RUNNING HEAD: SUPPORTING AUTISTIC PEOPLE IN SECURE SERVICES

Supporting Autistic People in Secure Hospitals and Beyond

Magali Barnoux[1],

&

Peter E Langdon[2]

[1] Magali-Fleur Barnoux is a Lecturer in Forensic Psychology and Intellectual and Developmental Disabilities, and Chartered Psychologist, Tizard Centre, University of Kent, CT2 7NF

[2] Peter E Langdon is a Honorary Consultant Clinical and Forensic Psychologist and Professor, Centre for Educational Development, Appraisal, and Research (CEDAR), University of Warwick, CV4 8UW and Brooklands Hospital, Coventry and Warwickshire Partnership NHS Trust, Birmingham, B37 5RY and Herefordshire and Worcestershire Health and Care NHS Trust, Worcester, WR5 1JR

Abstract

Around 50% of individuals residing in specialist learning disability forensic services in England and Wales are thought to be autistic. Among these are a small, but significant group of people who require care in a hospital environment under the Mental Health Act (1983, as amended 2007) due mental health problems and associated offending or offending-like behaviours. This chapter outlines some of the characteristics and features associated with this group along with the key factors for consideration in their care and treatment. Interventions, psychological therapies, and behavioural support approaches are discussed, along with some of the factors pertinent to discharge planning and community support provision for this complex and vulnerable group of people.

Introduction

The Winterbourne View abuse scandal in 2011 and the negative media reports which ensued (Ford, 2018; Kelso, 2018) were pivotal in triggering a series of policy changes aimed at improving care and support for autistic people and/or those with learning disabilities in the United Kingdom. The NHS Transforming Care agenda (Department of Health, 2012) pledged to reduce the numbers of inpatient beds for autistic people and/or those with learning disabilities by implementing a national framework, *Building the Right Support* (DoH, 2015), which sought to increase community provision for those who display behaviours that challenge, have mental health problems, or present with a risk of engaging in offending or offending-like behaviours.

There are currently 1,115 individuals residing in specialist learning disability

forensic services in England and Wales, of which around 50% are thought to be autistic (NHS Digital, 2020). Unfortunately, the number of autistic people in inpatient settings have not greatly changed since 2015 and the Transforming Care agenda has been heavily criticised. One of the reasons why *Building the Right Support* has not achieved its aims is because there is a small, but significant group of people who require care in a hospital environment under the Mental Health Act (1983, as amended 2007) due to mental health problems and associated offending or offending-like behaviours, which cannot be safely managed in the community. Whilst autistic people are no more likely to break the law compared to non-autistic people (King & Murphy, 2014), for many who do commit crimes, contact with the criminal justice system will ensue. Detention in hospital under the Mental Health Act 1983 (as amended, 2007) for a period of assessment and/or treatment can occur prior to or during a criminal trial, or prior to sentencing. At the disposal stage, where there is a guilty verdict, individuals could receive a fine, community sentence, prison sentence or detention in a secure hospital.

Across all secure inpatient services in England and Wales, there are secure hospitals commissioned to provide specialist care and treatment for autistic people and those with learning disabilities who have a history of criminal offending or seriously harmful behaviour. (NHS England, 2018). Care and treatment in these specialist inpatient forensic services is tailored to the additional needs of the service users and provided by a specialised workforce including psychiatrists, psychologists, nurses, allied health professionals (e.g., speech and language therapists, occupational therapists), social workers, and support workers. This chapter aims to provide an overview of the characteristics and key factors for consideration in supporting autistic people in a secure hospital environment.

Characteristics of Autistic People in Secure Forensic Hospitals in the UK

Circumstances of Admission

Autistic individuals are likely to be admitted to secure inpatient hospitals from (i) the community (home address or supported accommodation); (ii) criminal justice agencies (i.e., courts or prisons); or (iii) transferred from another inpatient setting (Wong, Bhutia, Tayar, & Roy, 2015), with primary reasons for admission attributed to the commission of a criminal offence, a deterioration in mental health, and/or challenging behaviour which is serious and harmful in nature (Cowley et al., 2005; Lai & Weiss, 2017; Oxley et al., 2013; Wong et al., 2015). However, these are rarely mutually exclusive and often point to the complex overlap between mental health problems, offending behaviour, and challenging behaviour for those who are autistic and/or have a learning disability (Alexander et al., 2016).

For those with criminal convictions, admission to a secure hospital is likely associated with legal requirements around public safety and the need for specialist support related to the characteristics and features of autism and/or comorbid mental health diagnoses which mean they would be extremely vulnerable in a prison environment and necessitate hospital treatment. Conversely, those without a history of criminal offending may be detained in secure hospitals as a result of previous placement breakdowns (e.g., community settings, other inpatient settings) resulting from a deterioration in their mental health and/or challenging behaviour which is offending-like in nature which cannot be managed safely in other settings. These individuals are likely to show behaviours which present a risk of harm to themselves or others, which unaddressed, can lead to future involvement with the criminal justice system (CJS).

Mental Health Act (1983, as amended 2007)

Autistic individuals residing in forensic inpatient settings in England and Wales may be detained under Part II or Part III of the Mental Health Act 1983 (as amended 2007). Part III of the Mental Health Act 1983 (as amended 2007) deals with patients who have been involved in criminal proceedings and require assessment and/or treatment for a serious mental health problem in a secure hospital environment (sections, 35, 36, 37, 38, 47, 48). Some of these sections (37, 47, or 48) can be issued with or without a MoJ Restriction Order (Section 41 or Section 49) when there are concerns about public safety. With Restriction Orders, decisions to grant leave (Section 17), to authorise a return to prison following treatment, or to discharge an individual are decided by the MoJ.

It is thought around half of autistic individuals in secure inpatient hospitals are detained under Part III of the Mental Health Act 1983 (as amended 2007) and have a *current* conviction, caution, or reprimand (NHS Digital, 2020). However, a proportion of this group may instead be detained under Part II of the Mental Health Act (2007), where service users may have no *current* criminal proceedings against them but who require admission for assessment or treatment of a mental disorder due to the nature and degree of the associated risk (sections 2, 4, 5, 3, 136). Under these, temporary leave (Section 17) and discharge from hospital are decided by the patient's Responsible Clinician. In addition to a serious mental health problem, those under civil sections of the Mental Health Act 1983 (as amended 2007) may require care in a secure setting due to a history of contact with the CJS (i.e., previous spent criminal convictions, cautions, or reprimands) and/or a history of behaviour which is offending-like in nature which cannot be safely managed in other settings.

Stay in Hospital

The complex overlap of mental health problems, offending behaviour, and challenging behaviour often results in poorer outcomes for autistic people, following admission to secure services (Alexander et al., 2016). If they are admitted, they may have higher levels of restraint, seclusion, enhanced observations, and as required medication, as well as lengthy stays and delayed discharges from hospital settings, compared to those without developmental disabilities (Esan, Chester, Gunaratna, Hoare, & Alexander, 2015; Washington, Bull, & Woodrow, 2019).

Underpinning these poor outcomes are the lack of well-defined care pathways for within the National Institute for Health and Care Excellence (NICE) guidelines, further complicated by legal restrictions imposed by the MoJ, and the limited capacity and capability of health and social care providers in the community (Barnoux, 2019; Washington et al., 2019). However, there is agreement that a diagnosis of autism alone does not predict treatment outcome (Esan et al., 2015) but rather a range of other factors which require careful consideration in the assessment of risk, interventions, and opportunities for leave and/or discharge from hospital.

Factors to Consider in the Care and Treatment of Autistic Individuals in Secure Hospitals

Barnoux et al. (2020) recently undertook a qualitative evaluation of Alexander et al.'s (2016) typology of autistic people detained in hospital under the Mental Health Act (1983, as amended 2007) and reported the subtypes possessed face validity and good inter-rater reliability. Below, the factors contributing to the typology are outlined, along with implications for how these may inform care pathways.

Forensic Risk

Historically, a number of high profile publicised cases, alongside research studies based on cases studies and small biased samples contributed to the misconception that some of the core features of autism play a direct role in certain crime types such as firesetting, violence, and sexual offending (Allen et al., 2008; Siponmaa, Kristiansson, Jonson, Nyden, & Gillberg, 2001). Specifically, these studies suggested deficits in social communication, empathy, cognitive perspective taking, and circumscribed interests were linked to individuals' abilities to predict and understand the consequences of their actions, thus leaving them at increased vulnerability to criminal offending (Barry-Walsh & Mullen, 2003; Dein & Woodbury-Smith, 2010; Woodbury-Smith & Dein, 2014). Whilst these factors may feature independently in existing theoretical approaches to offending, higher quality research studies suggest the role of autism in the aetiology of offending is relatively small. Autistic people have been reported to commit the full range of criminal offences (Faccini & Allely, 2019; Melvin, Langdon, & Murphy, 2017) and evidence suggests the range of static and dynamic risk factors documented in the wider offending population do not differ substantially for autistic individuals at risk of offending (Lofthouse, Totsika, Hastings, & Lindsay, 2018; Nicholas, Gray, & Snowden, 2018).

Like in any forensic hospital, the development of care and treatment plans need to be based upon a well-developed formulation of forensic risk incorporating security measures (e.g., observations, leave, ward activities), psycho-social interventions, and behavioural support. There are a number of actuarial and structured risk assessment tools which are suitable for use with this population and shown to have reasonable predictive validity. For a more detailed discussion on risk assessment, see Chapter 9.

Personality Disorder and Psychopathy

Personality disorder and psychopathy are well-established factors relevant to the assessment of risk and treatment responsivity. Specific traits seen in these disorders, particularly around empathy, emotional recognition and regulation, play an integral role in the aetiology of offending. However, the interplay between the clinical features of autism, personality disorder, and/or psychopathic traits requires a nuanced understanding and careful consideration in the assessment of risk and rehabilitation. Where autistic adults present with psychopathy, individuals experience what has been referred to as a cognitive 'double-hit', where an impaired empathic response to others' distress (i.e., *affective empathy*) may co-occur with, but is separate from, the cognitive differences in perspective taking sometimes associated with autism (i.e., *cognitive empathy*; Rogers, Viding, Blair, Frith, & Happé, 2006). Consequently, callous and unemotional traits should not be dismissed as part of the clinical features of autism, but rather should be considered independently in risk assessments, interventions, and opportunities for leave and/or discharge from hospital (Rogers et al., 2006).

Severe and Enduring Mental Health Problems

Co-morbid mental health problems in autistic people with a history of criminal offending are discussed in detail in Chapter 2. For individuals with severe and enduring symptoms (e.g., hallucinations, delusions), treatment readiness for interventions addressing criminogenic needs is likely to be hindered and pharmacological interventions (e.g., anti-psychotics) may be necessary in order to allow for subsequent therapy and rehabilitation. The valued role these treatments have in helping recovery from severe and enduring mental illness should not be underestimated, and while rightly, there is an increasing drive to prevent and reduce psychotropic prescribing for people with developmental disabilities, it is important that this helpful and necessary

policy does not result in the denial of treatment to those who genuinely need it.

Challenging Behaviour

Autistic people in secure inpatient services with a history of criminal convictions may present with behaviours which have been labelled as "challenging", for which specialist support is required alongside support and intervention for mental health issues and/or offending behaviour (Wardale, Davis, & Dalton, 2014). Professionals should remember to consider that some behaviours may be related to sensory needs. In the ward environment, behaviours described as challenging may include self-injury (e.g., head banging), aggression (e.g., punching, spitting, biting), inappropriate sexual behaviour (e.g., groping), and property damage (e.g., setting fires)which can adversely impact the individual themselves, service users, and staff.

However, within this complex group of people, the conceptualisation of challenging behaviour needs to be nuanced. There are similarities between behaviours that are labelled criminal and those that are seen as challenging, as the underlying reason that drives the behaviour may be similar, but the behavioural manifestation may be different (Barnoux & Langdon, in press). Further, there are instances where some behaviours which would be labelled as "criminal" would not be seen as such when exhibited by some people with learning disabilities and/or autism due to the requirement for *mens rea* ("guilty state of mind") to be present for a person to be judged to have committed a crime in England and Wales (Barnoux & Langdon, in press). Where behaviour labelled as challenging is "offending-like", specialist support and intervention in the hospital environment plays an integral part in the reduction of risk, promotion of rehabilitation, and facilitating opportunities for discharge.

Interventions and Psychological Therapies for Autistic People in Secure Forensic Hospitals

Treatment Approaches for Autistic Individuals with a History of Offending Behaviour

Secure hospitals do not have a package of standardised interventions developed specifically for autistic service users. Rather, interventions and psychological therapies offered in these settings vary greatly and are often contingent on the knowledge and specific expertise of the staff. Underpinning this variability in professional practice is an evidence base still very much in its infancy. In their systematic review on treatment effectiveness for offending behaviour in autistic individuals, Melvin, et al. (2017) reported treatment approaches and effectiveness in reducing re-offending varied substantially across studies, highlighting the need for more controlled trials. For a detailed overview, see Chapter 8.

The impact of the clinical features of autism on treatment outcome (i.e., *treatment responsivity*) has garnered increasing attention. In particular, there are a number of structural (e.g., mode of delivery) and psycho-social factors (e.g., empathy, emotion recognition and regulation, cognitive differences, information processing, communication preferences, social vulnerability) which merit careful consideration when adapting and delivering a treatment programme for behaviours labelled as criminal in autistic people (Melvin, Murphy, & Langdon , 2020a, 2020b). There is a body of literature describing adaptations to psychological therapies for use with autistic individuals more generally (e.g., Kerns, Roux, Connell & Shattuck, 2016), and similar adaptations would be required when providing psychological interventions aimed at mitigating forensic risk. For a detailed discussion, see Chapter 10.

Positive Behaviour Support

Current UK policy advocates the use of behavioural support plans as part of a model of care based on proactive and preventative strategies for managing behaviours that challenge for vulnerable people within various settings (National Offenders Management Services (NOMS), 2013; NICE., 2015a, 2015b; Social Care, Local Government and Care Partnership Directorate., 2014). Positive behavioural support (PBS) is a framework for developing and delivering interventions based on a set of overarching values which promote inclusion, choice, participation, and equality of opportunity (Gore et al., 2013). PBS combines person centred approaches and evidence-based behavioural science to understand the reason underlying behaviours labelled as challenging and subsequently inform decision-making with the overall aim of improving the quality of a person's life and that of the people around them in the least restrictive way possible (Social Care, Local Government and Care Partnership Directorate., 2014).

In forensic and community settings, PBS can be implemented by a single practitioner, a team of professionals, or at an organisational level (Gore et al., 2013). The implementation of PBS should be person-centred and values-based and include: (i) a *functional assessment* to understand the underlying reasons for challenging behaviour, or in this case, offending or offending-like behaviour; and (ii) the development of a detailed *behaviour support plan* which includes a tiered system of preventative and reactive strategies by which the needs of the person can be met to enhance quality of life. Behaviour support plans should always be co-produced with the individual, their carers, relatives, and/or advocates (*service user involvement*). There may be tensions that arise when coproducing a PBS plan for someone who has a history of criminal offending. Individuals may want to include activities and interests which increase risk,

or are offence paralleling behaviours, and these need to be managed carefully. For example, someone who has a sexual interest in children may wish to spend time watching children's television or visiting areas that are frequented by children. Some team members may see this as unproblematic and infantilise the person or attempt to construe such as an unproblematic circumscribed interest. However, such activities and interests would need to be managed carefully for someone where there is a genuine risk of harm.

In a systematic review evaluating the use of, and effectiveness of PBS in forensic settings, Collins, Barnoux, and Baker (2021) identified 11 studies focusing on PBS interventions in forensic settings, of which only 5 included service users as participants (as opposed to staff). Findings suggest PBS training (i) improves staff knowledge in the antecedents and causes of challenging behaviour, (ii) increases staff confidence in the management of challenging behaviour and (iii) is likely to have a positive impact on the care and treatment of service users within forensic settings. However, only 3 of the included studies conducted with service users measured challenging behaviour as an outcome variable. Whilst these reported sustained reductions in aggression and challenging behaviour and increased quality of life as a result of implementing PBS (Davies, Lowe, Morgan, John-Evans, & Fitoussi, 2019; Dodds, Legg, Sinfield, Armstrong, & Cheng, 2015; Langdon et al., 2017), none included participants with a diagnosis of autism. Collins et al. (2021) further highlight that the existing evidence base is limited and generally of poor methodological quality thus limiting our ability to ascertain the effectiveness of PBS in forensic settings. Improvements are needed in terms of measuring outcomes related to reductions in the frequency and intensity of challenging behaviour and the use of restrictive practices, length of stay, improvements in quality of

life, and the longer-term impact of PBS. While more rigorous research is needed, PBS remains a recommended intervention for challenging behaviour and implementation across forensic service lines is likely to contribute positively towards reduction of risk, rehabilitation, discharge from hospital, and support within the community.

Planning for Discharge and Community Care

Discharge planning for autistic people who are in hospital is associated with some specific challenges, many of which are not markedly dissimilar from those faced by people without autism, including those with intellectual disabilities. For some, the potential loss of the structure and routines of an inpatient environment, while adapting to new routines in the community, is challenging. Well-coordinated plans where individuals are afforded time to learn about and experience changes are helpful in promoting successful discharge. This could be ensuring the provision of good information about future accommodation and support coupled with an opportunity to form relationships with new support staff early within the discharge process. The sharing of good information with future providers, coupled with specific training to help mitigate risk (e.g., extensive training in PBS and risk management plans) is also vital. Across much of England, there is a lack of specialist forensic mental health teams focused specifically upon autism, while there are teams in some areas for those with intellectual disabilities and there is a national service specification (NHS England, 2017). Some of these teams may be experienced in working with autistic people, but they may not be directly commissioned to work with this group. At times, there may be conflict between different community-based services as to whether they are best

placed to provide support to autistic people upon discharge from hospital, especially when they do not also have an intellectual disability.

Conclusions and Key Points

- There is a small but significant group of autistic people who require specialist care in a hospital environment under the Mental Health Act (1983, as amended 2007) due to a serious mental health problem and offending or offending-like behaviours which cannot be safely managed in a community setting.
- Autistic individuals are likely to be admitted to these hospitals from a range of community, criminal justice, or health settings. For some of these individuals, the predominant issue will be one of challenging behaviour, where issues associated with autism, sensory needs, and communication are paramount for their recovery. For others, they are likely to require specialist treatment for enduring mental health problems, while for some, there may be comorbid psychopathy which increases risk for whom longer stays and physical and relational security will be important to help mitigate risk into the future.
- It is thought around half of autistic individuals in secure inpatient hospitals are detained under criminal sections of the Mental Health Act 1983 (as amended 2007) and are likely to have been charged or convicted of a criminal offence or have a current police caution or reprimand. Those that are detained under civil sections are likely to have a history of contact with the criminal justice and/or a history of behaviour which is offending like in nature.
- Outcomes for this group are related to factors which point to the complex overlap of mental health problems, offending behaviour, challenging behaviour, and clinical features associated with autism.

- Practising professionals should give careful consideration to forensic risk, personality disorder and psychopathy, severe and enduring mental health problems, and challenging behaviour in the development of individualised care and treatment plans.
- Treatment approaches and effectiveness are varied for this group and more controlled trials are needed. However, treatment responsivity can be improved by adapting and tailoring programmes to meet individuals' needs.
- The use of PBS as part of a model of care has shown to contribute positively towards the reduction of risk, rehabilitation, and opportunities for discharge, though more research is needed.

References

Alexander, R., Langdon, P. E., Chester, V., Barnoux, M., Gunaratna, I., & Hoare, S. (2016). Heterogeneity within autism spectrum disorder in forensic mental health: The introduction of typologies. *Advances in Autism*, 4, 201-209.

Allen, D., Evans, C., Hider, A., Hawkins, S., Peckett, H., & Morgan, H. (2008). Offending behaviour in adults with Asperger syndrome. *Journal of autism and developmental disorders, 38*(4), 748-758.

Barnoux, M. (2019). Community services and transforming care: reflections and considerations. *Tizard Learning Disability Review*, 24(1), 33-37. https://doi.org/10.1108/TLDR-12-2018-0034

Barnoux, M., Alexander, R., Bhaumik, S., Devapriam, J., Duggan, C., Shepstone, L., … & Langdon, P.E. (2020) The face validity of an initial sub-typology of people with

autism spectrum disorders detained within psychiatric hospitals. *Autism, 24(7),* 1885-1897. Doi: 10.1177/1362361320929457

Barnoux, M., & Langdon, P.E. (in press) Positive Behaviour Support. In P.E. Langdon and G.H. Murphy (Eds) Working within community settings with people with learning disabilities and/or autism who are at risk of coming into contact with criminal justice: A compendium for health and social care staff. Health Education England.

Barry-Walsh, J. B., & Mullen, P. E. (2004). Forensic aspects of Asperger's Syndrome. *Journal of Forensic Psychiatry & Psychology*, 15(1), 96-107.

Collins, J., Barnoux, M., & Baker, P. (2021). Managing challenging behaviour using applied behaviour analysis and positive behaviour support in forensic settings: A systematic review. *International Journal of Positive Behavioural Support, in press*

Cowley, A., Newton, J., Sturmey, P., Bouras, N., & Holt, G. (2005). Psychiatric inpatient admissions of adults with intellectual disabilities: predictive factors. *American Journal on Mental Retardation*, 110(3), 216-225.

Davies, B. E., Lowe, K., Morgan, S., John-Evans, H., & Fitoussi, J. (2019). An evaluation of the effectiveness of positive behavioural support within a medium secure mental health forensic service. *Journal of Forensic Psychiatry & Psychology*, 30(1), 38-52. doi:10.1080/14789949.2018.1459785

Dein, K., & Woodbury-Smith, M. (2010). Asperger syndrome and criminal behaviour. *Advances in Psychiatric Treatment*, 16(1), 37-43.

Department of Health (2012). Transforming care: A national response to Winterbourne View Hospital. London: Department of Health.

Dodds, N., Legg, G., Sinfield, P., Armstrong, D., & Cheng, W. (2015). The application of a positive behavioural support framework in a low secure adolescent inpatient unit. *International Journal of Positive Behavioural Support*, 5(2), 33-42.

Esan, F., Chester, V., Gunaratna, I. J., Hoare, S., & Alexander, R. T. (2015). The clinical, forensic and treatment outcome factors of patients with autism spectrum disorder treated in a forensic intellectual disability service. *Journal of Applied Research in Intellectual Disabilities*: *JARID*, 28(3), 193-200. doi:10.1111/jar.12121

Faccini, L., & Allely, C. S. (2017). Rare instances of individuals with autism supporting or engaging in terrorism. *Journal of Intellectual Disabilities and Offending Behaviour, 8*(2), 70-82. https://doi.org/10.1108/JIDOB-11-2016-0022.

Ford, R. (2018), "Autistic teenagers 'locked in padded cells and abused'", retrieved 02 Dec 2018, from The Sunday Times: https://www.thetimes.co.uk/article/autisticteenagers-locked-in-padded-cells-and-abused-b9pbchtkz.

Gore, N. J., McGill, P., Toogood, S., Allen, D., Hughes, J. C., Baker, P., . . . Denne, L. D. (2013). Definition and scope for positive behavioural support. *International Journal of Positive Behavioural Support, 3*(2), 14-23.

Hart, S. D., Cox, D. N., & Hare, R. D. (1995). Hare psychopathy checklist: Screening version (PCL: SV). Multi-Heath Systems.

Kelso, P. (2018), "Deaths in secure hospitals reviewed by government after Sky investigation", available at : https://news.sky.com/story/deaths-in-securehospitals-reviewed-by-government-after-sky-investigation-11546371 (accessed 02 Dec 2018)

Kerns, C. M., Roux, A. M., Connell, J. E., & Shattuck, P. T. (2016). Adapting cognitive behavioral techniques to address anxiety and depression in cognitively able emerging adults on the autism spectrum. *Cognitive and Behavioral Practice*, 23(3), 329-340.

King, C., & Murphy, G. H. (2014). A systematic review of people with autism spectrum disorder and the criminal justice system. *Journal of Autism and Developmental Disorders*, *44*(11), 2717-2733.

Lai, J. K., & Weiss, J. A. (2017). Priority service needs and receipt across the lifespan for individuals with autism spectrum disorder. *Autism Research*, 10(8), 1436-1447.

Langdon, P. E., Dalton, D., Brolly, K., Temple, P., Thomas, C., & Webster, T. (2017). Using positive behavioural support as a treatment for trauma symptoms with a man with intellectual disabilities. *International Journal of Positive Behavioural Support*, 7(1), 31-37.

Lofthouse, R., Totsika, V., Hastings, R. P., & Lindsay, W. R. (2018). Offenders with Intellectual and Developmental Disabilities. The Wiley Handbook on Offenders with Intellectual and Developmental Disabilities: Research, Training, and Practice. Wiley.

Melvin, C. L., Langdon, P. E., & Murphy, G. H. (2017). Treatment effectiveness for offenders with autism spectrum conditions: A systematic review. *Psychology, Crime & Law*, 23(8), 1-29.

Melvin, C. L., Langdon, P. E., & Murphy, G. H. (2020a). "I feel that if I didn't come to it anymore, maybe I would go back to my old ways and I don't want that to happen": Adapted sex offender treatment programmes: Views of service users with autism spectrum disorders. *Journal of Applied Research in Intellectual Disabilities*, 33, 739-756.

Melvin, C. L., Langdon, P. E., & Murphy, G. H. (2020b). “They're the hardest group to treat, that changes the least". Adapted sex offender treatment programmes for individuals with Autism Spectrum Disorders: Clinician Views and Experiences. *Research in Developmental Disabilities*, 105, 103721.

National Offenders Management Services (NOMS). (2013). Minimising and managing physical restraint: Safeguarding processes, governance arrangements, and roles and responsibilities.

NHS Digital (2020). Learning Disability Services Monthly Statistics. Retrieved from http://digital.nhs.uk/pubs/ldsmAug20.

NHS England (2018). Service Specification Medium Secure Mental Health Services (Adult). Retrieved from https://www.england.nhs.uk/wp-content/uploads/2018/03/adult-medium-secure-service-specification-dec-20.pdf

NHS England. (2017). Transforming Care - Model Service Specifications: Supporting implementation of the service model. London: NHS England.

NHS England (2015). Building the right support: a national plan to develop community services and close inpatient facilities for people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition. Department of Health.

National Institute for Health and Care Excellent (2015a). Challenging behaviour and learning disabilities: Prevention and interventions for people with learning disabilities whose behaviour challenges. (No. Ng11).National Institute for Health Care Excellence. Retrieved from https://www.nice.org.uk/guidance/ng11/resources/challenging-behaviour-

and-learning-disabilities-prevention-and-interventions-for-people-with-learning-disabilities-whose-behaviour-challenges-pdf-1837266392005

National Institute for Health and Care Excellent. (2015b). Violence and aggression: Short-term management in mental health, health and community settings. (No. Ng10). London: National Institute for Health Care Excellence. Retrieved from https://www.nice.org.uk/guidance/ng10/resources/violence-and-aggression-shortterm-management-in-mental-health-health-and-community-settings-pdf-1837264712389

Nicholas S., Gray N.S., Snowden R.J. (2018) Static Risk Assessment in Offenders with Intellectual and Developmental Disabilities. Offenders with Intellectual and Developmental Disabilities. Wiley Blackwell.

Oxley, C., Sathanandan, S., Gazizova, D., Fitzgerald, B., & Puri, B. K. (2013). A comparative review of admissions to an Intellectual Disability Inpatient Service over a 10-year period. *British Journal of Medical Practitioners*, 6(2), 36-40.

Rogers, J., Viding, E., Blair, R. J., Frith, U., & Happé, F. (2006). Autism spectrum disorder and psychopathy: shared cognitive underpinnings or double hit? *Psychological Medicine*, 36(12), 1789-1798.

Siponmaa, L., Kristiansson, M., Jonson, C., Nyden, A., & Gillberg, C. (2001). Juvenile and young adult mentally disordered offenders: The role of child neuropsychiatric disorders. *Journal of the American Academy of Psychiatry and the Law*, 29(4), 420-426.

Social Care, Local Government and Care Partnership Directorate. (2014). Positive and proactive care: Reducing the need for restrictive interventions. London: Department of Health.

Wardale, S., Davis, F., & Dalton, C. (2014). Positive behavioural support training in a secure forensic setting: The impact on staff knowledge and positive behavioural support plan quality. *International Journal of Positive Behavioural Support*, 4(2), 9-13.

Washington, F., Bull, S., & Woodrow, C. (2019). The transforming care agenda: Admissions and discharges in two english learning disability assessment and treatment units. *Tizard Learning Disability Review*, 24(1), 24-32. https://doi.org/10.1108/TLDR-04-2018-0012

Weston, L., Hodgekins, J., & Langdon, P. E. (2016). Effectiveness of cognitive behavioural therapy with people who have autistic spectrum disorders: A systematic review and meta-analysis. *Clinical Psychology Review*, 49, 41-54.

Wong, Y. L., Bhutia, R., Tayar, K., & Roy, A. (2015). A five decade retrospective review of admission trends in a NHS intellectual disability hospital. *Advances in Mental Health and Intellectual Disabilities*, 9(3), 108-115. https://doi.org/10.1108/AMHID-07-2014-0030.

Woodbury-Smith, M., & Dein, K. (2014). Autism spectrum disorder (ASD) and unlawful behaviour: where do we go from here? *Journal of Autism and Developmental Disorders*, 44(11), 2734-2741.