
Article:
Lewis, A., Pritchett, R., Hughes, C. et al. (1 more author) (2015) Development and implementation of autism standards for prisons. Journal of Intellectual Disabilities and Offending Behaviour, 6 (2). pp. 68-80. ISSN 2050-8824

https://doi.org/10.1108/JIDOB-05-2015-0013

Development and Implementation of autism standards for prisons

Introduction

Prison mental health services

Mental health disorders occurring amongst those in custody in England and Wales are generally managed by multidisciplinary mental health teams. These teams may be located within the prison or be a service provided by community based mental health teams undertaking 'in-reach'.

In the past, prison mental health services were commissioned and provided by the Home Office (former name of the Ministry of Justice) separately to the National Health Service's community services. However, these have been integrated within the NHS remit for the past 15 years. This change in commissioning and provision was precipitated by the landmark *'Changing the Outlook'* report (Department of Health, 2001) which introduced the 'principle of equivalency', establishing that healthcare services provided within custodial settings should be of equal to standard to those available outside. It explicitly stated that prison mental healthcare should meet the national standards (National Service Framework, NSF) developed for mental health services in the wider community (Department of Health, 1999).

This new strategy undoubtedly led to improvements in the quality of mental health provision within custodial settings. These services primarily focused on the identification and management of prisoners with severe mental illness (SMI) and the issue of timely transfer to hospital for those whose needs could not be adequately managed in custody (Durcan and Knowles, 2006, Sainsbury Centre for Mental Health, 2007). More recently attention has begun to be focused on those in custody with less acute or severe mental health needs whose needs were often overlooked by services previously. This has led to increased interest in widening services to address conditions such as autistic spectrum disorders, anxiety and mild to moderate depression (Durcan et al., 2014, Exworthy et al., 2012, Forrester et al., 2013).

Autistic Spectrum Disorders

Over the past two decades there has been increasing recognition of the disadvantages facing people who have autistic spectrum disorders (ASD). These are lifelong conditions characterised by qualitative impairments in social communication, social interaction, and social imagination with a restricted range of interests and often stereotyped repetitive behaviours and mannerisms. ASD affects approximately 1% of people.

The clinical expression of ASD is not uniform but varies with an individual, their development, changing environmental demands and with the presence of comorbidities. However, people with ASD typically experience difficulties or misunderstandings in their daily lives as a result of their condition. Recognition of this disadvantage resulted in the

development of the Autism Act, 2009. This placed a duty on the Government to produce a strategy and statutory guidance in relation to people with autism. The strategy, 'Think Autism', was published in 2010 and was updated in 2014 (Department of Health, 2010, Social Care Local Government and Care Partnership Directorate, 2014). In addition to this specific legislation, people with ASD also benefit from the protection provided by the Equalities Act, 2010.

A NHS Confederation report, 'Reasonably Adjusted' (National Development Team for Inclusion, 2012) evaluated adjustments made by NHS mental health services to enable equal access and effective treatment for people with ASD. It established that, while pockets of imaginative and positive practice exist, few mental health services have comprehensively and systematically audited their practice and redesigned their delivery arrangements to ensure that people with ASD obtain fair access and effective interventions.

The rising awareness of the prevalence of autistic spectrum disorders and the difficulties experienced by people with such disorders has prompted those working within the criminal justice system (CJS) to consider how people with ASD experience and interact with the CJS. The "Think Autism" strategy contained actions for the criminal justice system and the Ministry of Justice set up a cross-Government group in order to deliver on these requirements.

Autism and the Criminal Justice System

People with ASD may come into contact with the CJS as a result of being victims of crime, offenders or through misunderstandings related to their behaviour. For those whose contact is a consequence of offending, a proportion will end up being remanded in or sentenced to custody.

There is much uncertainty and conflicting evidence about the prevalence of ASD amongst those coming into contact with the CJS for any reason, and the prevalence amongst defendants in particular. Problems arise due to, amongst other things, the different diagnostic methods used, the different populations studied and the different definitions used.

Most community studies have suggested that there is an average or lower than average rate of offending amongst people with ASD (Woodbury-Smith et al., 2006, Hippler et al., 2010, Ghaziuddin et al., 1991) although higher rates were found in one study (Allen et al., 2008).

Nevertheless several studies have suggested that the prevalence of ASD amongst adult prisoners and those in secure mental health services is greater than that found in the general population. No studies conducted in English prison populations have been published. However, it has been suggested that there are likely to be many individuals with unrecognised ASD in custody (McAdam, 2012, Myers, 2004). This perception is supported by a number of unpublished small scale research projects which suggest elevated levels of ASD

amongst English adult prisoners. A report from Birmingham City Council Health and Social Care in 2012(Overview and Scrutiny, 2012), found that 5.5% of prisoners in Birmingham Prison had a diagnosis or were suspected to have an ASD (80 individuals). Three other prison projects were presented at The Care and Treatment of Offenders with an Intellectual and/or Developmental Disability Conference in 2015; the projects (conducted at four English adult prisons) all found rates of ASD higher than the general population. Three of the establishments used the Autism Quotient Questionnaire (AQ-10) to make diagnoses and found prevalence rates between 5-9%.

Studies undertaken of adult populations in the English high secure hospitals and in a Dangerous & Severe Personality Disorder (DSPD) unit also found significantly increased rates in these specialised groups compared with the general population (Scragg and Shah, 1994, Hare et al., 1999, Hawes, 2003).

Conversely, studies of adult prison populations undertaken in other countries have found much lower prevalence rates (Myers, 2004, Mouridsen et al., 2008, Robinson et al., 2012) creating some doubt as to the true prevalence.

There have been no published studies of the prevalence of ASD amongst English adolescent offenders within secure settings or in the community. This deficit was noted in a recent report by the Children's Commissioner which made a strong recommendation for more research into the identification and management of neurodisabilities, including ASD, in young people who offend (Hughes et al., 2012).

A study found 20% of young offenders in community and custodial settings met criteria for a learning disability (Chitsabesan et al., 2006) and other studies with this population (Bryan et al., 2007, Gregory and Bryan, 2011, Games et al., 2012) indicate approximately 60% have significant speech language and communication needs. These findings suggest that an increased prevalence of ASD in this population could be anticipated.

Studies of young offenders in other countries have consistently found increased rates of ASDs, although there is a wide variability in absolute prevalence between studies. A Japanese study (Kumagami and Matsuura, 2009) found a prevalence rate of 21.4% amongst juveniles attending court. Swedish studies of young offenders referred for community forensic assessments found 15% to have a definite ASD (Siponmaa et al., 2001) and an ASD prevalence of 17% was found amongst detained youth (Ståhlberg et al., 2010). An American study (Cheely et al., 2012) examined the prevalence of young people with ASD amongst those charged with criminal offences in one State, using criminal justice databases and developmental disabilities surveillance records they found a prevalence rate of 5%. A Dutch study of an adolescent forensic clinical population found an ASD prevalence of 24% (Barendregt et al, 2014) whilst a study of a Swedish forensic adolescent clinical population found a prevalence rate of 12% (Anckarsater et al., 2007).

Several reviews have attempted to distil the main conclusions regarding prevalence from the highly varying studies in existence. Most of these reviews (Cashin and Newman, 2009, de la Cuesta, 2010, Mouridsen, 2012) have been selective descriptive reviews, rather than systematic reviews which limits their utility. A recent systematic review(King and Murphy, 2014) has been published. The authors expressed some reservations about the possible confounding effects of the different methodologies and samples used, but noted that all of the existing prevalence studies had rates of more than 1%, leading them to conclude that it was 'likely that people with ASD are somewhat over represented within the CJS'.

This recognition of the likelihood of a significant population of people with ASD within the CJS has prompted consideration as to how they may be identified and their needs addressed.

Management of people with Autistic Spectrum Disorders in prisons

Custody is a challenging environment for most people and may be disproportionately so for people with ASD who have been shown to experience higher than average levels of stress and poorer ability to cope with stress relating to everyday functioning in the community (Hirvikoski and Blomqvist, 2015). This may result in them experiencing unnecessarily high levels of distress whilst in prison and gaining less benefit from attempts at rehabilitation. In addition, the difficulties experienced by prisoners with ASD may adversely impact on everyday prison processes and result in inefficient or increased use of resources or other operational disruption.

From the authors' experience, the difficulties experienced by people with ASD can result in them attracting attention within a custodial environment, although the reasons behind their difficulties may be unrecognised (see case study in chapter 12 of CMO Annual Report(Chief Medical Officer, 2012)). They can be viewed as being deliberately disruptive or rude rather than their behaviour being attributed to distress or misunderstanding. Alternatively, they can experience be victims of bullying but struggle to communicate this to staff and thereby fail to access support.

There has been little work evaluating the experience of people with ASD in custodial settings. A Welsh survey (Allen et al., 2008) of adults with ASD who had come into contact with the CJS found that participants' experiences of being arrested and of court were almost universally poor. The small group who were sentenced to custody found this part of their CJS experience to be more mixed. Whilst there were elements of incarceration that they all found hard, a range of experiences of prison life were viewed very positively by the participants.

In 2013 the National Offender Management Service (NOMS) commissioned the National Autistic Society (NAS) and other charitable bodies to conduct a review of the service provided to prisoners with learning difficulties and disabilities (National Offender

Management Service, 2013). Although the review found that staff knowledge of some aspects of autism was good, it noted they struggled to recognise those aspects in offenders they saw daily and had instead misunderstood their behaviour. There was frustration expressed by staff that they hadn't received information about autism before and could see mistakes they had made in managing situations due to their lack of knowledge and understanding. Some of the individuals with a diagnosis were amongst the most challenging on the wings and managing and understanding their behaviour was problematic. Autism often acted as a 'barrier to engagement' with prison processes.

In January 2014, the Criminal Justice Joint Inspection published Phase 1 of 'A joint inspection of the treatment of offenders with learning disabilities within the criminal justice system'(HMI Probation, 2014). Phase 1 focused on arrest to sentence, Phase 2 (*HMI Probation*, 2015) looked at custody and community. The reports included people with autism. Both publications reported a lack of support and understanding shown by the police, prisons and the courts to people with learning disabilities and with autism. This is consistent with earlier studies of awareness of ASD in the UK Police Force (Chown, 2010, Modell and Mak, 2008).

Although these reports suggested a lack of ability within many prisons to identify and engage with people with ASD, pockets of good practice exist. Several prisons have described their attempts to develop specialist services to improve the identification of offenders with ASD (Underwood et al., 2013, Lewis and Turner, 2014). Both projects have highlighted the unique difficulties encountered by mental health services in successfully meeting the needs of this vulnerable population. These include diagnostic difficulties arising as a consequence of time constraints and difficulties in obtaining adequate developmental histories.

Woodbury-Smith & Dein (2014) highlighted the need for research to be translated into clinical practice. They suggested that training to increase the ability of prison staff to recognise symptoms of ASD, the development of specific pathways of care for individuals with ASD in prison and the introduction of specialist wings for prisoners with ASD may help to improve their custodial experience. In an earlier paper the same authors also highlighted the need for care when managing transitions through the CJS (Dein and Woodbury-Smith, 2010). Another paper suggested that mental health staff could improve the management of prisoners with ASD by undertaking an educational and consultative role with prison and court staff (Freckelton, 2013).

Recognition of the unique challenges inherent in developing effective ASD services within custodial settings and a wish to achieve a more pervasive cross-functional impact on the management of prisoners with ASD prompted the new approach introduced in this paper.

Prison ASD Service

A multidisciplinary specialist autism service has existed within this prison since 2012. This has input from speech and language therapy, nursing, occupational therapy, psychology and medical staff. Assessments involves the young person, a parent/carer and staff members and comprises comprehensive developmental interviews together with the use of several specialist autism tools (typically the Autism Quotient Questionnaire - 50 (AQ50) and the Autism Diagnostic Observation Schedule (ADOS)).

In 2014 the prison ASD service was audited using the Green Light Toolkit(National Development Team for Inclusion, 2013). This is an audit tool which was developed in November 2013 by the National Development Team for Inclusion (NDTI) on behalf of the NHS Confederation in an attempt to address the deficits identified in the *Reasonably Adjusted* report(National Development Team for Inclusion, 2012) amongst NHS services. It provides tools for services to review their provision for people with ASD against national standards, the facility to benchmark against other services and a database of reasonable adjustments made by other NHS organisations which can be reviewed by services seeking to innovate and share learning.

The audit part of the toolkit involves 3 brief audits with increasingly difficult standards ('Basic', 'Better' and 'Best'). The prison ASD service was audited using all three audit scales. The results indicated that the service was operating largely at a 'Better' level. However, it was evident from the findings that, in order to achieve a higher standard of care for people with ASD, it would be necessary to reconceive the management of ASD from being just a mental health responsibility to an approach cutting across all functions and involving the whole prison.

National Autistic Society

The National Autistic Society (NAS) is the UK's leading charity for people affected by autism. It has been running the Autism Accreditation programme since 1992. Autism Accreditation provides an autism-specific quality assurance programme for organisations throughout the UK and across the globe. Successful achievement of the programme's standards is recognised by the award of a kite mark representing endorsement by the NAS. Regular oversight and ongoing audit are important components of the system.

Autism Accreditation standards provide frameworks for good practice. Services are supported by Accreditation Advisors to meet the standards. Continuous improvement through reflective practice and self-evaluation are cornerstones of the framework. Services are able to conduct online self-evaluations through web enabled audit and management reporting systems. Achievement is evaluated by a moderated peer review system reporting to an independent Award Panel before Accredited Status is conferred.

Autism Accreditation has been achieved by a wide range of services including NHS Trusts, GP surgeries, museums, leisure centres, cinemas and private companies. However, it has never been attempted by a correctional facility. The multi-agency applicability of the NAS Autism Accreditation appeared to offer a way to achieve our desired whole prison approach to the identification and management of ASD. Therefore an approach was made to the NAS to collaborate and develop standards suitable for a prison environment.

The timing of this approach fitted well with work that the NAS had already carried out on behalf of the National Offender Management Service (NOMS) in 2013/14 looking at autism awareness in three prisons.

A period of liaison took place between the Accreditation Director of the NAS, the Governing Governor and the Health and Education management leads within the prison and culminated in a partnership arrangement being agreed in late 2014. This landmark project marks the first development of autism standards for prisons worldwide.

Project Aims

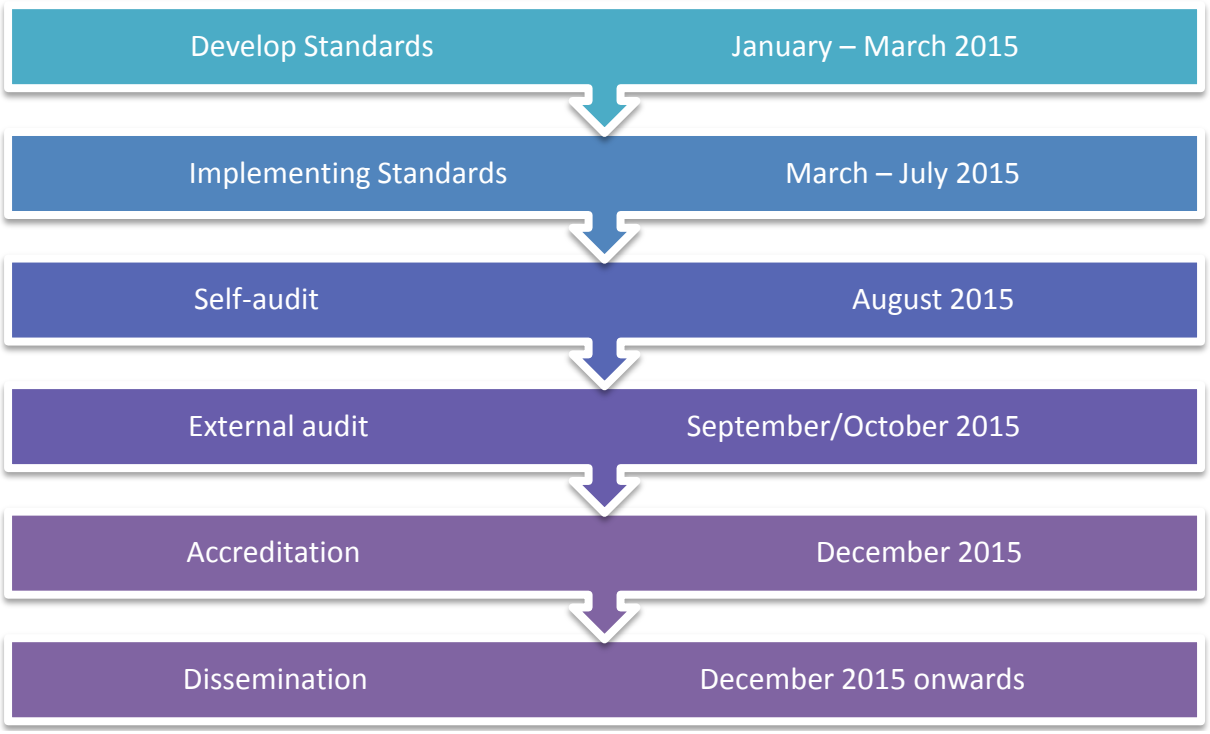
The aims of the project were:

- To develop autism standards specifically for the secure estate.
- To improve partnership working within prisons
- To ensure best practice is delivered across the estate
- Better recognition of the needs of people with autism
- Understanding the reasonable adjustments that can be put in place to support people with autism
- To ensure best outcomes for people with autism

Project Outline

The project was divided into 6 phases which took place over a 12 month period and are summarised in Figure 1.

Figure 1: Timetable for development of standards



Development of Standards

The aim was to develop a set of Autism Accreditation standards that were adapted to the realities of the environment, staffing and management in custody. The standards would set out the appropriate adjustments and levels of understanding and awareness expected across the different functions within the prison.

It was acknowledged from the start that the prison was not a homogenous institution and that it was not reasonable to expect a single level of understanding and standard of practice across the whole establishment. It was agreed that front line discipline and primary care staff should not be expected to have a specialist level of knowledge about ASD but a higher standard should be expected of staff working in mental health and education. Therefore, the prison was divided into four areas for the purposes of the audit: Education, Mental Health, Primary Care and Discipline. Each area would be audited separately and all four areas would need to meet the relevant standards in order for the prison to be awarded Autism Accreditation by the NAS.

The existing NAS Autism Accreditation standards were reviewed and it was agreed that, with some modifications to take account of the unique prison environment, the ones for Education and Forensic Mental Health Services could be used to evaluate these departments within the prison. Separate and less technically demanding standards were also in existence (the Autism Access Award) and it was agreed that, with some amendments, these could be used to audit Primary Care services including nursing, GPs,

opticians and dentists. However, nothing existed which would be appropriate to use as a framework to evaluate the Discipline quadrant so these standards were developed *de novo.*

A steering group was set up with representation from Mental Health, Primary Care, Education and Discipline and also from the NAS. It was chaired by a senior prison governor and met monthly. Each of the four areas to be evaluated set up internal working groups which met regularly and reported their progress back to the monthly steering group meeting.

The first task of the steering group was to evaluate the existing standards for Mental Health, Education and Primary Care and work out whether they needed amending and, if so, how this could be achieved without diluting the stringency of the standard. The evaluation considered the impact of each standard at each stage of a person's journey through the prison from reception to release/transfer.

The second task was to develop a new 'discipline' standard which would be used to evaluate the sensitivity of the everyday prison processes and environment to the needs of people with autism. This was achieved by considering which aspects of everyday life within the prison were likely to impact on a prisoner with ASD and to develop frameworks of good practice around these. The evaluation considered the effect of the processes affecting the whole pathway from reception to release and considered how they should be amended to improve the identification and support prisoners with ASD. The frameworks developed were then used as the basis for the new audit standards.

For each of the four audit areas standards were set for Statements of Intent & Policy, Admission & Advance Information, Environment, Routines & Procedures, Training, Safeguarding, Monitoring of Outcomes and Feedback and Discharge.

Below are examples taken from standards from each of the 4 areas (discipline, education, mental health and primary care) together with illustrations of how the prison tried to meet these standards.

Figure 2:

Extract from Subtopic 6.1 of Discipline Standards: Managing behaviours of concern and encouraging positive behaviour

1. Are staff offered guidance on how to apply the de-escalation training to situations that cause difficulties for prisoners with autism?

Evidence:

- *The Minimising and Managing Physical Restraint package has been modified to include information about ASD specifically sensory issues relevant to restraint*
- *Control and Restraint (C&R) training within the prison has been amended to provide staff with an awareness of issues that may arise if a person with ASD needs to be restrained or observes another person being restrained and how to manage these.*

6. In what ways is autism taken in to account in adjudications?

Evidence:

- *All adjudicating governors have received bespoke training to increase their understanding of ASD and how it may influence a prisoner's participation in the adjudications process.*
- *A system is in place so that, prior to each adjudication, the adjudications officer contacts the prison mental health team to ascertain whether there are any known mental health issues (such as an ASD) which need to be considered.*
- *Adjudicating governors have a low threshold for adjourning adjudications should they suspect an undiagnosed ASD or other mental health issue is adversely affecting the adjudication process to enable a mental health opinion to be obtained.*

Figure 3:

Extract from Subtopic 3.1 of Education Standards: The Learning Environment

1. Are sessions delivered in an uncluttered, ordered environment with clearly defined spaces and clear visual clues to enable confident movement from one area to another?

   Evidence:
   - *Wherever possible classrooms have desks arranged to allow easy flow of movements – typically in a C or U shape with plenty of space in the middle.*
   - *The classrooms are designed to accommodate between 8 and 12 learners depending on the size of the class*
   - *A dedicated room is available for 1:1 learning support and quiet timeout if needed*
   - *Classrooms are clearly marked and learners are directed to classroom by prison staff on arrival to department*
   - *Easy read timetables on walls*

2. Are education staff made aware of the environmental issues and potential strategies to reduce the anxiety that people with autism might experience?

   Evidence:
   - *This is specifically addressed in staff training sessions and materials*
   - *Easy read timetables are displayed on wall*
   - *Any changes in set timetables are given well in advance and explained to students when necessary.*
   - *Low stimulus room available for de-escalation/ time out*
   - *Small class sizes minimise noise levels*
   - *1:1 teaching available for those unable to tolerate group lessons*

Figure 4

Extract from Subtopic 5.1 of Mental Health Standards: Training and Development

Subtopic 5.1: Do all relevant staff have sufficient knowledge and understanding of autism spectrum disorders to enable them to fulfil their role effectively?

1. Do clinicians, qualified and non-qualified staff including medical practitioners and the wider Multi- Disciplinary Team have autism specific qualifications, training in autism or experience of autism appropriate to the needs of their role?

Evidence:

- *All members of CMHT have undertaken in-house ASD training*
- *Licences purchased enabling selected CMHT staff to complete specialist online autism training (NAS Ask Autism modules)*
- *The team's consultant psychiatrist and speech and language therapist have Autism specific qualifications and are highly experienced in the diagnosis and management of ASD and existing comorbidities.*

2. Are there a range of therapeutic interventions available to meet the needs of the person with autism, run by appropriately trained clinicians?

Evidence:
A range of therapeutic interventions are delivered by the CMHT which address both the core features of ASD and comorbidities including:

- *Individual speech, language and communication therapy sessions*
- *Social skills training*
- *Anxiety/stress management*
- *Relaxation sessions*
- *Behavioural management*
- *Activity scheduling*
- *Medication*

Figure 5

Extract from Subtopic 8.1 of Primary Care Standards*:* Communication and Sensory Sensitivities

1. Is there a body map available where individuals can indicate places they like or dislike to be touched and which they can use to indicate where pain or discomfort is experienced?

   Evidence

   - *Body maps available in primary care for use of staff*
   - *Body map incorporated into SystmOne templates*

2. Are staff conducting appointments aware of Hyper and hypo sensitivity and are these taken into account when conducting appointments?

   Evidence:

   - *Healthcare staff have engaged in training around sensory sensitivities and strategies to manage these*
   - *Healthcare staff have access to factsheet on ASD and strategies*
   - *A member of nursing staff with additional autism training is on duty at all times*

The third task was to begin a programme of increasing staff awareness about ASD throughout the prison. It was decided that, in addition to regular training session, to appoint 25 'Autism Champions' within the prison who would undergo special training about ASD so that they could act as a resource for other staff. Staff from all prison departments were invited to register to become 'Autism Champions' and the response was excellent. All came with a high level of enthusiasm and many came with valuable personal experience of ASD through having friends or family members with the diagnosis or having previously worked closely with offenders with ASD. Care was taken to ensure that champions were appointed from a range of departments. Training involved a mixture of face to face sessions delivered by mental health and NAS staff and online training using the NAS 'Ask Autism' online training modules.

Testing of Standards

Once the standards had been developed the project moved on to testing them. This was with two aims. First to check the relevance and feasibility of the standards and secondly to

determine how each function could evidence that it is meeting each standard. It was agreed it would be helpful to use interviews with staff and service users as well as traditional paper gathering techniques as evidence.

Audit

A comprehensive internal audit took place in August 2015 and the NAS independent audit will occur in September 2015. It was decided that it would be sensible for the audit team to include staff from other prisons, as the environment is specialised and it could take an audit team unfamiliar with such a context additional time to understand the setting before being able to complete the audit process.

The audit will comprise a 'walk through' the prisoner journey by a member of the audit team, from reception, to induction units, to residential wings and education/workshops. This will be undertaken as though the team member doing the walk through were a prisoner with autism. The audit will also include opportunities to observe lessons and workshops as well as interviews with key staff across a range of functions including the Governing Governor. Several opportunities will be provided for inspectors to speak to prisoners about their experiences. Paperwork such as policies and procedures, training packages and resources and prisoner and carer feedback will also be inspected.

If each area within the prison meets at least 85% of its standards and has plans as to how it will achieve the remaining 15% of standards, then the prison will be awarded Autism Accreditation status by the NAS. This will be a great achievement but will not mark the end of the process as it is intended that a once every three years audit cycle will continue and that continuing improvements will be made. Staff from NAS Autism Accreditation will continue to support the prisons between audit to encourage continuous development and provide oversight.

It has been a significant and time-consuming piece of work, developing and implementing the standards, and it will be important to be sure of the effectiveness of this ongoing project. We will evaluate this with a range of outcome measures including:

- Use of force, in levels of violence, adjudications and negative reports.
- Safety for prisoners with autism, other prisoners and staff.
- Barriers to engagement with prisoners with autism
- Effects on rehabilitation, early release and rates of re-offending
- Management of co-morbid health issues for prisoners with autism.
- Staff sickness rates

we will report our findings in a follow up paper.

Dissemination of learning

As knowledge about the project has become widespread both the prison and the NAS have been contacted by a number of other prisons which have recognised the difficulties experienced by people with ASD within their establishments and are interested in learning from our experience. The work has attracted Ministerial attention and in March 2015 the Prisons Minister issued a statement encouraging all prisons to seek Autism Accreditation(Ministry of Justice, 2015).

A Network Meeting was held in June 2015 at which practical advice and learning points were shared with other prisons who had registered an interest in seeking similar Autism Accreditation. Discussion also took place to decide on appropriate ways to evidence meeting of standards. From June 2015, three other establishments joined the pilot to ensure that the standards are transferrable across the adult estate and to other prisons.

A group has been developed to share best practice across the other prisons participating in the Autism Accreditation process.

Pilots are also due to begin developing similar standards with the Community Rehabilitation Companies (part of the National Probation Service) and the Police.

Implications for Practice

The consequences of the successful implementation of these standards are likely to include reduced distress for people with ASD and improved engagement with rehabilitative and day to day prison processes. This is likely to offer prisoners benefits both within the custodial environment and post-release. It will also enable prisons to meet the duties imposed on them by the Autism Act and Equalities Act to make 'reasonable adjustments' to their services in order to ensure that people with autism obtain fair access and effective interventions.

The implementation of these standards is particularly relevant for Young Offenders Institutions (YOIs). A new tool has been developed to improve the identification of health problems amongst young offenders, the new Comprehensive Healthcare Assessment Tool(Shaw et al., 2014), this incorporates a specific screen for ASD which is likely to lead to increased detection of these disorders. The CHAT is now compulsory for all receptions into youth custody (and there are plans to extend its use to Youth Offending Services in the future). Implementation of these autism standards in YOIs could ensure that a framework of good practice exists to support young people identified as having ASD by the CHAT.

Implementation of these standards is likely to require allocation of staff time and some costs in relation to staff training. Training costs can be minimised by using the prison mental health team to provide staff training. It is hoped that once implemented the new framework of care will mean that the prison is better able to meet the needs of people with ASD and

result in less disruption to everyday processes, increasing overall efficiency within the prison.

References

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**,** 748-758.

ANCKARSATER, H., NILSSON, T., STAHLBERG, O., GUSTAFSON, M., SAURY, J.-M., RÅSTAM, M., GILLBERG, C., ANCKARSÄTER, H. & STÅHLBERG, O. 2007. Prevalences and configurations of mental disorders among institutionalized adolescents. *Developmental Neurorehabilitation,* 10**,** 57-65.

BARENDREGT C, BONGERS I, VAN DER LAAN A, VAN NIEUWENHUIZEN C (2014) Prevalence of ASD in youth forensic psychiatry and associated offending behaviour. Youth, Risk and Mental Health: Multiple Roads to recovery. 4th European Congress for Forensic Adolescent Psychiatry, Psychology and other involved Professions. Manchester

BRYAN, K., FREER, J. & FURLONG, C. 2007. Language and communication difficulties in juvenile offenders. *Int. J. Lang. Commun. Disord.,* 42**,** 505-520.

CASHIN, A. & NEWMAN, C. 2009. Autism in the criminal justice detention system: A review of the literature. *Journal of Forensic Nursing,* 5**,** 70-75.

CHEELY, C., CARPENTER, L., LETOURNEAU, E., NICHOLAS, J., CHARLES, J. & KING, L. 2012. The Prevalence of Youth with Autism Spectrum Disorders in the Criminal Justice System. *Journal of Autism and Developmental Disorders,* 42**,** 1856-62.

CHIEF MEDICAL OFFICER 2012. Annual Report. Our Children Deserve Better:Prevention Pays. *In:* HEALTH, D. O. (ed.). London.

CHITSABESAN, P., KROLL, L., BAILEY, S., KENNING, C., SNEIDER, S., MACDONALD, W. & THEODOSIOU, L. 2006. Mental health needs of young offenders in custody and in the community. *British Journal Of Psychiatry,* 188**,** 534-540.

CHOWN, N. 2010. 'Do You Have Any Difficulties That I May Not Be Aware of?' A Study of Autism Awareness and Understanding in the UK Police Service. *International Journal of Police Science & Management,* 12**,** 256-273.

DE LA CUESTA, G. 2010. A selective review of offending behaviour in individuals with autism spectrum disorders. *Journal of Learning Disabilities and Offending Behaviour,* 1**,** 47-58.

DEIN, K. & WOODBURY-SMITH, M. 2010. Asperger syndrome and criminal behaviour. *Advances in Psychiatric Treatment,* 16**,** 37-43.

DEPARTMENT OF HEALTH 1999. **National service framework: Mental Health**. *In:* HEALTH, D. O. (ed.). London.

DEPARTMENT OF HEALTH 2001. **Changing the outlook: a strategy for developing and modernising mental health services in prisons**. *In:* **HEALTH, D. O.** (ed.). London.

DEPARTMENT OF HEALTH 2010. **Think Autism: Fulfilling and rewarding lives: the strategy for adults with autism in England**. *In:* **HEALTH, D. O.** (ed.). London.

DURCAN, G. & KNOWLES, K. 2006. London's prison mental health services: A review. London: Sainsbury Centre for Mental Health.

DURCAN, G., SAUNDERS, S., GADSBY, B. & HAZARD, A. 2014. The Bradley Report five years on: An independent review of progress to date and priorities for further development. London: Centre for Mental Health.

EXWORTHY, T., SAMELE, C., URQUÍA, N. & FORRESTER, A. 2012. Asserting Prisoners' Right to Health: Progressing Beyond Equivalence. *Psychiatric Services,* 63**,** 270-275.

FORRESTER, A., EXWORTHY, T., OLUMOROTI, O., SESSAY, M., PARROTT, J., SPENCER, S.-J. & WHYTE, S. 2013. Variations in prison mental health services in England and Wales. *International Journal of Law and Psychiatry,* 36**,** 326-332.

FRECKELTON, I. 2013. Autism Spectrum Disorder: Forensic Issues and Challenges for Mental Health Professionals and Courts. *J. Appl. Res. Intellect. Disabil.,* 26**,** 420-434.

GAMES, F., CURRAN, A. & PORTER, S. 2012. A small-scale pilot study into language difficulties in children who offend. *theory, research and practice in educational psychology,* 28**,** 127-140.

GHAZIUDDIN, M., TSAI, L. & GHAZIUDDIN, N. 1991. Brief report: Violence in asperger syndrome, a critique. *J Autism Dev Disord,* 21**,** 349-354.

GREGORY, J. & BRYAN, K. 2011. Speech and language therapy intervention with a group of persistent and prolific young offenders in a non-custodial setting with previously undiagnosed speech, language and communication difficulties. *International Journal of Language and Communication Disorders,* 46**,** 202-215.

HARE, D. J., GOULD, J., MILLS, R. & WING, L. 1999. *A preliminary study of individuals with autistic spectrum disorders in three special hospitals in England*. London: *National Autistic Society*.

HAWES, V. *Developmental disorders in prisoners volunteering for DSPD assessment*. *In:* DALE, C. & STOREY, L., eds. The 2nd International Conference on the Care and Treatment of Offenders with a Learning Disability, 2003.

HIPPLER, K., VIDING, E., KLICPERA, C. & HAPPÉ, F. 2010. Brief Report: No Increase in Criminal Convictions in Hans Asperger's Original Cohort. *J Autism Dev Disord,* 40**,** 774-780.

HIRVIKOSKI, T. & BLOMQVIST, M. 2015. High self-perceived stress and poor coping in intellectually able adults with autism spectrum disorder. 19**,** 752-757.

HMI PROBATION 2014. *A joint inspection of the treatment of offenders with learning disabilities, within the criminal justice system – phase one - from arrest to sentence*. *In: PROBATION, H. M. S. I. O.* (ed.). Manchester.

HMI PROBATION 2015. *A joint inspection of the treatment of offenders with learning disabilities, within the criminal justice system – phase two – in custody and the community*. *In: PROBATION, H. M. S. I. O.* (ed.). Manchester.

HUGHES, N., WILLIAMS, H., CHITSABESAN, P., DAVIES, R. & MOUNCE, L. 2012. Nobody made the connection: The prevalence of neurodisability in young people who offend. *In:* COMMISSIONER, T. O. O. T. C. S. (ed.). London.

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**,** 2717-2733.

KUMAGAMI, T. & MATSUURA, N. 2009. Prevalence of pervasive developmental disorder in juvenile court cases in Japan. *The Journal of Forensic Psychiatry & Psychology,* 20**,** 974-987.

LEWIS, A. & TURNER, K. 2014. Developing a 'better' Autistic Spectrum Disorder service in a Young Offenders' Institution. *Youth, Risk and Mental Health: Multiple Roads to recovery. 4th European Congress for Forensic Adolescent Psychiatry, Psychology and other involved Professions.* Manchester.

MCADAM, P. 2012. Knowledge and understanding of the autism spectrum amongst prison staff. *Prison Service Journal***,** 26-30.

MINISTRY OF JUSTICE 2015. Prisons seeking National Autistic Society Help to improve support for prisoners. London: Ministry of Justice.

MODELL, S. J. & MAK, S. 2008. A Preliminary Assessment of Police Officers' Knowledge and Perceptions of Persons With Disabilities. *Intellectual and Developmental Disabilities,* 46**,** 183-189.

MOURIDSEN, S., RICH, B., ISAGER, T. & NEDERGAARD, N. 2008. Pervasive Developmental Disorders and Criminal Behaviour: A Case Control Study. *International Journal of Offender Therapy and Comparative Criminology,* 52**,** 196-205.

MOURIDSEN, S. E. 2012. Current Status of Research on Autism Spectrum Disorders and Offending. *Research in Autism Spectrum Disorders,* 6**,** 79-86.

MYERS, F. 2004. *On the Borderline? People with Learning Disabilities and/or Autistic Spectrum Disorders in Secure, Forensic and Other Specialist Settings*. *In: HEALTH, S. D. C. F. M.* (ed.).

NATIONAL DEVELOPMENT TEAM FOR INCLUSION 2012. Reasonably adjusted? Mental Health Services for People with Autism and People with Learning Disabilities. *In:* HEALTH, D. O. (ed.). London.

NATIONAL DEVELOPMENT TEAM FOR INCLUSION 2013. Green Light Toolkit 2013: A guide to auditing and improving your mental health service so that it is effective in supporting people with autism and people with learning disabilities. *In:* HEALTH, D. O. (ed.). London.

NATIONAL OFFENDER MANAGEMENT SERVICE 2013. Improving Services for Offenders with Learning Disabilities and Learning Difficulties: A Literature Review. *In:* SERVICE, N. O. M. (ed.).

ROBINSON, L., SPENCER, M. D., THOMSON, L., STANFIELD, A., OWENS, D., HALL, J. & JOHNSTONE, E. C. 2012. Evaluation of a Screening Instrument for Autism Spectrum Disorders in Prisoners. *Plos One,* 7.

SAINSBURY CENTRE FOR MENTAL HEALTH 2007. Getting the Basics Right: Developing a Primary Care Mental Health Service in Prisons. *In:* HEALTH, S. C. F. M. (ed.). London.

SCRAGG, P. & SHAH, A. 1994. Prevalence of Asperger's syndrome in a secure hospital. *British Journal of Psychiatry,* 165**,** 679-682.

SHAW, J., BAILEY, S., TARBUCK, P., CHITSABEAN, P., THEODOSIOU, L., LENNOX, C. & ET AL 2014. The Comprehensive Health Assessment Tool (CHAT). Manchester: The Offender Health Research Network.

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**,** 420-426.

SOCIAL CARE LOCAL GOVERNMENT AND CARE PARTNERSHIP DIRECTORATE 2014. Think Autism: Fulfilling and Rewarding Lives, the strategy for adults with autism in England: an update. *In:* HEALTH, D. O. (ed.). London.

STÅHLBERG, O., ANCKARSÄTER, H. & NILSSON, T. 2010. Mental health problems in youths committed to juvenile institutions: prevalences and treatment needs. *Eur Child Adolesc Psychiatry,* 19**,** 893-903.

UNDERWOOD, L., FORRESTER, A., CHAPLIN, E. & MCCARTHY, J. 2013. Prisoners with neurodevelopmental disorders. *Journal of Intellectual Disabilities and Offending Behaviour,* 4**,** 17-23.

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**,** 2734-2741.

WOODBURY-SMITH, M. R., CLARE, I. C. H., HOLLAND, A. J. & KEARNS, A. 2006. High functioning autistic spectrum disorders, offending and other law-breaking: findings from a community sample. *The Journal of Forensic Psychiatry & Psychology,* 17**,** 108-120.