OLD AGE FORENSIC PSYCHIATRY

September 2025

About 40% of people in the UK are aged 50 years or more, the threshold for being regarded as 'old' in the criminal justice system. Nearly one in five is over 65. It is, therefore, hardly surprising that numbers and proportions of older offenders and of older victims of crime are rising but actual figures are elusive. Statistics seem rather to focus on service use; although remaining very much in the minority in prisons, it is nevertheless plain that the only growth age groups in prisons are of those aged 50 or over[1].

This newsletter highlights research and thinking around some of the special needs of older people in forensic psychiatry and the criminal justice system. This is welcome, but we start with words of caution first that the matters raised do not imply an elderly crime wave and, secondly, that many, probably many more older people will have become victims of crime rather than perpetrating it.

It has repeatedly been shown that fear of crime is highest among older people, although actual victimisation seems to remain much lower than among young people[2]. That said, older people may be disproportionately likely to suffer from particular types of crime or less likely to get relevant help. We may need more research here - to inform prevention of such victimisation where possible, and resolution of harms where not.

In prisons or specialist hospitals older offenders still form a minority group, and it always seems difficult to provide for minority groups. One of this Newsletter authors - Brid Dineen - draws out a further key dilemma here, from the Tomlin group's paper: the absence of consensus around what defines 'older adult' within forensic settings.

We suggest that this is less important than the question 'what needs may some older people have that cannot be met without some reform of prison or specialist services?' Thoughts about vulnerabilities are important, but so they are for all patients; thoughts about cognitive impairments are vital, but so they are for all patients many, if not most people using forensic mental health services need specific help with cognitive problems; thoughts about physical disabilities are important, but few using forensic mental health services or prisons are in good physical health. Strangely, three things that we think are very important are not picked up strongly: 'super-risk' to others, loneliness/isolation and end of life care.

Tom Dening and Jen Yates focus on knowledge about care needs for older people in specialist forensic mental health services, drawing on the consensus work of Jack Tomlin and colleagues, an international group with experience in Belgium, Germany and the UK. This is a welcome, comprehensive perspective on some of the special healthcare needs, although omitting reference to a key skill generally more applicable to older patients and one that most secure unit staff feel wholly unprepared for end-of-life care. A paper by Adam and Jonathan Hurlow and others[3] is useful here.

Among the papers that Anna Sri and Paula Murphy commissioned, perhaps we most miss evidence on the risks, criminogenic needs and responsivity of older prisoners and patients. Perhaps this is where we most need new research in this area? As with any other age group, older offenders and offender-patients will have committed, collectively, a very wide range of acts judged as offending. Public order offences have become newsworthy; some commit more truly antisocial acts such as theft, but some are in the system for very serious crimes indeed. A study in Broadmoor hospital, completed in 2004, showed that median length of stay of the 16 patients of 60 years or over then resident was 17 years, with a range of 1-57 years[4], nearly three times the median of their younger peers. Perhaps at least some older people are among the most dangerous in the country? From our own experience, a very sweet looking old lady in her 70s in a high security setting, while lacking capacity to scale fences or walls, had lost none of her will to dispose of others and had explicit and achievable plans for poisoning fellow patients. A frail 80 year-old man in a wheelchair similarly seemed ill-placed in high security, until viewing the walls of his room, covered with sexually explicit pictures of women almost obliterated by his attacks, mostly with a rather blunt pencil, but still the intent to harm seemed high.

As more people are given ever longer sentences for their crimes, the growing incarcerated group of older offenders will pose a very special challenge. Some, however, are entering the system late after a lifetime of serious offending, for example those with a record of non-recent sex offences against children. Specialist forensic mental health input will clearly be as important as that from older age psychiatry specialists.

Prisoners and forensic mental health patients have rarely had active and successful social lives. Episodes of imprisonment or hospitalisation commonly disrupt social networks at any age, but older peoples' networks may be particularly fragile. Particular reluctance to leave the society of a well-run hospital unit may follow. Further, for longer stay patients, the wider community is very different from the one they left. Exploration of optimal programmes for community reintegration may be one of the most important areas for development here – underscoring probably the most important point raised by Marco Picchioni in his article about recognising 'old age forensic psychiatry' as a specialist field. His other points, however, seem, in effect, calling for quantitatively rather than qualitatively different services.

Finally, Artemis Igoumenous tries to introduce us to what forensic psychiatrists really look for in this field. While the answer seems reassuring – that they want access to specialist assessment, advice and support, and certainly not to ship such patients elsewhere – one outcome of this research was also troubling. Just 12% of North London forensic psychiatrists completed the survey. Artemis does not translate the percentage into actual figures, but we doubt if they even reach double figures. It is so hard to respond to every request that might lead to service improvements, but information from active clinicians is essential if developments are actually going to be helpful.

So, Anna and Paula have introduced us to another important field where too little is known, and we will certainly think about how we might support research in this field.

In the meantime, we are excited by two Crime in Mind supported development projects that are well underway. Howard Ryland (Oxford University) and Danny Whiting (Nottingham University) have successfully embarked on a research priority setting partnership exercise for adult secure mental health services with the James Lind Alliance (JLA)[5]. The range of engagement and quality of meetings and survey tool development, steered by the JLA, is impressive; we shall suggest adding specific work with older offender-patients for consideration. At the other extreme, Heidi Hales, Annie Bartlett, Fleur Souverein and Enys Delmage are developing a website to support their Group of International Researchers in Adolescent Forensics (GIRAF) – with the exciting prospect of facilitating studies of the rather different ways young offenders and offender-patients are managed and treated worldwide – almost a natural experiment as the young people and their problems are rather similar but the legal and practice framework for intervening very different.

Finally, we want to draw attention to two imminent new activities. We are about to announce new seed corn funding small monies, but past project bear witness to how much can be achieved[6,7]. We are also going to start some work around research ethics approval. Many researchers in psychiatry/psychology generally are encountering damaging delays and barriers, but they are perhaps particularly acute for forensic mental health research. Far from offering protections, it has been suggested that lengthy processes are now putting research for some of those people who most need it in serious jeopardy. We will be putting out a call through the members' website to hear about your experiences. Of course, we most want models of good practice in a form we can share but we want to hear about problems too and to think with you about solutions.

So, there are busy times ahead enjoy this newsletter and if you feel inclined to contribute to future issues and/or have particular topics you would like to see covered in our webinars or in the newsletter, do get in touch.

John Gunn & Pamela Taylor

Co- chairing Crime in Mind

References

1. https://committees.parliament.uk/publications/2149/documents/19996/default/
2. https://hmicfrs.justiceinspectorates.gov.uk/our-work/article/criminal-justice-joint-inspection/crimes-against-older-people-inspection/
3. Hurlow A, Hurlow J, Neil W and Pullinger A. (2021) Advance care planning ahead of life-altering clinical deterioration in secure settings: Do not wait until a crisis. *Criminal Behaviour and Mental Health* 31: 221-225. DOI: 10.1002/cbm.2203
4. Yorston G and Taylor PJ (2009) Older patients in an English high security hospital: a qualitative study of the experiences and attitudes of patients aged 60 and over and their care staff in Broadmoor Hospital. *The Journal of Forensic Psychiatry & Psychology* 20(2): 255–267 DOI: 10.1080/14789940802327259
5. https://www.jla.nihr.ac.uk/priority-setting-partnerships/adult-secure-inpatient-and-community-forensic-mental-health-services
6. Theodorou A, Sinclair H, Ali S, Sukhwal S, Bassett C and Hales H. (2024) A systematic review of literature on homicide followed by suicide and mental state of perpetrators. Criminal Behaviour and Mental Health 34 (1): 10-53. https://doi.org/10.1002/cbm.2322
7. Burghart M and Backhaus S. (2024) The Long-Term Consequences of Family Violence Victimization: An Umbrella Review of Longitudinal Meta-Analyses on Child Maltreatment and Intimate Partner Violence. Journal of Family Violence https://doi.org/10.1007/s10896-024-00768-y

Care for older forensic mental health patients

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Research involving older people in the forensic system has largely concentrated on older prisoners, see for example reviews by Di Lorito et al (2108a and b) of prevalence of mental disorders and the lived experience of older prisoners, respectively.

Within forensic mental health services, most research has focused on in-patient settings with relatively little attention to community-based patients. Claudio Di Lorito's work reviewed the literature and found, as might be expected, high levels of mental and physical health issues among older patients (Di Lorito et al., 2018c). Obesity and diabetes are highly prevalent (Tomlin et al., 2022).

Two other important questions identified were **whether there should be separate accommodation for older forensic patients,** and **how the prospect of discharge (usually after admissions lasting years) could be very daunting.**

For the NIHR-funded ENHANCE study, led by Chris Griffiths and Kate Walker, we examined issues for older forensic patients, in particular barriers and facilitators to moving through the system, by means of interviews with staff and patients.

Environmental (e.g., physical, structural and facilities), relational (staff, family and friends) and individual (characteristics, feelings, behaviours) factors were identified as enablers and/or obstacles to wellbeing, recovery, progress and quality of life (Walker et al., 2023a).

We found that multidisciplinary input, an individualized approach and implementing holistic and needs-led care facilitated progress towards recovery and independence.

Barriers included lack of resources, excluding the patients in care planning, gaps in expertise and knowledge, and a lack of specialised units that could address mental health, forensic and elderly needs (Walker 2023b).

From this work, we have published a consensus guidance document on the care of older forensic patients (Tomlin et al., 2023), intended to complement the European Psychiatric Association guidance on forensic psychiatry. The main recommendations include: involve older patients in treatment and service organization decisions, adapt interventions to be responsive to this group, train staff to recognize physical vulnerabilities and cognitive decline, and embrace methods of communication developed in other areas of are, such as dementia care.

References

Di Lorito C, Völlm B, Dening T. (2018a) Psychiatric disorders among older prisoners: A systematic review and comparison study against older people in the community. Aging & Mental Health 22(1): 1-10. DOI: 10.1080/13607863.2017.1286453.

Di Lorito C, Völlm B, Dening T. (2018b) A systematic review on the individual experience of ageing prisoners through a Good Lives Model framework. International Journal of Geriatric Psychiatry 33(2): 252-262. DOI: 10.1002/gps.4762.

Di Lorito C, Völlm B, Dening T. (2018c) Ageing patients in forensic psychiatric settings: a review of the literature. International Journal of Geriatric Psychiatry 33: 1548–1555.

Tomlin J, Walker K, Yates J, Dening T, Völlm B, Griffiths C. (2022) Older forensic mental healthcare patients in England: demographics, physical health, mental wellbeing, cognitive ability and quality of life. NIHR Open Research 2:9. doi: 10.3310/nihropenres.13248.2.

Tomlin J, Walker K, Yates J, Dening T, Goethals K, Völlm B, Griffiths C. Care for older forensic mental health patients: a consensus guidance document. European Psychiatry 2023; 66(1): e44: 1-13. doi: 10.1192/j.eurpsy.2023.2413.

Walker K, Yates J, Dening T, Völlm B, Tomlin J, Griffiths C. (2023a) Quality of life, wellbeing, recovery, and progress for older forensic mental health patients: a qualitative investigation based on the perspectives of patients and staff. International Journal of Qualitative Studies in Health & Well-being 18:1, 2202978, doi: 10.1080/17482631.2023.2202978.

Walker K, Furtado V, Yates J, Dening T, Völlm B, Griffiths C. (2023b) Systems and processes that enable progress for older forensic mental health patients. International Journal of Forensic Mental Health 22(2): 93-104. doi: 10.1080/14999013.2022.2080304.

We must be wise to the needs of older forensic mental health patients

A commentary by Dr. Bríd Dinneen (CT3) on Jack Tomlin et al.'s paper Care for Older Forensic Mental Health Patients: A Consensus Guidance Document


European Psychiatry

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Research Article

Care for older forensic mental health patients: A consensus guidance document

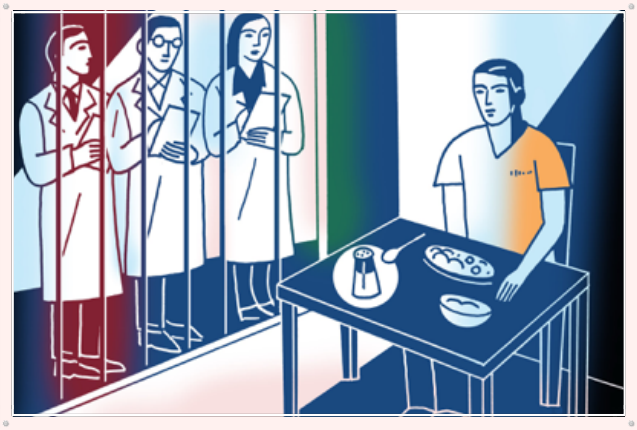
Jack Tomlin[1], Kate Walker[2], Jen Yates[3], Tom Dening[4], Kris Goethals[5], Birgit Völlm[1] and Chris Griffiths[2]

Abstract

Twenty percent of inpatients in secure mental health settings are over the age of fifty and our ageing population is set to increase this proportion further (1). Tomlin et al argue, it is therefore more important than ever, to investigate and understand the needs and experiences, as well as outcomes of this group.

This guidance document summarises the literature on older forensic mental health patients and synthesizes the evidence into five sections.

The first section attempts to profile this group using epidemiological evidence from a range of studies collating demographic, clinical and legal information.



They note the absence of consensus around what defines 'older adult' within forensic settings. In acknowledging that age-related physical health needs of people with serious mental health conditions often occur up to ten years earlier, they determine that this broadly defined population have needs that are influenced but not solely contingent on age (2).

They advocate for a 'level and need' based approach as a more useful way of thinking about specialised services. Addressing this treatment gap is one of six priorities set out by the college for 2024-26 which includes access to physical health care as well as high-quality, timely and safe, social and environmental interventions (3).

The second part of the guidance focuses on qualitative research. Thematic analyses of narrative accounts of care in this population were found to align with those of younger forensic patients. Boredom, understaffing and lack of autonomy were common themes and were broadly similar across ages, settings and countries (4). Whilst no homogenous 'older adult voice' emerged across this literature, unique older offender related themes did. The importance of making sense of one's place in the world, daily living while in care (practical adaptations for older adults, activities and atmosphere) as well as treatment and recovery needs emerged (5).

The third part of the guidance provides an overview of existing interventions targeted at this group. In summary, there are no tailored interventions or services for older patients in secure hospital units or in the community and there is little to no research evaluating the efficacy of the ‘all ages’ support currently offered. Even less is known about the experiences and needs of older women and older people from ethnic minorities.

Section four and five consider future directions for research and make recommendations for practitioners working within this setting. They conclude that the current limited research suggests that older forensic patients have a distinct set of psychological and physical health needs compared to their younger counterparts.

The need for research that explicitly includes older women and ethnic minorities is also highlighted.

A lack of understanding around the needs of this population mirrors the scarcity of dedicated interventions and tailored support available to older adults on their journeys through secure settings and their transition into the community, the impact of which is not known. RCT studies and longitudinal studies that examine change over time to measure efficacy of interventions for this population are, they conclude, desperately needed.

Tomlin et al. also argue that we have a (growing) patient group who have unique needs and challenges and who experience services differently. We need, they believe, to grow our understanding and thus appropriate/ tailored provision. It seems clear that we must be wise to the needs of older forensic mental health patients.

References

[1] Di Lorito C, Völlm B, Dening T. Ageing patients in forensic psychiatric settings: a review of the literature. Int J Geriatr Psychiatry. 2018;33(12): 1548–55. doi:10.1002/gps.4981.

[2] Merkt H, Haesen S, Meyer L, Kressig RW, Elger BS, Wangmo T. Defining an age cut-off for older offenders: a systematic review of literature. Int J Prison Health. 2020;16(2):95–116. doi:10.1108/IJPH-11-2019-0060.

[3] Advocating, educating and collaborating to achieve excellence in psychiatry Strategic Plan 2024-26

[4] Coffey MJ. Researching service user views in forensic mental health: a literature review. J Forensic Psychiatry Psychol. 2006;17(1):73–107. doi: 10.1080/14789940500431544.

[5] Yorston G, Taylor PJ. Older patients in an English high security hospital: a qualitative study of the experiences and attitudes of patients aged 60 and over and their care staff in Broadmoor hospital. J Forensic Psychiatry Psychol. 2009;20(2):255–67. doi:10.1080/14789940802327259.

Old Age Forensic Psychiatry: A Specialized Field

Where it exists as a distinct speciality, Forensic Psychiatry tends to focus on people of working age, usually men with psychotic mental disorders and personality pathology.

Old age forensic psychiatry is a highly specialised and increasingly needed complimentary branch that addresses the complex interplay of mental disorder, physical illness, aging, offending and the legal system. Old Age Forensic Psychiatry tends to focus on mentally disordered offenders aged 65 and over, and on younger individuals with early onset neurodegenerative disorders.

The emergence of Old Age Forensic Psychiatry is a relatively recent development, driven by several factors. Globally, populations are aging, leading to a demographic shift with a larger proportion of individuals living into old age. With increased lifespan comes a higher prevalence of age-related mental disorders such as dementia and depression, while psychosis can have been lifelong, but can also develop for the first time. All of these can significantly impact an individuals' cognitive function, decision-making abilities and behaviour. These elements can, in turn, lead to violent offending and contact with the criminal justice legal system, often for the very first time in an individual's life.

Key areas of practice in Old Age Forensic Psychiatry include diagnostic evaluation, assessing 'capacity' to offend in older adults with cognitive impairment, evaluating fitness to plead, and assessing future risk of harm both to others, but also to the self. The assessment process can be more intricate than in working age Forensic Psychiatry, requiring an appreciation of both geriatric medicine and old age and forensic psychiatry. It typically involves full review of past medical history, collateral information from family and caregivers, and careful consideration of how age-related and environmental changes might compromise an individual's presentation at the point of assessment. Comprehensive neuropsychological testing is often needed as well as neuroimaging,

Current challenges in the field are numerous. Differentiating between normal age-related cognitive decline, lack of effort, and pathological conditions can be difficult. The presence of multiple comorbidities, polypharmacy, excessive medicine doses and lack of reliable third party informants, can all significantly complicate assessments. Additionally, ethical considerations around individuals' vulnerability, capacity and best interests are paramount. Old Age Forensic Psychiatrists often play a crucial role in ensuring that older adults within the legal system receive appropriate and equitable consideration, balancing justice with the unique vulnerabilities and needs of this population.

The typical aims of a custodial sentence in the elderly person with dementia can probably never be achieved. As our societies continue to age, the demand for this specialised expertise will undoubtedly grow.

With that in mind some suggestions for future service development and research include:

1. **Development and Validation of Age-Specific Forensic Assessment Processes:** Current diagnostic, cognitive evaluation and risk assessment in prisons and Forensic Psychiatry are not optimized for older people. Training and research is needed to develop and validate processes and instruments that better account for age-related changes, comorbidities, and the unique presentation of mental disorders in later life within forensic contexts.

2. **Impact of Specific Neurocognitive Disorders on Offending:** Research is required into the specific mechanisms through which various types of mental disorder in old age, such as depression, dementia and other neurocognitive disorders influence the risk of violent offending, including the roles of disinhibition, impaired judgment, and executive dysfunction.

3. **Understanding the Roles of Comorbidity and Polypharmacy:** Further work is needed to help us to understand how multiple physical health conditions and the use of multiple medicines, for example SSRIs, interact with mental disorders to influence impulsivity, behaviour and risk in older people.

4. **Ethical and Legal Framework Evolution:** Work is needed to explore how existing legal processes and ethical guidelines should or can be adapted to better accommodate the complexities of mental capacity, criminal responsibility, and the rights of older adults within the criminal justice system, particularly in cases involving cognitive impairment.

5. **Care Pathway Optimization and Service Design:** Research into optimal service delivery models, including the balance between age-specific units in prisons and hospitals and integrated care, and the development of seamless care pathways for older adults transitioning between different levels of security, or from prison to the community need to be established and tested.

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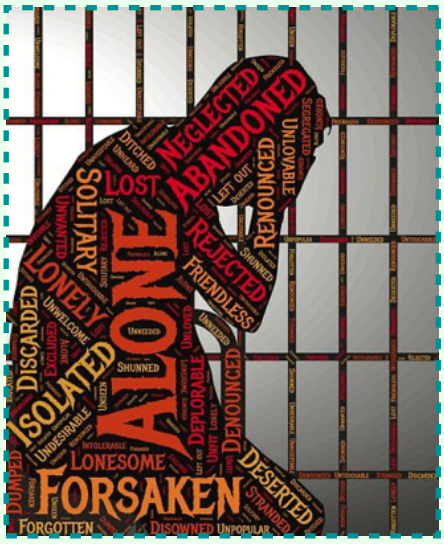
Old Age Forensic Psychiatry: Research

Cognitive disorders are common and debilitating conditions. Whilst data on the prevalence of cognitive impairment in forensic settings is sparse, there is evidence to suggest that it occurs more commonly in older forensic patients than equivalent age groups in the general population (di Loreto et al. 2019, Verhulsdonk et al. 2023). There is also evidence indicating that the proportion of older people within forensic settings is rising. Prisons have seen a substantial growth in their ageing population (de Toit et al. 2019) with a similar trend predicted in the secure hospital setting (Tomlin et al. 2023).

One would therefore expect age associated cognitive disorders including dementia to become increasingly prevalent in forensic cohorts. This has important implications when considering the already complex and multifaceted needs of the forensic population.

Advancing age yields an additional layer of complication, with some research suggesting that forensic service users, due to their poorer health status, driven by factors like chronic illness, comorbidity and functional impairment, may experience old-age specific needs 10 years earlier than general population counterparts (Merkt et al. 2020).

There are established services that provide specialist assessment and support for people with cognitive decline, as recommended in National Guidance, that are accessible to the general public via the NHS. The extent to which forensic patients utilise similar services or receive specialist input is unclear. Similarly, it is not clear the extent to which NICE recommendations to manage cognitive decline and dementia are being implemented in forensic settings (NICE, 2018), although there is evidence to suggest that provision for older forensic patients more widely may be limited within the existing infrastructure (Walker et al. 2022, Yorston et al. 2009).



Given that the need for age specific services is well recognised and services catering specifically to older adults are well established in other spheres of health and social care, it has been argued that forensic services need to be adapted and/or expanded to better accommodate the needs of their ageing population (Tomlin et al. 2023).

In 2024 we surveyed clinicians working within North London forensic services, with the aim to gain insight into services available for cognitive disorders. Our online survey had 20% return rate, and it was only completed by forensic psychiatrists. Despite the limited responses, data collected indicated forensic teams struggling to access the specialist assessment, advice and support required to adequately meet the needs of their cognitively impaired service users. Psychiatrists acknowledged that it can be difficult to diagnose cognitive disorders owing to the high complexity of forensic service users and would value easier access, through specific pathways, to specialist services who can offer support with diagnosis and treatment.

Based on the findings of this study alone, we would recommend that hospital trusts that incorporate forensic services initiate the strategy of either establishing or strengthening the relevant care pathways so that forensic service users with cognitive disorders can easily access the specialist support they need.

Further research in this area is warranted. A national survey, with improved reach within the forensic network could result in a greater number of responses from a wider variety of professionals. This is turn could yield data of greater depth and breadth.

References

Di Lorito, C., Völlm, B., & Dening, T. (2019). The characteristics and needs of older forensic psychiatric patients: a cross-sectional study in secure units within one UK regional service. The Journal of Forensic Psychiatry & Psychology, 30(6), 975 - 992. hqps://doi.org/10.1080/14789949.2019.1659390

du Toit, S. H. J., Withall, A., O' Loughlin, K., Ninaus, N., Lovarini, M., Snoyman, P., Butler, T., Forsyth, K., & Surr, C. A. (2019). Best care options for older prisoners with dementia: a scoping review. International Psychogeriatrics, 31(8), 1081 - 1097. hqps://doi.org/10.1017/S1041610219000681

Merkt, H., Haesen, S., Meyer, L., Kressig, R. W., Elger, B. S., & Wangmo, T. (2020). Defining an age cutoff for older offenders: a systematic review of literature. International Journal of Prisoner Health, 16(2), 95 - 116. hqps://doi.org/10.1108/IJPH-11-2019-0060

National Institute for Health and Care Excellence. (2018). Dementia: assessment, management and support for people living with dementia and their carers. [NICE guideline NG97]. hqps://www.nice.org.uk/guidance/ng97

Tomlin, J., Walker, K., Yates, J., Dening, T., Goethals, K., Völlm, B., & Griffiths, C. (2023). Care for older forensic mental health patients: A consensus guidance document. European Psychiatry, 66(1), e44 - e44. hqps://doi.org/10.1192/j.eurpsy.2023.2413

Verhülsdonk, S., Folkerts, A. K., Hufnagel, S., Bohn, C., Hoeo, B., Supprian, T., & Kalbe, E. (2023). Frequency of cognitive impairment in older forensic inpatients: results of a pilot cross-sectional study. The Journal of Forensic Psychiatry & Psychology, 34(1), 37 - 55. hqps://doi.org/10.1080/14789949.2023.2168206

Walker, K., Yates, J., Dening, T., Völlm, B., Tomlin, J., & Griffiths, C. (2022). Staff perspectives on barriers to and facilitators of quality of life, health, wellbeing, recovery and reduced risk for older forensic mental-health patients: A qualitative interview study. Journal of Health Services Research & Policy, 27(4), 287 - 300. hqps://doi.org/10.1177/13558196221094512

Yorston, G., & Taylor, P. J. (2009). Older patients in an English high security hospital: a qualitative study of the experiences and attitudes of patients aged 60 and over and their care staff in Broadmoor Hospital. The Journal of Forensic Psychiatry & Psychology, 20(2), 255 - 267.

hqps://doi.org/10.1080/14789940802327259

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Research can transform lives.

We want to support discoveries about what helps people with mental disorder who have been victims of criminal behaviour, or perpetrators of criminal behaviour, and their families, and the clinicians and others who treat them and, indeed, the wider community when its members are in contact with these problems.

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