CIM NEWSLETTER Summer Edition

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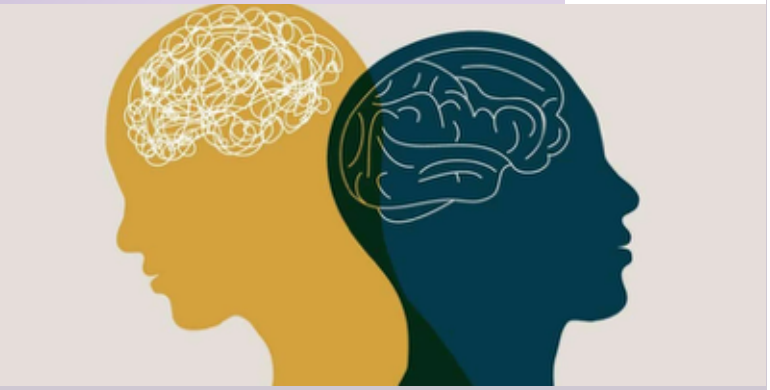
Forensic and Learning Disability Psychiatry



Forensic intellectual disability service needs?

Welcome to our latest newsletter, with its focus on people with intellectual disabilities or neurodevelopmental disorders. It is timely. For England and Wales, the Mental Health Act 2025[1] is now law. It should be implemented alongside a substantial research budget. Then, the first call on such a budget should be for people with learning disabilities and/or other neurodevelopmental disorders.

A major element in this legislative reform is that 'once the government is confident that enough community provision is in place, having a learning disability or autism will no longer be a reason for people to be detained under Section 3 of the 1983/2007 Act unless they have a co-occurring mental disorder.' This means that, should you need a period in hospital with one or more of these disorders but cannot or will not consent to that, then you must break the criminal law in some fairly serious way to facilitate detention there.

The principles behind the reforms are sound. They include enabling people to have more say in their treatment and care plans, ensuring that they thus receive timely, effective and appropriate treatment whilst safeguarding their dignity and respecting their personal values. The vision is that this will facilitate treatment under the least restrictions compatible with their safety and the safety of others, including shortening any period of detention in hospital whenever this has been deemed necessary. Civil detention if health and safety really are at risk remains an option for people who have one or more mental disorders from most recognised categories (substance use disorders alone have long been an exception), but the new legislation removes this option for people with intellectual or neurodevelopmental disorders and thus marks them as specially different. The hope is that society will step up to the mark and provide better community services in a timelier way; the fear is that it will not and that more people with neurodevelopmental disorders may come into conflict with criminal law and, at best, be forced into more restrictive services. So, do we have a good enough baseline of service use and good enough resources to monitor the impact on real lives of this substantial change?

Current official statistics for people in hospital because of learning disability in England and Wales[2] show 3,775 in February 2026, of whom nearly 80% (n=2,965) were then detained under the prior mental health legislation; just one fifth were voluntary inpatients. The majority of the detained patients were under civil orders (1,885, 64%); most of the rest under part 3 (forensic) orders. The civilly detained majority, in future, must be elsewhere. The figures are small, but they are not trivial. We need to be sure that the new legislation delivers the hoped for benefits and neither raises the numbers of people needing specialist forensic mental health services, nor pushes a group of vulnerable people into prison – nor even just pushes them into a slightly different civil law framework that may may not be ready for this shift[3]. So, we need research to establish what really follows this legislative change.

For this newsletter, Paula Murphy and Anna Sri, our newsletter editors, have brought together some work from forensic mental health neurodevelopmental disorder teams. All three papers are calling for more community service, more expertise and more recognition of the capacity needed for individual tailoring of treatment plans. The huge concerns about difficulties in accessing the assessments that could help support early interventions and likely prevention of forensic-related needs programmes are noted. Verity Chester and Regi Alexander point out that in 2024 alone, over 200,000 people in England were waiting for an autism assessment. On a happier note they do note that the Royal College of Psychiatrists delivered the National Autism Training Programme for Psychiatrists (NATPP) to over 1,500 psychiatrists; the trained felt satisfied and more confident. Has this translated into improved early intervention?

Once having crossed into offending, all want to see more specialised services available within the community. All three contributing groups want these. Sanjib Ghosh argues that this could reduce need for inpatient care. Jane McCarthy and Iain McInnon report that the shortage of community placements is responsible for delays in detained patients returning safely in a timely way to their home communities. Their survey of Mental Health Trusts/Boards brought a very good response rate, with the positive finding that about half have access to specialist forensic mental health services. Their emphasis, though, is mainly on how to help inpatients move on. We'd also like to highlight the community sentence option – with a mental health treatment requirement (MHTR) whenever that would safeguard the treatment as well as the offender-patient and safety[4]. Of course the MHTR is for resolving problems rather late in the pathway, but, still, is a mechanism for enabling an offender-patient to stay in the community while resolving their problems and one for which there is good evidence of tertiary prevention[5,6,7], albeit not specific to people with learning disabilities.

So, there are many of research questions for this field, a few good people working in it and ready to do more, given funding. Please raise your voices in a call for that!

John Gunn & Pamela Taylor

Co- chairing Crime in Mind

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4 Royal College of Psychiatrists (2021) Position Statement on Mental Health Treatment Requirements (MHTRs) Ps04/21 ps04_21---mental-health-treatment-requirements.pdf

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The essential need to divert people with intellectual disabilities and associated severe challenging behaviour away from inpatient secure settings to bespoke community care

Patients with severe and persistent challenging behaviour who are placed in medium secure, generic or learning disability (LD,) services often experience poor outcomes, due to a mismatch between their complex neurodevelopmental needs and the highly structured, offence-focused ward environment (Alexander et al., 2015; Allen et al., 2016). Multiple studies and service reviews highlight that such individuals, often requiring continuous 1:1 or 2:1 staffing, do not typically benefit from the group-based interventions central to secure LD wards and are exposed to increased risk of restrictive practices like frequent and prolonged seclusion and segregation (Allen et al., 2016; Care Quality Commission, 2022; Deb et al., 2015). These approaches frequently result in increased patient distress, sustained behavioural incidents, and unnecessarily prolonged admissions, contributing to institutionalisation (Care Quality Commission, 2022; Rosen et al., 2018).

Challenging behaviours in these populations are strongly linked to neurodevelopmental conditions (such as autism spectrum disorder), communication difficulties, and sensory processing issues (Matson & Kozlowski, 2011; Rosen et al., 2018). Placement in an unsuitable secure setting may escalate aggression and self-injury while placing significant strain on staff and reducing the quality of life for all patients within the unit (Deb et al., 2015; Allen et al., 2016). Evaluations of service models also find that care designed to manage one "high need" individual within the confines of a ward model can limit therapeutic opportunities for the wider patient group and generate substantial resource pressures (Alexander et al., 2015; NHS England, 2017).

There is robust evidence supporting the transition to bespoke, community-based services for individuals with high support needs. Evaluations of intensive community support demonstrate significant reductions in challenging behaviour, decreased use of restrictive practices, and improved overall wellbeing for service users (Deb et al., 2015; NHS England, 2019; Royal College of Psychiatrists, 2020).

These community placements, when combined with highly individualized behavioural supports and crisis admission pathways to non-forensic psychiatric intensive care settings (PICU), align with principles of least restrictive care and the Transforming Care agenda (NHS England, 2019; Royal College of Psychiatrists, 2020). By prioritizing integrated, patient-centred services, this approach enhances clinical outcomes, meets ethical and human rights standards, and reduces inappropriate secure hospital use (NHS England, 2019; Care Quality Commission, 2022; Alexander et al., 2015).

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A UK-wide survey of community forensic services for adults with intellectual disability and/or autism

As a group of clinicians working across the UK, we wanted to understand how successful delivery of community forensic services for those with intellectual disability (ID) and/or autism was happening in practice so hence why we undertook a national survey as detailed below (McKinnon et al, 2024).

Transforming Care has been the national policy over the past decade with a key aim to reduce the number of people with ID and autism in hospital. This policy is supported by a national service model known as Building the Right Support. This model outlined nine key principles including the development of specialist forensic support in the community for those with ID and/ or autism at risk of engaging in offending behavior and to support the safe discharge from hospital back to the community. It is important to acknowledge that people with intellectual disability and autism spectrum conditions are overlapping but different populations.

An online survey of 78 UK Trust/ Health Boards providing mental health and or intellectual disability services was undertaken. 49 (63%) responded and of these 51% (25) had access to specialist community forensic services with thirteen operating from a single Trust or Board and the other twelve providing the service over a large regional footprint. All these specialist community services included psychiatry, psychology and nursing as core members of the team.

Our findings found that all the specialist teams provided advice and consultation to other teams and professionals and engaged in direct work with people with intellectual disability and/or autism. Around two thirds of the services also had statutory responsibility for the person's mental health care including responsibilities under the relevant mental health legislation. Specialist forensic community teams were associated with better access to offence-related interventions and co-production of patient care plans.

If no specialist community forensic team existed responsibility went to generic services either an intellectual disability community team or mainstream forensics teams. These teams appeared not to be well equipped to manage risk in this population. The person referred may not have met the referral criteria or there was a lack of expertise or ability to adapt therapeutic approaches.

The provision of well managed suitable community placements being in short supply was brought to light leading to the potential delay in discharge from hospital. The issue of the current legal frameworks being sufficient to support people in the community was highlighted with concerns around potential unintended consequences of the new Mental Health Act 2025 for England and Wales (Tromans et al., 2023).

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Autism within the Criminal Justic System

Autism is estimated to affect around 1% of the general population. However, a recent systematic review by Chester et al. (2025) found that autistic people may be substantially overrepresented within the criminal justice system (CJS). Reported prevalence varied widely, ranging from 0–60% across prisons, courts and forensic psychiatric services, and from 15–30% within forensic intellectual disability services.

Despite these high figures, autism is often diagnosed late among individuals in the CJS. Autism charities have described the current diagnostic pathway as a "broken system", with long waiting times a major barrier. In 2024 alone, over 200,000 people in England were waiting for an autism assessment (NHS England, 2024). For some individuals, autism is first recognised only after a psychiatric assessment following an offence (Billstedt et al., 2017; Kawakami et al., 2012). Smith (2021) described cases in which autism went unrecognised for years among people in prison or forensic psychiatric services, limiting treatment progress and appropriate support.

Improving outcomes for autistic people in the CJS requires earlier recognition and diagnosis. Psychiatrists have a key role in this process, including the careful clarification of developmental histories, use of autism screening tools, and systematic clinical interviews to establish the presence of co-occurring neurodevelopmental conditions and mental disorders. Understanding how this complex clinical picture relates to offending behaviour is essential too.

Between 2023 and 2025, the National Autism Training Programme for Psychiatrists (NATPP) was delivered by the Royal College of Psychiatrists (Health Education England. (n.d.). This programme aimed to improve early recognition of autism and promote autism-informed practice in mental health services. Around 1,500 psychiatrists completed the foundation course and over 250, the enhanced course. Participants reported substantial improvements in confidence across key autism-related competencies, and meaningful changes to clinical practice. The programme offers useful insights for future workforce development in this area.

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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.

More effective prevention is the ideal, when this is not possible, we need more effective, evidenced interventions for recovery and restoration of safety.

We are very grateful for any donations to assist us in this mission. Donations help us to fund research projects and educate policy makers and communities.

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