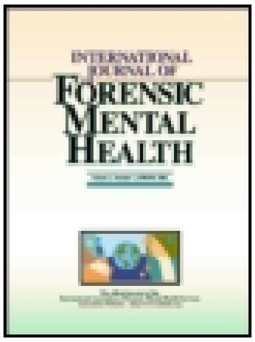

International Journal of Forensic Mental Health

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/ufmh20

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To cite this article: M. Duff, W. Paki, (Waikato, Te Arawa, Ngaaruahine), R. Butler, C. McSweeney & B. McKenna (2023): The Development of a Forensic Intellectual Disability Model of Care: Synergy to Achieve Equity, International Journal of Forensic Mental Health, DOI: 10.1080/14999013.2023.2178555

To link to this article: https://doi.org/10.1080/14999013.2023.2178555

INTERNATIONAL JOURNAL OF FORENSIC MENTAL HEALTH
https://doi.org/10.1080/14999013.2023.2178555

The Development of a Forensic Intellectual Disability Model of Care: Synergy to Achieve Equity

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ABSTRACT

There is a relative lack of research focused on people with intellectual disabilities within forensic settings and limited information describing models of care. This article describes the process of enquiry and information gathering that was synthesized to develop a specific model of care for a specialist forensic intellectual disability secure care unit within a forensic mental health service in Aotearoa (New Zealand). The obligations to address the over representation of tāngata whenua (Māori; Indigenous people of Aotearoa) and to resist the dominant Western and mental health paradigms being ineffectively imposed within this specialist service, were acknowledged as central challenges. A literature review, consultation with tāngata whaikaha hinengaro (service users) and Māori cultural input provided a platform to synthesize diverse perspectives. This resulted in the weaving together of the important elements necessary in a model of care, to optimize specialist forensic intellectual disability care and rehabilitation in Aotearoa. This article has an emphasis on the research literature, but is not a research project, rather it is a description of the process leading to a negotiated model of care to achieve equity.

KEYWORDS

Forensic; intellectual disability; learning disability; model of care; equity

Introduction

People with intellectual disability (ID) who offend require specialized services to meet the level of care and security required to meet their needs (Lunsky et al., 2011). Such needs are complex. They combine a rehabilitative need adapted to cognitive ability, with an array of physical and mental health care challenges (Kitchen et al., 2014); trauma related experiences arising from abuse, neglect, institutionalization and psychosocial disadvantage (Devapriam & Alexander, 2012; Hollomotz & Talbot, 2021); and challenging behaviors, which pose a risk to self and others (Bowring et al., 2019), including sex offending (Marotta,2017). There is also strong evidence of the over representation of Indigenous people among forensic intellectual disability populations in such countries as Australia (McCausland et al., 2017) and Canada (Stewart et al., 2016), highlighting the cultural needs for those populations who sit outside the dominant culture of the service.

In Aotearoa (New Zealand), the New Zealand Disability Strategy (2016–2026) prioritizes the elimination of barriers that prevent people with a disability reaching their full potential and participation in their communities (Office for Disability Issues, 2016). The Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (IDCCR Act) removed one such barrier for people with an intellectual disability who offend, in providing courts with custodial alternatives to prison. Such services, called Forensic Intellectual Disability Secure Services (FIDSS) must function in keeping with the country's obligations to human rights declarations, including the United Nations Convention on the Rights of People with Disabilities (The UN General Assembly, 2007a) and the Declaration on the Rights of Indigenous Peoples (The UN General Assembly, 2007b).

FIDSS in Aotearoa are delivered under the High and Complex Framework established with the passing of the IDCCR Act. The Framework supports between 200-250 people, at any given time. As of 31st December 2020, there were 203 Framework service users. Of these, 85% were male; 57% under the age of 35 years old; and 37% Māori (the Indigenous people of Aotearoa) (Boshier, 2021, pp 13-14).

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Under Te Tiriti o Waitangi (the Treaty of Waitangi) signed in 1840, equity and equality of status, rights, and opportunities were guaranteed by the British Crown (the colonizers) to Māori. However, historic and contemporary access to power has privileged the colonizers to the devastating detriment of Māori, which is starkly reflected in health status (Ministry of Health, 2018, 2020). This inequity is reflected in the over-representation of Māori (37%) in FIDSS, given Māori comprise 16.5% of the population in Aotearoa (Statistics New Zealand, 2018). It is recognized that the provision of FIDSS must reconcile the cultural-historical context of Aotearoa, specifically the process of colonization leading to inequity for Māori. Throughout this document, the group of people who are subject to this Framework will be referred to as 'tāngata whaikaha hinengaro' (people in pursuit of mental strength; a Māori strengths-based term, for people with ID).

Secure hospital facilities form the most restrictive component of the tiered matrix of FIDSS, which emphasizes community care. Such hospital facilities are sited in the health system. The ID secure hospital service in Tāmaki Makaurau (Auckland), opened in 2006, is presently responsible for up to 17 tāngata whaikaha hinengaro. This includes 12 beds within a male only medium secure unit and, since 2021, five 'outlying' beds housed in a variety of forensic mental health units. Since opening, the service has struggled to maintain its disability identity, being hosted by a larger forensic mental health service. Over the years, this has raised some challenges for ID service delivery, which reflects different legislation; different admission and discharge processes; and different staff skill sets, competencies and training needs (Prebble et al., 2013).

Even though there are some commonalities with the host forensic mental health service, policy and procedure development have not catered specifically for ID secure needs. The dominant culture has been the medical model of care with a recovery focus, while international best practice in forensic ID is based on a social care model supported by rights-based policy (Lawson & Beckett, 2021). Therefore, the development of a distinct model of care for the ID secure hospital service was required.

A model of care defines the way care is provided, including best practice and services for individuals, to ensure that they receive appropriate care from admission to a service to discharge (Kennedy, 2022; McKenna & Sweetman, 2020). A model of care provides clarity over roles, in order for staff to work at their full potential. Furthermore, it can contribute to a service's shared vision or values and be seen as an indicator of success (Kennedy, 2022). This includes ensuring that care and rehabilitation, alongside treatment planning, does not become fragmented, and is delivered in an efficient and cohesive manner. While some models of care take a broad approach in defining service delivery and the underlying values, others may be more prescriptive (Kennedy, 2022).

This service improvement initiative which is described, was aimed at developing and articulating a distinct model of care for the ID secure hospital service in Tāmaki Makaurau.

Method

The methodological approach to this service improvement initiative was based on pragmatism, which seeks practical and useful approaches that can help to answer complex questions (Patton, 2015). The complex question in this project was "what are the core components of a model of care for an ID secure hospital service in Aotearoa."

In this project, we undertook three steps toward answering this question. First, we undertook a narrative literature review. Second, we talked to tāngata whaikaha hinengaro about their values, in order to determine congruence between what the literature was highlighting and what those directly involved were telling us. Third, we took the insights gained from the other two processes to a Māori cultural advisor to negotiate the aligments and modifications required to make sure the model of care was culturally appropriate for tāngata whenua.

We intended to create a synergy (triangulation) of these three sources of understanding (evidence-based insight, service user insight and cultural insight), in order to develop a comprehensive expression of a collaborative model of care (Patton, 2015).

Literature review

A generic literature review was undertaken to identify relevant material to inform a model of care. This type of review seeks to identify and examine recent literature across a wide range of subjects, and typically provides a narrative synthesis of the evidence. Unlike systematic reviews, a generic literature review does not aim for exhaustive and comprehensive searching (Grant & Booth, 2009).

The focus of the review was models of care adopted in hospital-based services for individuals with ID who have offended, with results pertaining to prisons, courts or the community therefore excluded. In addition, publications detailing assessment tools, treatment interventions, or outcome studies were also out of scope.

Initial searches were conducted via several databases (Scopus, CINAHL, and Google Scholar) utilizing a set of keywords[1] . These were limited to English language publications from 1990 to 2021. Results were screened by title and abstract, and relevant publications were reviewed fully to establish relevance to the review scope. Further literature was obtained via recommendations from the project team; a review of reference lists from initial publications sourced; and a search of the national and international grey literature. This included a search for existing models of care from Aotearoa, and/or those which were 'culturally responsive'.

While the focus of the review was people with ID who have offended, it is recognized that individuals in forensic ID services may not have been convicted of an offense, but detained due to the risk of harm they pose to others (Browne et al., 2019). This review encompassed such people. Further, while the term 'intellectual disability' reflects the terminology adopted in Aotearoa, the search incorporated other terms used internationally such as 'learning disability'.

The literature reviewed was analyzed using the six phases involved in undertaking thematic analysis (becoming familiar with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the report) (Braun & Clarke, 2006). Initial coding was undertaken by RB and categories and themes were discussed and reviewed with BM. During this stage, the themes were given their final names.

Tāngata whaikaha hinengaro input

The input of tāngata whaikaha hinengaro was coordinated alongside the literature review. The model of care developed needed to reflect their values. An understanding of these values was gained through group and individual discussion with trusted staff.

In three group sessions and individual interviews, staff posed questions to tāngata whaikaha hinengaro about how they liked to be treated and what was important to them in their care. These questions were open-ended and allowed tāngata whaikaha hinengaro to discuss values in the service that were important to them. All the main unit tāngata whaikaha hinengaro ($n = 12$) provided some input through these opportunities.

Efforts were made to ensure even those with limited communication could offer their views. This included using key words and visuals in group discussions. Some tāngata whaikaha hinengaro, who were unable to work in groups, had 1:1 sessions using communication aids such as "talking mats"; mats to which pictures can be attached and re-arranged as required to aid expression (Stewart et al., 2018).

All of the values expressed were summarized and collated into themes using thematic analysis as outlined (Braun & Clarke, 2006), and presented back to the group for further consultation, to select the main values to reflect service delivery.

Negotiated consensus with Māori

In order to meet the Crown's obligations to Te Tiriti o Waitangi and to start to address the present inequities for Māori in the secure ID care facility, the clinicians involved in the project (MD and CS) negotiated the developing model of care with a Māori cultural advisor in the service. This was to ensure tāngata whenua participation in the design of ID services and in doing so, aimed to create a culturally appropriate model of care for this population in an Aotearoa context.

The resource for the project allowed the secondment of a Taurawhiri (Māori cultural advisor; WP) into the project team, for this purpose. Consultation with Te Rōpū Taurawhiri (the Māori cultural advisor team for the hosting forensic mental health service) was undertaken during the secondment, to discuss the project and request support for collective decision-making.

The resource for the project allowed the time for 'thinking spaces' to enable considered discussion and negotiation, which rarely occurs in the context of busy clinical work.

Ethics

Ethics approval was not required within the context of a standard service improvement initiative integrated with a literature review.

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[1] Searches utilised the following search string, along with various combinations of keywords: (forensic OR criminal) AND ("intellectual disability" OR "developmental disability" OR "learning disability" OR "autism" OR "foetal/fetal alcohol syndrome" OR "intellectually disabled offender") AND ("framework" OR "practice framework" OR "model of care" OR "model" OR "service" or "guideline") AND ("inpatient" OR "residential" OR "secure hospital").

Results

Literature review themes

Introduction

The literature review identified limited published material on models of care within forensic ID inpatient services, as reported elsewhere (Hall et al., 2010). The literature that does exist is descriptive and models not always described precisely (Lunsky et al., 2011; Royal College of Psychiatrists, 2014). Rather than an overall model of care, individual components of such a model were evident.

The key themes of a model of care for a secure hospital setting for people with ID who offend are security and safety; (re)habilitation; quality of life; trauma informed care; and cultural responsivity.

Security and safety

An overriding theme in the literature is for people with ID in contact with the criminal justice system to be cared for in the least restrictive setting (Burns et al., 2010; Hall et al., 2010; McGrath, 2019). However, it is acknowledged that secure hospital-based units have a role to play, for those service users most at risk (Hall et al., 2010).

Safety needs are often framed in the three components of therapeutic security (Kennedy, 2022; McKenna & Sweetman, 2020). Environmental or physical security includes the built environment and technology, which enables the detection and containment of safety challenges e.g., secure perimeters and alarms. Relational security relates to human resource input and can be divided into components, which are quantitative (e.g., ratio of staff to service users) and qualitative (relationships between staff and service users). Procedural security involves policies, practices, and legislation for controlling risk to ensure that risk assessment/management is systematic, dynamic, and tailored to the individual.

Relational and procedural security are often more important than physical security for people with ID who offend; this includes the need for a high staff-to-patient ratio in ensuring that risk is minimalised (Berber & Boer, 2004; Royal College of Psychiatrists, 2013).

A key theme in the literature is that the level of security provided should facilitate individuals progressing through less restrictive settings, with a final goal of transition to living in the community (Berber & Boer, 2004; Hall et al., 2014; McGrath, 2019; Royal College of Psychiatrists, 2013). Clearly articulated care pathways leading to reintegration in the community should be evident from the point of admission to a secure service (Burns et al., 2010). Achieving this outcome is dependent on the availability of appropriate community-based settings and support (Berber & Boer, 2004; Hall et al., 2014).

Rehabilitation

Rehabilitation is a major component in models of care for people with an intellectual disability who offend (Director of Forensic Disability, 2020; Hall et al., 2010; Royal College of Psychiatrists, 2014). However, while various interventions are described, there is a limited evidence base detailing comprehensive models of care adopting this approach.

Rehabilitation involves interventions aimed at reducing further criminal involvement (Chester, 2018; Director of Forensic Disability, 2020). It addresses risk factors for offending, which may include unemployment, aggression and substance misuse, all of which can be challenging to address due to clinical complexity, and a lack of adapted psychological programmes for this population (Aust, 2010; Chester, 2018; Odiyoor et al., 2019).

Good Lives Model (GLM). One comprehensive model for rehabilitation is the GLM, which is aimed at reducing the risk of re-offending and supporting people to lead a fulfilling life (Aust, 2010). As a strengths based approach, it draws on an individual's preferences and available resources, and supports people to achieve life goals (Gardner & Oxnam, n.d.; Barnao et al., 2010; Panting et al., 2018). While developed for use with mainstream prison populations, its potential use with people with ID who offend has been explored (Aust, 2010) and it has been adopted in some forensic inpatient services, including within Aotearoa (Gardner & Oxnam, n.d.; Director of Forensic Disability, 2020).

The evidence for this approach for people with ID who offend is limited (Panting et al., 2018). However, Aust (2010) asserts that the aims of the GLM (to reduce risk and help people achieve a 'good life') offer a way for services to achieve the conflicting goals of risk management and adoption of a person-centered approach.

Positive behavioral support (PBS). Another reported rehabilitative model of care for people with intellectual disability who offend is PBS (Gardner & Oxnam, n.d.; Kitchen et al., 2014; Davies et al., 2016; Hickman et al., 2018; Lynas, 2020b). PBS is an evidence-based, person-centered approach to managing potentially harmful behaviors. With a primary focus on enhancing quality of life, it aims to extend an individual's behavior repertoire, whilst also minimizing challenging behavior (e.g. via learning new skills or adaptation to the environment) (Tolisano et al., 2017). It is reported to integrate easily with other support models, including strength-based programmes such as the GLM (Lynas, 2020b).

PBS has several person-centered components including an ecological approach to understanding the mismatch between an individual's needs and their social environment; recognition of the functions of behavior and promotion of equivalent skills; focused support strategies, which achieve efficient management of challenging behaviors; and active promotion of quality of life and the reduction of restrictive practices (Kitchen et al., 2014; Tolisano et al., 2017).

The effectiveness of PBS is dependent on service user collaboration from the outset, multi-disciplinary involvement, and a service-wide commitment to embedding the values of PBS (Davies et al., 2016).

Quality of life

There have been significant changes in services provided for people with ID over the last 20 years, with a focus on quality of life emphasizing person-centered care (Aust, 2010; Burns et al., 2010; Clarkson et al., 2009). This involves a power shift from professionals toward service users, with greater consideration given to an individual's needs and aspirations, promotion of their rights, inclusion, independence, and choices (Aust, 2010). Within a secure ID inpatient setting, this involves individuals participating meaningfully in decision-making and being supported to exercise their rights (Hall et al., 2014; Lynas, 2020a), irrespective of the restrictions in such areas. Person-centered care also incorporates service user management practices, such as care plans, being developed in collaboration with the person and relevant stakeholders (Director of Forensic Disability, 2020; Hall et al., 2014).

In tailoring care to the individual, the location of care is often discussed, with widespread agreement that this should be close to their usual place of residence (Burns et al., 2010; Hall et al., 2010; Royal College of Psychiatrists, 2013). Without this, family relationships may be disrupted; links with local services severed; and an individuals' rehabilitation and discharge planning negatively impacted (Chester et al., 2017; Hall et al., 2010). Hall et al. (2010) posit that placement away from their communities is usually against the wishes of service users and their families, and due to a lack of appropriate local facilities.

While offering a range of benefits, the complexities of adopting a person-centered approach with people with ID who offend is acknowledged (Aust, 2010; Morris et al., 2021). Morris et al. (2021) argue that legal and policy frameworks act as barriers to collaborative approaches and equitable relationships between service users and carers. Others have highlighted the potential challenges of managing risk within this paradigm, including the need to protect the public from harm, while also providing effective care in the least restrictive environment (Aust, 2010).

Trauma-informed care

People with ID who offend are likely to have a background of trauma (Chester et al., 2017; Lynas, 2020c; Hollomotz & Talbot, 2021), including intergenerational trauma due to the effects of colonization (Ministry of Health, 2020). Trauma-informed care, therefore, has been highlighted as a best practice model when working with this group (Chester et al., 2017; Lynas, 2020c).

Drawing on trauma theory, the basic assumptions of trauma-informed care include realizing the impact of trauma and understanding potential paths for recovery; recognizing the signs and symptoms of trauma; integrating knowledge about trauma into policies, procedures and practices; and seeking to actively resist or avoid re-traumatisation. It involves sensitive inquiry into an individual's trauma history and supporting them via a service culture that emphasizes safety, collaboration, and empowerment among service providers and service users (Lynas, 2020c; Reeves, 2015).

It has been noted that trauma informed care is not exclusive of other models of care and can be integrated into other frameworks, such as PBS and strengths based programmes such as the GLM (Lynas, 2020c).

Cultural responsivity

There is some international evidence that a model of care for people with ID needs to be appropriate and responsive to the cultural, ethnic and religious backgrounds of the people it serves (Director of Forensic Disability, 2020; Hall et al., 2010; McGrath, 2019).

An Australian review of health services provided to people with mental health challenges or cognitive impairment in contact with the criminal/youth justice systems, recommended that partnerships be developed with the Indigenous health sector to develop supports for Aboriginal communities; provide capacity for people to return to their communities when appropriate;

and facilitate the design of culturally appropriate service models (McGrath, 2019).

A review of the cultural responsiveness of an individual Australian forensic ID service (Director of Forensic Disability, 2020) identified a range of measures in place in the service, including use of culturally appropriate methods and materials to enhance client engagement (e.g. books developed collaboratively with Indigenous elders); support for clients to establish links with Indigenous health services; use of culturally appropriate clinical assessments; resourcing to maintain links with the community of origin; promotion of Indigenous cultural events within the service; and staff engagement with family members. There was positive feedback from service users on activities that supported them to connect with their culture (Director of Forensic Disability, 2020).

In outlining the over-representation of Australia Aboriginal and Torres Strait Island Peoples with cognitive impairment in the criminal justice systems, McCausland et al. (2017) advocated for improvement through self-determination of Indigenous peoples; person-centered support; a holistic and flexible approach to service delivery; integrated service responses; and cultural, disability and gender-informed practice by service providers.

There is limited literature from Aotearoa focusing on meeting the cultural needs of Māori. The model of care at the secure ID service in Wellington outlines that *“the care and rehabilitation delivered … is responsive to each client’s cultural beliefs, values and experiences (Gardner & Oxnam, n.d., p. 11)”.* Although it recognizes a Māori approach to health and wellbeing (i.e., Te Whare Tapa Whā model) (Durie, 1985) and the importance of whānau (family) involvement, it does not reflect a negotiated process with Māori to address the inequity experienced by Māori.

Tāngata whaikaha hinengaro input

Tāngata whaikaha hinengaro were responsive to discussing values important to them in the environment in which they lived. From the discussion, core values were extracted, which were then grouped according to similarities. From this grouping three key themes arose, which are crucial in the consideration of the model of care from a tangata whaikaha hinengaro perspective (see Table 1).

First, there was a strong theme focused on the part they had to play in the model of care. They expressed a need to be able to live the way they wanted through exercising their autonomy (tino rangatiratanga). In doing so, they valued having the ability to make choices. Then through exercising such choice, the ability to take risks, make mistakes and learn as a result.

However, the focus was not just on them personally, they also wanted to be part of something bigger; a community both within the secure facility and a community outside of the secure environment, which included their whānau (family).

Finally, there was a theme which placed an expectation on staff who were involved in their care; that they were kind and engaging in the way that they interacted with them.

Negotiated consensus with Māori

Although the international evidence supports the need for service delivery, which is culturally responsive to the needs of tāngata whenua (Māori people), it does little to reveal the negotiated process necessary to correct the inequity of Māori living in FIDSS; a process guaranteed under the Te Tiriti of Waitangi. This is a vital step in the development of an integrated model of care, which is culturally safe, responsive and specific to the context of FIDSS service delivery in Aotearoa, where historic access to power has privileged colonial power to the devastating detriment of Māori.

The negotiated processes with Māori, which were built into this project, resulted in some givens in an eventual model of care:

- A Māori holistic model of health must be built into the model. ‘Te Whare Tapa Whā’ is a model for ‘hauora’ (Māori health and well-being), based around the four ‘tapa’ (walls) supporting the ‘whare’ (house). It involves consideration of ‘Taha Tinana’ (physical health), ‘Taha Wairua’ (spiritual health), ‘Taha Whānau’ (family connectivity and health) and ‘Taha Hinengaro’ (mental health) (Durie, 1985).
- Holistic Māori health (pae ora) involves people who are flourishing (mauri ora), within empowering whānau (whānau ora), in an environment capable of creating good health (wai ora) (Ministry of Health, 2020). The model of care must move from a focus purely on the individual to a focus that privileges collectivism by working with the whānau (family).
- For tāngata whaikaha hinengaro who are Māori, Māori-centric interventions must be made available

Table 1. Values of the tāngata whaikaha hinengaro.

Exercising their rights		
Rights	Choices	Succeeding
Equality	Being heard	Mistakes = opportunities for learning
Fairness	Agency	Positive Risk Taking
Non- Judgemental	Making supported decisions	Least Restrictions
Non- Discriminating	Meaningful activities	
Culturally safe	Opportunities	
Expectations of others		
Kindness	Explaining	
Respect	Communicating	
Dignity	Honesty	
Compassion	Being real	
Value Identity	People, not labels	
Being connected		
In partnership		
Together		
Jointly		
With whānau		

in the provision of care and be undertaken by tāngata Māori, who hold appropriate knowledge and skills. These interventions work to support the person and their whānau in shifting behaviors of concern to pro-social behaviors, from a Māori perspective, while promoting a secure cultural identity.

- To achieve equity, the model of care must address racism and discrimination in all its forms, including addressing biases, attitudes, assumptions, stereotypes, prejudices, and the structures and characteristics that may affect the quality of care that is provided. It calls attention to the reality that racism can present as systemic monocultural perspectives that advantage one sector of the population, while disadvantaging others. "Racism is a modifiable determinant of health that can impact mental and physical health and lead to poorer health outcomes for Māori" (Ministry of Health, 2020, p. 33).

Discussion

The model of care: "the Mason FIDSS approach"

The project team triangulated the understandings gained from the evidence-based literature review, the values of the tāngata whaikaha hinengaro and the perspective of Māori including cultural expertise and knowledge. Through triangulation, the intent was to detemine commonality, and the extent to which the concepts expressed in the understandings gained from each, could be integrated.

People with ID who offend have high and complex needs. The literature review revealed components required in a model of care to be centered on safety, rehabilitation, and quality of life, each of which are person centered. Yet both tāngata whaikaha hinengaro and the Māori cultural perspective centered these core components on both the person concerned and their wider social network (their whānau, hapū and iwi) to which tāngata whaikaha hinengaro belong and will return.

Placing tāngata whaikaha hinengaro and their whānau at the center requires a commitment by staff to create a comprehensive understanding of their mātāpono (core values), tirohanga (perceptions or views) and tikanga (protocols to define correct ways of behaving), which might be different to their own. The challenge is then to determine how to build knowledge and understanding of these social and cultural norms in the workforce, so that they are able to accommodate and implement these norms in a manner which is culturally safe, while acknowledging diversity across different Māori communities within Aotearoa.

Values

These were initially articulated by tāngata whaikaha hinengaro and refined in reference to discussions with the Māori cultural advisor. The values focus on expression of human rights, receiving compassion, having choices, being able to connect with social networks, succeeding in goals and being treated with respect and honesty. The core values are reflected in a mission statement for the model:

> "Our aim is to build good lives alongside you and your whānau using the current best practice to move towards inclusion through safe, person and whānau-centred care and rehabilitation."

Environment

Quality of life is a central theme in the literature review. An emphasis on a homely environment is necessary, as tāngata whaikaha hinengaro may stay in FIDSS for a long time. This involves encouraging people to personalize their environment, in order to maximize their quality of life.

Appropriate design of the physical environment influences positive clinical outcomes, increases safety and reduces stress for service users and staff (Ulrich, 2006). Conversely, design and environmental conditions within buildings can actively cause harm and contribute to mental and physical ill health (Ghaffarianhoseini et al., 2018).

However, the social environment is also crucial in maintaining safety. Relational and procedural security are more important than physical security for people with ID who offend (Berber & Boer, 2004; Royal College of Psychiatrists, 2013). However, within a secure environment, liberties and freedoms may be compromised to achieve the balance necessary to attain safety. It is important that residual liberties are maintained in the control of tāngata whaikaha hinengaro, to limit the loss of agency and autonomy, given this is a strong value in the model of care.

Staff team

The quality and effectiveness of service delivery ultimately rests with the skills, knowledge and attributes of the staff. The staff support team are a key element of the Mason FIDSS Approach (see Figure 1). The lack of specialist ID health professional training in Aotearoa has led to a reliance on overseas qualified health professionals, who may lack forensic specific training and have gaps in their understanding of the socio-cultural context of Aotearoa (McCarthy & Duff, 2019).

Incorporating a strong emphasis on a holistic view of health, as expressed through the insight of the cultural input, requires staff working within the Mason FIDSS Approach to move away from an historical emphasis on the medical model of service delivery. Instead, there is the need for a diverse multi-disciplinary team (Hall et al., 2010), suited to meeting the complex needs of the tāngata whaikaha hinengaro. Staff need a range of skills and backgrounds that bring together a mixed disability, forensic, cultural, social and health approach, which is effective in meeting the needs of tāngata whaikaha hinengaro.

Ensuring the right mix of staff numbers and skills to deliver optimal care and rehabilitation, without compromising quality of life or safety, remains a challenge. Appropriate training, supervision and support systems will need to be in place to maintain fidelity to core values and the mission statement.

Responsive approach to contemporary needs

This component of the model of care captures evidence-based approaches to rehabilitation highlighted in the literature review, combined with an emphasis on a holistic approach highlighted in the consultation with Māori. A responsive approach to contemporary needs (see Figure 1) involves a fundamental requirement to understand why the person has come into the service and what needs to be achieved for them to successfully move forward. The Mason FIDSS Approach integrates a values-driven and strengths-based approach to behavioral change, Positive Behavior Support (Tolisano et al., 2017); building on offense replacement behaviors that meet the desired future life for that person, the Good Lives model (Barnao et al., 2010); trauma informed care (Chester et al., 2017); and a holistic Māori approach to health (Durie, 1985). The goal is to help the individual develop a positive self-identity, and to connect with their whānau, community and peers.

For tāngata whaikaha hinengaro who are Māori, the model of care will provide a culturally specific and appropriate provision of care for the person and their whānau. The model provides FIDSS staff with a Māori lens, which privileges collectivism rather than individualism, and reveals how the wider cultural-historical context of Aotearoa, created by colonization, influences the social environment, in which behaviors are formed.

Safety

In the proposed model, the need to maintain the safety of the person, their whānau, their peers, staff and the general public permeates every aspect of the proposed model of care. Tāngata whaikaha hinengaro will be supported to reduce the risk they pose to themselves and others in a safe and therapeutic environment with a skilled staff team working within a set of core values that uphold human rights and focus on equitable outcomes and inclusion using a responsive approach to contemporary needs (see Figure 1).

Limitations

The development of this model of care needs to be considered in relation to a number of limitations. This project was primarily a service improvement initiative with an attempt to integrate elements of research. A research paradigm was not applied in full to the project, given time and resource constraints. Such an approach might have resulted in more

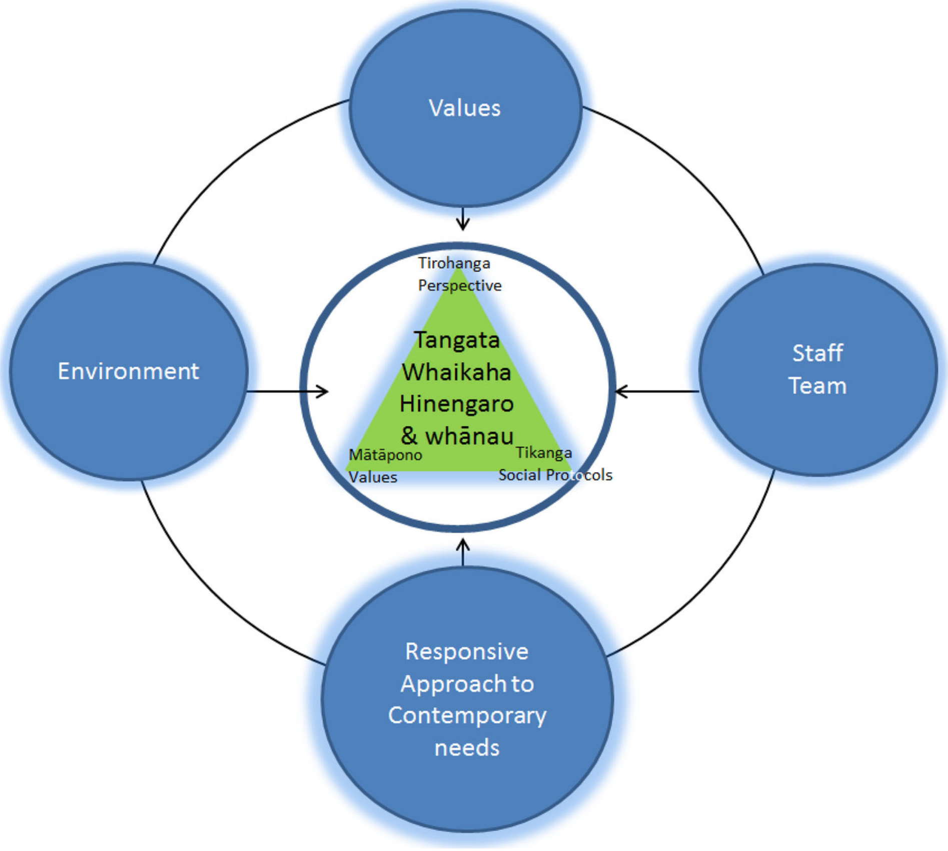

Figure 1. The Mason FIDSS approach.

considered understandings to influence the model of care achieved.

A critique of models of care (Kennedy, 2022), indicates such models should encompass goals (rather than principles), pathways and processes, treatments, evaluation and logic models. This project to date stops at the level of principles and goals, with further detail to be manualised at a later date.

The approach used to development the model of care purported to be collaborative. Yet the critical input of whānau into the design of model of care was absent given time and resource constraints. Refinement of the model with this input is a crucial next step.

The literature review is narrative in approach and was confined to literature on models of care in secure hospital-based settings. Models of care for people with intellectual disability who offend in prisons, courts or the community were excluded, yet community-based options which view the whole community as the vehicle for therapeutic change, may have provided further insights, given the outcome of the project that whānau should also be the central focus in the model of care. Again, time and resource constraints on this project meant that a systematic review was unable to be taken.

Finally, the vital input of tāngata whaikaha hinengaro was facilitated by "trusted staff". Facilitation by an independent advocate may have resulted in more in-depth discussion of tāngata whaikaha hinengaro values, given the inherent power dynamic relationship between staff and service users, in a secure setting.

Conclusion

The nature of intellectual disability means that tāngata whaikaha hinengaro will not 'recover' with treatment and medication. Risks to themselves and others will not diminish without the person and their whānau gaining some insight into the genesis of the risks. This also requires the development of the skills and supports necessary to help them to live safely with others. For some, that insight and understanding may be limited, with slow progress to a lesser degree of security.

This service improvement project has used the lens of multiple stakeholders to develop a model of care (The Mason FIDSS Approach), which weaves together a number of important elements to optimize specialist forensic intellectual disability care and rehabilitation in Aotearoa. The model brings together a disability behavioral model (Positive Behavior Support), with a strengths-based correctional model (the Good Lives Model). It also weaves in the need for cultural responsivity and interventions for Māori, in the provision of safe and values driven care and rehabilitation, that is contextualized to histories of trauma and abuse. It is mindful and specifically addresses the additional inequities resulting from the colonial experience of tāngata whaikaha hinengaro, who are Māori.

The next steps involve manualising the fine detail of the model, implementation and evaluation of the impact and benefits of this model of care. Given that the model of care is a complex blend of a cultural and a clinical paradigm, a "realist evaluation" framework is suggested. Such a framework seeks to understand which features and contextual factors of a model of care are critical in its implementation and continuous improvement (Pawson, 2013).

It is hoped that the insights gained through this collaborative project may assist other services internationally, where an over-representation of Indigenous peoples or ethnic minorities require cultural responsivity to be overtly expressed in their models of care.

Conflict of interest

The authors have no conflicts of interest to report.

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