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Autistic people within forensic psychiatric services and the criminal justice system: A systematic review

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ABSTRACT

Understanding autism prevalence within the Criminal Justice System (CJS) and forensic settings has implications for identifying clinical/forensic needs, planning responses, potentially improving outcomes. This systematic review aimed to synthesise studies investigating autism prevalence within CJS/forensic cohorts, and the prevalence of CJS/forensic involvement in autistic cohorts. Searches were conducted on 6 June 2023, alongside backward searching and expert consultation. Studies were synthesised narratively with reporting quality appraised. The search yielded 6481 articles. Following duplicate removal, titles and abstracts of 4207 articles were screened; 71 articles were full text screened and 41 met eligibility criteria. Prevalence rates of autism in CJS/forensic settings were examined in 25 studies, varied from 0–60%, with rates of autism higher than the general population prevalence estimate of 1% in 24 of 25 included studies. Prevalence rates of CJS/forensic involvement in autistic populations were examined in 16 studies, with reported rates varying by 3–71%. Studies examining prevalence of CJS/forensic involvement among autistic people indicate a rate of offending at a lower, or equivalent level to comparison samples. However, studies examining autism prevalence within CJS/forensic settings suggest over-representation. Possible explanations fall within three categories: pre-sentencing factors, autistic offender factors or post-sentencing factors. Implications for practice and research are discussed.

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Introduction

Understanding the forensic involvement of autistic people, and their prevalence in forensic psychiatric and CJS contexts is critical. Additional support is required for this group at every stage, in order that their rights are upheld, outcomes are fair and equal, and to provide opportunities to intervene, through preventative or rehabilitative programmes. The Global Autism and Criminal Justice Consortium (Cooper et al., 2022; Shea et al., 2021) described the seven-point Sequential Intercept Model for analysing points of contact (or 'intercepts') with the CJS, where intervention could divert individuals from further involvement. These contact points are 0) Community Services, 1) Law Enforcement, 2) Initial Detention and Investigation, 3) Courts, 4) Prisons/Jails/Confinement, 5) Re-entry to Society, and 6) Community Corrections. Issues with autistic interactions at each intercept can be mapped, and a subsequent roadmap put in place for policy, practice, and research improvements.

One of the critical factors affecting autistic people in community settings is access to diagnosis. Late recognition of autism is associated with several negative outcomes (Mandy et al., 2022). Nationally, the diagnosis of autism has been described as a broken system by autism charities, with 204,876 people in England on the waiting list for an assessment in 2024, many waiting months or years (NHS England, 2024), and with variations in diagnostic approaches between clinics and geographic locations affecting diagnosis rates (O'Nions et al., 2023). Norris et al. (2025) investigated the availability, efficacy, and experiences of post-diagnostic support for autistic adults. They reported that autistic adults desired low-level support services, psychoeducation, and peer support, but that provision of this standard of care was patchy, with many services only providing information and 'signposting'. This leaves people struggling without the right support and pushes some into mental health crisis (National Autistic Society, 2024). Indeed, it is often as part of a psychiatric assessment following an offence, that autism is recognised for the first time (Billstedt et al., 2017; Heeramun et al., 2017; Kawakami et al., 2012). These psychiatric assessments often reveal complex psychopathology with co-existing conditions including other neurodevelopmental disorders, like Attention Deficit Hyperactivity Disorder (ADHD), mental illnesses, personality disorders, trauma, physical health problems (Billstedt et al., 2017), and increased likelihood of self-harm and suicidality (Kim et al., 2024). Late diagnosed adults have reported the use of maladaptive coping strategies such as alcohol or drug abuse (Lupindo et al., 2023) which in turn could increase the risk of CJS involvement.

Those who have received an autism diagnosis in adulthood have expressed that it has helped them with greater self-acceptance and increased understanding of their autism-related challenges and how to manage them (Lupindo et al., 2023). Smith (2021) describes several cases where a person's

autism went unrecognised in community settings, throughout childhood, education, and despite years of evaluation from clinical teams, until eventually being diagnosed after several years of offending behaviour, prison incarcerations and admissions to forensic psychiatric services, which the author attributes to low autism awareness among professionals. When the diagnosis of autism was made, it enabled increased understanding of the person and reformulation of their difficulties, autism focused psychoeducation for the individual and their treating team, and ultimately treatment progress within their forensic pathway. There are many other factors influencing an autistic person's likelihood or interacting with the CJS. When considering vulnerability to offending in autism, general criminological risk factors are relevant, e.g. poor educational achievement or ADHD; as well as autism-specific risk factors, such as poor social understanding, circumscribed interests, difficulties in adjusting to the diagnosis, and social exclusion (Woodbury-Smith et al., 2005, 2006).

Once within the CJS, autistic people have an increased likelihood of negative experiences, such as use of force within police interactions, or having their communication needs unaddressed during court appearances (Archer & Hurley, 2013). Within prison or forensic psychiatric services, autistic individuals may be more vulnerable to experiencing bullying, exploitation, social isolation, and altercations with other inmates (Allely, 2015). Helverschou et al. (2018) highlighted that the processes of arrest, investigation, trial and imprisonment are often extremely difficult for this population. They interviewed nine autistic offenders in Norway about the circumstances surrounding their criminal acts, their views of the arrest, the police interrogation, the trial, the defence and their experiences of being in prison and/or life following the offence. Participants in this study highlighted their difficulties in unfamiliar situations, feelings of confusion about the reasons for their arrest, difficulties understanding the seriousness of their crimes, challenges understanding trial proceedings, and feelings of having their case misunderstood or poorly represented by defence lawyers. All six participants in this study who had experienced custodial sentences felt they coped well in prison, possibly due to environmental factors that had not been provided previously (e.g. structure and predictability). However, the authors felt this also reflected 'a sad indictment of the services and support available in the community that, for so many, prison was viewed as a mainly positive experience.'

Researchers have suggested that autistic offenders have different clinical and forensic profiles to the general offender population. Haw et al. (2013) reported that autistic forensic psychiatric patients were more likely to be admitted from prison or courts, possibly suggesting more serious offending, and offending behaviour was described as atypical, involving uncommon offences, e.g. arson, harassment, or stalking. It has been indicated that among autistic people who have offended, violent or sexual crimes are higher

than in comparison groups, while property offences are lower (Cheely et al., 2012; Kumagami & Matsuura, 2009) although this needs examining in larger, representative forensic samples. Furthermore, unlike the general offender population, Murphy (2003) reported that no high-secure patients with Asperger syndrome[1] had a history of serious antisocial behaviour or criminal convictions before age 18.

Despite this, autistic offenders are typically placed on conventional rehabilitation programmes (Murphy, 2010a), primarily developed for patients with personality and psychotic disorders, which have not been evaluated on this population. A recent systematic review evaluated the evidence of the effectiveness of interventions targeting recidivism for autistic offenders without intellectual disability and assessed whether core autistic features impact the effectiveness of these interventions (Salter & Blainey, 2024). The review included seven studies involving 10 male participants; three case reports, two qualitative studies, and two quantitative case series, published between 2002 and 2020. Four of these studies were psychological interventions, and these included adapted forms of cognitive behavioural therapy (CBT), the Adapted Sex Offender Treatment Program (A-SOTP) and the Equipping Youth to Help One Another Programme (EQUIP). The findings suggest that interventions for offending behaviours in autistic adults without intellectual disability (ID) are largely inadequate, but that the findings should be treated with caution due to a critical lack of research, especially randomised controlled trials, studies being concentrated in one geographical area of England, including only male participants, a lack of interventions reported from prison or probation and a preponderance from secure hospitals. The authors reported that included studies were of inadequate quality owing to various design limitations, and a lack of standardisation in both clinical and research methodologies within this field. These challenges are exacerbated by unavoidable confounding variables, the risk of bias, and the ethical implications of a no-treatment group, all of which contribute to the lack of evidence. An earlier review, which included treatments for people with ID, described 13 interventions, all of which were case series/reports with little or no direct comparisons to offenders without autism, with variability in treatment approach and impact (Melvin et al., 2017).

Understanding autism prevalence within CJS/forensic settings has significant implications for understanding the clinical and forensic needs of this population, planning of autism-specific responses, thereby potentially improving outcomes. We build on previous systematic reviews in this area which also examined prevalence, but which also focused on other aims such as assessing the types of offences committed by autistic people (Collins et al., 2023; King & Murphy, 2014). By focusing solely on prevalence, this will enable a depth of analysis on the myriad factors which can affect rates, such as the

approaches to screening and diagnosis described within papers. Therefore, the aim of this review was to systematically identify and synthesise studies that:

(1) investigate autism prevalence within CJS/forensic cohorts (i.e. studies that examine the number of autistic people within prisons, forensic psychiatric services, courts, or the youth secure estate); or,
(2) explore the prevalence of CJS/forensic involvement in autistic cohorts (i.e. studies examining self-reported criminal behaviour within community autistic samples, or those presenting official criminal records, such as police contact, charges and convictions among autistic cohorts); and,
(3) critically analyse the approaches to autism screening and diagnosis within these studies.

Relatedly, we attempt to answer the following research questions:

(1) How prevalent are autistic people within CJS/forensic cohorts?
(2) How prevalent is forensic/CJS involvement within autistic cohorts?
(3) How is autism being screened for, assessed and diagnosed within these studies?

Method

Search protocol

For this systematic review, a broad search strategy was employed, combining autism and forensic/CJS-related search terms adapted from a Cochrane review (Dennis et al., 2012) (crim* OR incarcerate* OR custod* OR delinq* convict* OR inmate* OR crime* OR offend* OR prison* OR forensic OR secure OR polic* OR probation) and autism terms (autis* OR Asperger* OR ASD OR ASC OR PDD OR pervasive developmental dis* OR neurodevelopmental dis*). The following electronic databases were searched from inception to 6 June 2023; Allied and Complementary Medicine (AMED), Cumulative Index to Nursing and Allied Health Literature (CINAHL), Excerpta Medica Database (EMBASE), ERIC, MEDLINE, and PsycINFO. The journal Advances in Autism was searched separately, due it being less well indexed. For this journal, as all the articles are autism-related, only the forensic search terms were used. Backward searching of articles that met the eligibility criteria for inclusion was also conducted. In line with the eligibility criteria, the search was limited to English language results. All titles and abstracts of articles that remained following removal of duplicates and non-English language results were screened against the eligibility criteria, by two investigators (VC and CM).

Upon initial screening, if papers met the inclusion criteria, full texts were accessed. Inter-rater reliability for the full texts was completed by two authors (VC and CM) and was initially, $k = 0.75$, indicating a good level of agreement between the two raters, which increased to $k = 1$, or 100% agreement following discussion. The review was registered on the PROSPERO database (Registration No. CRD42018087125).[2]

Eligibility criteria

Studies were included if they investigated the prevalence of autism within a CJS/forensic population, either where all participants were subjected to autism screening and assessment, or where studies reported autistic people identified through routine clinical practice. Studies examining the prevalence of CJS/forensic involvement in samples of autistic people were included provided the sample was diagnosed with autism, and the nature of CJS/forensic involvement was clearly reported (e.g. arrest, appearance at court, prison sentence, or detention). The eligibility criteria build on those described by King and Murphy (2014) and are outlined in Table 1.

Data extraction

For each article, data were extracted pertaining to the year and location of the study, the number of participants, mean age, sex, ethnicity composition of

Table 1. Eligibility criteria.

Inclusion criteria	Exclusion criteria
• English-language • Peer reviewed journal • Participants had a diagnosis of autism according to clinical criteria (ICD-10 (World Health Organisation, 1993); or DSM-IV-TR or 5) (American Psychiatric Association, 1994), or with a reported procedure for screening and assessing autism. • Participants involved in the CJS/forensic settings, i.e. police, courts, prison service, secure hospitals, probation; or participants within studies from other clinical settings/populations, but which measured CJS/forensic involvement using a clear definition. • Participants over the age of criminal responsibility in the study country (e.g. 10-years of age within England and Wales). • Authors report prevalence data or data that can be extracted to compute a prevalence estimate.	• Non-English language papers • Grey literature • Studies solely using measures of autistic symptoms/screening tools (e.g. that were not followed up with a diagnostic assessment). • Studies focused upon autistic witnesses/victims. • Literature reviews (including systematic reviews or meta-analyses). • Failing to satisfy the inclusion criteria (e.g. studies on secure attachment), or focusing on research topics unrelated to, yet with the same acronym of Autism Spectrum Disorder (such as Acute Stress Disorder), • Studies including participants with self-reported autism.[3] • Articles not including primary data, such as being book chapters/literature reviews, editorials, commentary, opinion, conference abstracts/proceedings • Dissertations which have not been peer reviewed.

the sample, and the population sampled (e.g. inpatients, prisoners). The methods employed for the diagnosis of autism and intellectual disabilities (if relevant) were recorded, alongside the definition of forensic/CJS involvement. Prevalence rates of autism were extracted for the studies focused on CJS/forensic settings and cohorts (studies that examine the number of autistic people within prisons, forensic psychiatric services, courts, or the youth secure estate), and rates of forensic/CJS involvement for the studies investigating in autistic populations (i.e. studies examining self-reported criminal behaviour within community autistic samples, or those presenting official criminal records, such as police contact, charges and convictions among autistic cohorts) were extracted and reported. Data were extracted 6 July 2023 by the first author. The Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA) checklist was followed, and how this was reported is detailed in Table 4 (Page et al., 2021).

Quality appraisal

No study design specifications were set for inclusion within the review. This was due to the anticipated variability in methodology of included studies as reported by others (King & Murphy, 2014). The Mixed Methods Appraisal Tool (MMAT) (Hong et al., 2018) was used to evaluate the quality of included studies. The MMAT is a 21-item checklist, used to rate the quality of quantitative (including cohort studies, cross-sectional studies, longitudinal studies, case-control studies and descriptive studies), qualitative, and mixed methods studies selected for review. Each article was appraised and scored using the criteria provided in the MMAT user guide (2018) by the first author. The MMAT guidance was reviewed by the study team ahead of this process, and support was provided by co-author CM in any areas of uncertainty regarding the quality score, so that there was agreement. Studies were appraised based on five areas relating to the appropriateness of methodology, data analysis techniques and data collection techniques, the representativeness of the sample, reliability of outcome data, and the researchers' interpretation of research findings.

Terminology

The terminology used to discuss autism has been the subject of research in recent years, with a move away from medical language to neuro-affirming language (Bottini et al., 2023). Arguments have been made that person-first terminology (e.g. 'people with autism') may perpetuate stigma by drawing attention to a disability through unconventional language, with disability advocates expressing preferences for identity-first language. A study assessing the language preferences of 654 English-speaking autistic adults

worldwide reported that though there were variations in terminology preference, the most popular terms were 'Autism', or 'Autistic person' (Keating et al., 2023). As such, within this paper, we will use these terms wherever possible, except where directly referring to a term or diagnosis used within a cited paper, to report their methodologies accurately. In this review, we use the term criminal justice system/CJS to refer to studies involving the police, courts, and prison, and the term forensic to refer to studies set within forensic psychiatric inpatient services or focused on cohorts who underwent forensic psychiatric examination/assessment (FPE/FPA).

Results

As highlighted within the PRISMA diagram (Figure 1), the database search yielded a total of $n = 6481$ articles. From the separate search of Advances in Autism, further 43 papers were identified, and two papers were identified from backward searching. Following removal of duplicates, $n = 4207$ articles remained for screening. Upon title and abstract screening, 4136 articles were excluded for reasons including focusing on research topics unrelated to, yet with the same acronym of Autism Spectrum Disorder (such as Acute Stress Disorder), failing to satisfy the inclusion criteria (e.g. studies on secure attachment), or not being published in English language. Additional reasons for exclusion were articles not including primary data, such as being book chapters/literature reviews, editorials, commentary, opinion, conference abstracts/proceedings or dissertations which have not been peer reviewed. Thus, the full texts of 71 articles were accessed and 41 met our inclusion criteria and none of our exclusion criteria. Reasons for exclusion at the full-text stage included failing to satisfy the inclusion criteria relating to the autism diagnosis ($n = 22$), the sample being reported in another included paper ($n = 6$), or not reporting prevalence data ($n = 2$). Figure 1 illustrates a PRISMA flow chart summary of the systematic search, and the tabulated results are presented in Tables 2 and 3. Studies are described narratively.

Study characteristics

The data set consisted of 35 cohort studies, and 6 surveys. The studies were based in 11 countries, with the majority being set in Sweden ($n = 13$), the United Kingdom ($n = 10$), USA ($n = 8$), Canada ($n = 3$), and Japan ($n = 2$). The following countries were the setting for one study each: Denmark, Finland, the Netherlands, New Zealand, and Norway. As such, the study settings were all high-income countries (The World Bank, 2025). The included studies fell into two categories; the first were studies that reported the prevalence of autism within CJS/forensic settings or cohorts ($n = 25$), and the second being

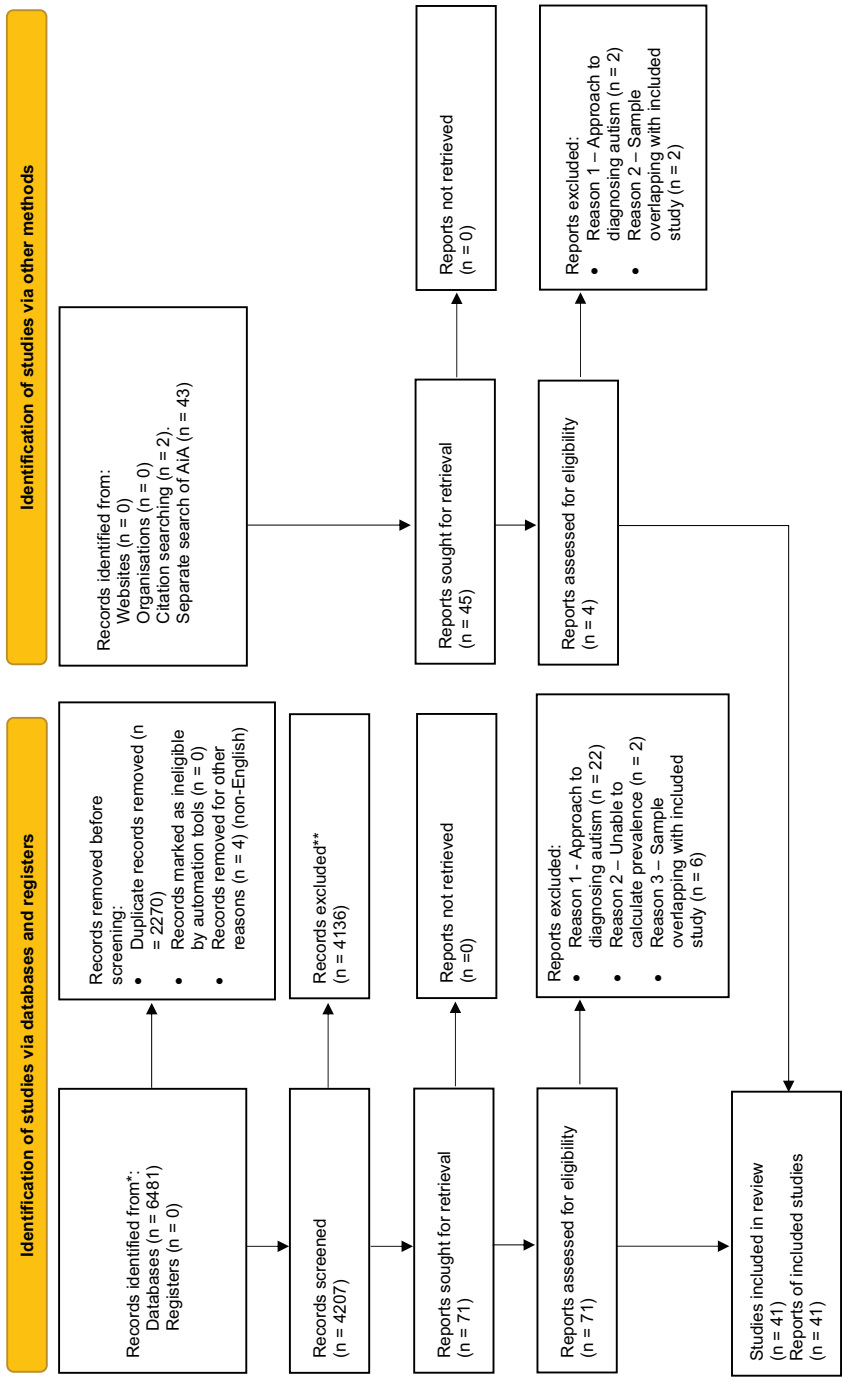

Figure 1. PRISMA 2020 flow diagram for new systematic reviews which included searches of databases, registers and other sources (Page et al., 2021).

Table 2. Studies reporting the prevalence of autism in the CJS.

Author and country	Study population	Demographic Characteristics	Diagnostic Methods	Autism prevalence findings	MMAT rating
1. Hales et al. (2022), England *Study category*: Youth secure	*Sample size*: 1322 *Context*: People within youth secure establishments.	Characteristics of ASC group: *Age*: Mean = NR; Range = NR Gender: Male 78.3% (36/46) *ID*: 5% *ED*: White ($n = 619$) Black ($n = 174$) Asian ($n = 56$) Mixed/Other ($n = 132$)	ASC (Autistic Spectrum Condition), made by a psychiatrist.	48 (4%)	2
2. Kumagami and Matsuura (2009), Japan *Study category*: Court	*Sample size*: 428 *Context*: juvenile cases from four courts in Japan. Three of the four courts (A, B, and C) dealt with all crime types, whereas court (D) was concerned with 'unique crimes' such as arson or sexual offences.	*Age*: Mean = NR; Range = 14–19 *Gender*: 93% Male (93%, 26/28 for PDD group) *ID*: 2% (6/428) *ED*: NR.	DSM-IV Pervasive developmental disorder (PDD)	PDD prevalence of 7% (28/428) in total study population: 0.2% (1/428) had autism 3% (12/428) has Asperger's syndrome 4% (15/428) PDDNOS There were differences in prevalence rates between the courts with 11 cases (3.2%) out of 335 cases across courts A, B and C, and a rate of 18.2% (17 of 93) in court D, which dealt with crimes such as sex offences and arson.	4

(*Continued*)

Table 2. (Continued).

Author and country	Study population	Demographic Characteristics	Diagnostic Methods	Autism prevalence findings	MMAT rating
3. Chaplin et al. (2022), England *Study category*: Court	*Sample size*: 9088 *Context*: Defendants referred to Court Mental Health Liaison and Diversion Services (CMHLDS).	*Age*: Mean = 37.5, Range = 17 to 89 *Gender*: 79.1% Male (7186/9088) *ID*: 3.8% (341/9088) *ED*: White 50.2%, Black 20.2% Asian 12% Mixed 6.1% Chinese 0.2% Unknown 6.4% Any other 4.9%.	ICD-10 criteria. Diagnoses assigned by assessing clinicians after reviewing historical clinical. records and undertaking new clinical assessments.	ASD 1.1% (n = 100).	4
4. Robinson et al. (2012), Scotland *Study category*: Prison	*Sample size*: 2458 *Context*: Prisoners screened for autism. Of these, 126 underwent further assessment using the measures outlined.	*Age*: Mean = 35.2; Range = 17.7–65.7 *Gender*: Male 94.4% = (119/126) *ID*: Average IQ = 92.5 (Range = 45–130) *ED*: NR	ASD screening instrument ASDI Adult Autism Spectrum Quotient (AQ) Ekman 60 Faces Test	Autism prevalence of 0% (0/126).	2
5. McCarthy et al. (2015), England, UK *Study category*: Prison	*Sample size*: 240 *Context*: Male prisoners within a category C prison.	*Age*: Mean = NR; Age range = ≥18 *Gender*: 100% male (240/240) *ID*: 10% (24/240) *ED*: NR.	Adult 20-item autism quotient (AQ-20). Participants scoring ≥ 10 on the AQ-20 were tested using ADOS and ADI.	Autism prevalence of 5% (12/240).	3

(*Continued*)

Table 2. (Continued).

Author and country	Study population	Demographic Characteristics	Diagnostic Methods	Autism prevalence findings	MMAT rating
6. Billstedt et al. (2017), Sweden *Study category*: Prison	*Sample size*: 270 *Context*: adult male young offenders sentenced for violent offences and serving time in Swedish prisons.	*Age*: Mean = 22; Age range = 18–25 *Gender*: Male 100% (270/270) *ID*: 1% (3/270) *ED*: NR.	DSM-IV-TR, ASDI, Autism Quotient and either a Diagnostic Interview for Social and Communication Disorders (DISCO) or ADOS.	Autism prevalence of 10% (26/270) within study population.	5
7. Anckarsäter et al. (2008), Sweden Study category: Secure Inpatient/ Forensic Psychiatric	*Sample size*: 330 *Context*: inpatients from two forensic psychiatry hospitals and two special institutions for maladapted adolescents.	*Age*: Mean = NR; Range = 11–47 *Gender*: Male 74% (31/42) *ID*: % = 100 *ED*: NR	DSM-IV. ASD diagnosis established based on clinical examinations/ structured diagnostics: Structured Clinical Interview for DSM-IV Axis I (SCID-I). ASDI administered to provide structured assessments of Gillberg & Gillberg criteria.	Autism prevalence across four sites was 19% (63/330) Adult settings = 22% (43/200) Adolescent settings = 15.4% (20/130)	3
8. Stinson and Robbins (2014), USA *Study category*: Secure Inpatient/ Forensic Psychiatric	*Sample size*: 235 *Context*: persons with intellectual, developmental, and cognitive disabilities who reside in a secure forensic psychiatric hospital in the Midwestern United States.	*Age*: Mean = 35.8; Range = 18–67 *Gender*: Male 86% (202/235) *ID*: % = 55 (130/235) *ED*: Caucasian (54.9%), African American (43.4%), Hispanic or Asian (1.7%).	DSM-IV-TR.	Autism prevalence of 15% (35/235).	2

(*Continued*)

Table 2. (Continued).

Author and country	Study population	Demographic Characteristics	Diagnostic Methods	Autism prevalence findings	MMAT rating
9. Esan et al. (2015), England, UK *Study category*: Secure Inpatient/ Forensic Psychiatric	*Sample size*: 138 *Context*: patients treated within a forensic ID hospital over a 6-year period.	*Age*: Mean 30 years (autistic subgroup), 31 years non-autistic subgroup); Range = NR *Gender*: Male 79% (107/138) *ID*: % = 100 *ED*: NR.	ICD-10.	Autism prevalence of 30% (42/138).	2
10. Krona et al. (2017), Sweden *Study category*: Secure Inpatient/ Forensic Psychiatric	*Sample size*: 125 *Context*: individuals sentenced to forensic psychiatric in-patient treatment during 1999–2005.	*Age*: Median at first crime was 20 years (range 15–72), and at first violent crime 27 years (range 15–7 2) *Gender*: Male 81% (101/125) *ID*: % = NR *ED*: NR.	DSM-IV.	Autism prevalence of 4% (5/125).	4
11. Griffiths et al. (2018), UK *Study category*: Secure Inpatient/ Forensic Psychiatric	*Sample size*: 347 *Context*: admissions to one of four locked, low/medium secure inpatient mental health services between 2007 and 2015.	*Age*: Mean = 33; Range = NR *Gender*: Male 36% (126/347) *ID*: 0% = (0/347) *ED*: ER.	ICD-10 Asperger's Syndrome.	49 had Aspergers (14%).	2

(*Continued*)

Table 2. (Continued).

Author and country	Study population	Demographic Characteristics	Diagnostic Methods	Autism prevalence findings	MMAT rating
12. Hill et al. (2019), England *Study category*: Secure Inpatient/ Forensic Psychiatric	*Sample size*: 100 *Context*: Patients admitted to a mixed-gender adolescent medium-secure forensic unit.	*Age*: Mean = 17; Range = 12–18 *Gender*: Male 60% (60/100) *ID*: 1% (1/100) *ED*: 82% (82/100) White British and 18% (18/100) having different ethnic backgrounds.	ICD-10.	Autism prevalence of 7% (7/100).	2
13. Sutton et al. (2013), USA *Study category*: Secure Inpatient/ Forensic Psychiatric	*Sample size*: 37 *Context*: Male adolescents who had been sentenced to treatment for sexual offences in a state facility.	*Age*: Mean = 17; Range = 14–20 *Gender*: Male 100% (37/37) *ID*: 0% (0/37) *ED*: 60% Caucasian (22/37), 35% African American (13/37), 5% Hispanic (2/37).	DSM-IV-TR criteria, based on: • Asperger's Syndrome Diagnostic Scale Enhanced Mental Status Clinical Evaluation Interview	Autism prevalence of 60% (22/37).	2
14. Siponmaa et al. (2001), Sweden *Study category*: Forensic Psychiatric Examination Referrals	*Sampe size*: *N* = 126 *Context*: patients under forensic psychiatric investigation (FPI) after committing serious offences.	*Age*: Median = 20; range = 15–22. *Gender*: Male = 97.6% (*n* = 123/126) *Intellectual disability (ID)*: 10% (*n* = 11/107) *Ethnicity (ED)*: NR	DSM-IV criteria Gillberg and Gillberg research diagnostic algorithm for Asperger Syndrome.	Calculated on a subsample of 112: PDD: 19 (15)* PDD NOS: 15 (6) Asperger: 4 (9) Total: 38 (30) *Also provided 'probable' cases, where information strongly suggested the diagnosis, but with insufficient detail to make a definite diagnosis.	3

(*Continued*)

Table 2. (Continued).

Author and country	Study population	Demographic Characteristics	Diagnostic Methods	Autism prevalence findings	MMAT rating
15. Soderstrom et al. (2004), Sweden *Study category*: Forensic Psychiatric Examination Referrals	*Sample size*: *N* = 100 *Context*: Consecutive patients of pre-trial FPI, who were perpetrators of severe violent or sexual index crimes, i.e. crimes where the life of another person had been threatened or taken (actual/attempted murder, manslaughter, aggravated assault in, aggravated unlawful threat, robbery, rape, sexual child abuse and arson).	*Age*: Median = 30; range = 17–76 *Gender*: Male 92% (92/100) *ID*: % = 17 (17/100) *ED*: NR.	DSM-IV criteria Gillberg and Gillberg research diagnostic algorithm for Asperger Syndrome. The Asperger Syndrome Screening Questionnaire The Asperger Syndrome Diagnostic Interview.	ASD prevalence of 18% (18/100): • 4% (4/100) for autistic disorder • 3% (3/100) for Asperger syndrome • 10% (10/100) ASD-NOS.	3
16. Wahlund & Kristiansson, (2006), Sweden *Study category*: Forensic Psychiatric Examination Referrals	*Sample size*: NR *Context*: Offenders found guilty of homicide or manslaughter referred for forensic psychiatric assessment (FPA) (1996–2001).	*Age*: Median = NR; range = 15–71 *Gender*: Male 100% (402/402) *ID*: IQ Autistic subgroup = Intellectual level, IQ < 85 (2/8) IQ 85 to 115 (5/8) IQ > 115 (1/8) *Ethnicity* = NR.	DSM-IV	Autism prevalence rate was 2% (8/402)*. *Total sample size for this sample was not stated, although the authors reported that there are 80–100 cases of homicide annually and the clear-up rate is about 80%, and approx. 75% of these defendants are referred for a presentence FPA. As such, we based this prevalence estimate on the midpoint of 90 cases of homicide per year, considering the clear up rate, referral for FPA, and the time period covered by the study, was 402 total cases.	4

(*Continued*)

Table 2. (Continued).

Author and country	Study population	Demographic Characteristics	Diagnostic Methods	Autism prevalence findings	MMAT rating
17. Enayati et al. (2008), Sweden *Study category*: Forensic Psychiatric Examination Referrals	*Sample size*: 2609 *Context*: 214 arsonists and 2395 other violent offenders referred for inpatient FPA from 1997–2001.	*Age*: Mean = arsonist group 34 for men and 40 for women, other violent offender group 36 for men and 35 for women; Range = NR *Gender*: Male % = arsonist group 72, NR for other violent offender group *ID*: % = arsonist group 10% ($n = 16$) for men and 9% ($n = 5$) for women, other violent offender group 3% ($n = 74$) for men and 3% ($n = 5$) for women *ED*: arsonist group non-Swedish nationals 14% for men and 17% for women, NR for other violent offender group.	DSM-IV.	Autism prevalence (including Asperger's syndrome) of 3% (84/2609) in total study population. Autism prevalence 7% (15/214) for arsonists Autism prevalence 3% (62/2395) for other violent offenders.	4
18. Lindberg et al. (2012), Finland *Study category*: Forensic Psychiatric Examination Referrals	*Sample size*: 77 *Context*: Adolescents sent for adolescent psychiatric evaluations between 2007 and 2009, due to being a threat of massacre at school.	*Age*: Mean = 15; Range = 13–18 *Gender*: Male 87% = (67/77) *ID* = 1/77 *ED*: All Caucasian native Finns.	Pervasive developmental disorders (F84) were made by the treating psychiatrist according to the ICD-10.	Autism prevalence 10% (8/77).	4

(*Continued*)

Table 2. (Continued).

Author and country	Study population	Demographic Characteristics	Diagnostic Methods	Autism prevalence findings	MMAT rating
19. Warren et al. (2013), USA *Study category*: Forensic Psychiatric Examination Referrals	*Sample size*: 2260 *Context*: forensic assessments between 1990–2007 where the defendant was deemed incompetent to stand trial.	*Age*: Mean = 36.14 Age range = NR *Gender*: Male 73.5% (1661/2260) *ID*: NR *ED*: Caucasian = 42% (941/2260), Ethnic Minority = 47% (1067/2260)	DSM categorisation of Pervasive Developmental Disorder.	Autism prevalence of 8% (184/2260).	4
20. Helverschou et al. (2015), Norway *Study category*: Forensic Psychiatric Examination Referrals	*Sample size*: 3382 *Context*: adults examined by the Norway forensic psychiatric service from 2000–2010.	Characteristics of autistic subgroup: *Age*: Mean = 25; Range = 15–67 *Gender*: Male 85% *ID*: 33% (16/48) *ED*: Norwegian citizenship – 98% (47/48), Other citizenship – 2% (1/48).	ICD-10.	Autism prevalence of 1% (48/3382).	4
21. Hedlund et al. (2016), Sweden *Study category*: Forensic Psychiatric Examination Referrals	*Sample size*: 87 homicide offenders, including 74 filicide offenders and 13 extra-familial homicide. *Context*: offenders subject to forensic psychiatric evaluations for offences involving 0–14-year-old victims in Sweden from 1992–2012.	*Age*: Mean = 37 for filicide offenders, 21 for extra-familial homicide offenders; Age range = NR. *Gender*: Male 66% (57/87) *ID*: % = NR *ED*: Swedish origin 67% (58/87), non-Swedish origin 33% (29/87).	ICD-9 (data from 1992–1996) and DSM-IV (data from 1997-).	Autism prevalence of 9% (8/87) in total study population. Autism prevalence of 7% (5/74) for filicide offenders 23% (3/13) for extra-familial homicide offenders.	4

(*Continued*)

Table 2. (Continued).

Author and country	Study population	Demographic Characteristics	Diagnostic Methods	Autism prevalence findings	MMAT rating
22. Sturup (2018) Sweden *Study category*: Forensic Psychiatric Examination Referrals	*Sample size*: 226 *Context*: Convicted serial-homicide offenders referred for Forensic Psychiatric Examination from 1973–2012 ($n = 25$) and single-homicide offenders during 2007 and 2009 ($n = 201$).	*Age*: Mean = 29 in serial offender group, 34 in single offender group; Range = NR *Gender*: Male 92% (208/226) *ID*: 1% (2/226) *ED*: NR.	DSM-IV.	Autism prevalence of 6% (13/226) in total study population: • 33% (8/25) for serial-homicide offenders • 3% (5/201) for single-homicide offenders.	4
23. Cunningham et al. (2021), USA *Study category*: Forensic Psychiatric Examination Referrals	*Sample size*: 2092 *Context*: youth referred for initial pretrial mental health evaluations of competence to proceed to adjudication from 1996 to 2017.	*Age*: Mean = 15; Range = 8–18 *Gender*: Male 86% *ID*: 22.4% (468/2092) *ED*: 61% White.	Primary clinical diagnosis of PDD, Autistic Disorder, ASD, Asperger's Disorder, and Other or Unspecified Neurodevelopmental Disorder.	Autism prevalence of 24.1% ($n = 504$).	4
24. Edberg et al. (2022), Sweden *Study category*: Forensic Psychiatric Examination Referrals	*Sample size*: 3365 *Context*: individuals sentenced to forensic psychiatric care after forensic psychiatric assessment (FPA) from 1997 to 2013.	*Age*: Median (ID subgroup = 29, Without ID subgroup = 36) Age range = NR *Gender*: Male (ID subgroup = 79.1%, without ID subgroup = 84.9%) *ID*: 7.7% *ED*: NR	Psychiatric diagnoses from the FPA were categorised according to DSM-IV.	Whole sample – n = 379 (11.3%). ID subgroup – n = 66 (25.5%) Without ID – n = 313 (10.1%).	4

(*Continued*)

Table 2. (Continued).

Author and country	Study population	Demographic Characteristics	Diagnostic Methods	Autism prevalence findings	MMAT rating
25. Rutten et al. (2022), Netherlands *Study category*: Forensic Psychiatric Examination Referrals	*Sample size*: 1799 *Context*: pre-trial forensic psychiatric assessments of 12–17-year-old male adolescents of between 2013–2014.	*Age*: Mean = NR; Range = 12–17 *Gender*: Male 100% *ID*: NR *ED*: NR	DSM-IV-TR	98 had a diagnosis of ASD (5.4%)	4

ED = Ethnicity distribution; ID = Intellectual Disability; NR = Not reported.

Table 3. Studies reporting the prevalence of CJS involvement in autistic populations.

Author and country	Study population	Demographic Characteristics	Diagnostic Methods	Offending prevalence findings	MMAT rating
1. Woodbury-Smith et al., (2006) England, UK *Study category*: Self-report	*Sample size*: 45 *Context*: *Autistic population*: 25 autistic adults compared with 20 non-autistic adults. *CJS involvement*: Self-Reported Offending Questionnaire (SROQ).	*Age*: Mean = autistic group 30, non-autistic group 41; Range = NR *Gender*: autistic group 6:1 male: female ratio; non-autistic group 2:1 male: female ratio ID: 0% (0/25) ED: NR	ICD-10 ADI-R.	From the autistic group, 48% (12/25) participants reported engaging in illegal behaviours on SROQ, compared to 80% (16/20) of their non-autistic peers (statistically significant difference, $p < 0.05$).	2
2. Blackmore et al (2022), England *Study category*: Self-report	*Sample size*: 1130 *Context*: *Autistic population:* Patients who received an ASD diagnosis from a diagnostic clinic, comparison group of 440 who did not receive a diagnosis. *CJS Involvement*: Self-reported offending behaviour in the participants' referral and assessment reports. Contact with the CJS included arrest, cautions, fines, community service and imprisonment. Offences categorised as violent, theft/burglary, substance, sexual, criminal damage, arson, stalking/harassment and other.	*Age*: Mean = 33; Range = 17–75 *Gender*: 73% Male (1142/1130) *ID*: % = 2 (suspected, no specific testing performed) *ED* = NR	ICD-10 research diagnostic criteria diagnosis of ASD – determined by consultant-led multidisciplinary expert consensus, informed by either: ADI-R ADOS-G/ADOS-2	ASD individuals significantly less likely to have had contact with the CJS than comparators (23% vs 32%).	3
3. Weiss and Fardella (2018), Canada *Study category*: Self report	*Sample size*: 90 *Context*: *Autistic population*: 45 autistic adults and 45 matched non-autistic controls *CJS Involvement*: Survey on violence perpetration. Juvenile Victimization Questionnaire-Adult Retrospective (JVQ-AR).	Age: Mean = autistic group 30, non-autistic group 32; Range = autistic group 18–53, non-autistic group 19–54 *Male*: % = autistic group 42.5, non-autistic group 50 *ID*: NR *ED*: ethnic minority status in autistic group 16%, ethnic minority status in non-autistic group 31%.	Autistic participants had to first identify as autistic by self-report, which was then verified by administration of the ADOS-2.	71% (32/45) of the autistic group endorsed at least one of the 19 forms of violence perpetration on the JVQ-AR, compared to 60% (25/45) of the non-autistic group, a difference which was not statistically significant ($p > 0.05$).	2

(*Continued*)

Table 3. (Continued).

Author and country	Study population	Demographic Characteristics	Diagnostic Methods	Offending prevalence findings	MMAT rating
4. Kawakami et al. (2012), Japan *Study category*: Psychiatric case note records	*Sample size*: 175 *Context*: *Autistic population*: individuals diagnosed with HFASD by child psychiatrists. *CJS Involvement*: The types, frequencies, onset, and the age at which their last criminal behaviour was observed extracted from clinical case notes.	*Age*: Mean = 16.83; Range = 7–30 *Gender*: 83% Male (147/175). *ED*: NR.	DSM-IV	21% (36/175) had criminal behaviour recorded.	2
5. Allen et al. (2008), Wales, UK *Study category*: Psychiatric case note records	*Sample size*: 126 *Context*: *Autistic population*: Persons identified from: local health boards, forensic/mental health/ learning disability practitioners, mental health practitioners, community learning disability/ mental health teams, specialist autism providers, probation services and prisons. *CJS involvement*: questionnaire of (a) nature of offending behaviour, (b) offending pattern, (c) criminal profile, (d) offences against the person, (e) relevant predisposing/ precipitating factors, (f) legal process and disposal.	*Age*: Mean = 34.8; Range = 18–61 *Male*: 100% (126/126) *ID*: 4% *ED* = NR	Clinically diagnosed with Asperger syndrome. n = 16 followed up with ASDI.	33 (26%) had engaged in offending behaviours that had or could have resulted in involvement in the CJS.	2

(*Continued*)

Table 3. (Continued).

Author and country	Study population	Demographic Characteristics	Diagnostic Methods	Offending prevalence findings	MMAT rating
6. Tint et al. (2017), Canada *Study category*: Police contact	*Sample size*: 284 *Context*: *Autistic population*: Autistic adolescents followed over 12–18 months. *CJS Involvement*: Parental interview. Police contact coded as present if parent indicated police were called, a warning issued, child adjudicated, or served time in juvenile detention.	*Age*: Mean = 18; Range = NR *Gender*: Male 79% (223/284) *ID*: 46% (132/284) *ED*: Caucasian 82% (234/284).	Participants had a formal autism diagnosis, verified by scoring ≥ 12 on the Social Communication Questionnaire.	16% (46/284) of the autistic individuals had been involved with the police.	2
7. Tint et al. (2019), Canada *Study category*: Police contact	*Sample size*: 40 *Context*: *Autistic population*: Autistic adults *CJS Involvement*: Participant survey of interactions with emergency services and police over 12–18 months. Police contact was coded if the parent indicated that police were called, a warning was issued, a child was adjudicated, or a child served time in juvenile detention.	*Age*: Mean = 36; Range = 18–61 *Male*: % = 45(18/40) *ID*: 0% (0/40) *ED*: Caucasian 88% (35/40).	Participants had to have a formal autism diagnosis, verified by scoring ≥ 26 on the Autism Quotient.	33% (13/40) reported involvement with the police during the study period, with a corresponding 14 classifiable incidents, including breach of court order ($n = 4$), care of other ($n = 4$), psychiatric crisis ($n = 3$), victim of verbal aggression ($n = 1$) and miscellaneous ($n = 2$).	2

(*Continued*)

Table 3. (Continued).

Author and country	Study population	Demographic Characteristics	Diagnostic Methods	Offending prevalence findings	MMAT rating
8. Cheely et al. (2012), USA *Study category*: Charges	*Sample size*: 609 *Context*: *Autistic population*: identified from South Carolina Autism and Developmental Disabilities Monitoring Project. *CJS involvement*: criminal charges recorded by the Department of Justice and the South Caroline Law Enforcement Division.	*Age*: Mean = 8; Range = 12–18 *Gender*: NR *ID*: 46% (207/454) *ED*: NR	DSM-IV-TR.	5% (32/609) were charged with a total of 103 offences. Mean number of 3.3 offences per autistic child compared to 5.7 offences for matched non-autistic comparison group (n = 32).	4
9. Yu et al. (2021), USA *Study category*: Charges	*Sample size*: n = 606 young adults with ASD, n = 1271 Individuals with ID and a population control group (n = 2973). *Context*: *Autistic population*: Data from the Carolina Autism Transition Study (CATS), a large epidemiological autism dataset. *CJS Involvement*: Charges, outcomes, and recidivism in juvenile and adult CJS linked with Department of Juvenile Justice (DJJ) and SC Law Enforcement Division (SLED) datasets.	*Age*: Mean = NR; Age range = 17–23 *Gender*: Male 81% (17/20) *ID*: ASD group included those with ID but % NR *ED*: 52% White.	DSM-IV TR criteria for autistic disorder, PDDNOS, or Asperger disorder.	3% involved with DJJ. 3% involved with SLED. Young adults with ASD not overrepresented in the CJS in general and were less likely to be involved in the adult justice system than their peers. They received similar charges and outcomes and were as likely to reoffend as their peers.	4

(*Continued*)

Table 3. (Continued).

Author and country	Study population	Demographic Characteristics	Diagnostic Methods	Offending prevalence findings	MMAT rating
10. Mouridsen et al. (2008), Denmark *Study category*: Convictions	*Sample size*: 313 *Context*: *Autistic population*: Former child psychiatric inpatients PDD: 113 with childhood autism, 86 atypical autism, 114 Asperger's syndrome, and 933 matched non-autistic children. *CJS involvement*: Convictions	*Age*: Mean = childhood autism 5 (at assessment) and 40 (at follow-up), atypical autism 9 (at assessment) and 44 (at follow-up), Asperger's syndrome 9 (at assessment) and 43 (at follow-up); Range = 25–59 (at time of follow-up) *Gender*: 75% Male (235/313) *ID*: 41% (128/313) *ED*: NR	ICD-9.	PDD group: 9% (29/313) convicted, compared to 18% (168/933) in non-autistic control group. Childhood autism subgroup: 1% (1/113) convicted, compared to 19% (64/339) for non-autistic control group. Atypical autism subgroup: 8% (7/86) convicted, compared to 15% (37/252) controls. Asperger's syndrome subgroup: 18% (21/114) convicted, compared to 20% (67/342) for controls.	2
11. Långström et al. (2009) Sweden *Study category*: Convictions	*Sample size*: 422 *Context*: *Autistic population*: Longitudinal registers for individuals hospitalized with autistic disorder/Asperger syndrome during 1988–2000. *CJS involvement*: Compares those committing violent or sexual offenses with those who did not.	*Age*: Mean = 18.3; Range = NR *Gender*: 71.3% Male (301/422) *ID*: NR *ED*: NR	ICD9/10	7%, ($n = 31$) autistic individuals were convicted of violent nonsexual crimes and two of sexual offenses. Compared to matched youth group, ASD group had lower rates of charges overall, lower rates of property offenses (trespassing, arson), but significantly higher rates of person offenses (assault).	4

(*Continued*)

Table 3. (Continued).

Author and country	Study population	Demographic Characteristics	Diagnostic Methods	Offending prevalence findings	MMAT rating
12. Lundström et al. (2014), Sweden *Study category*: Convictions	*Sample size*: 34864 *Context*: *Autistic population*: 954 autistic individuals born from 1984–1994, and 33,910 matched controls. *CJS Involvement*: Violent crime defined as homicide, assault, robbery, arson, any sexual offense (rape, sexual coercion, child molestation, indecent exposure, and sexual harassment), illegal threats, and intimidation recorded up to 2009 in the National Crime Register	*Age*: NR *Gender*: NR *ID*: NR *ED*: NR.	ICD-8/9/10	Autistic individuals not significantly ($p > 0.05$) more likely to commit violent offences relative to non-autistic peers (Adjusted OR = 1.1 [95% CI 0.6–1.9]).	4
13. Heeramun et al. (2017), Sweden *Study category*: Convictions	*Sample size*: 295734 *Context*: *Autistic population*: data from a population-based record-linkage cohort in Stockholm County comprising individuals followed up between ages 15–27. Of these, 5739 individuals had a recorded autism diagnosis. *CJS involvement*: Convicted for violent crimes identified using the Swedish National Crime Register.	*Age*: Mean = 20 for autistic group, and 21 for non-autistic group; Range = ≥15 *Gender*: Male 67% for autistic group and 51% for non-autistic group *ID*: 28% (1608/5739) for autistic group, NR for non-autistic group *ED*: NR.	ICD-9, ICD-10 and DSM-IV.	4.4% ($n = 250$) diagnosed with autism had received at least one conviction for a violent crime, compared to 7643 (2.6%) without autism	4

(*Continued*)

Table 3. (Continued).

Author and country	Study population	Demographic Characteristics	Diagnostic Methods	Offending prevalence findings	MMAT rating
14. Turcotte et al. (2018), USA *Study category*: Convictions	*Sample size*: 2525 *Context*: *Autistic population*: Caregivers of autistic youths. *CJS Involvement*: survey of police contact.	*Age*: Mean = NR; Range = 6–21 *Gender*: Male 82% (2063/2525) *ID*: NR *ED*: Caucasian 88% African American 6% Latino/ Hispanic 2% Other 3%	DSM-IV.	8% (199/2525) individuals had police contact. A significantly higher proportion of youth with Asperger's disorder had police contact (11.9%) than children with autistic disorder (6.2%) or PDD-NOS (6.8%).	2
15. Slaughter et al. (2019) USA *Study category*: Convictions	*Sample size*: 58678 *Context*: *Autistic population*: Autism categorised using the IDEA; law that ensures students (aged 3–21) with disabilities receive a public education. Of the overall dataset, there was an autism prevalence of 231/56678 (0.4%). *CJS involvement*: Longitudinal dataset of criminal case records of juvenile-justice-involved youth (JJY) who committed > 1 offense between 2006–2012 in Connecticut. Five crime types focused on: (1) crimes against persons (2) property offenses (3) status offenses (i.e. escape from custody or truancy) (4) drug law violations (5) public order offenses JJY from one school year were focused on and followed up for three years, of this group, 146 were diagnosed autistic.	*Age*: Mean = 14; Range = 6–20 *Gender*: Male 86% *ID*: NR *ED*: 76.9% White, 12% Black, 11% Hispanic.	DSM-5.	Across offence categories, there were no significant differences between the autistic and non-autistic groups, except that the autistic group committed significantly fewer property crimes.	4

(*Continued*)

Table 3. (Continued).

Author and country	Study population	Demographic Characteristics	Diagnostic Methods	Offending prevalence findings	MMAT rating
16. Bowden et al. (2022), New Zealand *Study category*: Convictions Police contact, charges and convictions	*Sample size*: 1197 people with autism and 147,879 without autism. *Context*: *Autistic population*: National birth cohort study of health data for those born between 1992–1995. *CJS Involvement*: Four CJS interactions recorded during an 8-year window between ages 17–25: • *police proceedings* • *court charges* • *court convictions* • *incarcerations*	*Age*: Mean = NR; Range = 17–25 *Gender*: Male 79% (392/1197) *ID* % = NR *ED*: European (90%), Māori (20.1%), Pasifika (5.0%), Asian (4.5%), MELAAb (1.0%), Other (0.5%)	DSM or ICD-10 diagnosis.	Police proceedings recorded for 23.6% of autistic people. Court charges recorded for 16.8%. Convictions for 12.8%. Prison sentences for 2%.	3

Table 4. PRISMA checklist.

Section and Topic	Item #	Checklist item	Location where item is reported
TITLE			
Title	1	Identify the report as a systematic review.	Page 1 & 5
ABSTRACT			
Abstract	2	See the PRISMA 2020 for Abstracts checklist.	Page 1
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of existing knowledge.	Page 2–5
Objectives	4	Provide an explicit statement of the objective (s) or question(s) the review addresses.	Page 5
METHODS			
Eligibility criteria	5	Specify the inclusion and exclusion criteria for the review and how studies were grouped for the syntheses.	Page 6
Information sources	6	Specify all databases, registers, websites, organisations, reference lists and other sources searched or consulted to identify studies. Specify the date when each source was last searched or consulted.	Page 5
Search strategy	7	Present the full search strategies for all databases, registers and websites, including any filters and limits used.	Page 5
Selection process	8	Specify the methods used to decide whether a study met the inclusion criteria of the review, including how many reviewers screened each record and each report retrieved, whether they worked independently, and if applicable, details of automation tools used in the process.	Page 5–6
Data collection process	9	Specify the methods used to collect data from reports, including how many reviewers collected data from each report, whether they worked independently, any processes for obtaining or confirming data from study investigators, and if applicable, details of automation tools used in the process.	Page 6
Data items	10a	List and define all outcomes for which data were sought. Specify whether all results that were compatible with each outcome domain in each study were sought (e.g. for all measures, time points, analyses), and if not, the methods used to decide which results to collect.	Page 6-7
	10b	List and define all other variables for which data were sought (e.g. participant and intervention characteristics, funding sources). Describe any assumptions made about any missing or unclear information.	Page 6-7
Study risk of bias assessment	11	Specify the methods used to assess risk of bias in the included studies, including details of the tool(s) used, how many reviewers assessed each study and whether they worked independently, and if applicable, details of automation tools used in the process.	Page 7

(*Continued*)

Table 4. (Continued).

Section and Topic	Item #	Checklist item	Location where item is reported
Effect measures	12	Specify for each outcome the effect measure(s) (e.g. risk ratio, mean difference) used in the synthesis or presentation of results.	N/A
Synthesis methods	13a	Describe the processes used to decide which studies were eligible for each synthesis (e.g. tabulating the study intervention characteristics and comparing against the planned groups for each synthesis (item #5)).	Page 8
	13b	Describe any methods required to prepare the data for presentation or synthesis, such as handling of missing summary statistics, or data conversions.	Tables 2 & 3
	13c	Describe any methods used to tabulate or visually display results of individual studies and syntheses.	Page 8
	13d	Describe any methods used to synthesize results and provide a rationale for the choice (s). If meta-analysis was performed, describe the model(s), method(s) to identify the presence and extent of statistical heterogeneity, and software package(s) used.	Page 6
	13e	Describe any methods used to explore possible causes of heterogeneity among study results (e.g. subgroup analysis, meta-regression).	N/A
	13f	Describe any sensitivity analyses conducted to assess robustness of the synthesized results.	N/A
Reporting bias assessment	14	Describe any methods used to assess risk of bias due to missing results in a synthesis (arising from reporting biases).	N/A
Certainty assessment	15	Describe any methods used to assess certainty (or confidence) in the body of evidence for an outcome.	N/A
RESULTS			
Study selection	16a	Describe the results of the search and selection process, from the number of records identified in the search to the number of studies included in the review, ideally using a flow diagram.	Page 9
	16b	Cite studies that might appear to meet the inclusion criteria, but which were excluded, and explain why they were excluded.	We removed these sections at the reviewers request.
Study characteristics	17	Cite each included study and present its characteristics.	Pages 8-45
Risk of bias in studies	18	Present assessments of risk of bias for each included study.	Page 8, Tables 2 and 3
Results of individual studies	19	For all outcomes, present, for each study: (a) summary statistics for each group (where appropriate) and (b) an effect estimate and its precision (e.g. confidence/credible interval), ideally using structured tables or plots.	Tables 2 and 3

(*Continued*)

Table 4. (Continued).

Section and Topic	Item #	Checklist item	Location where item is reported
Results of syntheses	20a	For each synthesis, briefly summarise the characteristics and risk of bias among contributing studies.	Page 32-33
	20b	Present results of all statistical syntheses conducted. If meta-analysis was done, present for each the summary estimate and its precision (e.g. confidence/credible interval) and measures of statistical heterogeneity. If comparing groups, describe the direction of the effect.	N/A
	20c	Present results of all investigations of possible causes of heterogeneity among study results.	Narrative throughout Results and Discussion section
	20d	Present results of all sensitivity analyses conducted to assess the robustness of the synthesized results.	N/A
Reporting biases	21	Present assessments of risk of bias due to missing results (arising from reporting biases) for each synthesis assessed.	N/A
Certainty of evidence	22	Present assessments of certainty (or confidence) in the body of evidence for each outcome assessed.	N/A
DISCUSSION			
Discussion	23a	Provide a general interpretation of the results in the context of other evidence.	Page 46-54
	23b	Discuss any limitations of the evidence included in the review.	Page 46-54 and throughout Results section.
	23c	Discuss any limitations of the review processes used.	Page 49-50
	23d	Discuss implications of the results for practice, policy, and future research.	Page 46-54
OTHER INFORMATION			
Registration and protocol	24a	Provide registration information for the review, including register name and registration number, or state that the review was not registered.	Page 6
	24b	Indicate where the review protocol can be accessed, or state that a protocol was not prepared.	Page 6
	24c	Describe and explain any amendments to information provided at registration or in the protocol.	Page 54
Support	25	Describe sources of financial or non-financial support for the review, and the role of the funders or sponsors in the review.	N/A
Competing interests	26	Declare any competing interests of review authors.	Page 1
Availability of data, code and other materials	27	Report which of the following are publicly available and where they can be found: template data collection forms; data extracted from included studies; data used for all analyses; analytic code; any other materials used in the review.	N/A

studies that reported the CJS/forensic involvement of autistic samples/cohorts ($n = 16$).

The sex distribution was reported in 40 included studies, and across studies, participants were predominantly male (81%). It is important to note that many of the samples were male only settings, while none were female only. Furthermore, this is likely to reflect historical issues affecting women and girls' access to autism diagnosis, including male oriented diagnostic criteria, screening tools and assessments (Trundle et al., 2025). Barnard-Brak et al. (2019) examined how many girls may be missing an autism diagnosis by comparing clinic and community-based data sets to national population estimates for sex distribution. The authors reported that 39% more girls should have been diagnosed with autism.

Ethnicity was reported within 16 studies, and Caucasians were most common in all studies, except one. It is possible this reflects the majority ethnicity of the study countries. However, the ethnicity characteristics of those within forensic/CJS contexts do not typically mirror those of the general population. Compared with the general population in the UK, people from ethnic minorities are over-represented within the prison population, with 27% identified as an ethnic minority in 2024, compared with 18% in the general population (Sturge, 2024). It is likely that the ethnicity of participants in the studies included in the present review reflects general population rates of autism. In the US general population, rates of autism diagnosis were highest among White children in nearly all birth cohorts prior to 2010, but were surpassed by Black, Hispanic, and Asian/Pacific Islander in the 2010 cohorts, and continued to increase in the 2012 birth cohorts (Roman-Urrestarazu et al., 2021). The authors felt this finding reflected efforts to increase autism awareness in minority groups. However, racial and ethnic disparities persisted over time among adults, with greater autism diagnosis rates among White compared with Hispanic and Black adults, which may represent the lasting impact of historically inequitable screening and diagnosis practices, as well as existing barriers to care faced by autistic adults (Grosvenor et al., 2024). Therefore, it is possible that autistic people within minority ethnic groups are currently not recognised within forensic/CJS contexts or represented within the included studies. McCarthy et al. (2015) felt that in their study, those from minority backgrounds were particularly at risk of neurodevelopmental (NDD) symptoms not being recognised within prison. They noted that the screening methods identified more white prisoners with NDD than was representative of the broader prison population, despite a lack of sampling or referral bias, which may indicate that the assessment tools used are not culturally sensitive, particularly in a prison setting or, that those making referrals to the study were more culturally attuned to consider (or report) the presence of NDD in white prisoners.

Quality appraisal ratings

Due to the nature of this systematic review, all the studies were quantitative, there were no randomised controlled trials or experiments, and all made use of descriptive or observational designs. As such, all included studies were categorised as quantitative descriptive studies according to the MMAT, and thus, Section 4 was completed for all. Section 4 of the MMAT requires rating on five items of quality; 1) 'Is the sampling strategy relevant to address the research question?'; 2) 'Is the sample representative of the target population?'; 3) 'Are the measurements appropriate? 4) Is the risk of nonresponse bias low?'; and 5) 'Is the statistical analysis appropriate to answer the research question?'. Of the 41 papers, one was rated as 5* (2%), 20 were rated as 4* (49%), five were rated 3* (12%), 15 were rated as 2* (37%), and none were rated as 1* or 0×. Scores for each study are included in Tables 2 and 3.

Prevalence rates of autism in the CJS

Prevalence rates of autism in the CJS/forensic settings were examined in 25 studies, with the majority ($n = 19$) based within forensic psychiatric/mental health settings (including secure psychiatric services and cohorts of forensic psychiatric assessment referrals) and the remaining six within CJS settings (e.g. prisons/court/youth secure establishments). The largest subgroup of studies were those focused on cohorts of people referred for forensic psychiatric assessment ($n = 11$), followed by studies set within forensic psychiatric settings ($n = 8$), of which six were mainstream/generic, and two were intellectual disability services. Three studies were set in prisons, two were set in courts, and one in the youth secure estate. Across these studies, rates of autism varied from 0% to 60%, and in 24 of 25 included studies, autism rates were higher than the general population autism prevalence estimate of 1%, with one study reporting rates equal to the general population. The studies are summarised in Table 2.

Youth secure establishments

One study investigated autism prevalence within the youth secure estate. Hales et al. (2022) reported the number of those diagnosed with Autistic Spectrum Condition among 1322 young people within secure establishments in England, who were aged either ≤15 years ($n = 183$), 16–17 years ($n = 787$) or 18+ years ($n = 71$). These establishments included Secure Children's Homes, Secure Training Centres or Young Offender Institutions, and within these settings, 48 (4%) were autistic. This study is limited by a lack of information regarding the diagnostic process which

affects reliability, but the authors report that clinical needs and diagnoses were collected from the electronic medical notes, with further coding of diagnostic classifications conducted by an adolescent forensic psychiatrist.

Court

Two studies focused on participants who had appeared in criminal court as defendants, with autism prevalence rates of 1.1% (Chaplin et al., 2022) and 7% (Kumagami & Matsuura, 2009). These two rates are markedly different due to differences in study methodology and the nature of the courts from which the samples were drawn. For instance, Kumagami and Matsuura (2009) examined prevalence in four juvenile courts in Japan using a classifier of pervasive developmental disorder (PDD). In contrast, Chaplin et al. (2022) identified 100 defendants diagnosed with ASD according to ICD-10, from a cohort of 9088 individuals who were referred to Court Mental Health Liaison and Diversion Services in England. Inconsistencies in the diagnostic process in both papers impacted the reliability and validity of findings. For example, Kumagami and Matsuura (2009) reported cases of both PDD diagnosed by a child psychiatrist using the DSM-IV for the purposes of the court appearance, alongside pre-existing diagnoses, where the procedure for diagnosing PDD was not stated. They did not specify how many participants were diagnosed using each method. Chaplin et al. (2022) also reported diagnoses which were assigned by assessing clinicians after reviewing historical clinical records and undertaking new clinical assessments. As such, the exact procedure for assessing autism according to ICD-10 is unclear. The authors attributed the low rate of autism in their study to a lack of expertise in the identification of autism within liaison and diversion services, noting that such services were traditionally developed for people with severe mental illness.

Prison

Three studies were set within European prison settings, and the prevalence rates ranged between 0% (Robinson et al., 2012) and 10% (Billstedt et al., 2017). Robinson et al. (2012) examined the utility of a new autism screening tool, the ASD Screening Instrument, with 2458 prisoners in Scotland , regarding test-retest reliability, convergent validity between tools, and sensitivity/specificity analyses. Sensitivity for the screening tool was measured in relation to scores of 32 or above on the AQ; and was low (28.6%), with a specificity of 75.6%. The area under the curve was 59.6%, which is poor (de Hond et al., 2022). The cut-off to indicate further assessment on the ASD Screening Instrument was set at 5; however, due to no prisoners meeting this cut off, any prisoners who scored above zero were invited to take part in the next stage of the study: a clinical interview including the administration of the 50-item Autism Quotient (Baron-Cohen et al., 2001), Asperger Syndrome/high

functioning autism Diagnostic Interview (ASDI) (Gillberg et al., 2001) and Ekman 60 Faces Test (Ekman & Friesen, 1976). The authors found no cases of autism and noted that the study was not designed to estimate prevalence, although it was the largest study examining autism screening in a prison setting. Several reasons were provided by the authors to explain the lack of autism cases, which included the non-participation of autistic prisoners in assessments (selection bias), their diversion from the CJS, or the likelihood of a lower level of offending. The authors stated that the tools used might not identify autistic people in this population. Given that none of the prisoners scored above the cut-off for autism on the new screening tool, and as such prisoners without any identified autistic traits were then being assessed, it is likely this was a factor. The non-participation of autistic prisoners in this study is problematic, and as such, the validity of any estimate taken from this data is questionable. Furthermore, prison officers were asked to complete the screening tool if they had known the prisoner for over a week, which is insufficient time to observe the behaviours and characteristics assessed by the screening tool.

In a cross-sectional study of a Category C UK Prison in England (closed prisons for prisoners who are not eligible for open conditions but are unlikely to attempt an escape), McCarthy et al. (2015) found 12 of 240 male prisoners met the autism criteria, yielding a prevalence rate of 5%, using the Autism Diagnostic Observation Schedule (ADOS) (Gotham et al., 2006) alongside the Autism Diagnostic Interview (ADI) (Lord et al., 1994); a combination of measures often described as the 'gold standard'. Use of two of the gold standard measures for autism assessment could increase the reliability and validity of their prevalence estimates. However, Kaufman (2022) highlighted that 'gold standard' proclamations have not been adequately scrutinized or researched and cautioned with use of such terms within psychological and psychiatric assessment. Highlighting another factor affecting autism assessment in CJS settings, McCarthy et al. (2015) reported being required to omit/amend some tasks of the ADOS due to test items being restricted on prison wings. This included the construction task, picture book, pictures, and cartoon pictures, and the creating a story task (participants were asked to create a story without using physical objects as props). Furthermore, being a cross-sectional study design means the estimate is valid within a specific timeframe, and is only representative of a Category C prison, rather than prisons in general. Sampling and study methods are similarly an issue in Billstedt et al. (2017), where among sample of 270 young adult offenders (aged 18–25 years) imprisoned for violent offences in Sweden, 10% were diagnosed with autism. Although a multi-site study including a full range of forensic services and levels of prison security, Billstedt et al. (2017) considered only offenders in emerging adulthood, who had committed one offence type, acts of violence, and lacked random sampling methods thus limiting generalisability, like

McCarthy et al. (2015). Also similar to McCarthy et al. (2015), the authors used 'gold standard' assessments for autism 'when possible' for participants potentially meeting diagnostic criteria for autism, e.g. either a Diagnostic Interview for Social and Communication disorders (DISCO) (Wing et al., 2002) or an ADOS (Lord et al., 2000), the ASDI (Gillberg et al., 2001) or a combined interview and observation schedule, in addition to clinical observation and participants self-report of atypical sensory perception.

Secure inpatient/forensic psychiatric settings

Eight studies were conducted in inpatient secure hospitals, and two of these focused on intellectual disability populations. The studies were set in the UK ($n = 3$), the USA ($n = 3$), and Sweden ($n = 2$), spanning high, medium, and low secure settings. Four studies focused on adults, one focused on both adults and adolescents, and three on only adolescents. Most of these studies were from individual services ($n = 6$), while two were multi-site. Between these eight studies, autism prevalence ranged from 4% (Krona et al., 2017) to 60% (Sutton et al., 2013). The four studies which took place in adult settings relied on case-file information accessed retrospectively, with no approach to screening and diagnosis reported outside of adhering to a diagnostic manual, which limits reliability and validity. These studies are affected by observational designs where researchers collected retrospective data, rather than proactive screening of every patient. Papers utilised cross-sectional samples from forensic psychiatric settings, which are at risk of bias and are not necessarily representative of the population being studied. Furthermore, autism diagnoses were extracted from patient casefiles.

Griffiths et al. (2018) reported that 49 (14%) of 347 admissions to four UK locked, low, and medium secure inpatient mental health services between 2007 and 2015 had Asperger Syndrome according to ICD-10. Krona et al. (2017) examined autism diagnosed according to DSM-IV among 125 individuals sentenced to forensic psychiatric in-patient treatment during 1999–2005 in Sweden, reporting a prevalence of 4% (5/125). Esan et al. (2015) reported that 42 (30%) of 138 inpatients within a medium-secure forensic intellectual disability service in England had ASD according to ICD-10 diagnostic criteria (World Health Organization, 1993). Stinson and Robbins (2014) reported that within a sample of 235 persons with intellectual disabilities in a secure forensic psychiatric hospital in the United States, which had maximum, intermediate, and minimum-security units, 15% were autistic according to DSM-IV-TR. These studies utilised differing conceptualisations of autism, with one focusing only on Asperger syndrome (Griffiths et al., 2018), while others focused on the broader ASD diagnosis according to ICD-10 (Esan et al., 2015; Griffiths et al., 2018) or DSM (Stinson & Robbins, 2014). As intellectual disability confers a higher probability of co-occurring autism (Brugha et al., 2016), rates in settings specifically for this population

are likely higher than other forensic settings and cohorts. In forensic intellectual disability services, autism prevalence ranged from 15 (Stinson & Robbins, 2014) to 30% (Esan et al., 2015).

Anckarsäter et al. (2008) reported an autism prevalence of 19% among 330 individuals recruited from forensic settings in Sweden. In this study, the ASD diagnosis was established based on clinical examinations and the Structured Clinical Interview for DSM-IV Axis I (SCID-I) (First & Gibbon, 2004), or the ASDI using Gillberg and Gillberg (1989) criteria. Semi-structured collateral interviews, including the questions according to the Asperger Syndrome Screening Questionnaire (ASSQ) (Ehlers & Gillberg, 1993) and the ASDI, were made whenever possible. The aut

hors reported rates separately for adolescent settings, defined as those between 11 and 18 years (15.4%), and adult forensic psychiatry hospitals (22%; one was specifically for violent or sexual offenders).

The remaining three studies looked at adolescent populations. Hill et al. (2019) reported an autism prevalence rate of 7% among a cohort of 100 consecutive patients admitted to an adolescent (age range 12–18) medium-secure forensic unit in England. The authors utilised recorded pre-existing clinical diagnoses made by consultant psychiatrists, based on the multidisciplinary team's comprehensive assessment, according to the ICD-10 . Sutton et al. (2013) examined prevalence among 37 adolescents (age range 14–20) with average intelligence sentenced to treatment for sexual offending in the USA and reported that 22 (60%) met autism diagnostic criteria. In making an ASD diagnosis, the authors: (1) reviewed previous functioning and psychiatric symptoms or developmental deficits from multiple sources including interviews with the participant, parents when possible, and facility staff when appropriate, alongside data from collateral documents (e.g. court reports; previous psychological, school, and physician evaluations; community facility reports), (2) completed the Enhanced Mental Status Clinical Evaluation Interview, and (3) used the Asperger Syndrome Diagnostic Scale (ASDS) (Myles et al., 2001), which captures observable and measurable behaviours across five subscales (language, social, maladaptive, cognitive, and sensorimotor) that can be evaluated by parents and or other professionals familiar with the individual. This study reported the highest rate of autism among studies set within CJS/forensic settings. This is likely to be a feature of the rigorous approach to screening and assessing autism, and the focus on a highly selected sample of adolescents convicted of sexual offending.

Cunningham et al. (2021) examined autism prevalence among 2092 charged adolescents (aged between 8 and 18.5) referred for competence evaluations by licensed psychologists at a state psychiatric hospital in the USA. Primary clinical diagnoses recorded were either PDD, Autistic Disorder, ASD, Asperger Disorder, and Other or Unspecified Neurodevelopmental Disorder, and using this conceptualisation, autism was diagnosed in 24.1%

of the overall sample. Similar to the adult literature, the adolescent studies found rates of autism that were higher than the national average, yet varied widely, from 7% (Hill et al., 2019) to 60% (Sutton et al., 2013). This is reflective of the wide-ranging approaches to assessing autism, and between study variation in sampling. However, many of these studies were biased and unrepresentative of autistic people within the CJS. Similarly, various approaches to assess autism were employed introducing heterogeneity, ranging from relying on diagnoses recorded in clinical case notes to diagnosis using 'gold standard' instruments. Despite these limitations, findings indicated that within inpatient secure settings, autistic people are overrepresented in relation to corresponding general population estimates.

Referrals for forensic psychiatric examination

Eleven studies examined autism prevalence among patients referred for forensic psychiatric examination and among these studies, rates of autism prevalence ranged from 1% (Helverschou et al., 2015) to 33% (Sturup, 2018). These variations relate to methodological differences, such as the sample size, the way autism was diagnosed, or inclusion of participants with comorbid intellectual disabilities. Indeed, all these studies focus on mentally disordered offenders, and as such, are highly selective in nature, yet some focused more narrowly on perpetrators of specific offence types, with a predominance of studies on violent offences, specific types of violent offence, arson, and sexual offending. Of these studies, two focused on adolescent populations and nine focused on adults. Studies were based in Europe (Sweden, Norway, the Netherlands, Finland) and the USA.

Among papers reporting adolescent populations, rates ranged from 5.4% to 31.7%. Of 1799 pre-trial forensic psychiatric and psychological assessments of 12–17-year-old male adolescents in the Netherlands between 2013 and 2014, Rutten et al. (2022) reported that 98 had an ASD diagnosis (5.4%) according to DSM-IV-TR. Cunningham et al. (2021) examined adolescents referred for initial pre-trial mental health evaluations of competence to proceed to adjudication in the USA from 1996 to 2017. The sample was considered according to two groups, adolescents with current or prior sexual charges ($n = 477$) and those without ($n = 1615$). Those with sexual charges were more likely than those without to have a primary clinical diagnosis of autism, with rates of 31.7% vs. 21.9%. Lindberg et al. (2012) evaluated 77 13–18-year-old adolescents undergoing psychiatric evaluations in Finland between 2007 and 2009 due to a threat of massacre at school. In this study, assessments of PDD were made according to the ICD-10, yielding a prevalence rate of 10%.

Two studies included both adolescents and adults. Siponmaa et al. (2001) focused on 112 patients (aged 15–22) under forensic psychiatric investigation (FPI) after committing serious offences. To diagnose autism, a semi-structured

psychiatric interview was conducted according to DSM-IV criteria and the research diagnostic algorithm for Asperger Syndrome (Gillberg & Gillberg, 1989). Rates were broken down into PDD (15%), PDD NOS (6%) and Asperger syndrome (9%), with an overall autism prevalence rate of 30%. Wahlund and Kristiansson (2006) examined 402 male offenders who had been found guilty of homicide or manslaughter and referred for forensic psychiatric assessment in Sweden (1996–2001) aged between 15 and 71 years. Using DSM-IV diagnostic criteria, eight individuals were reported as having autism, conferring a prevalence rate of 2%.

Moving on to the adult studies, Helverschou et al. (2015) examined 3382 adults who had been assessed by the forensic psychiatric service in Norway from 2000 to 2010, finding an autism prevalence of 1% (48/3382) as diagnosed according to ICD-10. Warren et al. (2013) examined rates of PDD, diagnosed using DSM criteria. This study focused on 2260 defendants deemed incompetent to stand trial and undergoing forensic assessments in the USA, and among this sample, 8% were diagnosed with PDD. Edberg et al. (2022) conducted a retrospective cohort study of 3365 individuals sentenced to forensic psychiatric care in Sweden in 1997–2013. Within this study, 11.3% of the whole sample had a diagnosis of autism according to DSM-IV. When the sample was separated into subgroups of those with intellectual disabilities vs those without, rates were 25.5% in the ID group compared to 10.1% in the non-ID group. These studies all used clinician assessment according to ICD-10 or DSM criteria. Soderstrom et al. (2004) reported a prevalence rate of 18% in a Swedish sample of 100 consecutive patients of pre-trial forensic psychiatric examinations following severe violent or sexual index crimes. These authors employed the ASSQ (Ehlers & Gillberg, 1993), and the ASDI (Gillberg et al., 2001), classifying cases according to the research diagnostic algorithm for Asperger Syndrome (Gillberg & Gillberg, 1989).

Enayati et al. (2008) reported that among people referred for an inpatient forensic psychiatric examination in Sweden, the rate of autism or Asperger syndrome diagnosed using the DSM-IV was 7% (15/214) for arsonists and 3% (69/2395) for other violent offenders. The authors reported that convicted persons awaiting sentencing but suspected of having committed a crime associated with a mental disorder can be referred for a forensic psychiatric examination, and that this may be influenced by several factors, such as a previous history of mental illness, odd or bizarre crime characteristics, disturbed behaviour in custody or during court proceedings. Hedlund et al. (2016) examined prevalence among 87 homicide offenders, including 74 filicide offenders (parental killing of a child) and 13 extra-familial homicide offenders involving 0–14-year-old victims, reporting a prevalence of 9% (8/87) overall, with 7% (5/74) filicide offenders and 23% (3/13) of extra-familial homicide offenders reported as autistic. This study was also set in Sweden, utilising

forensic psychiatric assessments. A study examining homicide offenders in Sweden between 2007 and 2009 reported 33% (8/25) of serial-homicide offenders and 3% (5/201) of single-homicide offenders had autism (Sturup, 2018). These studies were cross-sectional in nature and did not report their approach to screening and diagnosis. Instead, diagnoses were made according to a diagnostic manual, which limits reliability and validity. Likewise, studies were largely observational in nature, utilising convenience samples from forensic psychiatric assessments, which are biased and are not representative of the population being studied.

Section summary - prevalence rates of autism in the CJS

The range of prevalence estimates among studies can be attributed to the diverse methodologies reported: specifically, the way in which autism was classified and diagnosed, comorbidity within the sample, and characteristics of the CJS/forensic setting or cohort. The approach to autism classification and diagnosis is likely to affect prevalence rates, and a range of approaches to screen and diagnose autism were employed. Some used diagnoses recorded in clinical case notes (referencing a diagnostic manual), meaning that not all study participants were screened for autism, and affected by autism awareness among clinicians and within services over time. Others employed more systematic screening, increasing the likelihood of identifying cases, and use of specific tools or structured assessments to supplement the consideration of manualised diagnostic criteria. A minority of studies reported an approach to measuring autism that was closer to the 'gold standard'. Some studies reported rates of those with Asperger Syndrome, only a subgroup within the autistic spectrum, and a diagnosis which excludes people with intellectual disabilities. Other studies included participants with comorbid intellectual disabilities, which confers an increased probability for autism (Brugha et al., 2016). As such, studies reporting ASD vs Asperger Syndrome are likely to have higher rates in comparison.

Similarly, characteristics of the specific forensic/CJS setting affected reported rates (i.e. prison as compared to forensic psychiatric services) or the cohort (some studies focused on selected subgroups, such as only violent offenders), meaning the sample is not representative of the CJS as a whole. Some studies utilised small sample sizes within single services, while others included large cohorts of offenders across multiple settings, which are likely to be more representative. Forensic psychiatric services specifically for mentally disordered offenders had higher rates of autistic inpatients, while prisons had lower rates. Whether this is true difference, or reflective of reduced autism awareness in CJS settings such as courts and prisons, compared to forensic psychiatric services where awareness is typically higher, requires further research. Studies focused on specific

offence types, such as violence, arson or sexual offending, also had high rates of autism. It is possible this reflects biases within the referral of autistic offenders convicted for such offences to forensic psychiatric settings, or conversely, difficulties discharging such offenders.

Prevalence of CJS involvement in autistic populations

Prevalence rates of CJS/forensic involvement in autistic populations (i.e. studies examining self-reported criminal behaviour within community autistic samples, or those presenting official criminal records, such as police contact, charges and convictions among autistic cohorts) were examined in 16 studies, summarised in Table 3. Reported rates varied from 3% to 71% between studies. Five studies focused on adolescents, six included adolescents and adults, and the remaining five focused on adults only. The autistic populations sampled included community-based, psychiatric, or large cohorts with linked datasets. Ten studies included a comparison group, and rates of offending were lower in the autistic group in five studies, and equivalent in five studies (one study found conviction rates to be higher among the autistic group in contrast to the comparison group; although this effect was attenuated after adjusting for the presence of ADHD or conduct disorder). As such, across studies, the rate of offending behaviour, however defined, was equal to, or lower among the autistic group compared to the study comparison group. This finding builds on the previous review by King and Murphy (2014) which retrieved four studies with comparison groups, all of which reported that autistic people committed the same or fewer number of offences.

Self-report studies

This category details studies focused on self-reported offending behaviour by autistic people, which report the highest rate of offending behaviour, in comparison with other methods of measuring offending, such as official statistics of police contact, charges, or convictions, following patterns observed in the general population (Gomes et al., 2018). Weiss and Fardella (2018) focused only on violent offending, comparing rates between 45 autistic adults and 45 adults without autism. The Juvenile Victimization Questionnaire-Adult Retrospective (JVQ-AR) was used as a self-report measure of violence perpetration. Autism was assessed using the ADOS-2. Analysis focused on whether participants endorsed at least one of the 19 forms of violence perpetration on the JVQ-AR, which was 71% (32/45) for the autistic group compared to 60% (25/45) of the non-autistic group, a difference which was not statistically significant. Woodbury-Smith et al. (2006) examined offending behaviour among a community cohort of 25 autistic adults, compared to a non-autistic group of 20 adults in England. Significantly

fewer in the autistic group reported a history of engaging in illegal behaviours, 48% (12/25), compared to 80% (16/20) of their non-autistic peers.

Blackmore et al. (2022) examined self-reported offending behaviour of 1130 patients who received an ASD diagnosis from a diagnostic clinic in England, alongside a comparison group of 440 who did not receive a diagnosis. Diagnosis was determined by a consultant-led multi-professional expert consensus, according to ICD-10 research diagnostic criteria and informed by either the ADI-R and/or ADOS-G or ADOS-2. Autistic individuals were significantly less likely to have had contact with the CJS than non-ASD individuals (23% vs 32%). However, it is important to emphasise that the non-ASD comparison group in the study was a clinical sample, not drawn from the general population, who had co-occurring diagnoses (65% had at least one) which could have influenced offending behaviours and/or contact with the CJS. Between self-report studies, rates ranged from 23% to 71%. The two studies with the largest rates had small sample sizes and could be underpowered. In the two studies that included a comparison group, the autistic group had lower reported rates of offending behaviour, one of which reached statistical significance. The comparison groups varied, with one being a matched control group, the other convenience sample of people with other mental disorders which could have influenced offending behaviour. Self-reported criminal behaviour has been the subject of extensive research, highlighting discrepancies between official records and self-reports of delinquency, with many more self-reported offenses compared to police charges (Theobald et al., 2014).

Offending behaviour recorded in psychiatric case notes

Two studies focused on offending behaviour recorded among psychiatric inpatients or collected as part of a psychiatric assessment. Rates in this category ranged from 21% to 26.6%. Kawakami et al. (2012) examined rates of offending behaviour as reported in the clinical records of 175 individuals diagnosed with high functioning ASD according to DSM-IV in Japan (American Psychiatric Association, 2013). Of this sample, 21% (36/175) had criminal behaviour recorded. Allen et al. (2008) examined offending behaviour among 126 adults with Asperger syndrome identified from community mental health, intellectual disability and autism providers, probation services and prisons in Wales. Information on offending behaviour was collected from case-notes using questionnaires. Within this sample, 33 (26.6%) had engaged in offending behaviours that had or could have resulted in involvement in the CJS. This study covered a wide range of services, including community-based services, and forensic services, which is likely to have inflated rates of offending behaviour.

Police contact

Three studies examined police contact (either as a suspect or perpetrator; not as a victim of a crime) with individuals with autism residing in the community, with rates ranging from 3% to 16%. In this category, the highest rates were reported among adolescents and young adults. Tint et al. (2017) investigated police involvement among 284 adolescents with autism in Canada followed for 12–18-months. During the study period, 16% (46/284) of the autistic adolescents had been involved with the police, as reported by the parent on behalf of their child. Reporting a national birth cohort study which linked health and criminal justice system data, Bowden et al. (2022) compared the incidence of police proceedings between 1197 people diagnosed with autism (DSM or ICD-10) and 147,879 without autism in New Zealand. During the eight-year window covered by the study, 282 young people with autism were proceeded against by police, yielding a prevalence of 23.6%. Reporting the lowest rate in this category, and the only study focused on adults, Tint et al. (2019) examined self-reported police contact among 40 autistic adults over 12–18 months in Canada, highlighting that 3% (13/40) reported involvement with the police during the study period.

Charges

Three studies examined criminal charges, and rates between these studies varied from 3% to 16.8%. Cheely et al. (2012) examined the criminal charges of 609 adolescents (age 12–18) with autism in the USA. Of the total study population, 5% were charged with a total of 103 offences, and a mean number of 3.3 offences per autistic adolescent compared to a mean of 5.7 offences per non-autistic adolescent within a matched comparison group ($n = 32$). Yu et al. (2021) examined involvement in both the juvenile and adult CJS for young adults aged 17 to 23 years with ASD ($n = 606$), compared to individuals with ID ($n = 1271$) and a population control group ($n = 2973$) in the USA. Of the individuals with ASD, 3% were charged with at least one offense by the time they reached young adulthood, compared with 7.5% in the comparison group. Bowden et al. (2022) also reported on court charges in their cohort study, comparing 1197 people with autism and 147,879 without autism. Over an 8-year period, court charges were laid against 16.8% of those with autism, in contrast with 21.4% of the comparison group. However, the autistic people charged with an offence were significantly more likely to be charged with serious and violent offences, offences against the person and against property.

Convictions

In the six studies examining convictions, rates varied from 4.4% to 12.8%. Four were large data linkage studies focused on adolescents or young adults. Bowden et al. (2022) examined convictions in 1197 people diagnosed with

autism compared to those without ($n = 147,879$): 12.8% were convicted contrasting with 7.2% of the comparison group. Heeramun et al. (2017) examined the characteristics of those convicted for violent crimes in Sweden ($n = 295,734$) among a large cohort of children and adolescents (aged 0–17 years) ($n = 735,096$), who were followed up from 15 years (the Swedish age of criminal responsibility) through up to a maximum of 27 years of age. Autistic individuals were identified through psychiatric assessments, which typically cover social, medical, and developmental history, observation, and cognitive testing, recorded on a database according to diagnostic manuals. By the end of follow-up, 250 (4.4%) diagnosed with autism, and 7643 (2.6%) without autism had received at least one conviction for a violent crime. Autistic individuals, particularly those without intellectual disability, initially appeared to have a higher risk of violent offending; however, after adjusting for the presence of ADHD or conduct disorder, the risk estimates markedly attenuated. Among autistic individuals, male sex and psychiatric conditions were the strongest predictors of violent criminality, along with parental criminal and psychiatric history and socioeconomic characteristics. There was some evidence that a delayed diagnosis of autism was associated with a greater risk of violent crime, while better school performance and intellectual disability appeared to be protective. Slaughter et al. (2019) examined a cohort of 58,678 juvenile-justice-involved adolescent (JJY) in the USA. Autism diagnoses were made within school using a structured evaluation tool which was consistent with DSM-5 (2013); but only those with autism recorded as a primary diagnosis were included ($n = 231$, 0.4%). This excluded those where autism was recorded as a secondary need. In this study, offences were recorded in three ways. Offences were first analysed for one school year 2010–2011. During this year, there were differences in offending types between the autistic and non-autistic groups, with rates of status offences higher in the autistic group (7% vs. 3.5%), significantly lower rates of property offences (0.7% vs. 9.8%), lower rates of drug violations (0.7% vs. 4.2%) and public order offences (7 vs. 10.5%), and similar rates of crimes against persons (2.8% vs. 2.8%). Offences were then analysed for the school years 2006–2010. During this period, rates of crimes against persons (23.1% vs. 15.4%) and public order offenses (29.4% vs. 33.6%) were similar across groups, lower status offenses (18.9% vs. 1.2%), significantly lower property violations (8.4% vs. 23.8%), and lower drug law violations (1.4% vs. 7%) among the autism group. Recidivism was defined as the commission of one or more offenses regardless of the offense type within three school years (2010–2013) for individuals who had one offense between 2006 and 2010. Fewer with autism (29.9%) committed a further offence compared to those without (32.5%), although these differences were not statistically significant.

The remaining three studies in this category focused on the recorded convictions of autistic people within inpatient psychiatric settings.

Mouridsen et al. (2008) examined the offending behaviour of 313 former child psychiatric inpatients with PDD in Denmark, including 113 with childhood autism, 86 with atypical autism and 114 with Asperger's syndrome, and compared rates to a matched non-autistic comparison group of 933 children. This cohort was followed up until adulthood, and convictions were obtained from the nationwide Danish Register of Criminality. The PDD group were less likely to have been convicted (29/313, 9%), compared to 18% (168/933) in the non-autistic comparison group. Långström et al. (2009) investigated convictions for violent or sexual offenses among 422 adolescents hospitalized with autistic disorder or Asperger syndrome (diagnosed according to ICD9/10) during 1988–2000 in Sweden. Thirty-one individuals with ASD (7%) were convicted of violent nonsexual crimes and two of sexual offences. Lundström et al. (2014) examined the occurrence of violent offences among 954 autistic children compared to 33,910 matched (by age, sex, and residential area) comparison children from population-based registers of all child and adolescent mental health services in Sweden. They reported that autistic children were not significantly more likely to commit violent offences relative to their non-autistic peers. Five of six studies in this category had comparison groups, and in all these studies, the autistic groups number of convictions were equal to or lower than comparisons.

Section summary - prevalence of CJS involvement in autistic populations

Study methodologies among the papers examining CJS involvement among autistic populations varied widely, including self-report among community autistic samples, offending behaviour reported in psychiatric case-notes; and official records, such as police contact, charges, and convictions. Ways in which to measure criminal behaviour have been the subject of extensive research, and there are two major approaches; official records; and self-reports (Gomes et al., 2018). The primary limitation of official crime reports is that they provide an underestimate of offending. Not all offences are reported to the police, recorded by the police, only some offenders are convicted and even fewer sentenced to custody (Gomes et al., 2018). As such, self-report methodologies were developed, and research concluded that this technique had predictive validity, while noting it should not replace officially recorded data, and that the most accurate measure is likely to be a combination of official records and a self-report questionnaire (Gomes et al., 2018). Within this systematic review, the highest rates of offending behaviour among autistic cohorts were evident within the studies utilising self-report methodology, in accordance with the general literature. While the validity of self-report methodology has not been explored with autistic populations, there is no reason to suggest that it would be any less valid. Likewise, the lowest rates utilised officially recorded criminal statistics. Within this category, some studies utilised small convenience samples, while others reported large

datasets of autistic cohorts linked with official records of CJS involvement, maximising generalisability. Furthermore, some studies focused on specific types of offending behaviour, such as violence, and are thus not representative of all offending behaviour. Levels of psychiatric comorbidity, such as intellectual disabilities and other mental disorders varied, all of which affect reported rates.

Discussion

The aim of this systematic review was to synthesise studies that investigated the prevalence of autistic individuals within CJS/forensic cohorts and settings, and the prevalence of CJS/forensic involvement amongst autistic people. Within the studies examining the prevalence rates of autism within CJS/forensic settings and cohorts, rates varied from 0% to 60% and were higher than the prevalence of autism in the general population of 1% in 24 of 25 papers, with the remaining study reporting a rate lower than general population. Therefore, this suggests autistic people are overrepresented within the CJS. Prevalence rates of CJS involvement in autistic populations were examined in 16 studies, and reported rates varied from 3% to 71% between studies. Of the 10 studies that included a comparison group, rates of offending were lower in the autistic group in five studies, and equivalent in five studies. As such, the rate of offending behaviour however defined, was broadly equal to, or lower among the autistic group compared to comparison groups. These findings raise questions as to why autistic people can simultaneously appear to be equally or less likely to engage in offending behaviour, as suggested by studies investigating the forensic involvement of autistic cohorts, and yet over-represented in studies examining autism prevalence in CJS/forensic settings. Potential explanations relate to the vulnerability of autistic people within the CJS pre- and post-sentencing, and factors intrinsic to the autistic offender. These factors will be discussed in the below sections.

Pre-sentencing factors

Autistic people appear disadvantaged at the pre-sentencing stage of involvement within the CJS. Autistic people may be more likely to be caught for their criminal behaviour and have communication/social difficulties in their interactions with police (North et al., 2008). Within police custody as suspects, autistic people may experience a range of intrusive processes (Calton & Hall, 2022). These include booking-in, fingerprinting, swabbing, drugs testing and police interview, alongside being detained in a cell while the investigation takes place, thus experiencing a loss of privacy, loss of control, and isolation (Holloway et al., 2020). The sensory aspects of autism may further exacerbate the impact of these factors, making them more vulnerable to adverse

outcomes (Holloway et al., 2020), such as increasing the likelihood of confession (Murrie et al., 2002). Similarly, if important legal information is not conveyed in an accessible way, this could lead to autistic detainees making ill-informed decisions in custody or entering a guilty plea. Autistic people have difficulty with receptive and expressive communication, particularly pragmatics, which affects both understanding and social discourse. This will likely disadvantage them in the highly verbal legal process (Larson et al., 2023) and court environment, including advocating for their rights in court, mounting a successful defence, instructing legal professionals, and cause difficulties following court proceedings. There are a number of schemes designed to support autistic arrestees or defendants in the UK, such as use of Appropriate Adults (Jessiman & Cameron, 2017; O'Mahony, 2010; Richards & Milne, 2020) during police interviews, or Registered Intermediaries (O'Mahony, 2010) during the court process, however these concessions are not consistently applied, and dependent on successful identification of the accused's autism by police or court staff. Modell and Mak (2008) found that only 20% of law enforcement officers could identify defining features of autism, and Hepworth (2017) stated that current policy and police staff training is insufficient during all initial stages of the CJS process. The availability of such schemes also varies worldwide (McCarthy et al., 2022). Taken altogether, it is possible that this disadvantage means that autistic people are affected by discrimination within the CJS due to a general lack of awareness and understanding of autism and its implications in this context (Chown, 2010). Furthermore, this situation possibly contravenes the Convention of the Rights of Persons with Disabilities (CRPD) which emphasises the right to equality before the law, equal protection of the law for all persons and the benefit of the law for people with disabilities, and requires that nations secure necessary supports for people with disabilities undergoing legal proceedings, as outlined in Articles 5, 12 and 13 (McCarthy et al., 2022).

Post-sentencing factors

It is possible that sentencing and post-sentencing factors may also affect the prevalence of autism within CJS/forensic settings and cohorts. It has been suggested that autistic defendants are sentenced more harshly, due to a lack of typically presented empathy or remorse (Archer & Hurley, 2013). However, several studies suggest autistic people may be diverted from the CJS following sentencing. The high number of autistic people within forensic psychiatric cohorts supports this narrative. Esan et al. (2015) reported that those with autism were less likely to be subject to restriction orders, a Mental Health Act (1983) provision where discharge from hospital can only occur following a Mental Health Tribunal or consent from the Ministry of Justice.

Bowden et al. (2022) reported that their finding that autistic young people were less likely to be charged and convicted, reflected a responsivity to autistic people and effectively diverting them away from the CJS. This is noteworthy considering a further commonly reported finding, that many autistic offenders only receive their autism diagnosis following their offence disposal (Helverschou et al., 2015), suggesting that courts may be identifying vulnerability, without the need to attribute this to a specific diagnosis in individual cases. This also raises the question as to how many autistic people are 'slipping through the net', having their autism going unrecognised at all stages of the CJS, from the point of the offence, to following disposal. Studies examining autism awareness across the CJS have concluded that knowledge among staff is low. Indeed, in their study within liaison and diversion court services, Chaplin et al. (2022) felt the lack of expertise in the identification of neurodevelopmental disorders within services traditionally developed for severe mental illness was evident and affected their reported prevalence rate. As such, training in autism is recommended for all people likely to encounter autistic people at risk of contact with the CJS to ensure equality in outcomes.

Another explanation as to why autistic people may be over-represented within prisons and forensic psychiatric settings is that a lack of autism sensitive forensic rehabilitative programmes and risk assessments may contribute to longer stays. This issue is discussed at length in relation to a case series by Smith (2021) where several individuals' autism had gone unrecognised within prison and forensic psychiatric services, and treatment progress was limited until the diagnosis was eventually made. This issue warrants further research in larger samples. While there are a limited number of specialist autism forensic units, the treatment programmes offered by such services are under researched. Autistic offenders are most often placed among 'neurotypical' offenders and (Murphy, 2010b) and expected to fit in with conventional therapeutic programmes (Murphy, 2010a), which are primarily developed for patients with personality and psychotic disorders, with few manualised treatment programmes that have been robustly evaluated (Salter & Blainey, 2024). Esan et al. (2015) reported that the autistic group within their cohort of offenders within an inpatient intellectual disability service had higher rates of restrictive interventions such as physical intervention/restraint, and observations, compared to those without autism. These measures are often used as proxy measures for institutional violence or increased mental health needs. This could present challenges to autistic people within an inpatient environment, and may be linked to longer lengths of stay, as inpatient teams are reluctant to discharge patients who have recently required these interventions. Forensic risk assessment and

management often does not consider factors associated with autism (Gunasekaran, 2012) which may also contribute to clinician unease in discharging. It is therefore possible that autistic inpatients and prisoners may experience poorer outcomes following hospital admission or imprisonment. However, research is lacking, and no studies have systematically examined outcomes of autistic offenders as compared to general offender groups (Alexander et al., 2016).

Autistic offender/offence factors

It has been suggested that it is characteristics central to the autistic offender (such as a lack of empathy), or their specific offences (Haw et al., 2013), that explain their over representation within forensic settings. For example, speculation that while autistic people commit offences as an equal rate to their non-autistic counterparts, when an autistic person does offend, they commit more serious offences and so spend longer in forensic services. Rates of autism were high among the highly selected cohorts of mentally disordered offenders who had committed serious offences such as violence, arson, or those of a sexual nature (Enayati et al., 2008; Kumagami & Matsuura, 2009; Sturup, 2018; Sutton et al., 2013). However, assessing the severity of offences by autistic people and non-autistic counterparts was beyond the scope of this review, and as such, this needs further exploration in future research. Assuming a causal relationship between autism and an individual's offending behaviour is a reductionist approach which can overshadow other pertinent risk factors for offending, and subsequently, a lack of tailored treatment (Pearce & Berney, 2016). Studies examining the characteristics of autistic offenders have emphasised the role of general criminogenic risk factors, such as low intelligence, poor school achievement, truancy, aggressive behaviour, and hyperactivity-impulsivity-inattention (Woodbury-Smith et al., 2005), as well as comorbid mental disorder in the offending behaviour of autistic individuals. Similarly, Heeramun et al. (2017) also emphasised the role of male sex, ADHD, conduct disorder, parental criminal and psychiatric history, socioeconomic characteristics and delayed autism diagnosis as key risk factors for offending in autism; while better school performance and intellectual disability appeared to be protective. Conversely, autism should not be disregarded when contextualising offending, and while it may not be a causal factor, some literature suggests that it can be relevant within an individual's pathway to crime. Several authors draw links between offending and social communication/interaction issues such as difficulties with emotional regulation and literal/rigid thinking (Baliousis et al., 2013; Chester & Langdon, 2016). Cases have also described instances of violence in response to sounds that triggered sensory issues (Larch, 2016; Mawson et al., 1985), alongside the role of circumscribed interests in offending (Woodbury-Smith et al., 2010).

Drawbacks and limitations

Due to the variety of methodologies used within the research in this area, it was not possible to complete a meta-analysis of the data collected, as has been reported by previous authors (King & Murphy, 2014). A meta-analysis would have enabled us to obtain a weighted average of results from included studies and thus answering the research question would have been more straightforward. The included studies utilised the diagnostic criteria in use at the time of publication, meaning that some studies utilise language that is not currently preferred by the autistic community, or use criteria that is now outdated. Only studies written in the English language were included, due to lack of resources for translation. Limiting systematic reviews to English-only can result in biased estimates and reduce generalizability (Jackson & Kuriyama, 2019). Relatedly, all included papers were conducted in high-income countries, which means they are unlikely to represent the world view. All authors are based in England, and as such much of the research we draw upon is from our country and does not represent legal systems operational elsewhere worldwide. It is possible that the search terms did not identify all relevant studies, although this was supplemented by backward searching. Quality appraisals were completed solely by the first author which may introduce bias, errors, and discrepancies and which reduces reliability. The included research represented a range of methodologies, yet quality as rated by the MMAT was variable, with difficulties with sampling strategy/representativeness, measures of autism, and risk of response bias which impact the reliability of findings. Authors of previous systematic reviews on this topic have noted similar difficulties with the literature (Collins et al., 2023; King & Murphy, 2014). Considering the seven points of the Sequential Intercept Model, most of the prevalence studies were at points 0) Community Services, 1) Law Enforcement, 2) Initial Detention and Investigation, 3) Courts, 4) Prisons/Jails/Confinement. There were no studies which considered prevalence of autistic people who were at points 5) Re-entry to Society, or 6) Community Corrections that met criteria for inclusion. As such, we know less about autism prevalence for these stages of the CJS. All these factors should be considered when interpreting the review findings, and if this review were to be repeated in future, it is recommended that these limitations are addressed.

Conclusions

The studies included in this systematic review investigated autism prevalence in the CJS/forensic settings and CJS/forensic involvement among autistic populations. Findings suggested that autistic people are overrepresented within CJS/forensic settings, despite studies suggesting that autistic people

offend at a rate equal to or lower than their non-autistic counterparts. Despite the over representation of autistic people in CJS/forensic settings, a lack of responsivity to the needs of this population has been highlighted. A further consideration regarding these findings is whether the high rates of autism within the forensic settings reported in this review, are indeed a negative outcome. The studies reported here were predominantly from forensic psychiatric services, which are a key part of the liaison and diversion strategy for mentally disordered offenders, and well established in much of Europe, recognising that this group of offenders often do not thrive in overly punitive environments such as prison (e.g. Allely, 2015; Helverschou et al., 2018), and instead require a therapeutic setting which emphasises rehabilitation. While concerns rightly remain about the appropriateness of forensic psychiatric services for this often-vulnerable group of offenders, especially regarding the treatments being offered, their experiences of services, and the acceptability of their length of stay, it may be considered preferential to a length stay in prison whereby criminogenic needs may remain unaddressed.

However, research has also indicated that autistic offenders have a poorer experience and heightened exposure to challenges within forensic settings, due to poor autism awareness, sensory processing issues (Murphy & Mullens, 2017), communication difficulties, and a lack of risk assessments and rehabilitation programmes tailored to their specific criminogenic need (Gunasekaran, 2012). Murphy and Mullens (2017) interviewed seven autistic people within one high secure service, reporting that although participants praised access to therapies including psychological and occupational, they also reported difficulties with aspects of their admission, including sensory issues with noise, having items associated with their interests restricted, and social stressors with other patients. In a study evaluating autism awareness training among staff working in forensic psychiatric services, it was reported that most staff feel under skilled with this group, due to a limited understanding of autism (Murphy & Broyd, 2019).

Much discussion has centred on whether conditions such as intellectual disability and autism should be included within the Mental Health Act within England and Wales, which facilitates the diversion from criminal justice to mental health settings, with some stakeholders preferring that they be removed. However, international experience has shown that removing such conditions from mental health legislation can have difficult consequences. In New Zealand, people with intellectual disabilities were excluded from The Mental Health (Compulsory Assessment and Treatment) Act (1992) unless they had another mental disorder. Following this, people with intellectual disability were inappropriately placed in prison, forensic mental health services, or discharged to the community without support or legal framework to underpin compulsory community supervision. Consequently, the New

Zealand Government passed standalone legislation: The Intellectual Disability (Compulsory Care & Rehabilitation) Act 2003 (IDCCRA); and the Criminal Procedures (Mentally Impaired Persons) Act 2003 to address the subsequent legislative gap (McCarthy & Duff, 2019; Tromans et al., 2023). While intellectual disabilities and autism are not synonymous, removing autism from the Mental Health Act could have similar implications if alternative provisions are not put in place.

Future research recommendations

There are various issues in the evidence base attempting to measure autism prevalence in the CJS. Therefore, if we were to design a perfect study of autism prevalence in the CJS, what would such a study look like? Migliavaca et al. (2020) developed a comprehensive set of items to guide the conduction of primary prevalence studies. These items were classified by three domains: population and setting, condition measurement, and statistics. Many of the items in the population and setting domain relating to the selection of the sample, in that it should be unbiased, representative, an appropriate size, random, and consider ethnicity characteristics. The others related to participation rate, the response rate, and assessment of non-responders. For condition measurement, the condition should be measured appropriately, accurately, precisely, should be valid and reliable, standard and unbiased, and reproducible. The prevalence estimate point, or period should be defined and of an appropriate length. An ideal prevalence study measuring autism and CJS involvement would ideally take the recommendations from Migliavaca et al. (2020) into account when planning the sample, designing the approach to screening for and assessing autism, defining the forensic involvement, including settings which serve both sexes, and record ethnicity. Furthermore, it would be useful to consult widely prior to such a study, involving stakeholders such as autism diagnosticians, representatives from forensic/CJS settings, and autistic people with experience of forensic/CJS settings/involvement.

It is important to note that prospective prevalence studies have been attempted in this field, but researchers report a series of challenges making the study of this area difficult. These challenges relate both to ethical and procedural difficulties in completing research within forensic settings, and in completing research with autistic people. For example, Dein et al. (2021) reported difficulties gaining approval from a National Research Ethics Service (NRES) Committee for their prospective study of autism prevalence within medium secure forensic psychiatric services. The ethics committee were concerned that asking potentially disturbing questions could lead to a worsening of psychiatric symptomatology, and/or violence within this population, were conscious of the power difference that exists between health

professionals and patients detained within forensic units for lengthy periods; and worried that patients might believe that non-participation in research would impact negatively on their treatment. These concerns were addressed by clarifying the benign nature of the content of questionnaires, and by emphasising the experience of the lead researcher in undertaking forensic patient interviews, emphasising the right to refuse consent and by agreeing that local site clinicians would make the initial approach to potential participants, instead of the lead researcher. There were subsequent difficulties gaining site approvals for research to take place which led to significant time delays. Dein reported a lack of response from clinicians contacted with requests to support the research, and a lack of identified participants from clinicians who did respond positively to the initial contact. Then, once potentially eligible participants were identified, one-fifth were acutely unwell, and therefore not approached for research purposes, one could not be recruited due to a lack of fluency in English, and half of those eligible declined to participate, without citing reasons. It was felt the refusal rates might be due to autistic people finding social situations (especially novel ones) difficult.

Robinson et al. (2012) planned a multi-centre study involving 12 prisons in Scotland, which required prison officers to screen prisoners, followed by a clinical interview in which further autism assessment would take place. Their interviews were also affected by non-participation (selection bias). Although screening was completed for most prisoners, fewer of those screening positive than negative on the tool chose to take part in the clinical interviews, suggesting that autistic individuals were less likely to take part. Overall, 26% of those eligible declined to take part, and a further 16.5% were unavailable due to court appearances, release or prison transfers. Conversely, reflecting on the strengths of their study, McCarthy et al. (2015) felt that having researchers trained in NDD embedded in the prison offering face-to-face interviews and assessments was critical to their success, noting that previous prison-based studies relied on using prison staff as informants or self-rating screening tools; methods were unlikely to be suitable for prisoners with such disorders. As such, researchers planning such projects are encouraged to seek out and utilise feasibility information from researchers who have undertaken similar projects to maximise the likelihood of a successful project.

The difficulties researching this area in a prospective manner could explain the preponderance of retrospective cross-sectional studies in this field, largely conducted by clinician-researchers working within the service that serves as the study setting. These studies benefit from reduced difficulties accessing services, patients and data, as the authors have access to these within their clinical role. In England and Wales, this type of project can be conducted according to service evaluation guidelines, which is a much simpler and quicker process than the ethics process required for prospective research (Health Research Authority,

2025). It is possible that in this study type, non-participation is ameliorated by repeated contact between clinicians and patients, the development of therapeutic relationships and rapport, which supports the completion of diagnostic assessments which are then recorded and accessed within later research. It is possible that these types of studies could be improved to bridge the gap between the prospective prevalence vs the cross-sectional methodologies. Firstly, studies could improve on the way they report the procedure for screening, assessing, and diagnosing autism within their services and CJS settings. It would be useful to record whether the person was diagnosed prior to their offence/admission or within the study setting, at what age they were diagnosed, the tools used to assist in making the diagnosis, and specifying the diagnostic criteria followed. Indeed, the cross-sectional studies accessed for this review varied greatly in the level of information provided, to the extent that some were excluded at the full-text stage. As such, we recommend the systematic screening and collection of autism data within CJS/forensic settings, echoing calls from a recent professional consensus article (Woodhouse et al., 2024) and to include those self-identifying as autistic, given recent developments in this area (McDonald, 2020). Future research would ideally consider all stages within the CJS, for example those specified in the Sequential Intercept Model, which considers contacts between autistic people and community services, with law enforcement, throughout detention and investigation, court, prisons, re-entry to society, and community corrections (Cooper et al., 2022; Shea et al., 2021). Furthermore, the samples reported in included studies were largely Caucasian male, and it is unclear whether subgroups of ethnic minorities are overrepresented within the CJS. Similarly, given their minority status, the responsivity of the CJS to female autistic offenders is worthy of future research focus. There is a need to systematically review the literature on the socio-demographic, clinical and forensic profiles of autistic offenders. Examining these characteristics could develop an understanding of the risk factors for engaging in offending behaviour among this population, and assist the development of risk assessments, offending prevention and rehabilitative programmes, with the aim of encouraging equal outcomes for autistic individuals at risk of offending, or who have offended.

Notes

1. Asperger's syndrome was removed as a category from the 2013 DSM-5 and replaced by an overarching diagnosis of 'Autism Spectrum Disorder'.
2. There are some discrepancies between the PROSPERO record and the present manuscript. Firstly, the present iteration focused only upon prevalence,

whereas the PROSPERO record was a broader systematic review with multiple aims. The search and extraction dates changed as searches were re-ran due to original timeframe delays.

3. We recognise the barriers in accessing autism assessments, and that some people choose to self-diagnose their autism. As one of the aims of this review was to investigate approaches to screening and diagnosis, we chose not to include self-diagnosed individuals. Nevertheless, no studies retrieved within the systematic search investigated self-diagnosed autistic individuals. We discuss this further in the recommendations for future research.

Disclosure statement

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