of information about offenders with LD throughout the criminal justice system.

2. Service provision for LD and borderline LD inmates in Feltham needs to be tailored to individual needs. The nature of the help required by the small group of LD inmates in Feltham YOI is debateable, although much of the intensive assistance provided by traditional community-based LD services may not be appropriate – especially for the borderline LD sample. Participants with mild or
borderline LD in our research noted that they wanted help around many of the same areas that non-LD participants did (i.e. finding accommodation, education and finding work). The additional help they require to facilitate this may include providing information in an accessible format and/or the availability a place to go to access information and advice regarding complex issues that arise in their life. Further assessment of individuals falling into the mild and borderline LD group will enable additional services to be specifically tailored.

Finally, we should stress that ninety-three per cent of the sample recorded IQ composite scores that were below average. Whilst many in this group fall beyond the definition of LD adhered to in this report, key stakeholders (including Hounslow PCT and Feltham YOI) need to consider the impact of this level of cognitive function on effective service delivery in general. With the majority of the inmate population below average on measures of crystallized thinking and the ability to solve new problems, we need to consider the extent individuals benefit from the generic rehabilitative services provided.
Chapter 1: Introduction

The Government’s *Valuing People - the Strategy for Learning Disability for the 21st Century* White Paper (Department of Health, 2001) set out the first national strategy for learning disability services in the UK for 30 years. This document included a list of actions to be taken up by primary care trusts and local authorities to reduce health inequalities for this group. The framework includes the recommendation that the Prison Service identify the education and healthcare needs of the learning disabled, within the context of addressing their sentence requirements.

Since April 2004 healthcare within Feltham Young Offenders Institution (Feltham YOI) has been provided by Hounslow Primary Care Trust (Hounslow PCT). The PCT provides services directly to people who are learning disabled living in the London borough of Hounslow. This study was commissioned by Hounslow PCT in 2004 to assess the likely level of need for LD services in Feltham YOI. The first stage of the research involved a review of the literature and assessment of the feasibility of measuring the prevalence of LD among inmates in Feltham YOI (see Herrington et al., 2004). Here we present the results of that prevalence study.

**Research aims**

The aim of the study was primarily:

- To establish the prevalence of LD among inmates aged 18-21 years in Feltham YOI.

However, there were also two secondary aims:

- To describe the differences (if any) between inmates with a LD and those without in terms of
  - socio-demographic differences (including housing, employment and educational differences)
  - offending history
  - substance misuse
  - contact with services (including health services) in the community
• To pilot the use of a screening tool developed in Australia - the Hayes Ability Screening Index (HASI) - and in so doing glean data to calibrate a reliable threshold value for its use with this group in the UK.

Defining learning disability
A comprehensive review of the research literature examining offenders with a LD was conducted (see Herrington et al., 2004). Key findings are presented below.

The terms learning disability, intellectual disability, mental handicap and mental retardation have been used - almost interchangeably - throughout the research literature (Murphy et al., 2000). In the UK, learning disability (LD) is the term most commonly used and describes a condition characterised by the following:

• A significant impairment of intelligence
• A significant impairment in adaptive behaviour – (i.e. a diminished ability to adapt to the daily demands of the normal social environment in areas such as communication, self-care, home living, social skills, involvement in the community, self direction, health and safety, academic ability, leisure and work)
• Such impairment will manifest itself before the age of 18 (RCN, 2006; BPS, 2000; AAMR, 1992)\(^1\).

LD is not a mental health issue per se, although there are some mental health conditions that are associated with LD (e.g. autistic spectrum disorders, attention deficit and hyperactivity disorders). In general, people with LD find it harder to learn, although this is possible with help. People with severe LD need a lot of day-to-day support whilst those with mild or moderate learning disabilities can live relatively independently (The Foundation for People with Learning Disabilities website, 2006). LD is different to specific learning difficulties such as dyslexia, where individuals may have normal, low or high levels of intelligence (Mental Health Primary Care in Prison website, 2006).

Whilst clinical practices vary, in general a diagnosis of LD is done in two stages. Firstly, intelligence is measured, most commonly by standardised tests of intelligence quotient (IQ). The World Health Organisation’s International Classification of

\(^1\) Some people with LD prefer to use the term learning difficulties to describe this condition. However, for the sake of clarity we will use the term learning disability (LD) throughout this report.
Diseases (1992) - referred to as ICD-10 proposes the following bands of disability based on the measurement of IQ.

- Mild disability characterised by an IQ of 50-69
- Moderate disability characterised by an IQ of 35-49
- Severe disability characterised by an IQ of 20-34
- Profound disability for IQ levels below 20

These bands are presented as a guide for practitioners rather than absolute distinctions (WHO, 1992). Researchers and clinicians also refer to a borderline disabled group, whose IQ scores range variously from 70 to 75, up to 79.

Secondly, impairment of adaptive behaviour is measured by using standardised scales such as the Vineland Adaptive Behaviour Scales (VABS) (Sparrow et al., 1984) to examine, for example, daily living and coping skills, nature and extent of interpersonal relationships and communication skills. These are generally completed by a third party who knows the individual well (e.g. a parent or care provider), although research has found that direct administration is also reliable (Sparrow, Cicchetti and Balla, 2005; Voelker et al., 1990)².

**Learning disability and offending**

Despite a standard clinical framework for the ‘diagnosis’ of LD³, resource limitations and practical considerations have often led researchers to find alternative ways of identifying LD in study populations. There is considerable variation across research studies in the methods used to identify LD. Even when a common measurement is applied, for example relying on the measurement of IQ, different types of tests have been used leading to the possibility of confounding variables. This means it is difficult to make comparisons across studies (McBrien, 2003; Lindsay et al., 2002).

It is estimated that almost 1.5 million people in the UK (DOH, 2001) or approximately two per cent of the population (Mental Health Primary Care in Prison Website, 2006) suffer from some degree of LD. Debate continues around the veracity of these

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² Whilst one might suggest that offending is an example of impaired adaptive behaviour, motivation for offending and the machinations of the criminal justice system undoubtedly play their part.

³ In practice identification of LD in a clinical setting varies between services. Some services require an IQ score of 69 or less to be eligible for additional help, whilst others will consider both IQ and adaptive behaviour, and still others will concentrate more on the benefit an individual is likely to derive from the service.
figures, and it is widely thought that there remain individuals with LD who are not known to LD services (Whitaker, 2004).

There has been considerable discussion in recent years regarding whether this group is over-represented within the criminal justice system (McBrien, 2003; Murphy and Mason, 1999). There is some evidence that individuals with LD who engage in criminal activities may have less complex strategies for evading detection, be more easily caught than other offenders, or be rearrested more frequently (Cockram, 2005; Murphy, 2000; Brown and Stein, 1997). However, in contrast there is a suggestion that this group is ‘protected’ from the criminal justice system by LD service providers, who under report the offending behaviour of their clients (Lyall et al., 1995).

Prevalence studies of LD and offending have approached the issue in two ways:

- By examining the level of offending among the population known to LD services.
- By examining the level of LD among the offending population.

From the first stance, studies have estimated that between four and 14 per cent of those in contact with LD services show challenging behaviour at some time (Oliver et al., 2003), and Crocker et al., (2006) found that 52 per cent of their sample had displayed aggressive behaviour in the preceding 12 months. McBrien (2003) presents research examining all individuals known to LD services in a large city, where ten per cent had had some contact with the criminal justice system as a suspect. In retrospective interviews with service providers in Cambridge (Lyall et al., 1995) and London (McNulty et al., 1995), two and five percent of clients respectively had reported contact with the criminal justice system.

The transformation of behaviours into criminal activities depends on a number of complex decisions. Even where events are reported to the police and a suspect is identified and charged, there is considerable room for discretion (Holland et al., 2002). LD service providers may label behaviour as ‘challenging’ rather than criminal and offences such as theft and criminal damage might not be reported to the police (Holland et al., 2002; Brown and Stein, 1997; Lyall et al., 1995). Alexander et al., (2006) reported ‘offending-like behaviours’ that did not lead to contact with the police in 58 per cent of their sample. Lyall et al., (1995) found a hesitance by some service providers to report even serious sexual offences, including rape. As a result, illegal
and anti-social behaviour by those with LD may take place much more frequently than statistics suggest (Ashman and Duggan, 2004; Holland et al., 2002).

Recent reviews of studies assessing the prevalence of LD among the offending population show great variance, ranging from less than one per cent to more than 45 per cent (Lindsay, 2002). For some, levels of LD have been found to be consistent with the wider non-offending community (Holland, 1991). For others, the frequency of LD found among offenders is higher than for the general population (e.g. Murphy et al., 2000; Hayes, 1997; 1996a; Zimmerman et al., 1981). A recent survey among young offenders in secure and community settings in the UK found 23 per cent had an IQ less than 70 (Harrington and Bailey, 2004). Whilst in another study, 20 per cent of prisoners were found to have a ‘hidden disability’ (encompassing LD and learning difficulties such as dyslexia, dyspraxia and ADHD) which would undermine their performance in education and employment (The Dyslexia Institute, 2005). A comparison study found self reported anti-social behaviour to be more prevalent among individuals with LD, although the authors concluded that the additional risk factors experienced by this group (e.g. low socio-economic status and mental health problems) accounted for this disparity (Dickson et al., 2005).

Such varying findings are likely to be the result of methodological differences; definitions of LD; country-specific policies regarding the diversion of LD offenders away from the criminal justice system and into treatment; as well as cultural variations in LD prevalence and cultural appropriateness of testing methods (e.g. Glasson et al., 2005). Additionally, prevalence levels are unlikely to be static throughout the criminal justice system with LD identified and individuals diverted into treatment at different stages of the process (McBrien, 2003; Mason and Murphy, 2002). As such, one would expect the prevalence of LD to diminish at each progressive stage of the system (e.g. at arrest, court, probation and prison).

The disparity across studies conducted to date makes it difficult to provide a general estimate of LD among offenders and/or estimate of offending among LD populations. That said, the research literature has identified two relatively distinct LD groups:

- Those usually known to LD services, although the decision making processes involved regarding the classification of behaviour as challenging or criminal is unclear.
Those who are socially and cognitively disadvantaged, but not to the degree whereby they would be regarded as clinically LD and so afforded the assistance of specialist services. They are arguably the more vulnerable and prevalent group within the criminal justice system (McBrien, 2003).

Regarding this latter group, one study found that individuals with mild or borderline LD were more likely to have had the police called in response to an aggressive incident than those with more severe LD; and were ten times more likely to have been arrested at some point in their lifetime (Crocker et al., 2006). Another study found young males living independently with mild or borderline LD were more likely to misuse substances (typically the overuse of alcohol) leading to problematic behaviours such as aggression and erratic mood changes than those with more profound disabilities (Taggart et al., 2006). With such behaviour, one might expect the borderline/mild LD group to be overrepresented in the criminal justice system then, rather than those with a more pronounced LD (who may even lack the basic skills required to become involved in crime in the first place).

Additionally of course there is likely to be a group of individuals who are offending, and whose condition fulfils the diagnostic criteria for LD, but who are not known to or in contact with specialist LD services (Whitaker, 2004).

**Managing offenders with a learning disability**

*The Mental Health Act (England and Wales) 1983* currently provides the legal framework for the compulsory admission and treatment of patients suffering from mental disorder, including LD. The Act establishes that ‘mentally disordered’ people who are subject to criminal proceedings have the same right to psychiatric assessment, treatment and care as anyone else, and that anyone in prison who needs treatment that can only be given in a hospital should be admitted to an appropriate service. Prison hospitals and healthcare centres do not qualify as hospitals under the Act. Thus there is some legal provision for the diversion of LD offenders from incarceration into treatment, provided of course that they are diagnosed and that appropriate (secure) forensic LD services are available. In 2004 the Government produced a *Draft Mental Health Bill 2004* for consultation. The Bill

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4 Holland et al., (2002) characterise this latter group as predominantly male; with a history of impulsivity, risk taking and conduct disorder in childhood; substance abuse and social exclusion in adolescent and adult life. It is suggested that any attempt to change offending behaviour amongst this group will require flexible, long-term, multi-agency work (Holland et al., 2002), which isn’t stifled through misguided adherence to an arbitrary IQ <70 cut-off.
received widespread criticism from stakeholders due to its length and complexity, and in early 2006 the Government abandoned this draft legislation, deciding instead to make amendments to the existing Mental Health Act 1983 (DoH, 2006; The Guardian, 2006; BBC, 2006). At the time of writing it was anticipated that the Government would publish a Bill amending the 1983 legislation before the end of 2006, with implementation expected by 2008 (Mental Health Alliance, 2006).

The Prison Service *Disability Strategy* (HM Prison Service, no date) sets out prison policy for the management of disabled inmates, including those individuals with levels of LD or borderline LD who do not qualify for transfer into treatment services. (The practicalities of this strategy are set out in Prison Service Order 2855 (HM Prison Service, 2005). This strategy was developed in response to the *Disability Discrimination Act 1995* (DDA), which was extended to cover education through the *Special Educational Needs and Disability Act 2001*. The legislation defines disability as “a physical or mental impairment which has a substantial and long-term adverse effect on his ability to carry out normal day-to-day activities” (DDA, 1995, part 1, paragraph 1(1)). The DDA was further extended in 2005 to insert a ‘Disability Equality Duty’, aimed at tackling systematic discrimination and ensuring that public authorities built disability equality into all aspects of their work (DDA, 2005).

Prisons are expected to ensure that disabled prisoners have equality of opportunity and access to a range of facilities, and to respond sensitively to the particular needs of the individual, including to their education and healthcare needs (discussed below). Crucially it is not sufficient for an institution to assert that they did not know about an individual’s need (DDA, 1995). Thus the identification of inmates with a LD amounts to a legislative requirement, and allows an institution to provide care in line with needs.

**Learning disability and Hounslow PCT**

LD is regarded as a health issue, and specialist services are provided through the Department of Health. Poor health is associated with people who are unemployed and in lower socio-economic groups. Individuals with a LD also often fall into this category and might not understand the consequences that their decisions can have

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6 The DDA 2005 also extended the definition of disability to include individuals diagnosed with cancer, HIV infection or multiple sclerosis; and the removal of the requirement that “mental illness must be clinically well-recognised if it is to be basis of mental impairment” (DDA, 1995: para 1(1)).
on their health (RCN, 2006). This group are more likely to experience certain health problems such as vision and hearing difficulties, physical disabilities, as well as chronic health conditions, such as epilepsy and thyroid conditions (Mencap, 2004; Emerson et al., 2001). As a group they are also more likely to be exposed to the risk factors associated with the onset of mental health problems – such as difficult life events. In addition, individuals with LD are much more likely to die before the age of 50 than the non-LD population (Mencap, 2004); exacerbated by reduced use of general practice surgeries and preventative screening and health promotion measures by this group (Davies and Duff, 2001; Wilson and Haire, 1990). Even among individuals with LD who are registered with a GP, health screening has revealed high levels of unmet physical and mental health needs (Mencap, 2004). The National Patient Safety Association has identified undiagnosed medical conditions as one of the key concerns for the safety of people with LD (NPSA, 2004).

The Government’s *Valuing People* White Paper set out a commitment to improve the healthcare of individuals with LD. Since 1st April 2004, Hounslow PCT has been providing a range of services to Feltham YOI, including primary healthcare, mental health care, dentistry, ophthalmology and substance misuse support. They do not, at present, provide any specific services for LD inmates. Transfer to forensic LD services based in the community (under the Mental Health Act 1983) will only occur where the inmate also has persistent mental illness and is not getting better in prison (Herrington et al., 2004). The involvement of PCTs in the provision of healthcare to prisoners allows the opportunity to identify those with LD and their health needs, and then where necessary, ensure access to health and other services they might not have used otherwise.

The purpose of this second stage of the research was to conduct an assessment of the prevalence of learning disability in Feltham YOI, and specifically among those inmates aged 18 to 21 years. This could assist Hounslow PCT in its commissioning decisions regarding the necessity for specific LD services in Feltham YOI.

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7 Research has found that a large number of prisoners are unemployed (prior to custody) and drawn from lower socio-economic groups and are also affected by poor health (Social Exclusion Unit, 2002). One report found that 46 per cent of sentenced adult males in custody had a long standing illness or disability (Bridgwood and Malbon, 1995).
Chapter 2: Methodology

The sample comprised 185 inmates selected randomly from the main wings of ‘Feltham B’ (housing young adult males aged 18-21 years). Participants completed four assessment items examining IQ, adaptive behaviour and education and offending background. The fieldwork involved in this study was conducted between December 2005 and January 2006.

Sample selection and recruitment
A stratified random sampling technique was used to select participants from each of the main wings (10). The inpatient, detox and segregation wings were excluded from this process due to concerns surrounding security and the health of these inmates.

To account for the high turnover of inmates, a list of random numbers, representing cell door numbers, was generated each week. This was done using an internet based random number generator. The number of participants selected for interview was dependent on:

- The number of interview slots available for the week (therefore dictating the total number of interviewees required).
- The proportion of the total population that each wing housed.

A random list of cell door numbers for each wing was generated. Additional random numbers for each wing were also provided, creating a ‘reserve list’ in the event that an inmate in a selected cell refused to participate or was unavailable at the time of interview. All inmates were drawn from single occupancy cells.

An officer from the prison health centre made the initial approach to the inmate, outlining the research and if they were agreeable, booked them an interview slot for the following week.

Twenty inmates refused to take part when first approached by the prison officer – reportedly because they ‘couldn’t be bothered’. Seventeen who had agreed to take part were transferred to another prison, or went to court and didn't return for the interview; nine prisoners refused on the day of appointment. ‘Replacement’ inmates
were selected from the reserve list in these instances. A total of 221 interviews were conducted, however 36 were later removed from the prevalence analysis either because they were not drawn from the random number list (4), or because there were concerns regarding the administration of the K-BIT2 and/or HASI (32).

**Assessment tools**

Four assessment tools were administered in the following order

- The research questionnaire
- The Hayes Ability Screening Index (HASI)
- The Kaufman Brief Intelligence Test – 2 (K-BIT2)
- The Vineland Adaptive Behaviour Scales – 2 (VABS2)

A detailed description of each instrument and its rationale for use in this research is presented in Appendix 1. The feasibility study found a criticism of earlier research had been that it didn’t assess participants’ adaptive behaviour (Herrington et al., 2004). Measuring both IQ and adaptive behaviour was therefore considered essential.

The choice of instruments was based largely on a methodology prepared by Associate Professor Susan Hayes for the validation of the HASI because the generation of data to allow an assessment of the reliability of the cut-off score for use in the UK was a secondary objective of this research. In addition, the K-BIT2 was chosen because it had been used successfully in prior prevalence studies of LD in prisons (e.g. Murphy et al., 2000) and was considered easy to administer and able to effectively engage participants in a prison setting.

A brief overview of each tool is presented below.

**The research questionnaire**

The questionnaire (see appendix 6) collected socio-demographic details and information on offending history, self-reported health needs and extent and nature of contact with health and other services in the community and in Feltham YOI. The questionnaire took between 15 and 30 minutes to administer and provided researchers with a good opportunity to put interviewees at ease before conducting the psychometric assessment tests.
The Hayes Ability Screening Index (HASI)

The Hayes Ability Screening Index (HASI) is a short screening tool designed for use with people aged between 13 and late adulthood to identify those that might have a LD and therefore require further assessment. It is a non-specialist tool designed to be administered by criminal justice workers with/without a psychology background. It takes approximately 10 minutes to complete, and is deliberately over-inclusive, designed to capture those with borderline LD who may also benefit from specialist service provision. It is not designed as an indicator of LD in itself.

The Kaufman Brief Intelligence Test 2 (K-BIT2)

The K-BIT2 is a quick measure of verbal and non-verbal intelligence, providing an IQ composite score. It takes between 15 and 30 minutes to complete. It has been designed for use by psychologists and paraprofessionals and is suitable for participants aged four to 90 years. The K-BIT2 correlates highly with the Weschler Adult Intelligence Scale – Third edition (WAIS-III) and the Weschler Abbreviated Scale of Intelligence (WASI), which are regularly used in clinical assessments of LD (Kaufman and Kaufman, 2004). However caution must be used when using the composite score as the sole measure of IQ. Whilst IQ composites have been used (in part) to identify the presence or absence of LD for the purposes of this research, we must accept the limitations of this tool and do not propose to make any clinical judgements therein.

The Vineland Adaptive Behaviour Scales Second Edition (VABS2)

The Vineland Adaptive Behaviour Scales Second Edition (VABS2) is an individually administered measure of adaptive behaviour suitable for use from birth through to 90 years of age. Adaptive behaviour refers to the personal and social skills used for everyday living. The focus is on the behaviour exhibited rather than on behaviour that the individual is physically capable of. Data is collected through a semi-structured interview format with the individual or a third party who knows the individual being assessed well (e.g. a parent or caregiver) (Sparrow, Cicchetti and Balla, 2004; Voelker et al., 1990). The VABS2 took between 20 and 30 minutes to complete in this instance, although information relevant to the scoring of the VABS2 was also collected in casual conversation throughout the interview process.
Interviewer training

Interviewers (Victoria Herrington, Susan Harvey and Robin Betts) received training in the administration of the HASI, K-BIT2 and VABS2 from Dr Christopher Bennett, Clinical Psychologist at the Eric Shepherd Unit. Dr Bennett also observed interviews to ensure that assessment tools were being administered consistently. This observation process identified difficulties with the administration of the K-BIT2 and HASI. Thirty-two assessments were excluded from the analysis as a result.

The scoring on a random sample of assessments (10) was checked by Dr Bennett. Additionally, (and as a result of some identified inconsistencies in score calculations) all assessments were re-scored by a research assistant working with the Eric Shepherd Unit under the supervision of Dr Bennett. Dr Bennett further ensured consistency by dip-sampling these assessments too (10).

The interview process

Interviews were conducted in one of two rooms chosen for their privacy and comfort. For security purposes a prison officer sat in an adjacent room whilst the interviews were being conducted. As expected in a prison environment, extraneous noise was an issue on occasion throughout the research process, although interviewees did not seem perturbed by this.

Interviewers were provided with a fieldwork pack containing assessments, pencils, a stopwatch (for the HASI timed puzzle) and a research protocol outlining the interview procedure (see appendix 3). In brief, interviewees were welcomed and offered a drink and chocolate bar when they arrived. The interviewer then proceeded to read through the information sheet with the participant (see appendix 4), and obtain written informed consent (see appendix 5). The interview proceeded in the order described above, with short (comfort) breaks taken between assessment items if required.

On completion of the assessment items, participants were asked if they would like their general practitioner (if they had one) notified of their involvement in the research

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8 The interviewers also practiced using the research questionnaire.
9 Specifically protocol was not followed with respect to identifying the correct Basal (starting) point and ceiling (ending) item for the K-BIT. Administration instructions were not closely adhered to for the HASI.
10 Written information about the research had been developed in collaboration with Hounslow PCT’s LD services to ensure that they were presented in an accessible format. Care was taken by interviewers to ensure that participants fully understood this information before continuing with the interview.
(as requested by the NHS Ethical Committee). Participants were also asked to complete a *payment to participants form* detailing their name and prison number so that the £10 payment could be credited to their Feltham YOI account.

**Procedural difficulties**

There were a number of procedural obstacles to the research.

- Ethical approval was required from three committees: The NHS Ethics Committee, King’s College London Research Ethics Committee (required on the instruction of the Hounslow PCT research steering committee), and the Prison Ethics Committee. This process took in excess of seven months to negotiate\(^{11}\).

- The absence of a central research coordinator in Feltham YOI further complicated this process, and access to Feltham YOI had to be negotiated through Prison Health by Hounslow PCT. This was not an easy task and could only occur after full ethical approval had been obtained. The protracted time taken to secure access meant that two of the original research team – a Senior House Officer and a Registrar working on nine-month honorary contracts with a Psychiatrist specialising in LD in Hounslow PCT – could not take part in the field work.

- Criminal Records Bureau checks were required for all interviewers. One trained interviewer (a research assistant from the Eric Shepherd Unit) was unable to take part in the fieldwork due to the length of time taken for his details to be processed.

- Payment was required for the prison staff involved in coordinating the recruitment of participants, and escorting prisoners to and from the interview rooms. This had to be negotiated by Hounslow PCT.

These obstacles were overcome as a result of the commitment of key stakeholders in the project. However, anyone planning to undertake a similar study should not underestimate the difficulties that may be involved.

\(^{11}\) Ethical sanctioning of projects of this nature is essential, but it is hard to justify the involvement of three separate committees.
Chapter 3: Learning Disability in Feltham YOI

As noted previously, the identification of LD is dependant on an assessment of impairment in both cognitive functioning and adaptive behaviour. Impairment in cognitive functioning is measured as a score of two standard deviations or more below the norm on a standardised test of intelligence – i.e. an IQ score of less than 70 on a test where the norm is 100 (as in the Kaufman Brief Intelligence Test 2). Therefore we will use a cut-off of an IQ of 69 here, although in light of the research literature which suggests that individuals with a borderline LD may be particularly over represented in the criminal justice system, the analysis will also consider IQ scores falling between 70 and 79 (inclusive).

A second point to note with reference to the IQ scores concerns the clinical practice of quoting the results of intelligence tests in terms of an IQ range. This practice takes into consideration the possibility of error - the standard error of measurement - as a result, for example, of differences in the administration of the test. This practice is endorsed by the British Psychological Society and as such an individual with an IQ score of 69 on the K-BIT2 would, in clinical settings, be reported as having an IQ range of between 63 and 78 at the 90 per cent confidence interval. At the upper limit of our borderline range, an IQ composite score of 79 may reflect a true value of between 73 and 87. Likewise, a score of 86 should be presented as a range from 79 to 94, which at the lower end of this scale falls into the group classified as borderline LD. The use of these ranges is not practical in a research setting as an absolute cut-off score is required for analysis. We caveat our findings accordingly.

Impairment in adaptive behaviour is more difficult to ascertain, and the definition of LD does not stipulate the degree of impairment required. As such there is no firmly established cut-off score. Use of a standard deviations rule as above (i.e. impairment marked by a score two standard deviations below the norm, i.e. less than 70) has been mooted, although discussions with clinical psychologists have indicated that a composite score of less than 80 on the VABS2 would suffice in a clinical setting. For the sake of consistency we use a cut-off score of 69 or less on the VABS2 in the first
instance, although we consider cases with scores between 70 and 79 to illustrate sufficient impairment for an assessment of LD in a clinical setting\textsuperscript{12}.

**Sample characteristics**

Usable assessments were completed with 185 inmates. Appendix 2 outlines the demographic characteristics of these participants.

Two thirds of the sample was from Black and Minority Ethnic (BME) groups including mixed race (68 per cent)\textsuperscript{13}. Almost three quarters of the sample were remanded prisoners (73 per cent) and half had been in prison before (49 per cent). Almost three-quarters (70 per cent) had previous convictions and almost two-thirds had received a community sentence in the past (63 per cent). Forty per cent had served a prior custodial sentence (ranging from one to eleven terms).

Eighteen per cent had been in Local Authority care at some point previously. Eight interviewees were from the London Borough of Hounslow, nine had been residing outside of London and the remainder were drawn from other London boroughs.

**Measuring intelligence**

Composite IQ scores derived from the K-BIT2 (185) ranged from 53 to 119 with a mean of 83. Only eight per cent (14) had a composite score of 100 or more, illustrating that cognitive performance on the K-BIT2 was lower than average across the sample as a whole. Eleven per cent (21) had an IQ composite score of 69 or below, indicating a significant impairment in cognitive functioning. A further 12 per cent (22) had IQ composite scores between 70 and 74 (inclusive), and 16 percent (29) between 75 and 79 (inclusive). As such, 39 per cent produced results on the K-BIT2 that saw them fall in the mild or borderline LD range.

In assessing the reliability and validity of these composite IQ scores it is important to have a closer look at the individual test scores for participants, and specifically the difference in performance on the verbal and non-verbal measures. Where there is a

\textsuperscript{12} In practice, clinical diagnosis often takes place over several sessions and, dependent on a service’s requirements, may or may not adhere to these absolute cut-offs above when considering whether an individual has a LD. These absolute cut-offs are used in this research setting for convenience. Given this, we cannot conclude that every individual identified with IQ and adaptive behaviour scores under 70 in our study would be deemed suitable for a LD service, or that those with scores above this cut-off would not.

\textsuperscript{13} This figure represents a slightly higher proportion of BME inmates than the 58 per cent Her Majesty’s Chief Inspector of Prisons recorded in it’s report on Feltham YOI in 2005 (HMIP, 2005).
significant difference between the test scores (i.e. a difference of 17 points or more) the composite score cannot be regarded as a reliable measure of IQ and it is likely that the scores are indicative of some other impairment, perhaps in English language comprehension\textsuperscript{14}.

That said, it has been suggested that significant differences between verbal IQ and non-verbal IQ scores is not unusual for offenders and “…indeed the frustration arising from this difference can often be a factor in difficult school/peer behaviours, leading up to offending behaviour” (Hayes, personal communication, 2006). Hayes (2005) reported that the mean difference between verbal and non-verbal scores on the K-BIT was larger for juveniles (those under 18 years of age) than adults, and that juveniles performed better on the non-verbal than on the verbal measure. This is reflected in our data where mean composite scores for non-verbal IQ were higher than for verbal IQ\textsuperscript{15}.

Nonetheless, a total of 43 cases were removed from the analysis as a result of a significant difference between the two measures, leaving a sample of 142 participants (with IQ composite scores ranging from 53 to 115, with a mean of 83). Figure 3.1 illustrates the spread of IQ composite scores for this sample.

Of this valid sample, only seven per cent (10) scored 100 or more, ten per cent (14) had an IQ composite score of 69 or below, indicating a significant impairment in cognitive functioning. A further 13 per cent (19) had IQ composite scores between 70 and 74 (inclusive), and 16 percent (22) between 75 and 79 (inclusive). As such, 39 per cent could be considered to have an IQ in the mild or borderline LD range\textsuperscript{16}.

\textsuperscript{14} Given potential difficulties with comprehension and the likely impact this had on the K-BIT2 scores, composite scores for participants whose English language proficiency was rated as poor were excluded (2 cases).

\textsuperscript{15} Verbal composite scores ranged from 40 to 108 with a mean of 81.5 and a standard deviation of 11.6; Non-verbal composite scores ranged from 48 to 130 with a mean of 88.7 and a standard deviation of 12.9).

\textsuperscript{16} This is in line with the proportion of participants with a composite score of 79 or less before those with significant differences between their verbal and non-verbal scores were excluded. In light of this, future research may also wish to further consider participants whose verbal and non-verbal composite scores differ significantly.
Measuring Adaptive Behaviour

In six cases adaptive behaviour composite scores could not be calculated due to insufficient data. These cases were removed from the analysis. Composite scores derived from the VABS2 for the remaining 179 cases ranged from 71 to 132 with a mean of 89. As such no participants scored 69 or less on this measure (i.e. two standard deviations below the norm). Seventeen per cent (30) fell into a borderline range with a composite score between 70 and 79 which, as we have argued above, would suffice in many clinical assessments of impairment. Figure 3.2 illustrates the spread of adaptive behaviour composite scores.
Figure 3.2
Histogram showing adaptive behaviour composite scores and norm curve (179)

Whilst the mean composite score for this group is 11 points below the standardised norm (i.e. 100), in general participants fared better on this measure than for IQ.Whilst one might suggest that offending in itself represents a failure to adapt to the normal social environment, conversely, for many in the criminal justice system offending is the normal social environment. Certainly the life circumstances of many young people in the criminal justice system give rise to a greater need to manage independently day-to-day. Those with impairment may simply be more adept at hiding this, which must be considered when interpreting these scores (especially given that they have been based on self-reported behaviour).

Our findings represent a higher mean adaptive behaviour composite than the 76 found amongst adults by Hayes and Farnhill in 2003; and higher than the 83.4 found among juveniles by Hayes in 2005. This latter study found a significant difference in the adaptive behaviour composite scores between juveniles (under 18 years of age) and adults, with the average for adults being 64.9 (Hayes, 2005). The author
speculated that this may indicate that lower performing participants persisted with offending into adulthood. Whilst our sample were aged 18 to 21 years, it is possible that the relatively high mean adaptive behaviour composite score found here reflects a similar phenomenon. We also need to consider however that the subjective nature of the VABS2 and its dependence on self-reported behaviour may have led to a degree of overscoring.

If we also consider the average standard scores calculated for each of the three domains covered by the VABS2 (i.e. communication, socialisation and daily living skills), daily living skills was the lowest area of functioning (with a mean score of 86.5), followed by communication (93.2) and socialisation (96.2). by way of a comparison this differs with the findings of Hayes (2005) which found that communication was the lowest area of functioning for adults and juveniles, followed by socialisation, with daily living skills the least problematic. In each domain, juveniles outperformed adults (Hayes, 2005).17

By examining the percentile rankings in each of the three domains for the 30 participants whose adaptive behaviour scores fell in the borderline range (71 to 79), we can identify which area of adaptive behaviour proved most problematic for this group. More than three-quarters recorded scores in the fifth or lower percentile for daily living skills (24); socialisation and communication were less challenging (three and four in the fifth or lower percentile respectively).

Across the sample then it seems as if daily living skills was the most challenging area of adaptive behaviour for inmates. Typically questions in the daily living skills domain focused on cooking, cleaning and healthcare. Whilst the high proportion of low scores (in terms of percentile rankings) here may reflect a particular deficit - certainly the case in some instances - many respondents reported not having to cook and clean up for themselves and many relied on parents and siblings to complete domestic duties at home. Their current incarceration also largely removed the need to perform in this domain, unless working in laundry or cleaning roles. Given the VABS2’s reliance on actual behaviour, it is possible that participants were capable but not active in this domain, leading to underscoring here. Without further

17 The communication scores were 74.9 for juveniles, 49.4 for adults; socialisation scores were 91.1 for juveniles, 72.8 for adults; daily living skills scores were 96.1 for juveniles, 85.8 for adults (Hayes, 2005).
18 The percentile rankings on a standardised test like the VABS2 give a sense of where an individual’s behaviour lies in relation to their peers, with the percentile indicating the proportion of an individual’s peers s/he outperformed in the test. Thus a score in the 50th percentile indicates that an individual performed better than 50 percent of the population against which the test was standardised.
exploration of participants’ circumstances and motivation for their reported behaviour, these scores should be treated with caution.

**Measuring learning disability**

Given the data exclusions outlined above a total of 137 cases were considered to have valid and reliable IQ and adaptive behaviour composite scores. There was a significant (but mild) positive correlation between the composite scores of the K-BIT and VABS2 ($r = 0.420$, $p<0.01$) and Figure 3.3 illustrates this.

**Figure 3.3**

*Scatter plot of correlation between IQ and adaptive behaviour composite scores (n = 137)*

No participants had a score of 69 or below on both the K-BIT2 and VABS2 measures, which as we have discussed above means that there were no participants who fell below two standard deviations from the norm on both measures of IQ and adaptive behaviour. Five per cent (7) of this sample of 137 scored 69 or below on the K-BIT2 and in the borderline (71-79) range on the VABS2. We have argued that the
use of this borderline range for adaptive behaviour would likely fulfil the requirements for a clinical diagnosis of LD and as such for the purpose of this report we will regard this group has being identified as having a LD. We will refer to this group as the clinical LD group. A further five percent (7) had an IQ composite score between 70 and 74, and two per cent fell between 75 and 79 (3), together with an adaptive behaviour score of less than 79. These two groups represent an upper and lower borderline group, which may benefit from specialist service provision.\(^{19}\)

The study is based on a small sample, and the likelihood of sampling error must be considered. Whilst our measurements suggest a point estimate of 12 per cent (17) of the sample with signs of mild or borderline LD\(^{20}\), the true value in the population from which the sample was drawn could fall anywhere between 6.4 and 17.6 per cent (the sampling error being 12 percent +/- 5.6 per cent at the five per cent level). Our point estimate of the proportion with clinical LD is five per cent. The true value could lie anywhere between 1.3 and 8.7 per cent (the sampling error being five per cent +/- 3.7 at the five per cent level). If the true prevalence level lies at the lower end of this range this is consistent with that found in the wider community. If it falls at the upper end of this range, this represents a prevalence level four times that reported in the UK. Figure 3.4 below presents a breakdown of the IQ and adaptive behaviour scores for the sample.

\(^{19}\) Additional analysis was conducted on the five ‘outlying’ cases observable in the lower left hand quadrant of Figure 3.3. No patterns were discovered with regards to demographics amongst this group. In two cases, English was a second language, although proficiency had been rated by the interviewer as good. Two participants could not read or write. In two cases the interviewer noted the participant was not well engaged with the process. It is important to consider the impact these factors may have had on composite scores, which must be treated with the appropriate degree of caution.

\(^{20}\) The composite scores for this group ranged from 55 to 79 with a mean of 71 for IQ, and 73 to 78 with a mean of 76 for adaptive behaviour. For simplicity, this group will be referred to as the LD group.
## Figure 3.4
LD, borderline LD and non-LD groups

<table>
<thead>
<tr>
<th>Group</th>
<th>Group description</th>
<th>No. in group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not valid</td>
<td>Not calculated because K-BIT2 or VABS2 scores were not valid</td>
<td>48</td>
</tr>
<tr>
<td>LD group</td>
<td>Clinical LD group</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>K-BIT2 = 69 or less</td>
<td></td>
</tr>
<tr>
<td></td>
<td>VABS2 = 79 or less</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lower borderline group</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>K-BIT2 = 70-74</td>
<td></td>
</tr>
<tr>
<td></td>
<td>VABS2 = 79 or less</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Upper borderline group</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>K-BIT2 = 75-79</td>
<td></td>
</tr>
<tr>
<td></td>
<td>VABS2 = 79 or less</td>
<td></td>
</tr>
<tr>
<td>Non-LD</td>
<td>Low IQ</td>
<td>34</td>
</tr>
<tr>
<td></td>
<td>K-BIT2 = 79 or less</td>
<td></td>
</tr>
<tr>
<td></td>
<td>VABS2 = 80+</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Low adaptive behaviour</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>K-BIT2 = 80+</td>
<td></td>
</tr>
<tr>
<td></td>
<td>VABS2 = 79 or less</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clinical non-LD group</td>
<td>80</td>
</tr>
<tr>
<td></td>
<td>K-BIT2 = 80+</td>
<td></td>
</tr>
<tr>
<td></td>
<td>VABS2 = 80+</td>
<td></td>
</tr>
</tbody>
</table>

Closer analysis shows that both the LD group and non-LD groups can be broken into several sub-groups. Within the non-LD sample these groups represent those where one or other of the measures was above the clinical and/or borderline threshold. Given the inherent inaccuracies involved in the measures used (see appendix 1 for a review), these sub-groups illustrate that the prevalence of LD may actually be much higher. For example, overscoring on the VABS2 (e.g. through inaccurate reporting of behaviour by participants) may mean that a number of the 34 non-LD inmates with low IQ may actually fall in the LD group range. Hayes (2005) reported that correlations between the K-BIT and VABS subtests for juvenile male offenders were not as robust as for adult offenders, and suggested that multiple testing using a range of measures was advisable with this group. As such, we need to treat our findings with caution.

**Characteristics of the mild/borderline learning disabled sample**

Having noted the caveats, there is still merit in considering the differences between the groups. For ease, in this section we will compare the LD and non-LD groups as a whole rather than break the data down into the composite sub-groups, thus our ‘LD group’ comprise those participants classified in the clinical and borderline LD groups.
Percentages will be used to assist in comparisons, and significant differences will be highlighted. That said, given the small sample in the LD group and the scope for large sampling error, caution must also be used when interpreting these figures.

**Demographics**

Figure 3.5 below displays the demographic characteristics of the LD and non-LD samples.

### Figure 3.5 Comparison of LD and non-LD sample characteristics

<table>
<thead>
<tr>
<th>Demographic</th>
<th>LD sample (17)</th>
<th>Non-LD sample (120)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black and Minority Ethnic</td>
<td>82%</td>
<td>66%</td>
</tr>
<tr>
<td>White</td>
<td>18%</td>
<td>31%</td>
</tr>
<tr>
<td>Other</td>
<td>0%</td>
<td>2.5%</td>
</tr>
<tr>
<td><strong>Accomm</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NFA</td>
<td>6%</td>
<td>7%</td>
</tr>
<tr>
<td>Temporary accom</td>
<td>18%</td>
<td>3% *</td>
</tr>
<tr>
<td>Permanent accom</td>
<td>76%</td>
<td>88%</td>
</tr>
<tr>
<td>LA care previously</td>
<td>29%</td>
<td>17%</td>
</tr>
<tr>
<td><strong>Employment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unemployed</td>
<td>41%</td>
<td>57%</td>
</tr>
<tr>
<td>Employed</td>
<td>29%</td>
<td>26%</td>
</tr>
<tr>
<td>Full time study</td>
<td>24%</td>
<td>12%</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age left school (mean)</td>
<td>15 years</td>
<td>15 years</td>
</tr>
<tr>
<td>No qualifications</td>
<td>24%</td>
<td>26%</td>
</tr>
<tr>
<td>1 GCSE or more</td>
<td>29%</td>
<td>37%</td>
</tr>
<tr>
<td>Specialist school</td>
<td>40%</td>
<td>32%</td>
</tr>
<tr>
<td>Specialist help at school</td>
<td>41%</td>
<td>35%</td>
</tr>
</tbody>
</table>

* Significant to 0.05 level  
** Significant to 0.01 level

The only significant difference between the two groups was in relation to accommodation, with the LD sample more likely to have been in temporary accommodation immediately prior to custody (p<0.05).

Of the five LD participants who had attained at least one GCSE, only one was drawn from the clinical LD group. He had successfully completed a GCSE in art. The remaining four had a borderline LD and had completed between one and four GCSEs ranging from B (also in art) to E grades.
**Offending history**

A higher proportion of the LD sample reported prior contact with the criminal justice system than the non-LD group, and previous sentences served in both custodial and community settings; although this was not a statistically significant difference. Only two of the LD participants did not have any prior convictions. Figure 3.6 presents the criminal justice contact for these two groups.

**Figure 3.6 History of contact with the criminal justice system**

<table>
<thead>
<tr>
<th>Criminal justice contact</th>
<th>LD sample (17)</th>
<th>Non-LD sample (120)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current sentence</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Remand</td>
<td>76%</td>
<td>72%</td>
</tr>
<tr>
<td>Sentenced</td>
<td>0%</td>
<td>10%</td>
</tr>
<tr>
<td>Other</td>
<td>18%</td>
<td>18%</td>
</tr>
<tr>
<td><strong>Offence history</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Previous convictions</td>
<td>88%</td>
<td>73%</td>
</tr>
<tr>
<td>Custodial sentences</td>
<td>59%</td>
<td>38%</td>
</tr>
<tr>
<td>Community sentences</td>
<td>77%</td>
<td>65%</td>
</tr>
<tr>
<td><strong>Time in prison</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In Feltham YOI (mean)</td>
<td>2 months</td>
<td>3 months</td>
</tr>
<tr>
<td>In total (mean)</td>
<td>14 months</td>
<td>10 months</td>
</tr>
</tbody>
</table>

* Significant to 0.05 level  
** Significant to 0.01 level

Based on self-reported convictions, a greater proportion of the LD group were represented in all offence categories except for ‘fraud’ and ‘other’ offences. Figure 3.7 illustrates the percentage of each sample reporting prior convictions in each category. There were no significant differences between the two groups.
Half of the LD group reported being in contact with a probation or Youth Offending Team worker at the time of their arrest (8). Additionally, two had a social worker, two had a Connexions key worker, and two were in contact with case workers from the Job Centre.

**Results from the HASI**
As noted in Chapter one, a secondary aim of this research was to pilot the use of the HASI, and collect data allowing assessment of the suitability of the cut-off score for its’ use as a screening instrument in the UK. Unfortunately our dataset was too small to conduct a ROC curve analysis (which requires a sample of 50 LD and 50 non-LD cases) to formally assess this. It is hoped that our data can be pooled with similar datasets being collected in the UK to enable this.

Twenty-nine per cent (54) of the 185 participants screened using the HASI scored 84 or less, indicating the need for referral for further assessment\(^{21}\). There was a significant correlation between the HASI score and the IQ composite scores \(r = \)

\(^{21}\) A score of 84 or less denotes the need for further assessment, with a score of 85 + meaning there is no such need. In practice scores sometimes fell between these two figures (eg 84.50). Given the overly inclusive nature of the HASI these scores were rounded down to 84, rather than up to 85.
4.64, p<0.01) and the HASI and adaptive behaviour composite scores (r = 2.13, p<0.05). As expected, a one way ANOVA indicated that the LD group scored significantly lower on the HASI than the non-LD group (F (1, 135) = 7.569 p<0.01). Figure 3.8 illustrates in more detail the relationship between HASI referral and assessment of LD based on the IQ and adaptive behaviour composite scores.

**Figure 3.8**
The relationship between IQ and adaptive behaviour composite scores and HASI referral (n = 137)

<table>
<thead>
<tr>
<th>Mild/borderline LD</th>
<th>HASI referral</th>
<th>HASI non-referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>K-BIT2 = 69 or less</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>VABS2 = 79 or less</td>
<td></td>
<td></td>
</tr>
<tr>
<td>K-BIT2 = 70-74</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>VABS2 = 79 or less</td>
<td></td>
<td></td>
</tr>
<tr>
<td>K-BIT2 = 75-79</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>VABS2 = 79 or less</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>9</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>(true positives)*</td>
<td>(false negatives)*</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Non-LD group</th>
<th>HASI referral</th>
<th>HASI non-referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>K-BIT2 = 79 or less</td>
<td>15</td>
<td>19</td>
</tr>
<tr>
<td>VABS2 = 80+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>K-BIT2 = 80+</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>VABS2 = 79 or less</td>
<td></td>
<td></td>
</tr>
<tr>
<td>K-BIT2 = 80+</td>
<td>18</td>
<td>62</td>
</tr>
<tr>
<td>VABS2 = 80+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>35</td>
<td>85</td>
</tr>
<tr>
<td></td>
<td>(false positives)*</td>
<td>(true negatives)*</td>
</tr>
</tbody>
</table>

*These categorisations are intended as illustrative only, and based on the data collected. In order to ascertain the true rate of false negatives and false positives using the HASI a ROC curve analysis is required. The data collected is insufficient to allow this and as such no conclusions can be drawn.

The HASI referral could be regarded as incorrect in 44 of the 137 cases according to our data, representing 32 per cent of the sample. Taking into account the possibility of sampling error, the HASI could yield inaccurate conclusions for anywhere between 24 and 40 per cent of the population from which the sample was drawn. There was however a borderline significant relationship between our assessment of LD using

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22 We have noted the difficulties associated with measurements using the K-BIT2 and VABS2 throughout this report and stress that the groupings presented here must be treated with caution.
the K-BIT2 and VABS2, and identification of the need for referral using the HASI ($X^2 = 3.860, df 1, p<0.05$)\textsuperscript{23}.

A ROC curve analysis would determine the effectiveness of the current cut-off value, and whether a different value was more suitable. The data collected here is insufficient to allow this, although it is important to note that any change in the HASI cut-off value will likely result in an increase in either false negatives or false positives (e.g. reduction in the referral score from 84 will mean that a proportion of cases previously correctly identified as requiring referral (i.e. true positives) will fall above this threshold and become false negatives). Given that the aim of a screening tool like the HASI is to be over-inclusive; it is arguably better to maximise the false positives rather than the false negatives.

A closer look at the mean scores for each of the subtests within the HASI (i.e. self-reported learning / background, backwards spelling, puzzle, and clock drawing) indicates that the correctly identified LD group (our true positives) had a lower mean score across all subtests. The false positive, false negative and the true positive groups' scores followed in succession. Figure 3.9 illustrates the differences in the mean scores for each of these four groups across subtests.

IQ composite scores correlated with each of the HASI subtests at the $p<0.01$ level, except the drawing puzzle which correlated at $p<0.05$\textsuperscript{24}. Only the HASI background subtest correlated significantly with the adaptive behaviour composites ($r = 0.230, p<0.01$). Given the remit of this report and the small samples involved, further analysis comparing the means for each of the subtests across the false/true positive/negative groups is not appropriate. Such analysis using larger numbers would help determine whether a particularly high score on one of the subtests contributed more (or less) to the HASI classifying a LD individual erroneously.

\textsuperscript{23} The actual significance value for this statistic was $p = 0.049$.
\textsuperscript{24} HASI background ($r = 0.316, p<0.01$); HASI backwards spelling ($r = 0.341, p<0.01$); HASI puzzle ($r = 0.170, p<0.05$); HASI clock drawing ($r = 0.324, p<0.01$).
Figure 3.9
Mean scores for the four HASI subtests for the false and true positive and negative groups

![Bar chart showing mean scores for false positive, true negative, false negative, and true positive classifications based on HASI subtests.](image)
Chapter 4: Healthcare in Feltham YOI

This research was commissioned to help inform Hounslow PCT about the need for specialist LD services in the first instance. Through the course of the research much data on health service contact and self-reported health needs was collected. By comparing this data for the LD and the non-LD groups we will be better able to discuss the implications of this work for Hounslow PCT.

Service contact
Most participants in both groups were registered with a general practitioner (GP) and had had some contact with the healthcare services in Feltham YOI. Figure 4.1 presents the service contact history for the two groups. There were no significant differences between the groups.

Figure 4.1
Health service contact history

<table>
<thead>
<tr>
<th>Health service contact</th>
<th>LD (17)</th>
<th>Non-LD (120)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered GP</td>
<td>82%</td>
<td>81%</td>
</tr>
<tr>
<td>Medical treatment in last 12 months</td>
<td>35%</td>
<td>57%</td>
</tr>
<tr>
<td>Currently taking medication</td>
<td>24%</td>
<td>21%</td>
</tr>
<tr>
<td>Contact with health services in Feltham YOI (incl. medical and dental)</td>
<td>77%</td>
<td>79%</td>
</tr>
</tbody>
</table>

Across the total sample most contact with health services came in the form of a visit to the Accident and Emergency room (34), although treatment by a GP for miscellaneous ailments were also common (24), as was treatment by a dentist (14).

For both groups, contact with services inside Feltham YOI tended to consist of vaccinations for Hepatitis B and/or Mumps and general check-ups. However the non-LD group also seemed to make greater use of the nursing staff and doctors for treatment for headaches, general pain, and skin conditions. Whilst it is difficult to generalise, some non-LD participants commented that they were more strategic about addressing their healthcare needs whilst in Feltham. As the following quotes illustrate:
“I asked the doctor for Lactulose, but only because I’m in jail. If I was on the outside I wouldn’t have asked, but on the inside I thought, why not? If you need help people have more time to look after you” (non-LD group inmate)

I’ve asked to see the doctor, but no one has come to see me yet. I want to get a check up because now I have time to do it” (non-LD group inmate)

We cannot conclude that the non-LD inmates were more proactive than the LD group, although in light of the additional health concerns of individuals with LD and their under use of health services in general (highlighted in Chapter one) this area is worthy of further investigation.

Whilst beyond the scope of this report, anecdotally there seemed a degree of dissatisfaction surrounding the level of healthcare received by inmates interviewed. Many commented that it took a considerable length of time to get an appointment to see a doctor and one claimed “you have to be dying of a blood clot to get seen in here!” A number of interviewees suggested that nursing staff prescribed paracetamol regardless of the ailment. In approximately ten cases the symptoms described by participants during the research interview were such as to warrant their cases being highlighted by the researchers to prison health staff (with their permission). In many cases these ailments had not previously been identified by prison staff, perhaps illustrating the added benefit that having time to establish rapport and listen to inmates may have on identifying health issues. The development of additional health screening measures encouraging this level of interaction with inmates may be something that Hounslow PCT and those working in the prison health centre wish to explore further.

Substance misuse
There was a significant difference between the two groups in terms of reported alcohol use, with considerably fewer participants in the LD group drinking alcohol in the month preceding custody. One might speculate that this difference emanates from this group having more limited social networks, not frequenting bars / clubs, and having limited funds to buy drinks with. It is interesting however that there was no difference between the two groups in terms of their use of cannabis or other substances. Figure 4.2 presents the data for the two groups.
**Figure 4.2**
Substance misuse among the LD and non-LD groups

<table>
<thead>
<tr>
<th>Substance used in month prior to imprisonment</th>
<th>LD (17)</th>
<th>Non-LD (120)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heroin</td>
<td>0%</td>
<td>2%</td>
</tr>
<tr>
<td>Crack</td>
<td>6%</td>
<td>7%</td>
</tr>
<tr>
<td>Cocaine</td>
<td>6%</td>
<td>15%</td>
</tr>
<tr>
<td>Amphetamines</td>
<td>0%</td>
<td>6%</td>
</tr>
<tr>
<td>Cannabis</td>
<td>71%</td>
<td>69%</td>
</tr>
<tr>
<td>Alcohol</td>
<td>35%</td>
<td>76% **</td>
</tr>
<tr>
<td>Mean alcoholic units</td>
<td>15 units</td>
<td>15 units</td>
</tr>
<tr>
<td>Self-reported substance problem</td>
<td>18%</td>
<td>28%</td>
</tr>
<tr>
<td>Contact with CARATS</td>
<td>41%</td>
<td>43%</td>
</tr>
</tbody>
</table>

* Significant to 0.05 level
** Significant to 0.01 level

**Self reported needs among the LD group**

Whilst not directly related to healthcare, many in our LD group expressed a desire to address their needs around education (6) and employment (4) whilst in Feltham YOI. Typically education needs centred on wanting to get a trade, or getting help with basic reading and writing skills. For example:

* I want to get on bricks [bricklaying course] because I want to get a NVQ. I want to do something vocational - without reading or writing* (Clinical LD group inmate)

Education (5) and employment (8) were also key areas LD participants wanted to address following their release from Feltham YOI, particularly help applying for jobs and/or getting into vocational college courses. However, housing needs were also a concern for some (5), as illustrated in the following quote:

* I want help with housing when I leave. Then I will be ok. Without this though it will be the same cycle, I'll get released, get no help, have nowhere to live, commit crime and then end back in prison.* (Clinical LD group inmate)
This, in particular, is an area where specialist LD service provision and the related support networks they can help access may be of benefit to this group.
Chapter 5: Summary and recommendations

This report has presented the data collected from a prevalence study of learning disability conducted in Feltham YOI. Reliable general estimates of the numbers of prisoners with LD have been difficult to ascertain. This research aimed to establish the prevalence rate of LD in Feltham YOI among the 18 to 21 age group, and as such provide Hounslow PCT with evidence on which to base their health service commissioning decisions for the prison. The key findings from the research are presented below.

- Most inmates (93 per cent) for whom a valid IQ composite was calculated performed below the standardised norm on the Kaufman Brief Intelligence Test, second edition (K-BIT2).

- Ten per cent of participants had an IQ composite score of 69 or less on the K-BIT2, indicating a significant cognitive impairment.

- A further 13 per cent had IQ composite scores ranging between 70 and 74; 16 per cent had scores between 75 and 79. In total then, 39 per cent of participants had an IQ composite score of 79 or less.

- Eighty-four per cent of those for whom a valid adaptive behaviour composite score was calculated performed below the standardised norm on the Vineland Adaptive Behaviour Scales, second edition (VABS2). For 17 per cent, scores were sufficiently low to indicate that this impairment was significant (that is, a score of 79 or less).

- Five per cent (out of 137) of participants scored sufficiently low on measures of both IQ (i.e. a score of 69 or less) and adaptive behaviour (i.e. a score of 79 or less) to fulfil the broad diagnostic criteria for learning disability. In other words, seven interviewees could be regarded as learning disabled.

- This is an estimate based on a sample, and the estimate is subject to sampling error. The true population value may lie anywhere between 1.3 and 8.7 per cent. At the lower end of this range this represents a level comparable with the wider
community. At the upper end of this range, this represents approximately four times the prevalence of LD in the wider community.

- A further seven per cent of participants (10) had IQ and adaptive behaviour scores low enough to be regarded as having a borderline learning disability indicating some impairment that might benefit from specialist learning disability service provision (i.e. an IQ score between 70 and 79, and an adaptive behaviour score of less than 79).

- Based on these measurements then, we estimate that 12 per cent (17) of participants exhibited signs of a mild or borderline learning disability. This estimate is subject to sampling error, and the true value may lie anywhere between 6.4 and 17.6 per cent.

- Insufficient data was collected to ascertain the reliability or otherwise of The Hayes Ability Screening Index (HASI). That said, in 32 per cent of cases in our sample it identified the need for referral where the K-BIT2 and VABS2 assessments suggested that this was not the case (referred to in this report as false positives); or did not suggest referral where the K-BIT2 and VABS2 scores indicated a LD (false negatives). That said, there was a mildly statistically significant relationship between the assessment of LD using the K-BIT2 and VABS2 and the HASI.

- A greater proportion of the LD group reported having previous convictions in all offence categories except fraud and other offences. There were no significant differences between the groups in terms of reported frequency and/or nature of contact with the criminal justice system.

- Reported contact with healthcare services was largely similar across the two groups, although there seemed a greater degree of self-reported pro-activity about accessing health services in prison among non-LD participants.

- Reported alcohol consumption was significantly less prevalent among the LD sample in the month prior to imprisonment. There was no significant difference between the groups in terms of their reported use of other substances.
Implications for Hounslow PCT

Five per cent of the sample for whom valid composite scores were obtained could be classified as having a mild learning disability, with a total of 12 per cent falling into the mild / borderline range. This finding is considerably lower than expected in the initial scoping study, where interviewees suggested prevalence might be as high as 50 per cent (up to 80 per cent if the borderline range was considered) (Herrington et al., 2004). That said, when we consider the measurement error inherent in psychometric testing (reflected in the practice of quoting IQ scores in ranges) as well as the scope for sampling error in our limited sample, the actual prevalence of mild/borderline LD could be much higher. For example, our estimate of 12 per cent could be consistent with a population prevalence of 17 per cent.

Simple economics mean that it is difficult for our data to support the need for the development of specialist LD services in Feltham YOI. That said, since April 2004, Hounslow PCT has had a responsibility to provide an equitable level of care for all inmates in Feltham YOI. Likewise there is the legislative requirement under the DDA (1995; 2005) to ensure that an individual’s disability does not compromise their access to services. Furthermore, the Government’s Valuing People White Paper (DoH, 2001) promotes an equitability of service for individuals with a LD, regardless of their criminal justice status. As such the PCT has a duty to address the needs of this group of LD inmates, however low their numbers.

There will no doubt be discussion regarding the eligibility of the inmates we have identified as LD to access LD services provided by Hounslow PCT. Officials may argue that only those individuals whose IQ composite scores are 69 or less are eligible, or that that those ranging up to 75 may be included. Similarly, Hounslow PCT may decide that none of these inmates would be eligible for services because their VABS2 do not fall below 70. Such decisions are dependent on individual service admission criteria and are a matter for Hounslow PCT. Another point to consider however is the extent to which our mild/borderline LD sample would truly benefit from the type of help offered by traditional community-based LD services (even if they met the conditions for admittance to the service in the first place). Similarly, we need to question whether this group should be eligible for transfer under the provisions of the Mental Health Act 1983 to a secure forensic LD service. Whilst full investigation of these scenarios is beyond the scope of this report, two key recommendations can be made.
1. There is a need to develop a reliable screening system for LD in the criminal justice system

Given that somewhere between 1.3 and 8.7 per cent of the population in Feltham YOI fulfil (broadly) the clinical diagnostic criteria of LD, with a further seven per cent (+/- 4.4 per cent) falling into the borderline range, development of a reliable system for screening offenders for LD is an important recommendation. This could be done on two fronts;

- Through the widespread use of a non-specialist screening tool such as the HASI
- By increasing the awareness of LD among criminal justice workers.

Full assessments for LD involving measures of intelligence and adaptive behaviour are time consuming, costly and require the availability of suitably trained personnel to conduct them. A screening measure like the HASI can be administered by criminal justice workers quickly and accurately with minimal training. This could allow police officers to identify individuals who may benefit from the provision of an appropriate adult at the arrest stage; could assist probation officers in compiling pre sentence reports at the court stage; and could be used at prison reception to identify the need for referral to specialist services at the imprisonment stage. A ROC curve analysis is required to ascertain the reliability of the HASI as a screening measure in the UK. Whilst it might be preferable to over-identify LD from a healthcare perspective - with a subsequent full and detailed LD assessment rescinding this if necessary - a very over-inclusive tool is of little help in the criminal justice system where resources for follow up assessments may be more limited.

A second way to improve the identification of LD offenders may come through increasing awareness of the condition amongst police officers, probation officers and prison workers. LD is traditionally a health issue, and specialist services are provided through the Department of Health. Individuals with LD (particularly mild/borderline LD) can be adept at hiding their disability. By making criminal justice workers aware of LD and its prevalence, and equipping them with the information needed to help
this group, one would hope that any additional needs could be identified and dealt
with appropriately\textsuperscript{25}. Awareness might be improved by:

- Improving understanding of LD as a condition, how it can manifest, and the
  additional needs (including health needs) that this group are likely to have.
- Training workers to present written and verbal information to individuals in
  accessible ways, e.g. by using pictures and/or simplified language and
  concepts.
- Developing an understanding among workers that this group may acquiesce
  to demands and/or questions without fully understanding the implications.
- Providing workers with contact information and resources for local LD
  services, and promoting the coordination of LD and criminal justice services
  through joint working.

In doing this it is also important to promote the passing of information regarding LD
through the criminal justice system. Whilst this is currently encouraged through the
use of assessments such as ASSET and OAsys, which are designed to accompany
an offender through the system, in practice this vital information is often lost
(Herrington et al., 2004). It is hoped that by improving awareness of LD and the
associated difficulties these individuals may encounter (together with an appreciation
of the legislative requirements governing disability discrimination (DDA, 1995; 2005)),
criminal justice system workers will be increasingly likely to request such information,
and to ensure that it is passed on.

2. Service provision for LD inmates in Feltham needs to be tailored to the
individual’s needs.

In light of the rationale for this research – to assist Hounslow PCT in their
assessment of the need for specialist LD services in Feltham YOI – it would be
remiss to not make a recommendation regarding the needs for services. As noted it
is difficult to specifically recommend the development of specialist LD services in
Feltham YOI. That said, the PCT does have a responsibility to provide equitable care
for these individuals and failure to do so may result in the PCT and the Feltham YOI
being found neglectful under the DDA (1995; 2005).

\textsuperscript{25} Such needs include health and educational problems, and improving individuals’ understanding by
presenting information in an accessible format. LD in itself cannot be cured.
The nature of the specialist help required by this group is debateable. Beyond broad comments requesting help around education, employment and housing, specific needs were not identified in this research. We have suggested that much of the support provided by community-based LD services may not be appropriate for this group. Certainly, for the borderline LD group the additional help required may be little more than providing information in an accessible format and/or the availability of a place to go to access information regarding complex issues as they arise in life. Further assessment of individuals falling into the mild and borderline LD group is required to enable additional services to be tailored to their needs.

Finally we must also consider the needs of the high number of participants who performed below average on the standardised measure of intelligence. Ninety-three per cent recorded IQ composite scores below average. There is a long tradition linking low IQ to crime and delinquency, which includes debate about education; criminal policy; the role of ethnicity; and the appropriateness of IQ testing (see Vold et al., 2002). This discussion takes us beyond the definition of LD used in this report; however, key stakeholders (including Hounslow PCT and Feltham YOI) need to consider the impact of this finding for effective service delivery in general. If, as our data show, the majority of the inmate population perform below average on a measure of crystallized thinking (i.e. knowledge of words and their meanings) and the ability to solve new problems, to what extent are individuals able to get the most out of the prison experience? In other words we need to consider the degree to which generic prison services such as education, offender behaviour programmes, and substance misuse services, are presented in a format that is accessible to the majority of their clientele. Further research assessing comprehension and retention of information presented through these programmes is needed.
References


Department of Health (viewed on 8th August 2006). Why are we introducing a bill to amend the Mental Health Act 1983? http://www.dh.gov.uk/policyAndGuidance/HealthAndSocialCareTopics/MentalHealth.


The Dyslexia Institute (2005) the incidence if hidden disabilities in the prison population: Yorkshire and Humberside research. The Dyslexia Institute.


Appendix 1

Full description of assessment tools

The Kaufman Brief Intelligence Test 2 (K-BIT2)
The K-BIT2 is a reasonably quick measure of verbal and non verbal intelligence, providing an IQ composite score. It has been designed for use by psychologists and paraprofessionals and is suitable for participants aged four to 90 years. It comprises two subtests

- Verbal, comprising verbal knowledge and riddles. In the verbal knowledge test participants are asked to point to a picture (one of six) that best represents the word that the examiner says. In the riddles test the examiner will say a riddle and ask participants for a single word that answers the riddle.
- Non verbal, comprising matrices requiring participants to select a picture (one of at least five) that completes an observed pattern.

The vocabulary element examines a person's word knowledge and verbal concept formation - it measures crystallized thinking (i.e. knowledge of words and their meanings). The matrices measure fluid non-verbal skills - the ability to solve new problems. All matrices items contain pictures and abstract designs rather than words so that non verbal ability can be assessed even when language skills are limited. This makes it particularly useful with populations where they may be a high proportion of people whose first language is not English. However, the IQ composite score can only be calculated if both the verbal and non-verbal elements have been administered. Additionally, where there is a significant disparity between the verbal and nonverbal scores recorded, caution must be used.

Two assessment items on the vocabulary subtest were deemed (by the research team) to be contextually specific to an American audience. These items were pro-rated to avoid any underestimate of performance.

The K-BIT2 correlates highly with the Weschler Adult Intelligence Scale – Third edition (WAIS-III) and the Weschler Abbreviated Scale of Intelligence (WASI), which are regularly used in clinical assessments of LD. However, the authors of the K-BIT2
caution against interpretation of the obtained composite scores for clinical or diagnostic purposes:

“Brief intelligence tests are acceptable only if users steadfastly resist the temptation to diagnose, place or make neuropsychological interpretations based on the obtained scores...Multisubtest, comprehensive batteries of an individual's mental ability, administered by properly trained professionals with considerable psychometric and clinical experience, are essential for making diagnostic or placement decisions and inferring neuropsychological assets and deficits” (Kaufman and Kaufman, 2004: 3)

Whilst results from the IQ composite scores have been used (in part) to identify the presence of absence of LD for the purposes of this research, the authors accept the limitations of this tool and do not propose to make any clinical judgements therein.

The K-BIT took between 15 and 30 minutes to complete. Items in both the verbal and non-verbal subtests got progressively harder and the subtest was discontinued when a participant scored four consecutive incorrect responses (this representing the ceiling item). We found that this tool was particularly effective in maintaining participants' motivation and many participants reported that they enjoyed the challenge it presented them.

The Vineland Adaptive Behaviour Scales Second Edition (VABS2)
The Vineland Adaptive Behaviour Scales Second Edition (VABS2) is an individually administered measure of adaptive behaviour suitable for use from birth through to 90 years of age. Adaptive behaviour refers to the personal and social skills used for everyday living. Behaviour is assessed in three domains:

- Communication, comprising verbal, reading and writing skills
- Daily living skills, comprising looking after oneself, one's home and interaction in the community, and
- Socialisation skills, comprising use of leisure time and getting on with other people

The assessment is designed to be administered in a semi structured interview format to a third party who knows the individual being assessed well (e.g. a parent or
It requires the respondent to discuss the individual’s behaviour in each of these domains. The focus is on the behaviour exhibited rather than on behaviour that the individual is physically capable of. In prison and other settings it is often impractical to conduct this assessment with a third party, and in such cases direct administration to the individual concerned is appropriate (Sparrow, Cicchetti and Balla, 2004). This method has been shown to provide information consistent with that provided by a third part (Voelker et al., 1990).

The VABS2 took between 20 and 30 minutes to complete, although relevant information was also collected in casual conversation throughout the interview process. It is important to note one limit of the tool, specifically that the assigned scores were based largely on participants’ self reported behaviour and interviewers’ subjective interpretations. As such this assessment is open to a level of inconsistency and over and/or underscoring that is unlikely in the other tools. Results from this assessment must therefore be treated with particular caution.

The Hayes Ability Screening Index (HASI)

The HASI consists of two verbal and two performance subtests measuring intelligence and adaptive behaviour. Specifically these include:

- Asking participants if they have learning difficulties or a diagnosed LD.
- Spelling a word backwards.
- A timed puzzle where participants connect a sequence of letters and numbers
- A clock drawing exercise.

The HASI is a non-specialist tool and is designed to be administered by criminal justice workers with no psychology background. It takes approximately 10 minutes to complete, and is deliberately over-inclusive to capture those with borderline learning disabilities who may also benefit from specialist service provision. It is not a measure of learning disability in itself.

The HASI has been shown to be a reliable tool for identifying individuals who would benefit from further learning disability assessment in Australia. At the outset it was hoped that this research would provide an opportunity to calibrate a suitable threshold score for the reliable use of the HASI in the UK. This required a sample of at least 50 participants with LD and 50 without to allow a Receiver Operating Characteristics (ROC) Curve Analysis to be conducted. This was not achievable.
within the time and logistical limitations of this research, though efforts to pool this data with researchers engaged in similar projects are ongoing. Our decision to use the Kaufman Brief Intelligence Test – 2 (K-BIT2) and the Vineland Adaptive Behaviour Scales 2 (VABS2) was influenced by our intention to calibrate the HASI, as these were the tools against which the initial standardisation had occurred.
## Appendix 2

### Socio-demographic characteristics of the sample (n = 185)

<table>
<thead>
<tr>
<th>Demographic</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td>Mean: 19.5 years</td>
</tr>
<tr>
<td></td>
<td>Youngest: 18 years, 15 days</td>
</tr>
<tr>
<td></td>
<td>Oldest: 21 years, 1 month, 15 days</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td>White British: 20%</td>
</tr>
<tr>
<td></td>
<td>White other: 10%</td>
</tr>
<tr>
<td></td>
<td>Black British: 29%</td>
</tr>
<tr>
<td></td>
<td>Black other: 23%</td>
</tr>
<tr>
<td></td>
<td>Mixed race: 10%</td>
</tr>
<tr>
<td></td>
<td>Asian: 5%</td>
</tr>
<tr>
<td></td>
<td>Other: 3%</td>
</tr>
<tr>
<td><strong>Accommodation status (prior to custody)</strong></td>
<td>Permanent accommodation: 84%</td>
</tr>
<tr>
<td></td>
<td>Temporary accommodation: 6%</td>
</tr>
<tr>
<td></td>
<td>No fixed abode: 7%</td>
</tr>
<tr>
<td><strong>Who were you living with?</strong></td>
<td>Parents: 52%</td>
</tr>
<tr>
<td></td>
<td>Other relations: 9%</td>
</tr>
<tr>
<td></td>
<td>Partner: 8%</td>
</tr>
<tr>
<td></td>
<td>Friends: 7%</td>
</tr>
<tr>
<td></td>
<td>Alone: 21%</td>
</tr>
<tr>
<td><strong>Hounslow Borough residents</strong></td>
<td>4%</td>
</tr>
<tr>
<td><strong>Custodial status</strong></td>
<td>Remand: 73%</td>
</tr>
<tr>
<td></td>
<td>Sentenced: 10%</td>
</tr>
<tr>
<td></td>
<td>Convicted awaiting sentence: 10%</td>
</tr>
<tr>
<td></td>
<td>Sentenced and remand: 7%</td>
</tr>
<tr>
<td><strong>Time in Feltham YOI</strong></td>
<td>Mean: 3 months</td>
</tr>
<tr>
<td></td>
<td>Range: 2 days to 18 months</td>
</tr>
<tr>
<td><strong>Time in custody (this time)</strong></td>
<td>Mean: 4 months</td>
</tr>
<tr>
<td></td>
<td>Range: 2 days to 43 months</td>
</tr>
<tr>
<td><strong>Total time in custody</strong></td>
<td>Mean: 10.5 months</td>
</tr>
<tr>
<td></td>
<td>Range: 2 days to 60 months</td>
</tr>
<tr>
<td><strong>Employment status (prior to custody)</strong></td>
<td>Employed (full/part time): 25%</td>
</tr>
<tr>
<td></td>
<td>Unemployed: 54%</td>
</tr>
<tr>
<td></td>
<td>Education (full/part time): 20%</td>
</tr>
<tr>
<td><strong>Age left full time education</strong></td>
<td>Mean: 15 years old</td>
</tr>
<tr>
<td></td>
<td>Range: 9 to 20 years old</td>
</tr>
</tbody>
</table>
Appendix 3

**Learning and Living: Skills and Experiences in Feltham YOI**

**A Protocol for Researchers**

**Details of Specialist Psychological Support**

- Specialist psychological support will be provided by Dr. Christopher Bennett, Consultant Clinical Psychologist at the Eric Shepherd Unit, Abbots Langley, Hertfordshire, and his team.

- All researchers will receive training on use of the HASI, VABS-II and K-BIT II. This will be in two parts. Part one includes an overview of the tools, their administration and scoring. Researchers will then be expected to spend time becoming familiar with the tools (including the self-explanatory research questionnaire). Part two will involve supervised administration of the research tools.

- Dr. Bennett and his team will be quality checking the first three assessments (using the above tools) from each researcher. Feedback will be given to researchers, and additional training will be organised if necessary.

- In addition, Dr. Bennett and his team will also dip sample a further 5% (approximately) of the assessments conducted by researchers. Again, feedback will be given to researchers, and additional training will be organised if necessary.

- Dr. Bennett and his team will provide comprehensive supervision for the Research Assistant appointed by the Eric Shepherd Unit to work on this project (Robert Keers), which will comprise face to face meetings / discussions and telephone support.

- All other researchers will be able to approach Dr. Bennett and their team for telephone advice and support when needed.

**Practicalities of conducting the research**

**Before the Interview**

- A Researcher Toolkit containing all the equipment required to conduct the assessment (stopwatch, pencils, manuals etc) will be held in a designated location in Feltham YOI.

- Assessment packs – containing the scoring sheets (questionnaire, HASI, K-BIT and VABS) and proformas required to conduct the assessment will be stored in plastic folders with the Toolkit. One
assessment pack will be used for each interview. Each assessment pack will be assigned a unique ID number. This will be on a sticky label on the front of the plastic folder. This should also be indicated on each of the assessment tools used. All researchers will be provided with their own copy of the scoring information to score their assessments after the interviews.

- The Toolkits and the required number of Assessment packs should be collected when researchers attend the prison (exact location to be confirmed).

- Upon completion of each day’s fieldwork, researchers are responsible for returning The Research Toolkits (not the used assessment packs) to the designated location.

- Refreshments to offer to participants will be stored with the above Toolkits and Assessment packs (likely to amount to a carton of drink and a mars bar). Researchers should ensure that they have sufficient supplies for their interviews.

**During the interview**

- A list of individuals to be invited to take part in the research will have been compiled, and individuals will have been approached by prison staff on the wings in the first instance, to ask if they are willing to participate. If they have agreed, they will be bought to the interview room where it is the researchers’ responsibility to go through the information sheet and gain informed consent. The interview should progress in the following format:
  
  o Introductions / greetings / seating of participant ensuring that they are comfortable (in terms of temperature, how they are feeling, offer refreshments etc).
  
  o For security reasons the researcher should ensure that they occupy the seat nearest the exit, and that the security staff who are posted outside the room are aware interviewing is in progress.
  
  o Introduce the study via the information sheet. Ensure the participant understands the remit of the study, its length and structure (i.e. comprised of 4 sections containing questions and puzzles which get harder as the interview progresses).
  
  o Ensure the participant understands that they have been chosen by random and that this interview does not mean there is anything wrong with them.
  
  o Ensure they understand that no one is expected to get all of the questions right.
  
  o Also ensure the participant understands that the researcher is unable to feedback on their performance, but that if they have any concerns about this they should ask a member of staff to refer them to the Prison Health centre.
• Give the information sheet to the participant to keep.

• Get written informed consent from the participant. If a participant gives consent but refuses to sign the consent sheet the researcher should indicate this.

• If the researcher feels that the individual in question does not accurately understand the research project, they must terminate the interview (agreeing to pay the individual as promised) and refer the inmate to a member of the Prison Health Care team as a vulnerable person.

• Once consent has been obtained, the researcher must ensure that the participant has glasses/hearing aid if they usually wear them, and is feeling comfortable (i.e. not unusually unwell/anxious/distracted by extraneous matters). If any of these points apply the researcher must make a note of them on their forms. In addition, if the researcher feels that any other information is pertinent to the validity / reliability of the assessment (e.g. a participant appears to be deliberately under performing, horsing around, is distracted), a note should be made of this on the tools.

• A unique ID will be assigned to each assessment pack. The same number should also be written on each of the completed assessment sheets in this pack (excluding the consent form).

• The tools should be administered in the following order, in line with the training received from Dr. Bennett and his team.
  - Research Questionnaire
  - HASI
  - K-BIT
  - VABS

• Refreshments may be offered throughout the interview. Additionally, researchers should be aware of the importance of establishing and maintaining rapport with inmates. Researchers should seek to reassure participants without giving any positive or negative feedback about their performance.

• Researcher will be informed in advance of the interview if the participant requires the use of interpreters. Provision will be made for this and researchers must ensure that they inform the interpreter to repeat the researcher’s instructions and participants responses verbatim.

• The interview can be terminated at any time by the participant, and they will still receive their £10 payment to their Feltham YOI account. The interview can also be terminated at any time by the researcher if s/he feels uncomfortable / unsafe with the situation.
Before the end of the interview

- Upon completion of the tools, researchers should offer participants the opportunity to have their GP informed that they took part in the research study (as per the information sheet), explaining that their assessment results will not be passed on. The GP Notification Form must be completed.

- The researcher must also fill in the enclosed ‘Payment to Participant’ form and return this to the Prison Officer who has been responsible for escorting them. The Prison Officer will ensure that this form is passed to the finance department and that prisoners’ accounts are credited accordingly. Prisoners should be informed of this and should be told to use the contact details on the information sheet if they have any queries.

After the Interview

- Assessments should be scored as soon as possible once participants have left the interview room. Researchers should complete the ‘Results Checklist’ and place it at the front of the completed assessment pack.

- A participant’s completed assessments should be stored (and held securely) in their plastic assessment folder. Their unique ID sticker will be placed on the front, and the same number should be written on all of the tools too.

- Consent forms should not be assigned a unique ID and should be stored separately from completed assessments.

- Please do not leave completed assessments or consent sheets in Feltham YOI. Instead, these should be held securely by you and returned to Vicki Herrington or Sue Harvey as soon as possible.

- If researchers have any further queries they should contact either Vicki Herrington (02078481756 / 07766272059) or Sue Harvey (02083215937).

ICPR and Hounslow PCT
November 2005
Appendix 4

LEARNING AND LIVING: SKILLS AND EXPERIENCES IN FELTHAM YOI

INFORMATION SHEET

The Institute for Criminal Policy Research at King’s College London and Hounslow Primary Care Trust are asking you to take part in a project looking at what skills people have and what help they need when they come to Feltham YOI.

Who is paying for the study and what is it about?

- Hounslow Primary Care Trust is the local Health Service organisation in the Feltham YOI area. They are paying for the research so that they can find out what help people need when they come to Feltham YOI. They want to find out about people’s learning skills and experiences, and how they look after themselves.

- The Institute for Criminal Policy Research is part of King’s College and is helping Hounslow Primary Care Trust with this study.

- The law says that people must be treated fairly and organisations like the prison have to make sure that people have access to the right type of support for them. The NHS and Prison Health Service therefore need to be able to find out what sorts of needs people have.

- There is not a good way of doing this at the moment – and we hope that this research might be able to help us find out if there is a quick check that doctors and nurses can do to find out about people’s needs.

- We are asking a group of people from Feltham to take part. Taking part does not mean that there is anything wrong with you, or that you have any particular needs.

What will taking part involve?

- If you agree to take part a researcher will interview you in a private room for about **1 hour and 30 minutes**.

- There will be 4 sets of questions in total.

- These questions will include us asking things about your life before you came to prison, including who you lived with, and if you had a job or were studying. We will also ask you some very general questions about your health and about the types of crimes the police have charged you with. We will also ask you to do a few puzzles.

- The puzzles will get harder as we go along and no one will get all of them right. Please just listen carefully to the researcher and try your best.
• You will be provided with something to drink and eat whilst you are being interviewed.
• **We would like to say thank you for taking part in the research so at the end of the interview we will credit your Feltham YOI account with £10.**

**Will anyone know what we talk about?**

• The research is completely separate from custody in the Prison.

• All of the research is completely confidential and anonymous. This means that we will not write down your name or address and will not tell anyone what we talk about. We will give you a special number instead, and use this to identify you.

• **We are not allowed to tell other prisoners or prison officers what we talk about at all.** The only time we must tell the prison staff what you say is if you say you are going to hurt someone, or if you are going to hurt yourself, or if you are doing something against the law. We will tell you if we have to talk to the prison staff about this.

• If the researcher thinks that it might be good for you to get some extra help, they will talk to you about this at the end of the interview. If you would like and agree to some extra help, the researcher will speak to a member of staff in the healthcare unit and they will talk to you about your needs.

• We will ask you whether it is ok for us to tell your GP that you have helped us with the research. We would like to do this so that they are able to contact us if you ask them something about the research project. We will not tell your GP what you have told us, or that the research took place whilst you were in prison. If you do not want us to contact your GP then we will respect your wishes.

**Can I change my mind?**

• Taking part in our project is voluntary. This means that you can decide to say no if you like and no one can make you take part. Nothing bad will happen to you if you decide to say no.

• Also, you are allowed to stop the interview at any time if you do not want to take part anymore. Nothing bad will happen to you if you decide to do this.

**What happens afterwards?**

• We hope that this research will be able to tell us if there is a quick test we can do to find out about people’s learning, social and communication abilities so the health services can find out what help people need.
• Because this research is just a test, and because we do not want to write down your name, we are not be able to tell you any of your personal results from the interview.
• Instead, after the research is finished we will write a report and give a summary of what we found out overall to the prison.
• We will not tell anyone your individual results.
• We might use things you have told us in the report but this will be anonymous and we will not say who told us.
• You will be able to get this report by talking to a prison officer or member of the healthcare staff. If you have left the prison and would like to find out about the research, you can contact us using the details below and we will send you a copy.

What about if I am worried or confused?
• If there is something you do not understand or if you would like to know more about our project - you can ask any of the researchers involved.
• If you are worried about anything that we ask you, or you think that you might need some extra help - you can ask the researchers that you speak to. If they do not know the answer to your question, or if they cannot help you themselves, they will find someone who can.
• If the researchers have left, or if you have moved to another prison and you are still worried you can contact the prison health department by asking any prison officer, teacher, nurse or doctor. They will be able to contact specialist doctors to help. If you have gone home, you can contact your doctor and they will be able to help you.
• If taking part in this study has harmed you in any way you can contact King’s College London using the details below for further assistance and advice.
• If you would like more information about the research project, you can call Vicki Herrington on 02078481756 or Gillian Hunter on 02078481748, or Sue Harvey – who is a nurse on 02083215937

This study has been approved by the King’s College Research Ethics Committee, reference: 04/05-61

This study has been approved by the Wakefield Research Ethics Committee, reference: 05/Q124/12

This study has been approved by the Prison Research Ethics Committee
LEARNING AND LIVING: SKILLS AND EXPERIENCES IN FELTHAM YOI

CONSENT FORM

To be read or given to the interviewee at the start of the research:

Thank you for agreeing to take part in this study. I am a researcher from King’s College London working on this project.

- Have you read/had explained to you the information sheet for participants? Yes/No
- Have you had a chance to ask questions and discuss this study? Yes/No
- Have you received enough information about the study? Yes/No
- Do you understand that you can stop the interview at any time and that nothing bad will happen to you as a result? Yes/No

Interviewee’s statement
I understand the information I have been given and agree to be interviewed.

Signature .......................................................... Date ..........

Name (please print) ..............................................

Investigator’s statement:
I confirm that I have carefully explained the nature, demands and foreseeable risks of the proposed study to the volunteer.

Signature .......................................................... Date ..........

Name (please print) ..............................................
INTERVIEW SCHEDULE

Unique Research ID

Interviewer

Information sheet given
Consent form signed

Date of interview
Note to interviewers: Please ensure that each section is introduced, i.e. “I am now going to ask you a few questions about …”

Section One: Housing situation

1.1 What was your housing situation before coming to prison? (Prompt with examples below if necessary)

No Fixed abode  Temporary accommodation  Permanent accommodation

-Sleeping rough - Bed and breakfast - Hostel - Housing association - Co-operative

-Friends / relations sofa - Night shelter - Council accom - Private rented

-Squat - Probation/bail hostel - Owner occupier - LA care

-Other NFA (specify) - Residential rehab - Supported housing - Other perm (specify)

1.2 Who did you live with before you came to prison? (please tick all that apply)

Partner  Children  Friends  Parents

-Other relations - Alone - Other (Specify)

1.3 How long had you been living in this accommodation situation?

- Days / months / years (please circle)

1.4 What area were you living in before coming to prison? (Prompt Hounslow Borough or other area)

-Hounslow Borough - Other (specify)

1.5 Will you be returning to this area when you are released? Yes  No

1.6 If NO where will you go after release?


1.7 Have you ever been in Local Authority care?  Yes  No

Section Two: Offending

2.1 Are you a sentenced or remanded prisoner?  Sentenced  Remand

2.2 How long have you been in Feltham YOI?  Days / weeks / months (please circle)

2.3 Were you transferred to Feltham from another prison? Prompt whether they were held in another prison immediately before coming to Feltham, or whether they were sent to Feltham directly from the community.

2.4 How long have you been in custody this time? (Include time spent in other prisons on the same charge. I.E., if they are now sentenced, include the time that was spent on remand for the same offence if there was no break between these – i.e. without being released in the interim)

2.5 If already sentenced, do you know your release date?

2.6 What (alleged) offence(s) are you currently imprisoned/on remand for? (If participant denies committing any offences ask what they have been charged with by the police)
2.7 Do you have any previous convictions? (If necessary, prompt that a conviction means going to court and receiving a sentence – be it a custodial or a community sentence)

Yes □ No □ Go to Qu. 2.10

2.8 Approximately, how many previous convictions do you have?

□ □

2.9 Which of the following offences have you been convicted of? (Run through the list of offences. If the participant has previous convictions, ask how many)

<table>
<thead>
<tr>
<th>Offence type</th>
<th>Number of convictions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burglary</td>
<td></td>
</tr>
<tr>
<td>Robbery</td>
<td></td>
</tr>
<tr>
<td>Criminal Damage</td>
<td></td>
</tr>
<tr>
<td><strong>Theft/Handling (incl. shoplifting)</strong></td>
<td></td>
</tr>
<tr>
<td>Fraud/forgery</td>
<td></td>
</tr>
<tr>
<td>Violence against the person (ABH/GBH etc)</td>
<td></td>
</tr>
<tr>
<td>Drugs offences (possession / supply)</td>
<td></td>
</tr>
<tr>
<td>Driving offences (not including speeding / parking tickets etc)</td>
<td></td>
</tr>
<tr>
<td><strong>Other (specify)</strong></td>
<td></td>
</tr>
</tbody>
</table>

2.10 Have you been in prison before? □ Yes □ No Go to Qu. 2.13
2.11 **How many previous custodial sentences have you served?** If necessary prompt that this is where a court has sentenced them to a period of time in prison (Include Detention and Training Orders (DTOs) which are part custody and part community). Do not include time spent on remand.

- [ ] Sentences

2.12 **How much time in total have you spent in prison?** Include time spent on remand

- [ ] Days / weeks / months

(please circle)

2.13 **Have you ever served a community sentence?**

- [ ] Yes
- [ ] No

Go to section 3

2.14 **How many community sentences have you had?** (Prompt with examples from below. Where sentences have two parts (e.g. a supervision order with an attendance centre order attached) just list these as a supervision order because we are interested in absolute numbers of sentences

<table>
<thead>
<tr>
<th>Number of sentences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Detention and Training Order (DTO) (custody/community)</td>
</tr>
<tr>
<td>Community punishment and rehabilitation order</td>
</tr>
<tr>
<td>Supervision order / community rehabilitation order /</td>
</tr>
<tr>
<td>Community punishment order / reparation order (community service)</td>
</tr>
<tr>
<td>Action plan order</td>
</tr>
<tr>
<td>Attendance centre order</td>
</tr>
<tr>
<td>Referral order</td>
</tr>
<tr>
<td>Drug treatment and testing order (DTTO)</td>
</tr>
<tr>
<td>Curfew order</td>
</tr>
<tr>
<td>Other(s) (specify)</td>
</tr>
</tbody>
</table>
Section Three: Education and training

3.1 What were you doing immediately before you came to prison this time? (Please tick one)

- Full time employment/self employment
- Part time employment/self employment
- Full time student [prompt at school/college]
- Unemployed
- Part time student [prompt at college/other training centre]
- Other training (specify) [prompt vocational training]
- Other (specify) ________________________________

3.2 If employed before coming to prison, what was your job?

______________________________

3.3 How long had you been doing this job? Days / weeks / months (please circle)

3.4 How old were you when you left full time education? Prompt when you stopped attending school or college every day). Mark as N/A if they were still attending full time school or college when they were imprisoned this time.

______________________________ Years old

3.5 What qualifications do you have? Prompt from the list below. If they say none check if any are currently being undertaken
3.6 Did you need any extra help around reading, writing or learning at school?
Probe for special needs / teaching support

Yes [ ]  No [ ]  Go to Qu. 3.8

3.7 If YES what extra help did you receive?


3.8 Did you ever attend a specialist school? Prompt a school for special educational needs / behavioural difficulties etc.

Yes [ ]  No [ ]

3.9 Is there any other help that you would have liked at school? Probe if they would have liked help with their reading / writing etc


3.10. What education or training courses have you participated in since you came into Feltham? Exclude substance misuse courses. Probe whether they are currently attending these courses or have finished their contact with them (i.e. completed)

<table>
<thead>
<tr>
<th>Course</th>
<th>Completed</th>
<th>Currently attending</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Skills (literacy / numeracy)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Formal education (e.g. GCSEs) (specify)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Learn Direct course (specify)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NVQ (specify)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Construction training</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Food and Hygiene</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health and Safety</td>
<td></td>
<td></td>
</tr>
<tr>
<td>First Aid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Driving awareness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parenting skills</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Budgeting skills</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stress management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work skills (preparation for work)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Offender behaviour programme (e.g. ETS, STAR, R&amp;R, CALM, IPRS, Anger management)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other pre-release courses (specify)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Victim awareness courses / programmes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Listener / mentor schemes / Trailblazers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other courses (specify)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Section Four: Health and Emotional Wellbeing**

4.1 Do you have (are you registered with) a GP where you live? Prompt family doctor if necessary)

Yes □  No □

4.2 When did you last see a doctor before coming to prison? Include hospital/casualty visits. Do not include appointments regarding the collection of a
methadone script unless a doctor or nurse (rather than a pharmacist) was seen and they asked about their health)

Days / weeks / months / years ago
(please circle)

4.3 Are you currently receiving any medication or medical treatment? (Prompt epileptic / asthma medication / anti-depressants etc)

Yes □ No □ Go to Qu. 4.5

4.4 What medication or treatment are you currently receiving?

4.5 Were you taking any medication or had you had any other treatment for health related problems in the 12 months before you came to Feltham? (Prompt for physical, mental, dental health problems and treatments, e.g. epilepsy medication, antibiotics, antidepressants, counselling, asthma medication, fillings/caps etc. Exclude substance misuse treatments)

Yes □ No □ Go to Qu. 4.7

4.6 If YES, what medication or treatment did you receive in the past 12 months?

4.7 Were you asked about your health by a nurse or doctor when you first came into Feltham? (Probe for initial health screen at reception – they should have all had this – we just want to remind them here)

Yes ☐ No ☐

4.8 Have you met with a doctor or nurse since that initial health screen?

<table>
<thead>
<tr>
<th>Doctor seen</th>
<th>Nurse seen</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other health professional seen (specify) including Trailblazers</td>
<td>No health professional seen since initial screen</td>
</tr>
</tbody>
</table>

4.9 If YES, please tell me about your contact with them. (Prompt how put in contact/referred; why referred; how they helped; are they still in contact etc)
### Section Five: Drug and Alcohol use

5.1 Could you tell me a bit about your drug use in the month before you came to prison? Were you using any of the following substances? Run through the list of substances and where a participant says they were using it ask them how frequently, and what route they were using.

<table>
<thead>
<tr>
<th>Drug</th>
<th>Days used</th>
<th>Main Route(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0 = never</td>
<td>1 = oral</td>
</tr>
<tr>
<td></td>
<td>1 = daily or more</td>
<td>2 = snort/sniff</td>
</tr>
<tr>
<td></td>
<td>2 = 4 - 6 per week</td>
<td>3 = smoke</td>
</tr>
<tr>
<td></td>
<td>3 = 2 - 3 per week</td>
<td>4 = inject</td>
</tr>
<tr>
<td></td>
<td>4 = once a week</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5 = 1 - 3 in last month</td>
<td></td>
</tr>
</tbody>
</table>

- **Heroin**
- **Methadone** (prescribed)
- **Methadone** (non-prescribed / street)
- **Other opiates**
- **Crack Cocaine**
- **Cocaine powder**
- **Amphetamines**
- **Other (specify)**

5.2 How often did you drink alcohol in the month before you came to prison? Please tick one

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td></td>
</tr>
<tr>
<td>Daily</td>
<td></td>
</tr>
<tr>
<td>4-6 days a week</td>
<td></td>
</tr>
<tr>
<td>2-3 days a week</td>
<td></td>
</tr>
<tr>
<td>Once a week</td>
<td></td>
</tr>
<tr>
<td>1-3 a month</td>
<td></td>
</tr>
</tbody>
</table>
5.3 Can you tell me roughly how many drinks you would have in an **average drinking day** in the month before you came to prison? (Prompt for the number of beer, wine, spirits drunk, and approximate volume).

<table>
<thead>
<tr>
<th>Number of cans / glasses / bottles (please specify)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beer / cider</td>
</tr>
<tr>
<td>Wine</td>
</tr>
<tr>
<td>Spirits</td>
</tr>
<tr>
<td>Other</td>
</tr>
</tbody>
</table>

5.4 Do you think you had a problem with either drug or alcohol use **in the month before** you came into prison?

- No
- Yes – alcohol
- Yes – drugs
- Yes – alcohol and drugs
- Don’t know

5.5 Have you received support for your drug taking or drinking in the past? Prompt for help for substance misuse before coming to prison this time – include help given whilst serving other prison sentences if appropriate.

- No
- Yes – alcohol
- Yes – drugs
- Yes – alcohol and drugs
- Don’t know

5.6 If YES, what help did you receive? (Probe for the type of help (e.g. methadone script, subutex, detox, rehab, and counseling) and the service provider (e.g. AA/NA, GP, CARATs, Addaction, Turning point etc.)

5.7 Have you had any contact with substance misuse services / CARAT team since you came into Feltham?

- Yes [ ]  No [ ]  Go to section six

5.8 If YES, are still in contact with them?

- Yes [ ]  No [ ]
Section Six: Other services

6.1 What, if any, other services were you in contact with before you came to prison? (Prompt for things like social worker, LD services, Youth Offending Team)

6.2 What, if any, other services you would like to have contact with whilst you are in Feltham? Prompt for education / preparation for work / employment services; for health services; for counselling services; for substance misuse services; for offender behaviour services etc.)

6.3 What, if any, services would like to have contact with when you are released from prison? Prompt for education services; preparation for work / employment services; for health services; for counselling services; for substance misuse services; for offender behaviour services etc.)

Thank you very much for your time