

Ethical Issues in Clinical Forensic Psychiatry

Artemis Igoumenou
Editor

 Springer

Ethical Issues in Clinical Forensic Psychiatry

Artemis Igoumenou
Editor

Ethical Issues in Clinical Forensic Psychiatry

 Springer

Editor

Artemis Igoumenou

Senior Clinical Lecturer and Honorary Consultant Psychiatrist,

Division of Psychiatry, University College London

London

UK

ISBN 978-3-030-37300-9

ISBN 978-3-030-37301-6 (eBook)

<https://doi.org/10.1007/978-3-030-37301-6>

© Springer Nature Switzerland AG 2020

This work is subject to copyright. All rights are reserved by the Publisher, whether the whole or part of the material is concerned, specifically the rights of translation, reprinting, reuse of illustrations, recitation, broadcasting, reproduction on microfilms or in any other physical way, and transmission or information storage and retrieval, electronic adaptation, computer software, or by similar or dissimilar methodology now known or hereafter developed.

The use of general descriptive names, registered names, trademarks, service marks, etc. in this publication does not imply, even in the absence of a specific statement, that such names are exempt from the relevant protective laws and regulations and therefore free for general use.

The publisher, the authors, and the editors are safe to assume that the advice and information in this book are believed to be true and accurate at the date of publication. Neither the publisher nor the authors or the editors give a warranty, expressed or implied, with respect to the material contained herein or for any errors or omissions that may have been made. The publisher remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.

This Springer imprint is published by the registered company Springer Nature Switzerland AG

The registered company address is: Gewerbestrasse 11, 6330 Cham, Switzerland

Preface

The conception of this book started as an idea which occurred towards the end of my clinical training in forensic psychiatry. During the years of exploration of a fascinating medical field and a relentless study of textbooks and scholar contributions, it occurred to me that there were no books on ethical issues faced in everyday clinical practice. Hence, I started expanding my knowledge in particular ethical considerations and attending conferences to present my work. It was following one of these conferences that the proposal from Springer was offered to prepare and publish this book and I whole-heartedly accepted the challenge.

The aim of this book is to cover the gap in the existing literature and facilitate clinical thinking by focusing on ethical issues that clinicians face in everyday practice of forensic psychiatry. It is mainly aimed at forensic psychiatrists and forensic psychiatry trainees but should also be a useful guide for other forensic mental health clinicians, including psychologists, nurses, occupational therapists, and social workers. Likewise, it can be a helpful resource for psychiatrists and other doctors that find themselves looking after patients in prison settings or in countries where forensic psychiatry does not exist as a psychiatry subspecialty.

It is meant to be a practical guide of what a clinician should consider when faced with moral dilemmas in their day-to-day practice and offer direction for reflection. Forensic psychiatry is an exciting specialty but also one that brings forward a lot of ethical controversies.

This book consists of seven chapters. The first chapter puts in perspective the context of forensic psychiatry in different countries. It describes in detail forensic psychiatry practice in the UK, and subsequently moves on to the rest of Europe, Australia, Asia, America, and the Arab world.

The second chapter focuses on generic ethical issues. It starts with a definition of ethics and a discussion of ethical issues in mental health in general before moving to ethical considerations specific to forensic mental health.

The subsequent chapters focus on specialized areas of forensic clinical practice that come with specific challenging ethical issues. The third chapter focuses on ethical dilemmas arising from the prescription of medication for the treatment of sex offenders and issues around treatment vs punishment, autonomy, coercion, and free will are debated.

Chapter 4 is also dedicated in the treatment of sex offenders. It explores and discusses the ethical dilemmas in the use of polygraphy, a controversial method of truth facilitation, for the management of mentally disordered sex offenders.

Chapter 5 addresses ethical issues pertained in prescription of antipsychotics for mentally ill forensic patients, with particular focus on polypharmacy and prescription of high doses. It unfolds the clinical thinking behind medication prescribing and discusses it in context of the principles of autonomy, beneficence, non-maleficence, and justice. Issues around capacity, informed consent, and free will are also addressed.

Consequently, the use of electronic monitoring ("tagging") for offenders that are deemed dangerous is discussed in the sixth chapter. Electronic monitoring despite being used in the USA for a while has been heavily criticized and opposed. It has been gradually introduced in the UK and other European countries; hence, consideration of the ethical issues and dilemmas surrounding its use is timely and necessary.

The last chapter of this book focuses on patient populations within clinical forensic psychiatry that present with specific challenges. It is divided into two parts. In the first part, the authors discuss ethical issues in the assessment and treatment of forensic psychiatry transgender populations. In the second part, practical and ethical issues in the treatment of offenders with intellectual disability are addressed.

The list of moral dilemmas that clinicians face in their everyday clinical practice is not exhaustive as it would be impossible to debate all of them in one book. It is with this insight that we offer this book to clinicians with the hope that it will be a useful resource for those working in forensic psychiatry settings or work with offender populations when it comes to ethical decisions faced in their clinical practice.

Finishing this introduction, I would like to thank all authors for their excellent contributions to this book. I would also like to thank Springer for this opportunity and their confidence in delivering this book.

London, UK

Artemis Igoumenou

Contents

Part I Clinical Forensic Psychiatry

- 1 Clinical Forensic Psychiatry: Settings and Practices.** 3
Catherine Marshall, Katharina Seewald, and Hasanen Al Taiar
- 2 Forensic Psychiatry and the Mentally Disordered Offender:
Ethical Issues in the Treatment Provision within Secure Hospital
Environments—Clinical and Legal** 29
Oriana Chao, Despoina Konstandinidou, and Artemis Igoumenou

Part II Ethical Issues in the Treatment and Management of Sex Offenders

- 3 Introduction.** 47
Artemis Igoumenou
- 4 The Use of Medication for the Treatment
of Sex Offenders: Ethical Issues and Controversies** 51
Artemis Igoumenou
- 5 The Use of Polygraph Test in Clinical Forensic Psychiatry Settings . . .** 85
Nicky Collins

Part III Ethical Issues in the Assessment, Treatment and Management of Violent Offenders and Sex Offenders in Clinical Settings

- 6 Ethical Issues Arising from the Prescription
of Antipsychotic Medication in Clinical Forensic Settings** 99
Harriet Hunt-Grubbe
- 7 The Many Faces of Surveillance: Ethical Considerations
That Encompass the Use of Electronic Monitoring
in Criminal and Clinical Populations** 115
Harriet Hunt-Grubbe
- 8 Assessment and Management of Specific Populations** 135
Philip Baker, Sumi Ratnam, and Leah Wooster

- Index.** 151

Part I

Clinical Forensic Psychiatry



Clinical Forensic Psychiatry: Settings and Practices

1

Catherine Marshall, Katharina Seewald, and Hasanen Al Taiar

1.1 Forensic Psychiatry in the UK

Catherine Marshall

Clinical forensic psychiatry is the evidence-based assessment, treatment and rehabilitation of mentally disordered offenders. In practice, however, ‘the forensic patient’ is a term which encompasses a broader range of individuals, including those who have not committed an offence but have a mental disorder and are presenting with behaviour considered to be dangerous (relative to their environment) and are at risk of offending (Mullen 2000). Typically, forensic patients are those with chronic and complex mental disorders whose actions, having been wholly or in part influenced by their psychopathology, ultimately pose a serious risk to others. At times, this risk of harm is also extended towards themselves. Specialist forensic settings and services provide a greater degree of security and more intensive interventions in order to manage these risks and support the individual towards recovery and rehabilitation.

Detaching from the labels which link ‘mad’ behaviour with being ‘bad’ or ‘evil’ is arguably the biggest battle of modern-day psychiatry and perhaps the most challenging one in forensic psychiatry, given the dual stigmatisation of being an offender and having mental health problems (Adshead 2012). Criminology cannot be simply characterised as pathological, nor are all mentally disordered individuals assumed to lack capacity regarding decisions they make to break the law. One key aspect of

C. Marshall

Clinical Lecturer and Honorary Consultant Forensic Psychiatrist, London, UK

K. Seewald (✉)

Forensic Psychologist and Senior Researcher at Research & Development Division, Prison & Probation Services, Berlin, Germany

e-mail: katharina.seewald@krimd.berlin.de

H. Al Taiar

Consultant Forensic Psychiatrist, Oxford, UK

© Springer Nature Switzerland AG 2020

A. Igoumenou (ed.), *Ethical Issues in Clinical Forensic Psychiatry*,
https://doi.org/10.1007/978-3-030-37301-6_1

forensic psychiatry is to seek to reconcile when offending behaviour may be linked with mental disorder, with the aim of subsequently both optimising the person's mental health and reducing their risk of further offending, thereby protecting the public.

The laws in the UK appreciate that there can be a relationship between mental disorder and offending behaviour. However, the resulting interplay between criminal responsibility, mental health and the justice system is highly complex. Working in forensic psychiatry requires a comprehensive understanding of the application of the law in that jurisdiction not only from a clinical perspective but also within the context of the criminal justice process itself.

This chapter provides an overview of forensic psychiatry in the UK from a general clinical perspective. With regard to the relevant mental health law, three distinct jurisdictions (England and Wales, Northern Ireland and Scotland) exist, each with their own legislation governing the treatment of people with mental disorders.

Historically, in the UK, it has been the presence of mental disorder and risk which has dictated involuntary detention and treatment for mental disorder. In England and Wales, the Richardson review (1999) acknowledged the impossible reconciliation of the conflict between upholding values of autonomy for those with mental health problems and avoiding potential, albeit rare, risks posed to the public. Richardson's proposal in short sought to justify the detention and treatment of competent patients against their will, providing the caveat was followed that these patients needed to be assessed as presenting with a *higher* degree of risk, compared to patients who lacked capacity (Zigmond 2017). This was rejected by the government who ultimately upheld the maxim that detention and treatment decisions were made according to necessity, not capacity.

However, Scotland's review of its mental health legislation (Millan 2001) concluded that it was necessary to distinguish between incapacity arising from cognitive or physical health problems (including that termed brain disease) and 'significantly impaired decision-making ability' (SIDMA) occurring as a result of mental disorder. The Mental Health Care and Treatment (Scotland) Act manual (2003) explains that SIDMA occurs 'when a mental disorder affects the person's ability to believe, understand and retain information, and to make and communicate decisions. It is consequently a manifestation of a disorder of mind'. SIDMA is a criterion for determining compulsion in the Mental Health Care and Treatment (Scotland) Act.

More recently, Northern Ireland has advanced a new approach by enacting the Mental Capacity Act of 2016 which when fully implemented will repeal the country's separate Mental Health (Northern Ireland) Order of 1986. Described as a piece of 'fusion' legislation, the Mental Capacity Act of 2016 takes a non-discriminatory approach by standardising assessment regardless of whether the illness is of physical or mental origin: 'Impairment of decision-making capacity and best interests are the only criteria to be used when making decisions across health and social care' (Lynch et al. 2017).

The functional component of this legislation's capacity test is more than just a cognitive exercise and seeks to address the interplay between capacity and insight.

At a basic level, insight has been defined as how well the patient accepts that they are ill (Owens et al. 2010). However, clinical assessments of insight extend to include many factors such as insight with regard to treatment. The Northern Ireland Mental Capacity Act requires that the person must be able to ‘appreciate’ the relevance of the information they have been given as part of their decision-making process. It is therefore this part of the test which may not be met if a person’s thinking is affected by psychiatric symptoms that impair their insight into their condition or the treatments available.

Each of the jurisdictions legislates within their respective Acts for patients in contact with the criminal justice system. With regard to the forensic setting in Northern Ireland, although involuntary admission to hospital *can* take place (with necessary safeguards), the individual still *cannot* be treated against their wishes providing they are deemed to have capacity in this regard, making this legislation more progressive with regard to meeting the requirements of the UN Convention on the Rights of Persons with Disabilities (Centre for Mental Health and Capacity Law 2014).

Part III of the Mental Health Act of 1983 (as amended in 2007) in England and Wales outlines provisions for psychiatric assessment and treatment at various points as an offender moves through the criminal justice pathway. With approval from the Ministry of Justice, remanded and sentenced prisoners can be moved between the prison estate and secure hospitals. At the point of sentencing, psychiatric disposal options include treatment in hospital leading to discharge back into the community (the hospital order), as well as the hybrid order. In the latter, where the sentence is not already fixed by law, higher courts can direct the prisoner to hospital in conjunction with passing a prison sentence. For a psychiatrist recommending the hybrid order, this arguably introduces additional ethical considerations regarding potentially offering an opinion on the offender’s culpability. In effect, the offender is treated in hospital until which point no further treatment is required resulting in their return to prison to complete their sentence (Delmage et al. 2015). If a prisoner who has been transferred to hospital completes their sentence there, ongoing hospital detention may take place in the form of a hospital order (without any restriction) termed as a ‘notional Section 37’ in England and Wales. For transferred prisoners with life sentences or indeterminate sentences for public protection (discontinued in 2012), discharge via the inpatient pathway involves both the First-Tier Tribunal and Parole Board.

British psychiatry during the twentieth century was concerned with liberalisation, deinstitutionalisation and building upon community care (Gunn 2004). Forensic mental health services as we know them today began developing after the 1959 Mental Health Act ratified that a mentally unwell person, who was convicted of an offence, could be admitted to hospital for treatment. In 1975, the Butler Report led to the development of ‘regional secure units’, now referred to as medium secure services (Committee on Mentally Abnormal Offenders 1975), and the Reed Report went on to outline the core principles of secure care (Review of Health and Social Services for Mentally Disordered Offenders and Others Requiring Similar Services 1992). Recommendations made by the Bradley Report in 2009 noted the unmet

needs of offenders with mental disorders and addressed the importance of integrating liaison and diversion systems between specialist mental health services and the criminal justice system, in order to make sure mentally unwell offenders received parity of care with those in the community (Department of Health 2009).

A reduction in the number of high secure beds and a corresponding increase in medium secure provisions occurred. Data from commissioner guidance in 2013 identified in England that approximately 680 beds were occupied in high secure services, 2800 in medium security and 2500 in low security (Guidance for Commissioners of Forensic Mental Health Services 2013).

Earlier this decade, approximately a third of beds were estimated as being provided by the independent sector in England (Centre for Mental Health 2011a, b). In 2012–2013, England saw 1788 people admitted into hospital using part III of the Mental Health Act of 1983 (amended in 2007) (Annual Report 2013). Whilst forensic units expanded, inpatient provisions overall in psychiatry have reduced in the UK (Galappathie et al. 2017).¹ This trend of increasing forensic beds perhaps indicates a shift back towards focusing upon detention as means of public protection by the reinstitutionalisation of forensic patients (Priebe et al. 2005).

The team in forensic psychiatry is multidisciplinary:

- Specialist nurses with experience in forensic settings.
- Healthcare assistants.
- Consultant forensic psychiatrists.
- Junior doctors—core trainees and higher trainees.
- Clinical psychologists and psychology assistants.
- Psychotherapists.
- Drama and art therapists.
- Occupational therapists and assistants.
- Educational specialists for therapeutic settings.
- Social workers.
- Pharmacists.
- Members of the security department (for inpatient care).

Forensic psychiatry takes place in a variety of settings which can be largely separated into the criminal justice system (primarily prisons), secure inpatient services and outpatient care.

The basic pathway of forensic care is often dictated by the ease of access to psychiatric services in these settings. For instance, a person may come to the attention of healthcare professionals whilst in prison which leads to them being assessed by a forensic psychiatrist and ultimately transferred into a secure hospital. At a later date, following successful rehabilitation back into society, the individual may remain supported by a forensic community team.

¹ Figures depicting the use of the Act in England in 2016–2017 are not mentioned here as they have been acknowledged as unreliably low due to incomplete data submission from healthcare services (NHS Digital Mental Health Act Statistics 2017).

1.1.1 Criminal Justice System

Forensic psychiatry aims to identify, assess and treat individuals who are mentally unwell at any point that they come into contact with the criminal justice system. Where appropriate, this includes organising the diversion of those individuals into other suitable treatment settings such as secure hospitals or liaising with relevant community services.

1.1.1.1 Police and Court Diversion

At police stations, police officers on site or attending health professionals may raise concerns about an arrested individual presenting with symptoms of mental disorder. The types of concerns could range from questioning unusual behaviour associated with the alleged offence to general agitation or distress with expressions of suicidality in custody. By alerting psychiatric and approved mental health professionals on duty to complete further assessments under the auspices of mental health law, in England and Wales, this can result in the individual's transfer into psychiatric hospital. In practice, only prisoners with lower level offences will be bailed into standard locked wards or psychiatric intensive care units (PICU) within general adult inpatient services. Where the degree of the alleged offence is more serious and indicative of a need for a greater level of security to contain the individual, there is often difficulty in admitting 'out of hours' to secure units. Consequently, it is more common for the offender to be transferred to a prison on remand, with the recommendation that an urgent forensic psychiatric opinion be sought.

Mentally unwell offenders may also come to the attention of local Criminal Justice Mental Health Teams or Court Diversion Services. Typically, formal assessment of the prisoner by a mental health professional and representation of matters by a psychiatrist at the magistrates' court can lead to the prisoner's redirection into hospital via detention under the Act should this be deemed necessary and appropriate.

Forensic psychiatrists may be called to act as an expert witness in court. This is an aspect of forensic psychiatry which may be part of a clinician's usual employment or independent medicolegal work. Although mindful of their duties and ethics as a psychiatrist, the expert witness' primary duty is to assist the court on matters of his/her expertise in order to advance the administration of justice (Rix 2011). The expert may be instructed by the judge, prosecution or defence team's legal representative or associated agencies such as the probation service. These assessments can be required to address specific matters including the defendant's fitness to plead, psychiatric defences, for example, in relation to establishing their mental state at the material time and their capacity to form intent, and other mitigating factors on making sentencing recommendations. In this role, the interaction between the forensic psychiatrist and the prisoner is fundamentally different. Discussions are therefore not bound by usual doctor-patient confidentiality, and the prisoner needs to be made fully aware that disclosures could end up as evidence in court.

1.1.1.2 Prisons and Young Offender Institutions

Estimates are that 23% of the prison population has a need for secondary mental health services (Centre for Mental Health 2011a, b). The prison environment itself is understandably a psychological stressor, with those already known to have a mental disorder being at risk of deteriorating, as well as those who have no known history being at risk of decompensating and becoming mentally unwell. Although there has been some argument that the complex needs of some offenders would not have been met in the community either, 'once an offender is in the full-time care of the state, different standards apply' (Peay 2011), and determining whether prisoners may need inpatient (i.e. hospital) psychiatric care, and where this threshold lies, is a complex process that has to take into account the individuals' needs as well as available service provision.

In the same way that a competent prisoner can understand and consent to treatment for his or her physical health problems, so too can a prisoner for their mental disorder. The problem arises when either the necessary intervention cannot be supported in the prison environment or the prisoner does not hold insight into the need for an intervention and consequently does not accept treatment.

For patients not consenting to treatment for their mental health problems in England and Wales, although very limited interventions could potentially occur under the direction of statute minded to act in the best interests of those lacking capacity (should they be deemed to lack capacity), it is mental health law that provides the most appropriate safeguards and due process for these situations. However, compulsory treatment for mental disorder cannot be carried out in prison. As already outlined, legal provisions do, however, facilitate transfer of prisoners meeting the necessary criteria to hospital for assessment and/or treatment at each stage of contact with the criminal justice system.

Within prisons, psychiatric in-reach services follow a care delivery model akin to community mental health teams. Multidisciplinary teams including specialist psychiatric nurses, forensic psychologists and psychiatrists assess and treat referred prisoners and consider whether they can continue to be managed appropriately in the prison environment, either on the 'ordinary location' (prison wings) or in the hospital wing (when there is one). At one level, in-reach services could include ensuring maintenance of depot antipsychotic medication administration for a prisoner with a diagnosis of schizophrenia, for example, or initiation of antidepressant medication and focused psychotherapy for a prisoner with low mood. Managing dual diagnosis of mental disorder and harmful alcohol and/or substance misuse is also an important issue for mental health services in prisons often working in conjunction with specialist addiction services. The prison in-reach services also provide liaison with community psychiatric services for patients under Care Programme Approach (CPA) to try and support their transition and mental health follow-up on being released.

At the other end of the spectrum are the 'nontreatment' interventions in custody. Although led by the prison itself (as opposed to by healthcare resources), these services may overlap with the forensic pathway for some patients, such as probation services which provide behavioural programmes for offenders. Another example is

the development of psychologically informed planned environments (PIPEs) which were introduced for prisoners who were deemed likely to meet the eligibility criteria for the personality disorder pathway. They were ‘designed to have a particular focus on developing an enabling environment, which emphasises the importance and quality of relationships and interactions’ (Turley et al. 2013) for prisoners who had already completed high-intensity offending behaviour and treatment programmes.

1.1.2 Healthcare System

1.1.2.1 Inpatient Care

Patients in secure forensic hospitals in England and Wales are detained under the Mental Health Act of 1983 (as amended in 2007) and so have the opportunity to be engaged with the legal process regarding challenging their ongoing detention in this regard, including participating in First-Tier Tribunals and Hospital Managers’ Hearings. Some patients will have added ‘restriction orders’ in place associated with being sentenced to a hospital order or transferred as a sentenced prisoner, which are imposed by the court or the Ministry of Justice. They add in controls which are applicable for patients taking leave or being discharged into the community.

In secure hospitals, the multidisciplinary team works across several areas:

- Assessment, diagnosis and treatment of mental disorders.
- Optimising physical health.
- Specialist and structured risk assessment.
- Psychological interventions (via group programmes and individual work):
 - Psychoeducation in mental disorder; building insight; anger control; stress management; relationships; relapse prevention work.
 - Substance misuse work.
 - Sexual offending work.
 - Victim empathy work.
 - Engagement in occupational therapy to build up life skills and personal development.
- Rehabilitation pathway planning.
- Liaison with other relevant agencies.
- Supporting patient’s carers, family and friends.

Hospitals with different levels of security, high, medium and low, exist to accommodate forensic patients, accordingly reflecting the degree of risk they are assessed to pose. This kind of assessment is multidisciplinary and multifactorial, taking into account the patient’s current presentation, their past offending history and any extenuating circumstances such as whether they are considered a high-profile offender. *The Dundrum Quartet* is one example of a structured professional judgement tool which seeks to address in detail all the relevant risk information and principles that need to be considered in order to suitably determine the level of

security for a patient being admitted or transferred within a forensic service (Kennedy et al. 2012). Determining which services undertake gatekeeping assessments into secure services is dictated by local policies with some regions entering into 'partnerships' to distribute referrals.

How secure a hospital is deemed to be is directed by three areas: physical security, procedural security and relational security. Physical security refers to the building restrictions with guidance set for heights of surrounding fences, for example, the use of locks and alarms, etc. Procedural security sets in place the necessary operational policies such as protocols on restrictive practice, needed for an individual unit to follow in order to maintain their level of safety and security across all domains. Finally, relational security has been defined as 'the knowledge and understanding we have of a patient and of the environment and the translation of that information into appropriate responses and care' (see Think Act 2015). Examples of procedures that support good relational security might include standardising a handover process and setting minimum staff-to-patient ratios.

High secure hospitals (historically termed the 'special hospitals') most closely resemble the higher category prisons and are reserved for the few deemed to be in need of significant security to prevent them absconding from psychiatric care. The NHS Act (2006) states they require treatment under these conditions 'on account of their dangerous, violent or criminal propensities' (Guidance for Commissioners of Forensic Mental Health Services 2013). In practice, these hospitals also admit individuals where the risk they pose must also be considered in the context of the notoriety of their crime, if there has been a significant degree of media interest, for example.

Medium secure services must also follow standards with regard to security procedures; however, the nature of these units is to be adaptable according to the needs of the patients. Medium secure services may have a range of intensive care areas including seclusion suites, acute admission and rehabilitation wards. This is in order to safely manage their patient group which can include transferred prisoners who are on remand for serious offences, as well as hospital order sentenced patients, who, following progressing with their rehabilitation, may be independently accessing the community ('unescorted community leave') in preparation for resettlement and discharge. Within the latter group, the rate of progress following a recovery-based model is also variable, with some patients needing a slower paced reintroduction to society than others.

Commonly, low secure services are used as step-down transfer for patients from medium security who no longer require the level of physical restrictions in place there. Locked rehabilitation units may also liaise closely with forensic services and provide a longer period of rehabilitation for slower-stream patients who are not yet suited for community-based rehabilitative care.

Forensic supported accommodation (ranging from 'floating support' to 24 h staffed) in the community often provides a further step-down interim placement for forensic patients moving from hospital to the community.

In the UK, bespoke female secure services for women including Women's Enhanced Medium Secure Services (WEMSS) were developed in recognition of

the need for gender-sensitive environments with enhanced procedural and relational security as opposed to high levels of physical security measures (Eastman et al. 2012). There are additional specialist rehabilitation services for specific groups of offenders such as adolescents; those with severe personality disorders, neuropsychiatric conditions and a history of sex offending; deaf or hard of hearing patients; and those with intellectual disabilities and autism spectrum disorders.

As already outlined, a patient may have entered into a secure hospital through the criminal justice system at one of several different points. A patient may also move into secure services as a consequence of stepping up to a higher level of security, for example, into a medium secure service from a general adult inpatient service, or conversely by stepping down as part of a rehabilitative process moving from medium security into a low secure hospital.

1.1.2.2 Outpatient Care

Community Forensic Teams in England have developed roles in two key areas:

1. Assessing new referrals: this is to provide specialist risk assessment and advice on management in liaison with the healthcare professionals who are already involved in the individual's care. Assessments may take place in hospital or outpatient clinic settings.
2. 'Outreach' for community forensic patients: providing monitoring and formal supervision for patients that have been discharged from forensic settings into the community, some of whom remain liable to conditions imposed by the Ministry of Justice in England and Wales (conditional discharge). Where appropriate, this includes liaison with other criminal justice system agencies (police, probation and prisons) via Multi-Agency Public Protection Arrangement (MAPPA). Some patients may also be managed under joint care with general adult community mental health teams.

Ongoing debate exists as to the relationship between general adult services and forensic services, and consequently three main models for Community Forensic Teams have been described: parallel, integrated and hybrid models. Historically, the parallel model has been more common being based upon a structure where forensic specialists work in a separate specialist team with a large part of their caseload often comprised of managing patients who have been discharged from medium secure services directly into the community. The integrated model refers discharged forensic patients back into general community mental health teams for follow-up. The hybrid model combines the integrated model approach with shared care with forensic services during the patient's initial post-discharge period from a secure hospital setting (Mohan et al. 2004). In practice, different forensic liaison schemes offer consultatory and assessment services for Community Mental Health Teams. Community Forensic Teams are designed considering features from all these models according to local area and patient needs as well as available resources (Natarajan et al. 2012).

Community Forensic Teams work intensively with their patients to monitor their mental health, medication compliance, social engagement and work in the community as well as physical health monitoring and dealing with any comorbid difficulties such as substance misuse or challenging behaviours. Research has suggested that patients conditionally discharged into the community from forensic mental health services have a lower recidivism rate in comparison to release following imprisonment (Fazel et al. 2016). Provisions under the Mental Health Act of 1983 (as amended in 2007) allow patients who have been discharged into the community under restrictions imposed by the Ministry of Justice to be ‘recalled’ and readmitted into hospital should there be concerns about a deterioration in their mental state or increase in their risk in association with transgressions from their conditions of discharge.

1.1.3 Conclusion

Establishing what ‘forensic psychiatry’ represents, beyond the boundaries of the specialists who work in its field, can be quite misleading. Public opinions, the media and political views seemingly oscillate between wanting services to instigate more restrictions (usually following a publicised incident or inquiry) and being disapproving of restrictive practices because they oppose fundamental human rights. To patients, forensic psychiatry may represent many different things at different times, including being the system that holds them captive, as well as the system that provides opportunities for achieving an improved quality of life in the community. Practising with due professionalism in this specialty requires employing an inquisitive and ethically reflective mind. Forensic psychiatry poses challenging questions for the clinician and society itself, with conflicts arising with regard to determining culpability, the need for detention, treatment compulsion and autonomy, to name a few.

1.2 Forensic Psychiatry in Europe Outside the UK

Katharina Seewald

Along with all the differences in legal and administrative procedures across the European countries come several differences in the provision and organisation of forensic mental health services as well as in the training of medical professionals. Reasons for these dissimilarities can be found in historical background of legal systems and judicial understanding in the different nations (Nedopil et al. 2015). The work of the ‘Ghent Group’, a European network for forensic psychiatrists, is the best resource to explore the practical differences and also potential similarities between the European medicolegal systems, professions and service provision.

The group recently stated that Germany, Ireland, Sweden, Switzerland and the UK are those European countries that have established certificates of completion of

forensic training for medical professionals and Croatia as a new EU member has not yet established a certification but a substantive training programme (Nedopil et al. 2015). Other countries, such as Austria, Belgium, Denmark, Finland, the Netherlands, Norway and Spain, are more reserved when it comes to supporting a forensic specialisation, fearing that this would increase the likelihood to become separated from general psychiatry. Instead, diploma courses in forensic psychiatry to train their staff are offered in these states (Nedopil et al. 2015).

There are some countries in Mainland Europe (Europe outside the UK) that have not developed specific forensic psychiatric hospitals or services such as France, Italy, Greece and Cyprus (Nedopil 2009; Roesch and Cook 2017).

In most of the countries, the question of criminal responsibility plays a crucial role regarding the adequate diversion of offenders to either prison or forensic psychiatric services (Gordon and Lindqvist 2007). In the following, the variety of forensic systems in Mainland Europe will be exemplified focusing on a few selected countries.

1.2.1 Germany

1.2.1.1 Legal Framework

In Germany, mentally disordered offenders can be placed in a forensic psychiatric hospital if their criminal responsibility is either absent or diminished at the time of their index offense and if they pose a risk to commit further crimes (Edworthy et al. 2016; Roesch and Cook 2017).

1.2.1.2 Inpatient Care

The offender is then admitted as a psychiatric patient into forensic psychiatric facilities indefinitely. The offender will be discharged when the risk to commit further offenses is considered low enough to justify the release. Psychiatrists and psychotherapists as well as nurses, social workers, art therapists and occupational therapists work together to treat mental health conditions on the one hand and manage the recidivism risk on the other hand. An external forensic expert assesses the offender's risk in an evaluation statement every year to assist case managers (which can be psychiatrists or psychotherapists) in the hospital to come to informed decisions on stepwise reduction of security measures with the final goal to release the offender back into the community. If the offender's criminal responsibility is assessed not fully absent but partly absent (diminished), the individual can be given an additional prison sentence by the court.

Offenders who suffer from substance use disorders at the time of the offense (with fully or partly absent criminal responsibility and a high risk to commit future crimes) are referred to a specialised form of forensic hospitals targeting alcohol and drug addiction. The length of stay there is a maximum of 2 years with mostly additional prison sentence to follow.

1.2.1.3 Prison Psychiatry

Offenders who have been assessed as fully responsible for their offenses and are serving a prison sentence have access to psychiatric care whilst in prison. Psychiatric treatment has to be provided in every prison facility, and there are usually several psychiatric beds in prison inpatient healthcare wings for acute patients who need inpatient treatment during their stay in prison.

1.2.1.4 Outpatient Care

The number of facilities providing outpatient care for high-risk offenders either released from prison or from forensic psychiatric facilities in Germany is rising (Sauter et al. 2017). They are part of a risk management network consisting of probation services, court supervision, electronic monitoring if necessary and numerous community-based services including aftercare residencies to support offenders who have been discharged from prisons or forensic psychiatry hospitals.

1.2.2 Netherlands

1.2.2.1 Legal Framework

In the Netherlands, offenders with mental disorders can be referred to specific forensic psychiatric hospitals. Comparable to Germany, the diversion depends on criminal accountability which has five stages of responsibility from total absence to complete responsibility (Edworthy et al. 2016).

1.2.2.2 Inpatient Care and Outpatient Care

Offenders with personality disorders are referred to internationally known TBS hospitals (TBS is for TerBeschikkingStelling) based on a so-called TBS law (de Boer and Gerrits 2007). Offenders with other psychiatric disorders are treated in forensic units of general psychiatric hospitals or in one of three forensic psychiatric hospitals (Roesch and Cook 2017). In TBS hospitals, after the initial 2 years, an offender's detention will be reviewed every second year and can last for as long as necessary to protect society. An external expert opinion is needed to justify detention every sixth year (Edworthy et al. 2016).

TBS hospitals have their own outpatient services and residencies after discharge. Generally, the Netherlands has a highly developed system of aftercare services (Roesch and Cook 2017).

1.2.3 Scandinavian Countries: Sweden and Denmark

1.2.3.1 Sweden: Legal Framework and Inpatient Care

The forensic mental health service in Sweden is separated into two systems. One is the National Board of Forensic Medicine which is in charge of assessments for courts. Different to Germany, the term 'responsibility' is not known in the Swedish system. Nevertheless, the handling is quite similar. If the offender suffered from a

severe mental disorder at the time of the offense stated by a psychiatrist, the court can order forensic psychiatric treatment and/or reduction in sentence. The forensic treatment order is based on the mental health state and the lack of insight on the one hand and on the risk for future violence on the other hand, and the duration of hospitalisation depends on both criteria, as in Germany (Gunn and Taylor 2014; Roesch and Cook 2017).

The second system is represented by 20 regional healthcare providers which provide forensic treatment and care (Gunn and Taylor 2014). In five forensic psychiatric hospitals, there are only a few high security beds. Offenders with low risk can be referred to low secure forensic units or are likely to be managed in general psychiatric settings (Gunn and Taylor 2014).

1.2.3.2 Denmark: Legal Framework and Inpatient Care

The legal framework in Denmark is similar to the Swedish one. However, in Denmark, mentally ill offenders will locally be managed mostly in general psychiatric units according to their security needs or in forensic units within general psychiatric hospitals (Gunn and Taylor 2014; Roesch and Cook 2017). Additionally, prisoners do have the same right and access to medical care as individuals not in prison. If necessary, they will be referred to public hospitals or private practitioners accompanied by security personnel (Gunn and Taylor 2014).

1.3 Forensic Psychiatry in Australia

Katharina Seewald

1.3.1 Legal Framework

In Australia, each state has separate mental health legislation (Gunn and Taylor 2014). However, criminal responsibility is tested in each of those concerning whether the potentially mentally disordered offender could have had insight into the criminal act or into the fact that the doing was wrong. In case this has to be denied, the offender is to be detained in a secure hospital (Gunn and Taylor 2014).

1.3.2 Inpatient and Outpatient Care

The location of provision of forensic psychiatric care also varies from state to state. However, regardless of whether the service is provided in psychiatric hospitals, correctional facilities and inpatient or outpatient community settings, it is always offered by specialised forensic mental health service organisations (Roesch and Cook 2017). Community forensic mental health services are particularly important in the management of acquitted offenders or in the transition of discharged offenders with mental disorders (Every-Palmer et al. 2014).

1.3.3 Prison Mental Health

All prisoners have access to specialised mental health services within correctional departments and can be relocated into an inpatient psychiatric setting if necessary (Every-Palmer et al. 2014).

1.4 Forensic Psychiatry in Asia

Katharina Seewald

In Asia, the situation of forensic psychiatry varies widely. In China and Japan, mentally disordered offenders can receive a reduction in their sentence length or a treatment order (Roesch and Cook 2017).

There are (administrative) regions such as Hong Kong, where forensic care is provided on forensic wards and where there are community services in place to ensure a successful reintegration, and Bangalore, for example, where forensic inpatient treatment is delivered in general psychiatric facilities. In China, mentally ill offenders are treated in secure hospitals for offenders and non-offenders who pose a risk to themselves or others ('Ankang Hospitals'). In Singapore, a recent development (2010–2011) now provides treatment for mentally disordered offenders after release from prison and established a mandatory treatment order for offenders whose psychiatric disorder is linked to criminal behaviour. On the other hand, there are countries such as India with no noteworthy specialised forensic service for mentally ill offenders who will mostly be detained in prison facilities (Every-Palmer et al. 2014; Roesch and Cook 2017).

1.4.1 Japan

The most elaborated forensic psychiatric system can be found in Japan. There, specialised forensic mental health services recently (2005) developed in form of a 'Medical Treatment and Supervision Act' (MTSA; Fujii et al. 2014; Roesch and Cook 2017). It applies to offenders with no or diminished criminal responsibility, whose serious offense was caused by a mental disorder and was assessed so by forensic experts. The MTSA process replaces prison sentences for eligible offenders (Fujii et al. 2014).

The treatment order can refer to in- or outpatient treatment. There are specialised forensic psychiatric hospitals where inpatient treatment is delivered. Outpatient treatment and rehabilitation during the first 3 years after discharge is provided by probation services, outpatient psychiatric practices or community services and is centrally coordinated (Fujii et al. 2014; Roesch and Cook 2017).

1.5 Forensic Psychiatry in America

Hasanen Al-Taiar

As Benjamin Rush is considered to be the father of American psychiatry, so Isaac Ray is known as the father of forensic psychiatry in the USA. His contributions, as noted by historian forensic psychiatrist, Dr. Kenneth Weiss, are progressive and timeless. However, there could be a gap in professional recognition from the time of Isaac Ray in the late nineteenth century to the mid-twentieth century when people such as Gregory Zilboorg, the great psychiatric historian, took centre stage. Doctors Andrew Watson, Richard Lonsdorf, Jonas Robitscher, Jay Katz and Alan Stone began teaching not only in medical schools but also in law schools. Dr. Jonas Rappeport, considered the father of modern forensic psychiatry, developed his clinic in psychiatry and law in Baltimore and taught both at the University of Maryland and at Johns Hopkins. It was Dr. Rappeport, with several others, who initiated the modern era of rapid growth and proliferation of the field of forensic psychiatry by beginning the American Academy of Psychiatry and the Law (AAPL) in 1969.

Dr. Rappeport called together several teachers of forensic psychiatry in order to organise them as a scholarly group, to promote the field of forensic psychiatry and to aid in the teaching of this growing subspecialty. Three of the original group comprised the membership committee, Drs. Seymour Halleck, Ames Robey and Robert Sadoff, meeting in 1969, which listed 100 potential candidates for membership in the AAPL. Not surprisingly, all 100 agreed, and the organisation grew exponentially from that point to the present time, at which there are now well over 2500 members worldwide. The newsletter of the AAPL was developed as well as the bulletin of the AAPL, which later became the journal (JAAPL). Other journals, such as *The Journal of Psychiatry and Law*, *The Journal of Forensic Psychiatry* and *The International Journal of Law and Mental Health*, began to publish articles from contributors from around the world. There have been at least two other organisations of medical/legal interest that preceded the AAPL. One was the American College of Legal Medicine (ACLM) in which the fellows had to be dually qualified both in medicine and law and consisted primarily of pathologists and other nonpsychiatric physicians who had law degrees.

The other organisation was the American Academy of Forensic Sciences (AAFS), which included members from various medical, legal and scientific disciplines: forensic odontology, forensic pathology, and a small group of psychiatrists led by Drs. Meier Tuchler, Seymour Pollack and Bernard Diamond. Through the leadership of Dr. Richard Rosner, of New York University, came the development of fellowship training in forensic psychiatry at various university medical centres. Dr. Rosner, through the AAFS and AAPL, coordinated the efforts and initiated the accrediting committee that visited various programmes to ensure high quality of training and compliance with required curriculum. Dr. Rosner also led the way to

formal examinations of forensic psychiatrists with the inauguration of the American Board of Forensic Psychiatry (ABFP) in the late 1970s. That board certified several scores of forensic psychiatrists until 1994, when its sun set in favour of board certification through the American Board of Psychiatry and Neurology (ABPN). Subspecialty board examinations had been resisted by the American Psychiatric Association until the mid-1990s, when several subspecialty board examinations arose, including that for forensic psychiatry, which became a 10-year certification rather than lifelong as is the certification for general psychiatry. Scholarly programmes that were developed in various institutions became more formalised under the guidance of the Accreditation Council for Graduate Medical Education (ACGME). Currently, there are about 40 accredited fellowship training programmes in forensic psychiatry throughout the USA. The number of fellows in each programme ranges from one to four, and about 75 individuals are trained each year in forensic psychiatry and thus become eligible to take the board certification examination.

Many of the fellowship programmes have attorneys on the faculty and are affiliated with law schools in which mental health law or mental disability law is taught. The fellows are expected to know the landmark cases that are developed through the Supreme Court of the United States and other major courts where policy is determined. For example, historically, the concept of the right to treatment, initiated by Dr. Morton Birnbaum in his seminal article, 'The Right to Treatment', led to cases such *Donaldson v. O'Connor* (1968) that mandated the right to adequate treatment for those individuals who were involuntarily committed for psychiatric treatment. Other cases followed, including *Washington v. Harper* (1990) and *Sell v U.S.* (2003), which authorised treatment for those criminal defendants who were deemed incompetent to stand trial and who were believed to be able to become competent with appropriate treatment.

There are major differences between UK and USA with regard to the laws that govern psychiatric practice (both general and forensic) and the organisation of forensic mental health services, but also the training and practice of forensic psychiatrists. As in other countries, forensic psychiatrists provide expert opinion in criminal and civil court proceedings (e.g. competency to stand trial, opinion on criminal responsibility and 'legal insanity' as well as mental state opinion, risk assessment and sentencing), but also work in forensic mental health services providing assessment and treatment to mentally disordered offenders. Such services include inpatient forensic psychiatry clinics (dedicated forensic facilities such as maximum security units, and in some states special hospitals for sentenced prisoners, but also clinics within general psychiatry hospitals either dedicated forensic or ordinary units), outpatient services and correctional facilities (remand and sentenced such as maximum secure correctional settings). Services available and practice vary among the different states, however most states provide evaluations in the community and inpatient services that promote competency restoration in order to minimise length of stay in hospitals. Twenty states also have specific laws about the civil commitment of sex offenders who present with mental illness/disorder or personality disorder that puts them at risk of offending (even if they are not in need of

treatment). Canadian forensic psychiatry, after efforts over many decades, became a recognised psychiatry sub-specialty in 2009. As with USA, forensic psychiatry practice here is also focusing on the provision of expert opinion in criminal and civil courts, and secondarily providing care for mentally disordered offenders in forensic psychiatry hospitals and correctional facilities. Forensic psychiatry in Latin America is also governed by different laws in each country including criminal, civil but also mental health legislation. The Declaration of Caracas resulted in reforms in mental health in all countries (some more than others), especially focusing on community-based rather than hospital centered care, however this did not include forensic psychiatry. Forensic psychiatrists in Latin America also provide expertise in courts (albeit the concept of fitness to stand trial is not applicable here), but also clinical input in forensic hospital settings and correctional facilities.

Experienced forensic psychiatrists are seen almost daily in news articles about prominent criminal cases in which they testify about the mental state of the defendant at the time of the commission of the charged offense. Forensic psychiatrists have commented on a number of issues facing the community at large, including gun control, torture of terrorist suspects and death penalty cases. The development of biomedical ethics within forensic psychiatry has also become a major field in which the practice has been regulated through ethical considerations. Issues such as confidentiality, privileged communications, privacy and informed consent are important, as is the concept of ‘wearing two hats’, in which the treating psychiatrist, in most cases, should not testify as the expert witness for his or her patient. Various textbooks have emerged from both law professors and professors of psychiatry and from practising psychiatrists and are listed in the references of this chapter.

1.6 Status of Psychiatric Services and Forensic Psychiatry Services in the Middle East

Hasanen Al-Taiar

The Arab world has witnessed the cradle of civilisations since ancient years, and many Arab and Middle Eastern countries have established psychiatric services many centuries ago. The first recorded usage of the insanity defence can be found in Hammurabi’s code which dates back to around 1772 BC. It used some sort of insanity defence.

It is enlightening to learn about the medieval Islamic hospitals, called *māristāns*, which were once designed to provide therapeutic care. These *māristāns* were known to be safe, aesthetic and pleasing environments, in the aim of encouraging recovery. Arab countries were the first in the world to establish psychiatric hospitals, at a time when Western civilisation dealt with those suffering from mental illness by condemnation and punishment (705 in Baghdad, 820 in Cairo and 1270 in Damascus).

However, current psychiatric services in the Middle East remain underdeveloped in comparison to their counterparts in developed countries. Several factors play a role in that, including poor governmental planning underestimating the role of

mental health and well-being and stigma around psychiatric disorders caused by poor public awareness.

In many Arab countries, many people (especially those of low socioeconomic and educational backgrounds) with psychiatric conditions tend to consult traditional and faith healers before seeking professional help from psychiatrists or approved professionals (Al-Adawi 2002).

This chapter will allude to three different examples of healthcare systems in the Middle East, namely, Iraq, Oman and Egypt.

1.6.1 The State of Mental Health in Iraq

Iraq is a country that has suffered through 30 years of an oppressive regime and an ensuing war since 2003, which has devastated its society and left a public mental health crisis in its wake. Half of the Iraqi population is under 18 years of age, all of whom have lived their entire lives in conflict. The adult population is reported to have witnessed an array of reprehensible horror from kidnappings to ear amputations (Abed 2005). These conflicts have adversely affected the country's healthcare infrastructure, causing various mental health problems. The infrastructure was destroyed following the 2003 invasion that led to further destabilisation of available services (Crawford 2013), and whilst initial international response was supportive, the need for ongoing mental health services requires a stable, permanent solution in Iraq. There is enough evidence to suggest high levels of emotional distress among people who have been exposed to long periods of violent conflict (Abed 2005). According to the WHO, mental health disorders are the fourth leading cause of ill health in Iraqis over the age of five (Médecines sans Frontières 2009). Data collected on Iraqi children reveals a prevalence of an astounding 37% who suffer from mental health disorders, 10% of which was unsurprisingly in the form of post-traumatic stress disorder (PTSD) (Kutcher et al. 2015). The Iraqi government is currently neglecting the critical situation of the lack of adequate mental healthcare within the country. Paediatric and adolescent mental health must become a priority for Iraq as they are not only the bearers of displacement, malnutrition, lack of education and physical suffering, but they are also the future of the country.

1.6.1.1 Culture of Psychiatry and the Stigma in Iraq

For many decades, psychiatry in Iraq has held a stigma and has been a subject of great taboo, which has consequentially restricted people from seeking professional help when needed. These restrictions are derived from social, political and religious origins. People with psychiatric disorders have always been associated with an undertone of negativity, especially in low- and middle-income countries (Sadik et al. 2010).

Culturally, however, mental health carries a huge stigma not only for the patient but also for the associated family, where they are known to be very discreet in disclosing that they have members with mental health conditions. The problem is even bigger with women. If a woman wishes to seek treatment despite the risk of

besmirchment, she faces the additional burden of needing a male chaperone to leave the home, where he himself may refuse due to the associated stigma. It is reported that women with mental health problems and their siblings are less likely to have chances of getting married due to the stigma attached to the illness. In fact, in a study conducted in Baghdad to assess public attitudes, more than half of the respondents said they would be ashamed if a family member had a mental illness. The stigma attached to mental illness in Iraq is pervasive and forms an irrefutable barrier to mental healthcare. Advocating mental health and integrating it as part of overall healthcare are two important recommendations to improve access for patients to get help (Sadik et al. 2010).

1.6.1.2 Mental Health Workforce in Iraq

Skilled workforce is the basis for developing a healthcare system; without it, the healthcare system cannot function efficiently. In particularly low- and middle-income countries across the globe, recruitment and retention into psychiatry and other mental health professions remain a challenge (Kakuma et al. 2011). This shortage in the mental health workforce is one of the main barriers upon treating mental health conditions (Bruckner et al. 2011). Like most regions of conflict, Iraq's medical workforce is facing severe shortages. The International Committee of the Red Cross estimated that by the end of 2006, nearly half of the doctors in Iraq had left the country (18,000 doctors remained from the 34,000 previously practising) (The International Committee of the Red Cross 2006).

In 2014, records show that there were 0.37 psychiatrists and 1.64 nurses who worked in mental health, 0.22 social workers and 0.09 psychologists per population of 100,000 (Cetorelli and Shabila 2014; WHO 2016). An audit requested from the Health Directorates of both Basra and Nasiriyah in March 2016 showed similar figures. In Basra, the Director of Health, Riyadh Al-Halfi, reported that there are 0.36 psychiatrists per population of 100,000, 0.36 for psychiatric nurses and 0.11 for social workers. The figures presented for Nasiriyah showed even lower ratios of 0.15, 0.1 and 0 per population of 100,000 for psychiatrists, psychiatric nurses and social workers, respectively. These figures demonstrate the scarcity of health professionals within mental health, especially in smaller cities, showing that Iraq trails far behind the international averages of 7.7 specialist nurses in mental health per 100,000 people (WHO 2016).

Furthermore, there is a noticeable discrepancy among the various governorates across the country, as well as large disparities between urban and rural areas where some have no psychiatrists at all (Cetorelli and Shabila 2014). Moreover, psychiatry in Iraq lacks specialty training, where, for example, there are no child psychiatrists or mental health services that provide help to children and adolescents. The non-existence of child psychiatry poses a serious concern. Children and adolescents account for nearly half of the population in Iraq (Kutcher et al. 2015), and with years of war and large numbers of internally displaced refugees, the prevalence of mental disorders among this age group has risen (Al-Obaidi et al. 2010). Not only does this emphasise the burden of mental health, but it also adds the additional challenge of addressing the psychosocial needs in primary healthcare.

1.6.1.3 Forensic Psychiatry in Iraq

The Al-Rashad Psychiatric Hospital is the biggest inpatient psychiatric unit in Iraq and is located in the north of Baghdad. It was built as an asylum in 1952 and has the capacity of 1200 beds. There are four wards dedicated for forensic patients, one of which is for remanded prisoners awaiting a panel's decision about their culpability, mental health and any relevant disposals. Four general adult consultant psychiatrists and a similar number of specialist psychiatrists provide medical input to the forensic wards in addition to a small number of psychiatric nurses and psychologists. A panel of three psychiatrists is allocated for each patient to assess their mental health, any relationship with the offence and potential disposals.

The Ministry of Health (MOH) is currently considering the Iraqi mental health law, which derives some similarities with the British Mental Health Act.

1.6.2 Mental Health Provision in Oman

The percentage of expenditures on mental health is unknown. In Oman, the financing system in the MOH does not separate the mental health budget from other health sector budget (as there is no programmed budgeting). All medical services including access to the mental health services and essential psychotropic medications are 100% free to Omani citizens (WHO 2008).

1.6.2.1 Inpatient and Outpatient Services

There are 26 outpatient mental health facilities available in the country, of which two are for children and adolescents. In 2006, these facilities treated 386 users per 100,000 general population. Female users make up over 40% of the population in all mental health facilities in the country. The proportion of female users is highest in inpatient and outpatient facilities in general hospitals and lowest in mental hospitals. The vast majority of beds in mental health facilities in the country are provided by the mental hospital (2.88 beds per 100,000 population), followed by six general hospital-based inpatient psychiatric units (1.01 beds per 100,000 population) and forensic units (0.19 beds per 100,000 population). There has been a 23% increase in the number of the psychiatric hospital beds in the last 5 years. The majority of the service users are treated in outpatient facilities of the mental hospital. The percentage of child and adolescent attendees is comparatively low across all mental health facilities.

The distribution of diagnoses varies across facilities; in outpatient facilities, neurotic and mood disorders are most common, whereas, in inpatient facilities and the mental hospital, schizophrenia has the highest prevalence. Psychotropic drugs are most widely available in the mental hospital, followed by outpatient units and then inpatient mental health facilities in general hospitals.

Most of the mental health facilities are present in or near large cities. To promote equity of access to mental health services, Oman is encouraging the development of outpatient psychiatric units and facilities in catchment areas across the country.

Nine percent of the training for medical doctors is devoted to mental health, in comparison to 7% for nurses. Six percent of primary care doctors and 3% of nurses received at least 2 days of refresher training in mental health in 2006. Only doctors can prescribe psychotropic medications in primary care settings (WHO 2008).

1.6.3 Psychiatric Services in Egypt

The Al-Abbasiyah Hospital in Cairo is the teaching hospital in Ain Shams University in Cairo. There is a specialised forensic department which deals with mentally ill offenders in this hospital. There are around 30 beds for the patients who are remanded pending court disposals or trials. After sentencing, female patients are disposed to around 20 beds in the Al-Abbasiyah Hospital, and male patients are disposed to the El Khanka Central Hospital which has 40 beds for forensic patients.

Ain Shams University in Cairo used to grant a diploma in forensic psychiatry after a year of training in that hospital, but this qualification has recently stopped and the university is trying to reinstate it (Al-Taiar 2014).

1.6.3.1 Specialist Psychiatric Facilities

Evaluation of the status of mental health services in the country by the MOH in collaboration with the Egymen project confirmed that the country's healthcare system operates under extremely resource-restricted conditions, in terms of infrastructure, manpower and finances. Mental health specialist care is largely delivered at national level (national referral hospitals in Cairo and Alexandria) and at governorate level (one to two psychiatrists attached to each governorate hospital for around 3 million catchment population).

The total number of hospital beds for a population of over 75 million is 6156 (including the 680 forensic psychiatric patients at Khanka, 95 forensic beds at Abbassia and 13 forensic beds at Ma'amoura). This is an average of less than 1 bed per 12,000 population across the country as a whole, compared with a WHO recommendation of 5–8 beds per 10,000 population (WHO 1996 World Health Organisation Recommendations for Mental Health Services, WHO, Geneva). In practice, when the national hospitals are excluded from the calculation, since it is not good practice to use them to admit people from a long way away from their communities, in most governorates, there are only 20 beds per 3 M, i.e. 1 bed per 150,000 population. With the prevalence of probable psychosis running at least 0.2% (Kakuma et al. 2011), it would be helpful to have psychiatric services available in every district as well as every governorate and for every district hospital to have a 10–20-bed inpatient unit for brief admissions to assess and stabilise complex cases, as well as outpatient clinics. This would still leave the vast majority of psychosis cases to be managed at the health centre and dispensary levels.

There were 979 registered psychiatrists in 2009, including 285 consultant psychiatrists, the remainder classed as specialist psychiatrists. These figures have been increasing by around 6–9% a year (these statistics are not entirely accurate because

of emigration, temporary working in the Gulf countries and also some university professors who do not register themselves as having consultant status but rather only use their professorial title). Egypt has lost a high proportion of psychiatrists to rich countries. Of all medical graduates, 5% go into psychiatry training and 10% into nursing training. There were 1902 mental health nurses in 2006, 201 social workers and 77 psychologists. Specialists are mostly concentrated in the major urban centres, and so the specialist service for the other 30 governorates is largely delivered by one or two psychiatrists and a handful of psychiatric nurses for 3 million population. This lack of human resource and continued limited funding of mental health services severely curtail access to specialist care. Nonetheless, 25,443 outpatients were seen in 2006.

The mental hospitals are institutional in design (e.g. Al Abbassia has about 2000 beds) with large wards and little provision for personal possessions; patients are not allowed to wear their own clothes, and there are no ward-based activities and little opportunity for active rehabilitation. There are a striking lack of meaningful ward-based activities and a lack of multi-axial assessments, care planning and regular case reviews, and there are many long stay patients who could be rehabilitated (Al-Taïar 2014).

The Egypmen project recruited expert assistance to capacity build specialist expertise and develop services for forensic psychiatry, rehabilitation and child psychiatry, and continued support was given by the Finnish government from 2000 to 2009, the WHO Collaborating Centre of the Institute of Psychiatry in London from 2000 to 2009 and the British Royal College of Psychiatrists from 2006 to 2009. This comprised visits to Egypt by Finnish and UK experts; Egyptian study tours to Finland, England and other European countries; and specific tailored placements in the UK. Funding for service development from the Finnish government and the MOHP has continued to access expert assistance from the UK for forensic psychiatry and legislation (Jenkins and Loza 2010).

1.7 Conclusion

This chapter is an introduction to forensic psychiatry and provides information on forensic psychiatry practices mainly in the UK but also briefly in different countries worldwide. It is not meant to be a narrative of how to conduct forensic psychiatry but rather an illustration of current practice alongside a historical development of the growth and evolution of the field within psychiatry and medicine and how it has been influenced by other subspecialties in psychiatry and other disciplines of scholarly endeavours, such as law, psychology, criminology, nursing, social work and bioethics. The past half-century has witnessed the burgeoning of forensic psychiatry from the status of ‘alienism’ to that of multidisciplinary science, in which, increasingly, scientific techniques such as neuroimaging and psychological testing have influenced juries in a number of cases. To illustrate not only the growth of forensic psychiatry within medicine and law but the breadth of its influence spreading to various other fields, this book has authors of chapters from subspecialties in

medicine and psychiatry to nonphysician specialists who work with forensic psychiatrists in various cases. Perhaps the most common discipline working with the forensic psychiatrist is the forensic psychologist, who often complements the opinions given in particular cases through his or her work conducting interviews as well as a battery of appropriate psychological tests, which are regularly updated and modernised. Within the psychiatric profession, there are subspecialties that are both paramount to forensic psychiatry and also dovetail and intersect with this growing subspecialty. These include child psychiatry, geriatric psychiatry, social and community psychiatry, correctional psychiatry, addiction psychiatry, consultation and liaison psychiatry, psychosomatic medicine, psychopharmacology, sleep medicine and, most recently, neuroimaging (Felthous and Saab 2007).

References

- Abed RT (2005) Tyranny and mental health. *Br Med Bull* 72(1):1–13
- Adshead G (2012) Chapter 1: what the eye doesn't see: relationships, boundaries and forensic mental health. In: Kelly G, Aiyegbusi A (eds) *Professional and therapeutic boundaries in forensic mental health practice*. Jessica Kingsley Publishers, London, pp 13–32
- Al-Adawi S (2002) Perception and attitude towards mental illness in Oman. *Int J Soc Psychiatry* 48(4):305–307
- Al-Obaidi A, Budosan B, Jeffrey L (2010) Child and adolescent mental health in Iraq: current situation and scope for promotion of child and adolescent mental health policy. *Intervention* 8(1):1–88. <https://doi.org/10.1097/WTF.0b013e3283387adf>
- Al-Taiar H (2014) Forensic psychiatry services in the Arab world, the past and the future. *European Psychiatry* 29, 1. [https://www.europsy-journal.com/article/S0924-9338\(14\)78188-X/pdf](https://www.europsy-journal.com/article/S0924-9338(14)78188-X/pdf)
- Annual report (2013) Inpatients formally detained in hospitals under the mental health act 1983, and patients subject to supervised community treatment. Health and Social Care Information Centre, England
- Bruckner T, Scheffler R, Shen G, Yoon J, Chisholm D, Morris J, Fulton B, Mario Dal Poz M, Saxena S (2011) The mental health workforce gap in low- and middle- income countries: a needs-based approach. *Bull World Health Organ* 89:184–194
- Centre for Mental Health (2011a) Pathways to unlocking secure mental health care. CMH, London
- Centre for Mental Health (2011b) Mental health care and the criminal justice system (briefing 39). CMH, London
- Centre for Mental Health and Capacity Law (2014) Scotland's Mental Health and Capacity Law: the case for reform. Mental Welfare Commission for Scotland. https://www.mwscot.org.uk/media/371023/scotland_s_mental_health_and_capacity_law.pdf
- Cetorelli V, Shabila N (2014) Expansion of health facilities in Iraq a decade after the US-led invasion, 2003–2012. *Confl Heal* 8(1):16
- Crawford N (2013) Civilian death and injury in the Iraq War, 2003–2013, Costs of War [Internet]. Boston University; [cited 30 May 2016]
- De Boer J, Gerrits J (2007) Learning from Holland: the TBS system. *Psychiatry* 6(11):459–461
- Delmage E, Exworthy T, Blackwood N (2015) The 'hybrid order': origins and usage. *J Forensic Psychiatry Psychol* 26:325–336
- Department of Health, Home Office (1992) Vol. 1 final summary report. Review of health and social services of mentally disordered offenders and others requiring similar services (reed report). DoH, Home Office, London
- Department of Health (2009) The Bradley report. Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system. Department of Health, London

- Eastman N, Adshead G, Fox S, Latham R, Whyte S (2012) Chapter 8 Forensic Psychiatric Services. In Oxford Specialist Handbooks in Psychiatry: Forensic Psychiatry. Oxford University Press
- Edworthy R, Sampson S, Vollm B (2016) Inpatient forensic-psychiatric care: legal frameworks and service provision in three European countries. *Int J Law Psychiatry* 47:18–27. <https://doi.org/10.1016/j.ijlp.2016.02.027>
- Every-Palmer S, Brink J, Chern TP, Choi WK, Hem-Yee JG, Green B, Shiina A (2014) Review of psychiatric services to mentally disordered offenders around the Pacific rim. *Asia Pac Psychiatry* 6(1):1–17
- Fazel S, Fimińska Z, Cocks C, Coid J (2016) Patient outcomes following discharge from secure psychiatric hospitals: systematic review and meta-analysis. *Br J Psychiatry* 208:17–25
- Felthous AR, Saab H (2007) International handbook on psychopathic disorders and the law. Wiley, New York
- Fujii C, Fukuda Y, Ando K, Kikuchi A, Okada T (2014) Development of forensic mental health services in Japan: working towards the reintegration of offenders with mental disorders. *Int J Ment Health Syst* 8(1):21
- Galappathie N, Khan ST, Hussain A (2017) Civil and forensic patients in secure psychiatric settings: a comparison. *Br J Psychiatry Bull* 41:156–159
- Gordon H, Lindqvist P (2007) Forensic psychiatry in Europe. *Psychiatrist* 31(11):421–424
- Guidance for Commissioners of Forensic Mental Health Services (2013) Joint Commissioning Panel for Mental Health
- Gunn J, Taylor P (2014) Forensic psychiatry: clinical, legal and ethical issues. CRC Press, Boca Raton
- Gunn J (2004) Introduction: what is forensic psychiatry? *Crim Behav Ment Health* 14:S1–S5
- Home Office. Report of the Committee on Mentally Abnormal Offenders (Butler report) (1975) Great Britain. Parliament. Papers by Command; Issue 6244 of Statutory instruments H.M. Stationery Office
- Jenkins R, Loza N (2010) Mental health policy and development in Egypt - integrating mental health into health sector reforms 2001–9. *Int J Ment Health Syst* 4:17. <https://doi.org/10.1186/1752-4458-4-17>
- Kakuma R, Minas H, van Ginneken N, Dal Poz MR, Desiraju K, Morris JE, Saxena S, Scheffler RM (2011) Human resources for mental health care: current situation and strategies for action. *Lancet* 378(9803):1654–1663. [https://doi.org/10.1016/S0140-6736\(11\)61093-3](https://doi.org/10.1016/S0140-6736(11)61093-3). Epub 2011 Oct 16
- Kennedy HG, O'Neill C, Flynn G, Gill P (2012) Dangerousness, Understanding, Recovery And Urgency Manual (The Dundrum Quartet) V1.0.24 (14/07/12) Four structured professional judgement instruments for admission triage, urgency, treatment completion and recovery assessments. National Forensic Mental Health Service, Central Mental Hospital, Dundrum, Dublin 14, Ireland and Academic Department of Psychiatry, University of Dublin, Trinity College
- Kutcher S, Wei Y, Weist M (2015) School mental health: global challenges and opportunities. Cambridge University Press, Cambridge
- Lynch G, Campbell P, Taggart C (2017) Mental capacity act (Northern Ireland) 2016. *Br J Psychiatry Bull* 41(6):353–357
- Médecins Sans Frontières (2009) Healing Iraqis: The challenges of providing mental health care in Iraq. Médecins Sans Frontières. https://www.msf.org/sites/msf.org/files/english_iraq_mental_health_final_report.pdf
- Mental Health (Care and Treatment) (Scotland) Act 2003 Approved medical practitioner- training manual. <https://www.gov.scot/Publications/2005/05/1093513/35148>
- Millan B (2001) New Directions; Report on the Review of the Mental Health (Scotland) Act 1984. Scottish Executive
- Mohan R, Slade M, Fahy T (2004) Clinical characteristics of community forensic mental health services. *Psychiatr Serv* 11:55
- Mullen P (2000) Forensic mental health. *Br J Psychiatry* 176:307–311
- Natarajan M, Srinivas J, Briscoe G, Forsyth S (2012) Community forensic psychiatry and the forensic mental health liaison model. *Adv Psychiatr Treat* 18:408–415

- National Health Service Act -Chapter 41 (2006). <https://www.legislation.gov.uk/ukpga/2006/41/contents>
- Nedopil N (2009) The role of forensic psychiatry in mental health systems in Europe. *Crim Behav Ment Health* 19(4):224–234
- Nedopil N, Taylor P, Gunn J (2015) Forensic psychiatry in Europe: the perspective of the Ghent group. *Int J Psychiatry Clin Pract* 19(2):80–83
- Owens DC, McKenna PJ, Davenport R (2010) Clinical assessment: interviewing and examination. In: Johnstone EC, Owens DC, Lawrie SM, McIntosh AM, Sharpe M (eds) *Companion to psychiatric studies*. Churchill Livingstone Elsevier, London
- Peay J (2011) Mental disorder and detention, a perspective from prison. Chapter 11. In: *Mental health and crime*. Routledge, Oxford
- Priebe S, Badesconyi A, Fioritti A, Hansson L, Kilian R, Torres-Gonzales F, Turner T, Wiersma D (2005) Reinstitutionalisation in mental health care: comparison of data on service provision from six European countries. *Br Med J* 330(7483):123–126
- Richardson G (1999) Report of the Expert Committee: Review of the Mental Health Act 1983. Department of Health
- Rix KJB (2011) Chapter 1 ‘nature and duties of an expert witness’. In: *Expert psychiatric evidence*. RCPsych Publications, London
- Roesch R, Cook AN (2017) *Handbook of forensic mental health services*. Taylor & Francis, UK
- Sadik S, Bradley M, Al-Hasoon S, Jenkins (2010) Public perception of mental health in Iraq. *Int J Ment Health Syst* 4(26):5–6. [Cited 2016 Mar 20]
- Sauter J, Seewald K, Dahle K-P (2017) Wirksamkeit ambulanter forensischer Nachsorge - Was wissen wir wirklich? Übersichtsarbeit über den aktuellen Forschungsstand in der Bundesrepublik Deutschland. *Bewährungshilfe* 61(2):146–161
- See Think Act 2nd edition (2015) Royal College of Psychiatrists Quality Network for Forensic Mental Health Services
- The International Committee of the Red Cross (2006) *Civilians without protection: The ever-worsening humanitarian crisis in Iraq* [Internet]. Geneva. [Cited 1 April 2016]
- Turley C, Payne C, Webster S (2013) Enabling features of psychologically informed planned environments. NatCen Social Research. National Offender Management Service. Ministry of Justice Analytical Series
- WHO (2008) AIMS Report on mental health system in Oman [Internet]. http://www.who.int/mental_health/who_aims_oman_report.pdf
- WHO (2016) Psychiatrists and nurses (per 100 000 population) [Internet]. Who.int. [cited 5 June 2016]. http://www.who.int/gho/mental_health/human_resources/psychiatrists_nurses/en/
- Zigmond T (2017) Mental health law across the UK. *Br J Psychiatry Bull* 41:305–307



Forensic Psychiatry and the Mentally Disordered Offender: Ethical Issues in the Treatment Provision within Secure Hospital Environments—Clinical and Legal

Oriana Chao, Despoina Konstandinidou,
and Artemis Igoumenou

2.1 Generic Ethical Issues for All Psychiatry Disciplines

Oriana Chao

2.1.1 What Are Ethics?

According to the Oxford Dictionaries, ethics is defined as the *moral principles that govern a person's behaviour or the conducting of an activity* (Oxford Dictionary 2017). Within medicine, ethics usually operate within an established framework of values which serves as a reference from which to conduct the debate about the rightness or wrongness of an action (Mason et al. 2003). In their book, *Principles of Biomedical Ethics*, Beauchamp and Childress (Beauchamp and Childress 2001) refer to four *moral principles*, namely, respect for autonomy, non-maleficence, beneficence and justice. *Principlism*, as this is known, has an important but imperfect role in considering medical ethics. Ethical concerns can be found throughout medicine, and with advances in medicine, these are likely to increase. Reproductive medicine and death are frequently debated subjects. More generally, there are

O. Chao (✉)

Consultant Forensic Psychiatrist, London, UK

e-mail: oriana.chao@nhs.net

D. Konstandinidou

Specialty Trainee in Forensic Psychiatry, Manchester, UK

A. Igoumenou

Division of Psychiatry, University College London, London, UK

Honorary Consultant Psychiatrist Barnet Enfield and Haringey Mental Health NHS Trust, London, UK

questions around confidentiality and consent. In psychiatry coercion, restrictive practice and deprivation of liberty are particularly relevant, and within forensic psychiatry (albeit not exclusively), there is also the interface between health and the criminal justice system.

2.1.2 Recent History

In psychiatry, unlike other areas of medicine, patients can be treated against their will. According to the Mental Health Bulletin in the financial year 2015–2016, overall numbers detained under the Act had increased. *An estimated 1,805,905 people were in contact with adult mental health and learning disabilities services*, and of these an estimated 5.6% were admitted to hospital. There were 25,577 patients detained under the Mental Health Act 1983 on 31 March 2016; 20,151 were in hospital and 5246 were subject to Community Treatment Orders. In contrast, the numbers of patients detained under Part 3 of the Act have reduced to 1696 in 2015/2016 as compared to 2130 in 2011/2012. Whilst hospital orders have been imposed less frequently, there has been a marked increase of 25% in urgent transfers to hospital from prison under sections 48/49 in the last 3 years.

Back in 1957, the Percy Commission, which reviewed the law relating to mental illness and mental deficiency, concluded *the law should be altered so that whenever possible suitable care may be provided for mentally disordered patients with no more restriction of liberty or legal formality than is applied to people who need care because of other types of illness, disability or social difficulty* (The Percy Commission 1957). In the aftermath of this, the Mental Health Act 1959 became legislation and introduced new safeguards. Patients were detained for their health and safety or to protect others from harm (Bluglass 1978). Clinicians rather than magistrates had the power to detain, and Mental Health Review Tribunals were introduced to review detention (Gooding 2014). Consent to treatment was covered, albeit was not specific, and it did not sanction treatment without consent for informal patients (Bluglass 1978). For those who had been detained, treatment could be given without consent. Although good practice suggested discussion with relatives, or obtaining a second opinion from a colleague, it is not clear when this was introduced and how extensively it was embraced (Hilton 2007).

Under the Mental Health Act 1983, consent to treatment was formalised with specific legal frameworks around treatment including psychosurgery, electroconvulsive therapy and psychotropic medication. Additional reforms included the introduction of the approved social worker (ASW) who was able to make applications for compulsory admissions. There were also duties on local authorities under section 117 to provide aftercare services to patients detained under specific sections after their discharge from hospital. The Mental Health Act Commission was also created. Its role was to protect the interests of detained patients, review the Mental Health Act, appoint doctors to provide second opinions with respect to consent to treatment, and devise a code of practice (Turner et al. 1999).

In the years following the introduction of the Mental Health Act 1983, a number of significant pieces of legislation were passed, including the Human Rights Act 1998 and the Mental Capacity Act 2005. Changes to mental health legislation had considered the implications of these Acts, particularly the Human Rights Act, and several articles of the European Convention on Human Rights have relevance to mental health law, most notably in relation to detention and compulsory treatment (Mason et al. 2003). Article 5, *everyone has the right to liberty and security of person*, is highlighted in the case of *Winterwerp v Netherlands* (1979) which stipulates that minimum criteria for detention under mental health legislation must be justified (Mason et al. 2003). Public authorities have a duty to adhere to the Convention, and a declaration of incompatibility has to be made if they cannot comply (Branton and Bookes 2010). Indeed, this happened in the case of *R (on the application of H) v. Mental Health Review Tribunal North and East London Region* (2001) such that the secretary of state introduced a remedial order reversing the burden of truth in a tribunal from the patient to the hospital (Branton and Bookes 2010).

Although the government had wanted to replace the Mental Health Act 1983, objections to many of its plans meant the 1983 Act was instead amended in 2007, with the changes coming into force in November 2008. The principle amendments include a simplification of the definition of mental disorder to *any disorder or disability of the mind* with the removal of the four subcategories. Exclusion criteria have also been modified such that *dependence on drugs or alcohol* remain but *promiscuity, or other immoral conduct, sexual deviancy* have been removed. Learning disability is an exclusion *unless... associated with abnormally aggressive or seriously irresponsible conduct*. Once detained for treatment, one of the criteria is *appropriate medical treatment is available*. The definition is wide and states: *nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care...the purpose of which is to alleviate, or prevent a worsening of, the disorder or one or more of its symptoms or manifestations*. In effect, this allows those with personality disorder to be detained if the *purpose* is to alleviate the disorder. The amended Act also revised the professional roles. It introduced the Approved Mental Health Professional, which allowed other mental health professionals to take on this role (with the exception of doctors). Responsible Medical Officers were replaced with Responsible Clinicians, who could be non-psychiatrists, but initial detentions under the Act continue to require two medical doctors. This is controversial, particularly as according to *Winterwerp*, detention requires objective medical evidence, and under the amended Act there may be a non-medical Responsible Clinician. The introduction of Supervised Community Treatment through Community Treatment Orders replaced Supervised Discharge. This provides the power of recall followed by a 72 hour period in hospital for treatment, after which the Community Treatment Order can be revoked if a patient is not taking their treatment. As a result, leave of absence longer than 7 days requires consideration of Supervised Community Treatment.

The right to advocacy was also introduced. Independent Mental Health Advocates provided this service from April 2009 to help patients access information about

their detention, treatment and rights. (This is in keeping with Independent Mental Capacity Advocates available under the Mental Capacity Act).

Children's safeguards were added such that from April 2010 they had to be placed in *age-appropriate* settings with hospital managers having responsibility for this (Lawton-Smith 2008). The reality is there are 1459 CAMHS beds in England, of which 124 are low secure beds. Despite a 71% increase since 1999, according to the Education Policy Institute, the number remains insufficient and NHS England has agreed to provide 150–180 additional tier 4 beds (Campbell 2017).

The *Bournewood Gap*, in effect the detention of incapacitated patients under common law in the absence of safeguards or a right to appeal, was addressed by using the Act to amend the Mental Capacity Act of 2005 and introduce Deprivation of Liberty Safeguards. It was also used to amend the Domestic Violence, Crime and Victims Act of 2004 such that victims of violent or sexual offences detained in the hospital were allowed to make representation around conditional discharge and conditions if discharged under a Community Treatment Order (Lawton-Smith 2008).

2.1.3 Generic Ethical Issues

It is positive, as described above, that safeguards related to detained patients have increased over time. Nevertheless, both detained patients in hospital and those subject to a Community Treatment Order, or a conditional discharge from a hospital order with restrictions, may feel coerced into taking treatment. Capacity to consent to treatment is assessed, and if required, a second opinion appointed doctor provides a view. However, if a patient has capacity to consent and decides to refuse, and if the second opinion doctor concurs with the opinion of the treating team, they have no choice but to take the treatment (or be recalled, if in the community and they continue to refuse). Capacity to consent to treatment is not the only area in which a patient may find they lack control, even if they are capacitous. Patients do have recourse to appeal using the Mental Health Tribunal, and the burden now rests with the hospital to justify the detention/order. And whilst those providing evidence to the Mental Health Tribunal, particularly oral but also written, must justify detention, it may be difficult to do so in a manner that is not harmful to the therapeutic relationship. For those who have general welfare needs (not just medication requirements), guardianship allows care in the community where it cannot be provided without compulsory powers.

Detained patients are likely to have access to medical records through Mental Health Tribunal reports, and Care Programme Approach reports may also contain detailed information. Patients in hospital are often able to apply to see their records directly, and their legal representatives frequently make requests to view the records. Patients can request access to their medical records through a Subject Access Request (SAR), which is set out in the Data Protection Act of 1998. There are rules around this including the period by which the request should be met (How do I access my medical records (health records)? <http://www.nhs.uk/chq/pages/1309.aspx?categoryid=68>).

Confidentiality is noted by the General Medical Council as an *important ethical and legal duty but it is not absolute*. It discusses reasons when *one may disclose personal information without breaching duties of confidentiality*. Justification includes the patient consenting, disclosure to the benefit of the patient when they are unable to consent, disclosure required by law or as part of a statutory process, and disclosure in the public interest. Ideally, consent to disclose information should be requested. If the patient lacks capacity, information should be discussed with someone appointed to make health and welfare decisions for them. Information should be disclosed if the patient is at risk of serious harm and it is required by law. Even if it is not required by law, if there are concerns about risk to the patient, it should be disclosed, unless it will not benefit the patient. In capacitous adults, if the patient refuses, this should generally be accepted, even if they put themselves at risk of serious harm. This does not necessarily apply if someone else is at risk as well. Disclosure in the public interest without consent may not be straightforward and should be discussed with the Caldicott Guardian or other expert if possible (GMC 2017). The British Medical Association provides similar guidance. Their guidance notes: *in the absence of evidence to the contrary, patients are normally considered to have given implied consent for the use of their information by health professionals for the purpose of the care they receive. Information sharing in this context is acceptable to the extent that health professionals share what is necessary and relevant for patient care on a 'need to know' basis. Health and social care, although often closely related, do not always fall into the same category, and disclosure of information to social services usually requires explicit consent from competent patients.* (BMA 2016). The case of *W v Egdell* (1990)¹ sanctioned the duty to disclose private information if there was a risk to the public. Although ideally consent should be sought, prevention of harm can justify a breach (Adshead 2014). Indeed, the case of *Tarasoff* in the USA went further and highlighted the *duty to protect, not a duty to warn* (Felthous 2006).

In considering research, given forensic populations are often compulsorily detained, informed consent is important, as well as the ability to veto research that could lead to a direct risk. In epidemiological and clinical research, anonymisation and secure coding are often used in an effort to reduce the risk of breaches of confidentiality (Munthe et al. 2010).

2.1.4 Conclusion

Ethical concerns can be found throughout medicine, and with advances in medicine, these are likely to increase. The principles of respect for autonomy, non-maleficence,

¹W had schizophrenia and was detained in a secure hospital having shot seven people, killing five. Dr. Egdell was asked to prepare a report for a tribunal by his solicitor, but the application was withdrawn as the report noted an interest in guns and homemade bombs which predated his illness. Dr. Egdell sent a copy to the hospital and asked the hospital to send it to the tribunal. W claimed he had breached his confidentiality, but the court found in Dr. Egdell's favour due to the grave risk of harm.

beneficence and justice are key within all medical disciplines, as are questions around confidentiality and consent. In psychiatry, the safeguards related to detained patients have improved, but issues around coercion, restrictive practice and deprivation of liberty are considerations in everyday psychiatric practice. Forensic psychiatry also faces additional challenges arising from the interface between health and the criminal justice system.

In the following section, the focus will be specific ethical issues in the treatment provision within forensic psychiatry, especially within secure hospital environments. Particular emphasis will be placed on how the relationship between professionals and the patient is different in forensic psychiatry compared to other psychiatry settings and will discuss pertinent ethical considerations.

2.2 Specific Ethical Issues Related to Forensic Psychiatry

Despoina Konstandinidou and Artemis Igoumenou

Many of the ethical issues found within psychiatry may be heightened within forensic psychiatry, as by definition the patients are detained or subject to some sort of compulsory measures. Patients may have been admitted through the courts directly and transferred from prisons or other non-forensic hospitals. The involvement of forensic psychiatry services usually has a dual function: on the one hand, the assessment and treatment of a patient that presents with a mental disorder, and on the other hand, addressing the association of such mental disorder with offending; therefore, part of its role may also be to protect the public from future harm. As such, patients may be in the hospital for prolonged periods with complex relationships with their Responsible Clinician and other members of the team.

In addition to generic issues around detention, consent versus coercion and confidentiality managing forensic psychiatry patients bring into consideration issues stemming from the interface between psychiatry and the legal system as well as environmental factors such as hospital security, exclusion zones, restrictions or treatment in prisons/detention centres. Additional issues that need consideration include the effects of long periods of detention and case management from the Ministry of Justice, report writing and the effect on therapeutic relationships (court, annual progress and tribunal reports), scarcity of community placements that can manage both mental illness and criminality or risk of recidivism, imposition of therapies to progress, long-term segregation/seclusion, and high-dose medications to manage behaviours.

2.2.1 Deprivation of Liberty

The use of the Mental Health Act 1983 to detain patients considered to be mentally ill continues to rise. In the UK during 2015/2016, the total number of detentions under the Act was increased by 9% to 63,622 compared to 58,399 detentions in

2014/2015. This compares with an increase of 10% between 2013/2014 and 2014/2015 and is the highest number since 2005/2006 (43,361 detentions) (Annual Statistics 2016). The use of section 136 of the Mental Health Act 1983 (under which people can be brought to the hospital as a 'place of safety' where they are assessed for the presence of a mental illness/disorder) has also increased by 18% to 22,965.

Deprivation of liberty or liberty restrictions for patients detained in psychiatric hospitals are a common concern for psychiatric systems worldwide. Kuosmanen et al. in their 2001 study investigated whether patients had experienced deprivation of their liberty during psychiatric hospitalisation and sought their views about it. Their participants reported that the main restrictions of their liberty whilst in a psychiatric hospital included restrictions regarding leaving the ward, restrictions on communications, confiscation of property and the use of various coercive measures. The patients' experiences of being deprived of their liberty were unanimously negative, although some saw the rationale for using these interventions, considering them as part of hospital care (Kuosmanen et al. 2007).

Deprivation of patients' liberty may arguably be justifiable in occasions where priority is maintaining their safety (and the safety of others, including patients and staff) and preventing further deterioration of their mental state. A variety of methods are used in psychiatric hospitals to maintain safety including restrictions of patients' freedom to discharge self and leave the hospital, detention under the Mental Health Act, and restrictions of leaving the ward temporarily as a voluntary patient could do. Other methods, such as the use of seclusion or the use of restraint and forced administration of medication, are more controversial and generate a number of moral concerns. Deleterious effects and negative experiences of seclusion and restraint have been reported by patients who perceive them as punitive, coercive and traumatic. In spite of controversial research results and international recommendations, seclusion and restraint are part of everyday psychiatric hospital care, although empirical evidence of the effectiveness of these methods is still lacking. Several alternative approaches could be used to minimise the use of seclusion, restraint and forced use of psychotropic medication including timely de-escalation, empowering the patient to participate in decisions involving their care and the use of advance directives.

Mental health legislation is put in place to ensure not only that a patient is treated in the least restrictive environment with the least restrictive approach but also an acceptable quality of interventions involving deprivation of patients' liberty in psychiatric hospital care. Despite such legislation being advanced in some countries such as the UK, there is great variability of both legislation quality and content (e.g. the process of involuntary admission and treatment, and relevant safeguards), between European Union member states and worldwide. In some countries, relevant laws and regulations are outdated, and on occasion they serve to deprive patients of their rights rather than protect them.

Ethical considerations involving deprivation of liberty are more pertinent in some forensic psychiatric settings such as medium- and high-security forensic psychiatric hospitals where all patients are detained under the Mental Health Act.

2.2.2 Confidentiality

Trust is an essential part of the doctor-patient relationship, and confidentiality is central to this. Patients may avoid seeking medical help or may underreport symptoms, if they think their personal information will be disclosed by doctors without their consent or without the chance to have some control over the timing or amount of information shared.

The issue of confidentiality regarding patient information and disclosures has always been one of the most thought-provoking issues within the medical practice universally and even more so when it involves an area of clinical practice where medicine and law interfere, such as is forensic psychiatry. As discussed earlier in the chapter, confidentiality is an *important ethical and legal duty but it is not absolute* (GMC 2017).

Due to its great importance in patient care, the General Medical Council in the UK provides an exclusive guidance on what confidentiality involves and the duty of doctors to preserve it (by managing and protecting patient information) and also outlines the framework for considering when it is appropriate to disclose patients' personal information (GMC 2017). This guidance covers rules regarding:

- (a) Disclosure to support the direct care of an individual patient
- (b) Disclosures for the protection of patients and others
- (c) Disclosures for all other purposes

As a general rule, the GMC guidance highlights that good practice in handling patient information means seeking the patient's consent prior to disclosing his or her specific personal information. It is however occasionally the case in psychiatry, and particularly in forensic psychiatry, that the psychiatrist might need to disclose information about the patient without the patient's consent:

1. Disclosures approved under a legal process

The forensic psychiatrist can disclose personal information without consent if the disclosure is permitted or has been approved under section 251 of the National Health Service Act of 2006 which applies in England and Wales or the Health and Social Care Act of 2016 (Control of Data Processing) in Northern Ireland. These pieces of legislation allow the common law duty of confidentiality to be set aside for defined purposes where it is not possible to use anonymised information and where seeking consent is not practicable. There is no comparable legal framework in Scotland.

2. Disclosures in the public interest

Confidential medical care is recognised as an important right for every person and is believed to serve not only the specific person's best interest but also the public interest. This is based on the fact that if people are encouraged to seek advice and treatment for their medical symptoms and conditions, they are benefited, but also society is benefited directly or indirectly. On occasion though,

there can be a public interest in disclosing patient information, and the medical practice allows it if the benefits to an individual or society outweigh both the public and the patient's interest in keeping the information confidential. For example, disclosure may be justified to protect individuals or society from risks of serious harm, such as from serious communicable diseases or serious crime.

3. Disclosures about patients who lack capacity to consent

Forensic psychiatrists, as all clinicians within their own practice, must work on the presumption that every adult patient has the capacity to make decisions about the disclosure of their personal information. They must not assume a patient lacks capacity to make a decision solely because of their age, disability, appearance, behaviour, medical condition (including mental illness), beliefs and apparent inability to communicate or because they make a decision they disagree with. They must assess a patient's capacity to make a particular decision at the time it needs to be made, recognising that fluctuations in a patient's condition may affect their ability to understand, retain, weigh up information or communicate their decision. They should also allow time if possible for the patient's capacity to restore (if their condition allows it) before disclosing information. In case of lack of capacity to consent to disclosure of personal information, the psychiatrist has the obligation to disclose only proportionate and relevant information.

In forensic psychiatry, it is quite often the case that patient's personal information (including medical, psychiatric and social history, other conditions and behaviours as well as progress) are disclosed in an obligatory fashion to courts, tribunals and regulatory bodies (BMA 2017). The courts, including the coroner's courts, magistrates and crown courts, Mental Health Tribunals, and bodies appointed to hold inquiries such as the General Medical Council, have legal powers to require disclosure, without the patient's consent, of information that may be relevant to matters within their jurisdiction. Applications for court orders must be served on patients who, if they object to the disclosure of the information, must be given an opportunity to make representations to the court. In cases that these applications are served on the healthcare organisations where the patient resides, when they should be served on patients, it is the obligation of the healthcare provider to inform the patient of the application, so they can make their representations to court as necessary. Where a court order is served to the treating forensic psychiatrist (and involved health professionals in general) to provide evidence about a particular patient, then they are justified in disclosing information when they believe that this is a reasonable request, and they should disclose only as much information as is requested or they believe is required. Failure to comply with a court order to release records may be an offence, but health professionals should object to the judge or presiding officer if they believe that the records contain information that should not be disclosed, for example, because it relates to third parties unconnected with the proceedings. In any case, patients should be informed of disclosures ordered by a court.

These circumstances extend to report writing, when a psychiatrist or forensic psychiatrist is called as an expert witness (McClure 1999). Report writing comes however with additional ethical concerns.

Peter Gaughwin, in his article, makes a strong case that, notwithstanding the nature of the adversarial system, *the obligations to the legal system* (of medical practitioners providing medicolegal reports) *are those to the court, not necessarily to the referring lawyer*. He also highlights that treating psychiatrists, in particular, are subjected to considerable pressure, mostly arising from the patient's transference, to *please the patient* and provide that which is sought (i.e. a favourable report) (Gaughwin 1998).

Similarly, Paul Appelbaum (1997a, b) reflects on arising ethical issues such as *how ought a treating psychiatrist respond when a patient or the patient's lawyer requests that the psychiatrist prepares a report on the patient's unsuitability for custody of a child or agree to testify on the degree of emotional harm the patient suffered in an automobile accident?* Optimally, patients should be told why such behaviour threatens to undermine ongoing treatment. Applebaum suggests that an offer should be made to help identify another clinician to perform the forensic evaluation and argues how this response can have a powerful, positive effect on the psychiatrist-patient relationship (Appelbaum 1997a, b). From this, it would seem reasonable indeed that the only ethically available course of action for a treating psychiatrist is to decline any involvement in his or her patients' legal problems, whether civil or criminal.

It is however the case in some jurisdictions that clinicians (most often psychiatrist) do not have an option and are expected to acquire a dual role. Such is the case in some US states, particularly in smaller systems where there may be a limited number of providers, where psychiatrists working in correctional services may find themselves simultaneously assuming a treatment role and the role of a forensic evaluator (Cervantes and Hanson 2013). These two roles can at times be in conflict, as psychiatrists who assume the care of an inmate for purposes of treatment, are expected to act in the inmate's best interests, whereas forensic evaluators serve the interests of the judicial system. Such expectation of a dual role occurs despite a well-established and widely accepted principle that acting in dual roles (as a forensic evaluator and a treatment provider) for the same individual is not advisable and can lead to ethical conflicts (Strasburger et al. 1997; Reid 2002; Appelbaum 1997a, b; Sen et al. 2007; Konrad 2010).

Although there may be some advantages to having an evaluator assume both roles for the same individual from an efficiency standpoint, there are significant problems, including difficulty remaining objective and potential damage to the treatment relationship.

Nevertheless, whilst forensic psychiatrists may have the option in some jurisdictions to refuse writing medicolegal reports and present as expert witnesses for a civil or criminal law case that their patients are involved with, they have no choice in writing reports for Mental Health Tribunals, Annual Reports for the Ministry of Justice and other official reviews. Inevitably, this can cause strain in their therapeutic relationship with the patient and highlights the specific demands in the role of a forensic psychiatrist.

2.2.3 Ethical Dilemmas Arising from the Unique Relationship Between Patient and Clinicians in Forensic Psychiatry Settings

Naturally, the question arises of how we can balance good patient care, good therapeutic relationships and at the same time treatment imposing and freedom restrictions in secure settings.

Patient-focused research has indicated that most experiences of patients can be traced back to one core experience that makes the difference: *Am I being listened to?* (van den Hooff and Goossensen 2014). If patients experience being genuinely listened to, they feel more respected as human beings and less emotionally abandoned. The challenge for professionals is to explicitly pay attention and listen empathically to patients' struggles, whilst at the same time make the decision to treat the patient in a psychiatric hospital not voluntarily but detained using the Mental Health Act.

Fisher (1995), in his research focusing on the experience of nursing staff working in secure settings, concluded that balancing support for patient autonomy with the need to maintain unit control, was experienced by nurses as a tension between their desire to give patients latitude to manage their own behaviours, and their simultaneous responsibility for maintaining unit safety. As one nurse described it, this balancing is the very essence of psychiatric nursing practice: *...my whole job is to balance how much control to allow the patient and how much control to assume.* In the example that follows, a subject anguishes over the decision to give a patient the opportunity to manage his own behaviour: *I thought we were beginning to develop a good trusting relationship, but this particular day I got a funny feeling from what he was saying. He managed to contain his anger, but then walked into the dining room and hit another patient. He drew blood. I felt like I should have been able to see that coming. I wanted to give him a chance because he had handled himself before.* Another nurse stated, *I'm always asking myself, 'Did I act punitively?' 'Did his [the patient's] actions warrant my reaction?' or 'Did I act too quickly?'* These data characterise the actual mental struggle of the forensic psychiatric nurses as they attempt to find balance in their practice. Learning to balance support for patient autonomy with the need to maintain unit control evolves with experience in practice (Fisher 1995).

Such burning questions and concerns are as much relevant to nursing staff as to all mental health practitioners involved in the treatment provision within secure hospital environments, and forensic psychiatrists are not an exception.

Focusing on forensic psychiatrists, their practice has to be led by the universal psychiatric ethical rules: a psychiatrist must be able to demonstrate responsible patient care and ethical behaviour, with an emphasis on integrity, honesty, compassion, confidentiality, informed assent or consent, professional conduct and conflict of interest (American Board of Psychiatry and Neurology 2012). These rules not only ensure good patient care but also are an important step of building honest therapeutic relationships with their patients. At the same time, however, the legal system is counting on psychiatrists to answer questions such as the individual

patient's competency to stand trial, their intent to commit a crime, and the recommendations for treatment, management and supervision (Simon 2003). Whilst forensic psychiatrists often get the balance of safeguarding their therapeutic relationship with their patients and satisfying the legal system right, the effort behind keeping that balance is at times overwhelming.

In some countries, the legal system can become so entwined with the forensic psychiatry system that not only the therapeutic relationship of doctor-patient suffers but also questions are asked of forensic psychiatrists that are beyond their competencies. It is evident that, increasingly, voices within the global forensic psychiatric community are reiterating that the role of forensic psychiatry is to provide knowledge into the criminal psychopathology, within its limitation, but not to provide opinion regarding moral concepts such as evil.

The causes, development and management of criminal behaviours are legitimate areas for forensic study. When such criminal behaviours are associated with mental health problems, then forensic psychiatry has a role to play in the assessment, diagnosis and treatment of mental disorders so that indirectly criminal behaviours are reduced or diminished. The Gordian knot of evil however cannot be untied by forensic psychiatry. It is unreasonable to expect forensic psychiatrists to provide credible testimony about evil. Forensic mental health professionals have an important, but limited, consulting role when advising the courts about psychological matters including mental health. It is the law's final moral judgment of guilt upon individuals whom society brands as evildoers. This is more fundamental in some US states when evaluating the role of the psychiatrist in capital proceedings, and punishment and interrogation of detainees. It seems antithetical to the medical role the participation in criminal proceedings where psychiatrists are expected to assess fitness to be executed. Subsequently, a number of ethical and professional dilemmas arise: what should happen if incompetence is found, who would work to restore competence, does it need to be restored, and when a psychiatrist gives evidence to assist a judge to determine competence, is it deemed different from participation in capital punishment?

2.2.4 Forensic Research

When it comes to conducting research involving mentally disordered offenders, the ethical issues are as complex as those in everyday practise in forensic psychiatry. The forensic psychiatry population is indeed a very vulnerable patient population.

As very eloquently described in a recent article published in *Bioethics*: *The most serious threat to the ethical defensibility of forensic psychiatric research on selectively detained MDOs, is not the actual research situation and direct interaction between researchers and subjects. Instead, it resides in that step of the research process when the results are communicated to the wider society. Much of current practice in connection with forensic psychiatric risk assessment and media and policy consultancy is highly questionable for the simple reason that it serves to uphold and strengthen a prejudicial picture of MDOs, and people with mental health problems in general, that harms these people and supports unjust legal*

practices. In effect, we have argued that strong statements from scientific and professional organizations in support of a scientifically well-founded revision of forensic psychiatric risk assessment and consultancy practices are urgently called for (Munthe et al. 2010).

It is thus evident that ethical issues such as informed consent in the forensic psychiatric context, and questions such as when and how to communicate results derived from forensic research, can be daunting and difficult to answer.

2.2.5 Conclusions

Although the subject and the complexity of specialty requirements in the forensic psychiatric context (mental health diagnosis and management, law in mental health, boundaries, medications, psychological therapies, risk assessment and management, importance of the use of clinical judgement and evidence-based tools, skills in working in high pressure, different environments, long periods spent looking after patients [tolerance from both sides]) is seemingly endless, and the ethical issues that arise generate more questions than actually provide answers, it is vital to the forensic psychiatric community to actively voice these questions. It is important for forensic psychiatrists to keep revisiting these questions and challenge medical practice to maintain high ethical standards as they balance a very sensitive and demanding field, that between psychiatry and the law.

References

- Adshead G (2014) Three faces of justice: competing ethical paradigms in forensic psychiatry. *Legal Criminol Psych* 19:1–12
- Annual Statistics (2016) Inpatients formally detained in hospitals under the Mental Health Act 1983, and patients subject to supervised community treatment uses of the Mental Health Act: Annual Statistics, 2015/16. <https://digital.nhs.uk/data-and-information/publications/statistical/inpatients-formally-detained-in-hospitals-under-the-mental-health-act-1983-and-patients-subject-to-supervised-community-treatment/inpatients-formally-detained-in-hospitals-under-the-mental-health-act-1983-and-patients-subject-to-supervised-community-treatment-2015-16-annual-figures>
- American Board of Psychiatry and Neurology (2012) Forensic psychiatry core competencies outline. http://www.abpn.com/downloads/core_comp_outlines/2011_core_FP_MREE.pdf. Accessed 5 May 2012
- Appelbaum PA (1997a) A theory of ethics in forensic psychiatry. *J Am Acad Psychiatry Law* 25:527–531
- Appelbaum PS (1997b) Ethics in evolution: the incompatibility of clinical and forensic functions [editorial]. *Am J Psychiatry* 154:445–446
- Beauchamp TL, Childress JF (2001) *Principles of biomedical ethics*, 5th edn. Oxford University Press, Oxford
- Bluglass R (1978) Review of the mental health act, 1959: a summary of the white paper. *Psychiatric Bulletin*. pp 193–196
- BMA (2017) Confidentiality and disclosure of health information tool kit BMA. https://www.bma.org.uk/-/media/files/pdfs/.../ethics/confidentialitytoolkit_full.pdf

- Branton T, Bookes G (2010) Definitions and criteria: the 2007 amendments to the mental health act 1983. *Adv Psychiatr Treat* 16:161–167
- British Medical Association (2016) Confidentiality and disclosure of health information tool kit. <https://www.bma.org.uk/advice/employment/ethics/confidentiality-and-health-records/confidentiality-and-health-records-tool-kit>
- Campbell D (2017) X's case is only latest in shocking saga of children's mental health care. *The Guardian* 03/08/17 <https://www.theguardian.com/society/2017/aug/03/xs-case-is-only-latest-in-shocking-saga-of-childrens-mental-health-care>
- Cervantes AN, Hanson A (2013) Dual agency and ethics conflicts in correctional practice: sources and solutions. *J Am Acad Psychiatry Law* 41:72–78
- Felthous A (2006) Warning a potential victim of a person's dangerousness: Clinician's duty or victim's right? *J Am Acad Psychiatry Law* 34:338–348
- Fisher A (1995) The ethical problems encountered in psychiatric nursing practice with dangerous mentally persons. *Sch Inq Nurs Pract* 9(2):193–208
- Gaughwin PC (1998) Ethics, duty of care and forensic psychiatric assessment: a legal perspective. *Aust N Z J Psychiatry* 32:722–727
- General Medical Council (2017) Confidentiality: Good practice in handling patient information. https://www.gmc-uk.org/-/media/documents/Confidentiality_good_practice_in_handling_patient_information__English_0417.pdf_70080105.pdf
- Gooding P (2014) Change and continuity in mental health law: the long road to the United Nations convention on the rights of persons with disabilities and its implications for mental health and the law today. *Eur J Curr Leg Issues* 20(3):Web JCLI
- Hilton C (2007) Changes between the 1959 and 1983 mental health acts (England and Wales), with particular reference to consent to treatment for electroconvulsive therapy. *Hist Psychiatry* 18(2):217–229
- Konrad N (2010) Ethical issues in forensic psychiatry in correctional and other penal institutions. *Curr Opin Psychiatry* 23:467–471
- Kuosmanen L, Hatonen H, Malkavaara H, Kylma J, Valimaki M (2007) Deprivation of liberty in psychiatric hospital care: the patient's perspective. *Nurs Ethics* 14(5)
- Lawton-Smith S (2008) Briefing mental health act, The King's fund. <https://www.kingsfund.org.uk/publications/briefing-mental-health-act-2007>
- Mason JK, McCall Smith RA and Laurie GT (2003) *Law and medical ethics*. 6th edn. 2003 Lexis Nexis Butterworths. 616
- Mental Health Bulletin 2015–2016 (30 November 2016) Annual report
- McClure A (1999) Psychiatric ethics and forensic assessments. *Aust N Z J Psychiatry* 33(5). <https://doi.org/10.1080/0004867990476>
- Munthe C, Radovic S, Anckarsater H (2010) Ethical issues in forensic psychiatry research on mentally disordered offenders. *Bioethics* 24(1):35–44. <https://doi.org/10.1111/j.1467-8519.2009.01773.x>. ISSN 0269-9702 (print); 1467-8519 (online)
- Oxford Dictionary (2017). <https://en.oxforddictionaries.com/definition/ethics>
- Reid WH (2002) Forensic work and non-forensic clinicians, part I. *J Psychiatr Pract* 8:119–122
- R* (on the application of H) v. Mental health review tribunal north and east London region (2001) EWCA Civ 415
- Sen P, Gordon H, Adshead G et al (2007) Ethical dilemmas in forensic psychiatry: two illustrative cases. *J Med Ethics* 33:337–341
- Simon RI (2003) Should forensic psychiatrists testify about evil? *J Am Acad Psychiatry Law* 31:413–416
- Strasburger LH, Gutheil TG, Brodsky A (1997) On wearing two hats: role conflict in serving as both psychotherapist and expert witness. *Am J Psychiatry* 154:448–456
- The Percy Commission (1957) The report of the Royal Commission on the law relating to mental illness and mental deficiency (the Percy Commission). <https://navigator.health.org.uk/content/report-royal-commission-law-relating-mental-illness-and-mental-deficiency-percy-commission>

-
- Turner T, Salter M, Deahl M (1999) Mental health act reform: should psychiatrists go on being responsible? *Psychiatr Bull* 23:578–581
- Van den Hooff S, Goossensen A (2014) How to increase quality of care during coercive admission? A review of literature. *Scand J Caring Sci* 28(3):425–434. <https://doi.org/10.1111/scs.12070>. Epub 2013 Aug 13
- Winterwerp v Netherlands* (1979) 2 EHRR 387
- W v Egdell* (1990) Ch 359, [1989] 1 All ER 1089

Part II

Ethical Issues in the Treatment and Management of Sex Offenders



Artemis Igoumenou

Sexual offending is a general public area of concern that creates strong emotions among people who as a result strongly support strict legislation for sexual offenders, including long sentences, sexual offender registration and community notification. Any sexual crime (some more than others) has harmful effects for the victim, their family and also their communities. Despite plethora of research evidence on sexual offending (albeit not a uniform approach on typologies of sex offenders and motivations behind sexual offending), the public (as with other types of crimes) bases its attitudes on misconceptions (Clark and Duwe 2015; Blasko 2016). Public outcry, especially in cases involving sexual offences with child victims, has put pressure on legislators to act. In cases of sexual offenders who presented with mental health problems (including sexual deviancy and problematic sexual behaviours, learning difficulties, mental illness and personality disorders), pressure was also placed on clinicians to advance psychotherapy and medication interventions (Yaki 1985).

Despite the fact that recidivism rates for sexual offences (average recidivism rate across studies is 13.7%) are much lower than the rates for other offences, they create fear among the public and increased demand for effective management among policymakers and law makers (Fox 2015; Schmucker and Losel 2015), mainly based on the misconception that sexual offenders will most definitely commit another sexual offence in the future. Hence, different countries and jurisdictions have designed legislature to reduce risk of recidivism. Some countries like the USA and New Zealand have imposed indeterminate sentences for sexual offenders, so that supervision is imposed even after parole and conditional release. In Europe and the US community restrictions have been used despite their not proven effectiveness on

A. Igoumenou (✉)

Division of Psychiatry, University College London, London, UK

Honorary Consultant Psychiatrist Barnet Enfield and Haringey Mental Health NHS Trust, London, UK

e-mail: a.igoumenou@ucl.ac.uk

crime reduction. Such restrictions include sex offender registries, residency restrictions, electronic monitoring, polygraphy and community notification. Some of them may be helpful both for the offenders and the society; others however may have unintended consequences (harassment, threats, psychological, financial, housing and employment consequences) and even increase the risk of sexual recidivism, such as by resulting social isolation of some offenders (and their families) (Lobanov-Rostovsky 2014).

Sex offender programmes in prisons, hospitals and the community mainly target factors within the offender and his/her lifestyle and focus on risk. When planning reintegration in the community, factors such as housing, finances, employment, supervision and risk reduction are the focus, with the social needs of the offender usually being neglected (both as a quality of life factor and also as a potential risk factor). In the last few years, though, reintegration programmes started moving from the risk-need-responsivity principles to the good lives model, focusing more on the offender as an individual and targeting also factors such as social isolation, by involving ordinary citizens (Blasko 2016). This way, not only social isolation is targeted, but also stigma is reduced, and the offender is assisted to model prosocial behaviours and adopt a prosocial lifestyle, in an inclusive way so that (s)he may become a productive member of the society.

Research on public, clinicians and criminal justice officials' attitudes regarding sexual offender programmes and the management of sexual offenders in general has been controversial. Recent studies have shown that the public largely supports sex offender restrictions regardless of their effectiveness in reducing recidivism (Anderson et al. 2013). They also described fear and changes in their behaviours (self-protective, altruistic-protective) following awareness of sexual offenders in their communities (Call 2015). On the other hand, criminal justice officials' views varied according to their profession, the years of experience, their cultural background and education level; however, they also agreed with the enforcement of existing laws despite being doubtful of their effectiveness (Mustaine et al. 2015). Clinicians have also shown mixed support for sex offender management policies, by being less likely to support sexual offender management policies and more likely to believe in collateral consequences (and find these consequences unacceptable) than non-clinicians (Call 2015). Offenders themselves had mixed attitudes regarding registration and community notification laws; they supported the view that some offenders should be subjected to these laws. However, when considering themselves, their attitudes were more negative (that policies were unfair and ineffective in reducing recidivism) (Call 2015). Similarly, families of registered sexual offenders reported that they often suffer from the registration and community notification of their relatives (Mustaine et al. 2015).

Research has been conclusive that treating offenders that committed sexual offences is beneficial as they are less likely to reoffend compared to their non-treated counterparts (Blasko 2016; Schmucker and Lösel 2015). As we will expand in the following chapters, such treatment involves psychosocial approaches, medications and also community restrictions and monitoring (polygraph, electronic monitoring) that all carry overarching but also their individual ethical concerns.

References

- Anderson AL, Sample LL, Cain CM (2013) Residency restrictions for sex offenders: public opinion on appropriate distances. *Crim Justice Policy Rev* 26(3):262–277. <https://doi.org/10.1177/0887403413513897>
- Blasko BL (2016) In: Jeglic EL, Calkins C (eds) Overview of sexual offender typologies, recidivism, and treatment. Chapter 2 in sexual violence. Springer International Publishing, Cham. https://doi.org/10.1007/978-3-319-44504-5_2
- Call C (2015) Sex offender management policies and their unintended consequences: A national survey of the perceptions of professionals. PhD Thesis, Virginia Commonwealth University, Richmond, VA. <http://scholarscompass.vcu.edu/etd/3700>
- Clark VA, Duwe G (2015) What predicts where sex offenders live? An examination of census tract data in Minnesota. *Crim Justice Policy Rev* 24:488–510. <https://doi.org/10.1177/0887403415594200>
- Fox KJ (2015) Contextualising the policy and pragmatics of reintegrating sex offenders. *Sex Abus*:1–23. <https://doi.org/10.1177/1079063215574711>
- Lobanov-Rostovsky C (2014) Chapter 8: Sex offender management strategies. Sex offender management assessment and planning initiative, Office of Justice Programmes. <https://www.smart.gov/SOMAPI/printerFriendlyPDF/adult-sec8.pdf>
- Mustaine EE, Tewksbury R, Connor DP, Payne BK (2015) Criminal justice officials' views of sex offenders, sex offender registration, community notification, and residency restrictions. *Justice Syst J* 36(1):63–85. <https://doi.org/10.1080/0098261X.2014.965859>
- Schmucker M, Lösel F (2015) The effects of sexual offender treatment on recidivism: an international meta-analysis of sound quality evaluations. *J Exp Criminol* 11:597–630. <https://doi.org/10.1007/s11292-015-9241-z>
- Yaki M (1985) Medical treatment for imprisoned paraphiliacs: implementing a modified standard for deliberate indifference. *Yale Law Policy Rev* 4(1), Article 12):251–282



The Use of Medication for the Treatment of Sex Offenders: Ethical Issues and Controversies

4

Artemis Igoumenou

This chapter will cover the topic of using medications for the treatment of sex offenders (the term “chemical castration”, despite its negative connotation, is still used in scientific literature). After a brief historic background, it will focus on the use of medications (mainly antilibidinal medications but also antidepressants, anxiolytics and neuroleptic medications) to modify sexual drive. Such medications are currently used either voluntarily or coercively depending on the prevailing legal framework.

Sex offenders quite often are offered medication as a means to increase their autonomy, as an alternative to imprisonment or as a condition for their parole or discharge from hospital settings, with the expectation to improve outcome. The use of such medication for the treatment and management of paraphilias or other sexual deviant behaviours is rarely in isolation and often part of a complex care plan that includes psychotherapeutic and psychological interventions.

In this chapter, we will address ethical concerns over the prescription and use of medications in sex offender populations, especially in prison, in secure hospital settings and later in the community. We will focus on issues around consent, coercion, rationale and medical responsibility.

4.1 Background

Castration has been used throughout the centuries as a form of punishment, as well as for social or medical reasons. Surgical castration, the removal of the testes or parts of the core of the testes, preceded chemical castration, the use of medication

A. Igoumenou (✉)

Division of Psychiatry, University College London, London, UK

Barnet Enfield and Haringey Mental Health NHS Trust, London, UK

e-mail: a.igoumenou@ucl.ac.uk

© Springer Nature Switzerland AG 2020

A. Igoumenou (ed.), *Ethical Issues in Clinical Forensic Psychiatry*,
https://doi.org/10.1007/978-3-030-37301-6_4

to reduce sexual desire, fantasies and sexual functioning. Surgical castration was used in many cultures over the centuries and for many different reasons, including risk reduction or even artistic performance. Many ancient cultures, for example, used eunuchs to guard women's chambers or act as chamberlains. Male choir members were castrated in the eighteenth century in order to preserve their phonetic abilities and not have them changed during puberty ("castrati") (Scott and Holmberg 2003). In some ancient cultures, the captives of war were castrated as a punishment. Evidence suggests that surgical castration was used in the USA in the 1800s for social control reasons: castration of slaves when suspected of having sex with white women.

Focusing on offender populations, the use of surgical and later chemical castration for the management of sexual arousal and functioning of criminals, especially sex offenders, is not a new phenomenon. The USA used castration of prisoners as a punishment from 1899; it was initiated around the time that the eugenics movement was flourishing.

Eugenics movement was an American initiative of the late nineteenth century based on the ideas of Sir Francis Galton, a British scholar who studied the upper classes of Britain. Sir Galton introduced the term "eugenics" in 1883 which means "well born" and advocated that people who held the elite position in society had good genetic makeup that should be bred so that future generations possess the desired traits and humanity advances. His ideas never materialised in Britain but became the seed for the eugenics movement in America. Charles Davenport, a prominent biologist, led the movement alongside Harry Laughlin, a former teacher and principal.

Disparate from Sir Galton's plan, the eugenics movement in America was dedicated to eliminate "undesirable" or "negative" traits from the human race (including mental disability, dwarfism, promiscuity, pauperism and criminality) (Norrgard 2008). To that effect, studies were funded from corporations, the elite societies and private citizens to identify who possessed the "undesirable" traits. In 1910, the Eugenics Record Office (ERO) was established in New York (funded by Charles Davenport) with main mission to track family histories. Their purpose was "to improve the natural, physical, mental, and temperamental qualities of the human family" (Norrgard 2008). From these family histories, they found out that the "undesirable" traits, which they perceived to be genetically transmitted rather than a by-product of the society, were more prevalent in poor families, those of low socioeconomic status and those from ethnic minority or immigrant groups (Genetics Generation n.d. Introduction to Eugenics. <http://knowgenetics.org/history-of-eugenics/>).

In order to restrict these "undesirable" traits, they reinforced immigration laws but also started sterilisation programmes. Sterilisation programmes were operating in 33 states during the twentieth century, and it is believed that as many as 65,000 Americans underwent sterilisation. In most states, such programmes were run by the government and did not require people's consent. While the first to undergo the sterilisation procedure were the mentally ill, it quickly spread to include promiscuous individuals, blind, deaf, poor, those that suffered with alcoholism, criminals and also ethnic minorities (mainly African American women).

The eugenics movement started gradually losing popularity and lost scientific credibility and public/political support by the start of World War II. The fact that Hitler embraced some of the eugenics principles may have had a role to play. Although the last forced sterilisation under the eugenics movement was performed in 1981, they were stopped being used largely in the 1960s.

In Europe, surgical castration as a method of management of sex offenders was used first in Switzerland in 1892. It started being used more widely as a treatment at the beginning of the twentieth century; offenders were given the choice between surgical castration and imprisonment, although probably they did not have entirely free choice. From Denmark (the first European country with a castration law in 1929), its use spread quickly to Germany (1933), Norway (1934), Finland (1935), Estonia (1937), Latvia (1938), Iceland (1938) and Sweden (1944). It was also used in the Netherlands and the Czech Republic (Le Marie 1956; Weinberger et al. 2005). The main goal was to diminish sexual urges understood to be associated with sexual offending. Denmark and Germany also lead the way with research on the impact of the intervention; besides, they were the two countries with the most use of castrations (Weinberger et al. 2005; Harrison 2007). Since then it has stopped in most countries, it remained to be of limited use in Germany and Czech Republic (Aagaard 2014).

The theory behind using surgical castration to reduce sexual recidivism is based on the fact that by removing the testes (or parts of the core of the testes) of the offender, there will be reduction (even elimination) of testosterone levels that leads to reduction of sex drive, deviant fantasies and therefore sexual offending (Weinberger et al. 2005; McMillan 2013).

It is worth mentioning that the use of surgical castration did not only concern high-risk sex offenders, but it was also applied to mentally ill or individuals with learning disability or even homosexuals.

In 1944, a substance called diethylstilbestrol (progesterone compound) was used to control sexual behaviour in men. This was the first documented use of medication for that reason. Fifteen years later, Germany started using anti-androgens for males with paraphilias, and at the same time an American researcher (John Money) used medroxyprogesterone acetate (MPA) for the treatment of paraphiliac behaviour (Scott and Holmberg 2003).

In 1996, California enacted legislation requiring that offenders convicted of repeat sexual crimes against children have either surgical or “chemical castration” (California Penal Code, Section 645). This legislation did not initially require physician to examine the offender and make recommendations. It therefore imposed a medical treatment without medical consultation and for that matter without evidence that it may work on offenders that did not choose to have it (Berlin 1997). Notwithstanding the violations of offenders’ constitutional and human rights, it violated the physician ethics as it allowed nonphysicians to prescribe medications (Miller 1998). As expected, this piece of legislation received criticism from the medical community who recommended careful planning, using existing evidence to address the problem, and counselling with professionals if a medical treatment was to be used. They also advocated that such treatment should

not be imposed but rather be made available to offenders that needed it or would like to have it (Berlin 1997).

California however was not the only state enacting legislation imposing medication on male sex offenders. Eight legislatures passed similar laws (Montana, Oregon, Georgia and Wisconsin permit the use of “chemical castration” only; Florida, Louisiana, California and Iowa allow either “chemical castration” or voluntary surgical castration; and Texas allows for voluntary surgical castration), and at least 23 others have considered them within the first year. Of the nine states that made provisions for surgical or “chemical castration” of offenders, only Texas limited it to voluntary intervention under all circumstances and made provisions for the consent process (Scott and Holmberg 2003; Lai 2014).

A decade after California enacted its legislation, Poland imposed treatment with anti-androgenic medications for some sex offenders, particularly those with children victims. At the same time, high-profile cases in France brought up discussions about compulsory treatment for sex offenders. Czech Republic has established chemical and surgical castration of sex offenders in psychiatric hospitals under the realm of “protective treatment”. At the same time, the Department of Health supported in England an initiative to make available to sex offenders medications to manage sexual preoccupation, deviancy and sexual arousal on a voluntary basis (Grubin and Beech 2010). The difference with the US legislation was that it relied heavily on medical diagnosis and medical testimony that advised on evidence of whether “medication” can benefit the offender (Daley 2008).

Contrary to Europe and North America, Asia for the first time introduced “chemical castration” in 2010. Korea was the first country to develop legislation for the use of drugs to reduce sexual recidivism in offenders whose victims were children (initially under 16 years old and since 2013 expanded to include victims aged 19 years or younger). In Korea, medications are imposed and consent from the offender is not required (Lee and Cho 2013).

Similarly, in Australia (Western Australia, New South Wales, Victoria and Queensland), existing legislation covers the provision of “chemical castration” for specific categories of sex offenders (e.g. sex offenders with child victims). The consent of the offenders is not explicitly sought; however, scholars from the continent argue that without consent it is impossible to administer such medications (Lai 2014).

Today, American states including Georgia, Wisconsin and Montana, alongside European countries including Denmark, Sweden, Spain, Italy, Germany, England, Hungary and Czech Republic, offer androgen deprivation therapy as a “formally optional” intervention (Lai 2014). Lai (2014) and Douglas et al. (2013) used the term to describe the occasions that medications are offered to sex offenders “where no link is made between refusal to consent to androgen deprivation therapy and remaining incarcerated for the remainder of their sentence”.

Other countries however impose androgen deprivation therapy as a condition for release, so that some offenders cannot be released without taking it and they will be imprisoned again if they stopped the treatment after release. Such countries include the American states of Florida, Iowa, Oregon, California and Louisiana and

countries such as Belgium, Poland, South Korea and Australia (Western Australia, New South Wales, Victoria and Queensland) (Lai 2014).

In Europe, therapeutic interventions traditionally have been more prevalent than in Great Britain or North America. McAlinden (2012) attributes this to the fact that European countries follow a more medical approach to managing sex offenders with less weight placed on the social, legal and moral dimensions of the problem (McAlinden 2012). However, in the last few decades, practice in both Europe and the USA has turned again to more punitive approach, phenomenon that McAlinden (2012) attributes to an increase of the “sex offender problem” but also to the inconclusiveness of treatment effectiveness.

The British Offender Personality Disorder Pathway recommended in their recent guidance that prescription of medication to manage sexual arousal (MMSA) should be “completely voluntary” (Skett et al. 2016). Practice seems to be moving therefore from mandatory “chemical castration” that was used both as treatment and as punishment to “MMSA” as a completely voluntary treatment. The issue of consent in this case though arises, as will be discussed below.

4.1.1 Effectiveness of Existing Treatments

Research on recidivism rates or quality of life and sexual functioning of surgically castrated men is sparse. Heim, nearly 40 years ago, studied the sexual behaviour of 39 released sex offenders who volunteered to have surgical castration while imprisoned in West Germany. The participants reported significantly reduced frequency of sexual thoughts and acts (masturbation, coitus) as well as impaired sexual arousal and desire. One third of the participants reported being able to have sexual intercourse. He also found that sexual behaviour was affected only in males that were castrated between the age of 46 and 59. Helm concluded that his findings “do not justify recommending surgical castration as a reliable treatment for incarcerated sex offenders” (Heim 1981).

In the last few decades, the clinical and research interest in effective ways of managing sexual arousal in sex offenders has increased. Pharmacological methods have been in the focus as they are seen as a more immediate and more effective solution than psychotherapeutic and sociological interventions (Furby et al. 1989; Hall 1995; Hanson and Bussiere 1998; Hill et al. 2003; Lösel and Schmucker 2005) and less ethically controversial compared to surgical castration. To add to the equation, victims of sexual crime and the society in general ask for more effective methods of reducing sexual recidivism, considering the effects each one of these crimes has on individual, community and societal level.

From the non-pharmacological interventions, only cognitive behavioural techniques and relapse prevention have been tested in adult sex offender populations, albeit with conflicting findings among studies (Grossman et al. 1999; Quinsey et al. 1993; Gallagher et al. 1999; Lösel and Schmucker 2005; Mann et al. 2010). Such interventions (contrary to medications and surgical castration that aim to diminish sexual drive) focus on modifying the offender’s behaviours. They include aversion

therapy and covert sensitisation, imaginal desensitisation, masturbatory reconditioning, cognitive restructuring, social skills training, victim awareness or empathy, sex education, lifestyle management and relapse prevention (Grossman et al. 1999). Cognitive behavioural techniques showed promising results in recidivism reduction (Hanson et al. 2002; Lösel and Schmucker 2005), although they seem to be more effective in medium- to low- and medium- to high-risk groups (risk stratified according to Static-99) and not significantly effective in low- and high-risk groups (Friendship et al. 2003). In the last decade, a new treatment for antisocial children and adolescents showed promising results in reducing problematic sexual behaviours and sexual recidivism (Letourneau et al. 2009; Walker et al. 2004). Multisystemic therapy (MST) places emphasis on family work to reduce deviancy (Fanniff and Becker 2006; Henggeler 2012). Such intervention has not been tested in adult sex offender populations or against CBT. Evidence regarding the effectiveness of psychodynamic and psychoanalytic models, as well as family-based therapies, is lacking.

Alongside the question of whether or not psychological and pharmacological treatments work for sex offenders, there is also the question as to which treatment works best and for which type of offenders (and evidently under which circumstances and what duration). A recent review from Kim and colleagues looked into the effectiveness of treatment approaches for sex offenders (Kim et al. 2016). Their review is an update of a previous publication by Craig et al. (2003). Kim et al. concluded that medical interventions such as surgical castration and hormonal medications were more effective than psychological treatments. This finding corresponds to a previous meta-analysis by Lösel and Schmucker (2005) that showed larger effects on recidivism reduction with biological than psychological interventions. Kim et al. argued, however, that despite not being as effective as hormonal treatments, CBT remains the preferred treatment option due to reluctance to prescribe and ethical considerations that posit obstacles to high-quality research (RCTs are sparse due to ethical issues involving allocation to treatment or placebo arms) (Kim et al. 2016). They recommend primary research to focus on identifying which specific treatments (or combinations of) are more effective for specific groups of sex offenders.

Initial use of medications to only manage risk now moved to using medications to reduce subjective distress to the offender, reduce sexual preoccupation and enable engagement in therapy and rehabilitation. Such treatment can not only improve the offenders' life and rehabilitation but also indirectly provide public safety.

Alongside medications and psychological interventions in prisons and other institutions (detention centres, forensic psychiatry hospitals, approved premises), offenders that committed sexual offences are subject to community restrictions or "post-prison commitment" to ensure public safety and adherence to management plans (Becker and Murphy 1998). As shown by recent studies, released prisoners often return to the same criminogenic environment they came from or are released to neighbourhoods with similar disadvantages. This problem is usually amplified in sex offenders and is understandable that it does not assist their rehabilitation and deterrence from further crimes (Clark and Duwe 2015). It is therefore a holistic

approach that is needed in order to rehabilitate sex offenders, and factors that need to be addressed include housing, education, employment, medications, psychosocial interventions and therapy. Subsequently, there is a pressing need to improve and further fund prison programmes and post-release programmes (including step-down programmes, halfway houses) in order to amplify the effectiveness of interventions for sex offenders.

4.2 Neurobiology of Sexuality

Human sexual arousal, drive and behaviour have attracted the interest of clinicians and researchers alike, not only because it is integral part of human life and procreation but also as it is closely associated with quality of life and with overall health and wellness. They are essential parts of our existence, and although neurobiologically programmed, they are still shaped and coloured by our experiences.

Both male and female responses to sexual stimuli happen in four stages: excitement, plateau, orgasm and resolution, with desire, previous experiences and motivations playing an important role (Kingsberg et al. 2015). Although in both males and females sexual functioning involves neurochemical activity that implicates the brain, the central nervous system and the erogenous zones, the neurobiology of sexual functioning for males and females is better understood when discussed separately.

4.2.1 Males

Sexual functioning in males is rather complex and not fully explained. Despite the fact that sexual arousal and behaviour are influenced by a number of different hormones and neurotransmitters (including oxytocin, glutamate, endorphins, GABA, noradrenaline and acetylcholine), it can be simplistically explained by the action of two hormones: testosterone and dihydrotestosterone. Testosterone is the hormone predominantly responsible for the development of male gender characteristics. Its action starts in utero and is very important during puberty in order for the secondary gender characteristics to develop. It is also important for sexual functioning in males.

Primarily, testosterone in males is produced in the testes. Hypothalamus releases gonadotropin-releasing hormone (GnRH) that results in the release of luteinising hormone (LH) from the anterior pituitary gland (alongside follicle-stimulating hormone, FSH). LH stimulates the Leydig cells of the testes and testosterone is secreted. Small amounts of testosterone (approximately 5%) are also secreted by the cortex of the adrenal glands (Harrison 2007).

It has adrenergic effects, so it is associated with sexual development, sexual functioning and libido. It also has anabolic effects; it is therefore involved in tissue growth.

Testosterone (as well as other androgens) acts on a number of receptors that are found throughout the body, including on the spinal cord, the penis and also the brain (e.g. midbrain and hypothalamus). Testosterone seems to act synergistically with dopaminergic systems. The activation of dopaminergic systems in the

midbrain and the limbic system can activate appetitive drives including sex. Dopamine is also involved in the mechanisms of arousal and sexual behaviours, including the suppression of prolactin (a hormone responsible for reduction of sexual arousal and sexual ability). Testosterone is also shown to act antagonistically to serotonergic systems. Serotonin is a neurotransmitter that has been extensively studied in relation to mood and anxiety disorders and also impulsive aggression. Serotonin is a complex neurotransmitter as it acts differently on different types of serotonin receptors. Overall, it is believed to inhibit appetitive drives, including sex; to reduce libido and sexual arousal; and to delay (or inhibit) ejaculation (Bancroft 2005, 2009).

Therefore, reduction of testosterone levels either due to surgical removal of the testes (or parts of the core of the testes, as in testicular pulpectomy) or due to medications decreases libido, erections, ejaculations and spermatogenesis. Of note is that even after surgical castration some men will still be able to have erections and sexual intercourse, mainly due to testosterone produced by the adrenal glands.

4.2.2 Females

Similar to males, sexual functioning in females is complex and not fully understood. Researchers and clinicians have concluded that it depends on interactions of a variety of factors including neurobiological, psychosocial and somatic.

The activation of specific brain areas during exposure to sexual stimuli correlates to subjective sexual arousal in females but interestingly not necessarily to physiological (genital) arousal. This differentiates females from males, and some researchers hypothesised that “women perceive engorgement differently than men” (Levin et al. 2016). The main brain areas activated during female arousal and response include the hypothalamus, the amygdala, the thalamus, the anterior insula, the ventral striatum, the anterior cingulate cortex, the orbitofrontal cortex, the occipitotemporal cortex, the superior parietal lobe and the inferior frontal gyrus (Levin et al. 2016). The reward circuitry (including hypothalamus, basal ganglia—mainly striatum—prefrontal cortex, amygdala and hippocampus) plays a pivotal role (Kingsberg et al. 2015). The strength of the brain activation varies according to the phase of the woman’s menstrual cycle. Research however has not yet reached consensus on which brain areas are activated during genital stimulation and orgasm (Levin et al. 2016).

Similarly to males, excitatory pathways in females are also modulated by neuromodulators such as noradrenaline, oxytocin (stimulate arousal and sexual response), dopamine and melanocortins (which stimulate desire and attention), whereas inhibitory pathways are modulated by neuromodulators such as serotonin (controls satiety and plays part in response to inhibition), opioids (facilitate sexual rewards and also inhibit the hypothalamus post-orgasm to stop sexual arousal and desire) and endocannabinoids (induce sedation) (Kingsberg et al. 2015). In females, endocannabinoid levels are also associated with sexual arousal (Kingsberg et al. 2015).

Considering the fact that sexual arousal and behaviour are influenced by a number of different hormones and neurotransmitters (including oxytocin, glutamate, endorphins, GABA, nitric oxide, noradrenaline and acetylcholine), it seems that in females also testosterone plays a pivotal role (modulates the strength of brain responses to stimuli) (Levin et al. 2016). As is known, women produce in their ovaries 50% of circulating testosterone. According to recent studies, women with low levels of testosterone (due to medical reasons, medications or ageing) had reduced sexual desire and arousal, as well as sexual interest and pleasure (Kingsberg et al. 2015). In women, oestrogens also play a role in sexual functioning, especially oestradiol that affects the peripheral sexual response (Kingsberg et al. 2015).

Many researchers have argued that females' sexual responses are less spontaneous and more responsive than men's. Subsequently, psychological and social factors alongside the physiological response to sexual stimuli play an important role (Kingsberg et al. 2015; Knack et al. 2015). In females, therefore, mental states including depression, anxiety and stress can have a big influence on sexual functioning. Other factors such as attention, conditioned learning, early negative experiences (including childhood sexual abuse), relationship difficulties and personality traits are equally important (Levin et al. 2016).

4.2.3 Why Consider Medications for Sex Offenders?

As discussed, testosterone is an androgen that plays a pivotal role in male (and female) sexuality. It therefore has been considered as a possible target when developing treatments to reduce sexual arousal, manage sexual preoccupation, and by extension sexual offending. Research of males with pharmacologically induced hypogonadism revealed that such individuals indeed presented with reduction in sexual arousal, sexual motivation and sexual fantasies, attributed to the reduction of testosterone levels (Jordan et al. 2011).

Although the relationship between testosterone and sexuality is clear, the one between testosterone and aggression (physical and sexual) is rather complex. Research findings are diverse with some studies such as the systematic review by Wong and Gravel (2018), suggesting that there is no significant relationship between testosterone and sexual offending (Wong and Gravel 2018). A self-criticism for the Wong and Gravel review was that this review used a very small number of studies comparing testosterone levels between offenders and non-offenders and pooled research that includes diverse sex offender populations and different types of comparison groups and did not take into consideration single offence or repeat offenders. The authors conclude "it would be premature to state that no relationship exists between testosterone and sexual aggression" (Wong and Gravel 2018, p. 161), especially as testosterone levels may differ in different types of sex offenders; their subgroup analysis revealed, for example, differences in testosterone levels between child molesters and rapists. Other research, like the one by Bain and colleagues, suggests that sex offenders have higher levels of testosterone than non-sex offenders

(Bain et al. 1988a, b), indicating that this hormone can be a target for treatment but also highlighting the fact that further research is much needed.

Recent research by Kingston et al. (2012) opened new horizons in the understanding and treatment of sexual arousal and functioning in sex offenders. They looked at the relationship between precursor hormones (LH) and sexual recidivism and found that levels of LH were significant predictors of recidivism (both sexual and violent) (Kingston et al. 2012).

4.3 Medications for the Management of Sexual Arousal in Sex Offenders

4.3.1 Who Should Be Considered for Medications?

The aetiology for sexual offending is unclear which subsequently has an impact on the effectiveness of prevention and treatment programmes but also on decision-making regarding who can benefit from each of the treatment approaches (and equally who should be offered what). There have been many theories on what drives a person to sexually offend, including the psychoanalytic approach, family dynamics and behavioural theories (including deficits in interpersonal and social skills), the biological theory (focusing on the role of temporal lobe and the neurotransmitters) and the trauma-related theory (a victim of a sexual crime is more vulnerable to offend). These theories drive us to one conclusion that sexual offending has multiple causes and as such prevention as well as treatment programmes have to be comprehensive (Becker and Murphy 1998).

Research has shown that medications that lower testosterone levels are effective in reducing and managing deviant sexual thoughts, fantasies and urges in high-risk sexual perpetrators (Meyer III and Cole 2008). The majority of research has been done on male offenders with paraphilic disorders (quite often involved those that committed sexual offences against children); the applicability of the results in other sex offender populations is therefore rather challenging.

The initial intention to treat only high-risk sex offenders and only those with sexual deviancy is becoming more liberal, and medications could come to be available to all sexual offenders that have the potential to benefit from them. With the focus of the treatment being the psychological and physiological characteristics and impacts of the sexual drive rather than a diagnostic classification, more sex offenders can become eligible for treatment with medications (Grubin and Beech 2010). Good candidates for medications that manage sexual arousal are, for example, offenders that present with intrusive and obsessive thoughts about sex, deviant arousal or problem sexual behaviour associated with low mood or anxiety, sexual arousal or behaviour that is subjectively difficult to manage, high sex drive and psychometrically determined sexual preoccupation (Skett et al. 2016).

In order to be able to decide who has the potential to benefit from medications that affect sexual arousal and behaviours, prescribing clinicians have to complete a

comprehensive assessment drawing information not only from the sex offender but also from all sources available.

Supplementary to the basic psychiatric evaluation that assesses for mental illness, personality disorders, learning difficulties, developmental disorders, social skills, attachment difficulties and substance use disorders, sex offenders have to undergo specific assessments that cover detailed psychosocial history, cognitive distortions and sexual behaviours (Becker and Murphy 1998). In some countries, they even undergo phallometric assessment and polygraphy (Becker and Murphy 1998). As an aid for the above assessments, psychometric tools are used including the sexual compulsivity scale (Kalichman et al. 1994; Kalichman and Rompa 1995), HADS (Zigmond and Snaith 1983) and the severity indices of personality problems (SIPP-118) (Verheul et al. 2008). This is in order to help with treatment choices rather than to profile a sex offender but also can be essential in monitoring the effectiveness of treatment.

4.3.2 Medications

There have been two major categories of medications used: the selective serotonin reuptake inhibitors (SSRIs) and agents influencing the production and effects of androgens (steroidal anti-androgen treatments, GnRH analogues). Case reports on other medications (lithium, mirtazapine, antipsychotics, anticonvulsants, naltrexone) that have been tried in the past presented weak evidence and inconsistent effects; hence, their use is either very limited or was abandoned. In this section, we will present only the medications that are currently in use.

4.3.2.1 Antidepressants and Anxiolytics

Selective Serotonin Reuptake Inhibitors (SSRIs; Fluoxetine, Sertraline)

Antidepressant medications can be an option for managing sexual arousal in sex offender populations. In the past, tricyclics (clomipramine) and lithium were used to reduce deviant sexual behaviour in sex offenders (Kruesi et al. 1992) although more success stories (regarding overall treatment satisfaction from the offender and risk reduction) reported with SSRIs (Stein et al. 1992; Kafka 1994; Kafka and Prentky 1992; Garcia et al. 2013). No major differences were found among the different SSRIs (fluoxetine, sertraline, fluvoxamine) (Hill et al. 2003).

The main mechanism of action of antidepressants on sexual preoccupation and sexual offending is by affecting serotonin levels. Serotonin affects orgasmic and ejaculatory capacity and reduces sexual arousal. It can therefore be used to target sexual deviancy and sexual preoccupation not only by reducing impulsivity, obsessive thoughts/sexual fantasies and mood-related symptoms but also by inhibiting sexual activity (Garcia et al. 2013).

SSRIs as with other medications to manage sexual arousal need to be prescribed with caution and after thorough assessment of the offender. They do not act immediately (usually improvements start being observed after 2–4 weeks), and they should

always be part of a comprehensive treatment plan including psychosocial interventions. As with other treatment indications, regular monitoring of physical health, including liver, renal and cardiovascular function, is important (Hill et al. 2003).

Fluoxetine has been the SSRI most extensively used for managing sexual arousal. Fluoxetine shares its side effect profile with the other SSRIs. These side effects include common or very common ones such as abdominal pain (dose-related), constipation (dose-related), diarrhoea (dose-related), dyspepsia (dose-related), gastrointestinal effects (dose-related), nausea (dose-related) and vomiting (dose-related). However, they also have uncommon side effects such as serotonin syndrome or very rare ones such as angle-closure glaucoma. SSRIs also have side effects of unknown frequency such as anaphylaxis, angioedema, anorexia with weight loss, anxiety, arthralgia, asthenia, bleeding disorders, convulsions, dizziness, drowsiness, dry mouth, dyskinesias, ecchymoses, galactorrhoea, hallucinations, headache, hypersensitivity reactions, hypomania, hyponatraemia, increased appetite, insomnia, mania, movement disorders, myalgia, nervousness, photosensitivity, purpura, rash, sexual dysfunction, suicidal behaviour, sweating, tremor, urinary retention, urticarial, visual disturbances and weight gain (<https://bnf.nice.org.uk/drug/fluoxetine.html#sideEffects>).

Apart from the above list, fluoxetine presents with additional side effects such as alopecia, changes in blood sugar, chills, confusion, diarrhoea, dysphagia, dyspnoea, euphoria, flushing, haemorrhage, hepatitis, hypotension, impaired concentration, malaise, neuroleptic malignant syndrome-like event, palpitation, pharyngitis, priapism, pulmonary fibrosis, pulmonary inflammation, sleep disturbances, taste disturbance, toxic epidermal necrolysis, urinary frequency, vasodilatation and yawning (<https://bnf.nice.org.uk/drug/fluoxetine.html#sideEffects>).

As SSRI effects and side effects are better known than those of the other medication options and as they are better tolerated, they are usually used as the first-line treatment. Most guidelines recommend the use of two different SSRIs before switching to either MPA/CPA or GnRH analogues (Hill et al. 2003).

Buspirone

Buspirone has been used for the treatment of sex offenders, and research indicates success in reduction of paraphilic fantasies (Fedoroff and Fedoroff 1992). Due to the lack of robust research evidence and clinical experience, its use is however limited.

4.3.2.2 Anti-hormonal Substances

Since androgens, like testosterone and dihydrotestosterone, influence sexual behaviour (and as research has shown effects even on impulsive aggression in males; Garcia et al. 2013), a reduction of the androgen effects is the focus of hormonal treatment in sex offenders. In antithesis to surgical castration, anti-androgen medication treatment is reversible, and one could argue more ethically acceptable for sex offenders that request it. As with other pharmacological treatments, they should be offered in conjunction with psychotherapy for the management of symptoms of sexual arousal of sex offenders.

The first type of hormone that was used in the 1940s to reduce sexual interest and preoccupation in male sex offenders was oestrogens. Oestrogens have anti-androgen effects, and research found some effect in reducing libido and sexual activity (masturbation) in sex offenders. Due to cardiovascular and cerebrovascular side effects, their use was abandoned. Anti-hormonal substances used today for the treatment of sex offenders are either the steroidal anti-androgens MPA and cyproterone acetate (CPA) or the GnRH analogues (triptorelin, leuprorelin, goserelin) as described below.

Steroidal Anti-androgen Treatments (Medroxyprogesterone Acetate, Cyproterone Acetate)

MPA

MPA was synthesised in 1954 and was introduced 5 years later in the USA for treatment of gynaecological problems. It was used in 1958 as a method to reduce sex drive in men, but as long-term effects were unclear, in 1974 its use was stopped as the Food and Drug Administration (FDA) withdrew their approval. The FDA reappraised its use as a contraceptive in 1992 (Daley 2008).

It works by decreasing the amount of LH and FSH released by the anterior pituitary gland and also by increasing the metabolism of testosterone in the liver, therefore reducing testosterone levels. The subjective feelings of decreased testosterone levels include reduction in sex drive and lessening of erections and ejaculations. It also reduces sperm count. All effects are dose dependent, where higher doses mean lower levels of testosterone, leading to bigger effects on sexual desire and functioning. The effects are usually observed after 1–2 months of treatment (Garcia et al. 2013).

Considering its mode of action, MPA can be effective for sex offenders who recognise that their sexual drive (or sexual desire) played a pivotal role in their offending. It would therefore not be deemed appropriate for those that either do not accept they committed the offence or those that blame the crime on factors such as drugs, alcohol or stress, and case-to-case consideration should be given for those that have offended but the offence was not sexually motivated (e.g. violent offender which committed sexual offence to assert power).

Side effects include weight gain, fatigue, lethargy, sweats, nightmares, dyspnoea, leg cramps, hypertension, insomnia, thrombosis, increased blood sugar, diabetes mellitus, hyperinsulinaemic response to glucose, irregular gall bladder functioning, diverticulitis, testicular atrophy, decrease in testicular size, hypogonadism, hot and cold flushes and shortness of breath. Research has shown that all these side effects are reversible and sexual functioning should return within 6 months. Special consideration has to be given though to the fact that all knowledge of the above side effects comes from studies where women were taking MPA as contraceptive and we need to keep this in mind when offering MPA to males. Additionally, prescription of MPA to women for contraception differs from prescribing it for managing sexual arousal in that doses in the latter case are usually more than 40 times larger than the formal case.

MPA also comes with long-term side effects including osteoporosis, gynaecomastia and obesity. Again research involving male subjects that take MPA for managing sexual arousal is scarce; hence, the long-term consequences are vastly unknown.

Cyproterone Acetate (CPA)

CPA antagonises the action of testosterone on androgen receptors. It is a synthetic steroid, similar to progesterone, that acts both as progesterone and anti-androgen. It binds directly to all androgen receptors (including brain receptors) and blocks intracellular testosterone uptake and metabolism (competitive inhibitor of both testosterone and dihydrotestosterone). It inhibits GnRH secretion and decreases GnRH and LH release, hence inhibiting the production of sex steroids by the gonads.

By reducing the levels of testosterone, there is a reduction of sexual drive, fantasies and urges. It can also lead to reduction of orgasm, pleasure in masturbation, potency and sperm production as it also may lead to sexual frustration. With both MPA and CPA, the goal is to minimise sexual deviancy, drive and preoccupation and enhance ability to benefit from psychotherapy approaches while the person retains some sexual ability (Harrison 2007).

CPA side effects include hypersensitivity reactions, rash and osteoporosis (rare). Other side effects (frequency in not known) include breathlessness, fatigue, changes in hair pattern, hepatitis, hepatic failure, hepatotoxicity, jaundice, gynaecomastia (rarely leads to galactorrhoea or benign breast nodules), inhibition of spermatogenesis, reduced sebum production, lassitude, weight changes and risk of relapse of thromboembolic disease (<https://bnf.nice.org.uk/drug/cyproterone-acetate.html#sideEffects>). CPA side effects are reported to be completely reversible, and the person may return to previous functioning a couple of months after discontinuation (Garcia et al. 2013).

Progestogens such as MPA and CPA have been used in the treatment of male deviant hypersexuality for at least five decades. Research and clinical observation suggest that both medications are similar in suppressing libido and sexual arousal in men; they differ however in their pharmacology and side effect profile (Cooper 1986). As with all hormonal medication available for managing sexual arousal, the long-term side effects of MPA and CPA are unknown.

GnRH Analogues (Triptorelin, Leuprorelin, Goserelin)

GnRH is a decapeptide that is synthesised within the hypothalamus and is secreted directly into the hypophysiportal circulation. Its secretion stimulates the secretion of LH and FSH from the pituitary. The LH drives the production of testosterone from the testicles. GnRH activity is very low in childhood and is activated at puberty. GnRH activity is controlled by feedback loops (Hill et al. 2003).

Initial administration acts on pituitary level to stimulate LH release, which results in transient increase in serum testosterone (flare). The continuous use of GnRH analogues as part of the treatment to manage sexual deviancy and arousal in sex offenders (opposing to the physiologically pulsatile secretion) inhibits the secretion of LH from the pituitary, hence decreasing plasma testosterone levels and

subsequently libido. The potency of the GnRH analogues is larger than the naturally secreted GnRH.

GnRH analogues therefore work by decreasing deviant sexual fantasies, desires and abnormal sexual behaviours. The effects are associated with the reduction of serum testosterone and are reversible (Koo et al. 2014). They are better tolerated than MPA and CPA, with major side effects related to hypoadrogenism.

The three different compounds used are triptorelin, leuprorelin and goserelin. They share similar side effect profiles. Their efficacy and tolerability have not been compared as yet in a randomised trial. Of these, only triptorelin is licenced for use in Europe for male hypersexuality with severe sexual deviation.

The side effects of triptorelin include anaphylaxis, arthralgia, asthenia, asthma, breast tenderness (males and females), changes in blood pressure, changes in breast size, changes in scalp and body hair, depression, gastrointestinal disturbances, headache, hot flushes, hypersensitivity reactions, increased sweating, local reactions at injection site, mood changes, ovarian cysts (may require withdrawal), paraesthesia, pruritus, rash, urticaria, visual disturbances and weight changes. The frequency with which these side effects present is not known. When used for male hypersexuality with severe sexual deviation, triptorelin may also cause decrease in trabecular bone density, dyspareunia, loss of libido, migraine, musculoskeletal pain, musculoskeletal weakness, oedema of the face and extremities and palpitation (<https://bnf.nice.org.uk/drug/triptorelin.html#sideEffects>).

Due to their side effect profile and especially the risk of long-term osteoporosis, the sex offender should have regular medical reviews including annual bone density scans (to compare with the baseline scan which should be taken before medication initiation). On occasion, offenders may be offered medication to prevent bone density loss, such as vitamin D, calcium or bisphosphonates (Hill et al. 2003).

Administration should always follow informed consent and should be part of a more complex treatment plan (residency restrictions, tagging, polygraph, psychotherapy [individual, group, therapeutic community] and sex offenders' registry). In all cases, the prescriber should keep in mind that none of the medication is optimally effective on its own and they should be given in conjunction with comprehensive psychological treatments in offenders that have the potential to benefit. They should also monitor closely for side effects (short and long term) and consider how some of the side effects are worsening with the length of treatment (e.g. osteoporosis).

Good-quality trials comparing the effectiveness of the different medication options are much needed, as is research on their long-term side effects and benefits.

4.4 Use of Surgical and Chemical Castration in Legal Settings

There are different approaches in understanding and managing the risks posed by sex offenders. There is, for example, the clinical approach that advocates that the risk posed by sex offenders can be due to mental or personality disorder or

endocrine disorders and hence can be assessed, diagnosed and treated so that they “can be rehabilitated and the public protected” (Petrunik 2002). Another approach is the risk management/community protection approach that advocates for community social control (includes sex offender registries, civil commitment and community notification) (Petrunik 2002). Finally, the justice approach that focuses on the offence rather than the offender and advocates that offenders should be tried in a court of law and judges should decide on the sentence. All above approaches carry a number of concerns, inclusive of human rights considerations, ethical dilemmas, increased costs (implementation, maintenance, legislation, effectiveness) and potential harms (individual for victims and perpetrators and societal) (Petrunik 2002).

Surgical castration is no longer considered one of the standard options for the management of sexual offending either from the perspective of the clinicians or the criminal justice systems worldwide, due to the number of ethical problems it carries. It has however re-emerged as a management option in the last decade, especially for those sex offenders that are considered high risk and high harm (or the sexually violent predators/sexually dangerous persons as known in the some US states) (Weinberger et al. 2005). It is available as a voluntary option for sex offenders in Czech Republic, Germany and some US states (California, Iowa, Texas, Florida and Louisiana) (Douglas et al. 2013). And despite lack of clear indications (or research) of why a person would be considered for such a radical and nonreversible treatment, there has been academic and clinical thinking on the subject (Weinberger et al. 2005). Needless to say, most take the position that the involuntary castration of sex offenders is unethical. However, even situations where the offender is incarcerated or committed to hospital carry coercive potential when surgical castration is offered. On the other hand, the lack of availability of such treatment may infringe the rights of the offenders that want it and deprive them of a treatment that could help them to regain and sustain freedom. When adding to the equation the rights of the society (and the obligations of both clinicians and the criminal justice system to protect the public from a known risk) and the argument of clinical appropriateness of such intervention, the ethical discussion gets increasingly complex (Weinberger et al. 2005; McMillan 2013). Considering that neither surgical castration nor other interventions (CBT, medications) can absolutely diminish sexual reoffending, either alone or in combination, there is a notable preference towards the least “aggressive” and potentially reversible methods.

Chemical castration has been used both as punishment and as treatment, and the question “punishment or treatment” has preoccupied scholars and clinicians alike over the last few decades. It makes a great difference who decides for the prescription of medications and how it (may) affects the offender’s sentence. When the criminal justice system decides who has it, it inevitably becomes a punishment, and of course inherent problems arise such as the following: Who is a good candidate for it, is it/ can it become cruel, is it proportionate to the crime(s) committed, what is the purpose and what are the evidence that it can achieve the goal in most if not in everyone prescribed with it? The clinical, scientific and judicial communities in most countries agree that prescription of such medications needs to be based on the advice of those that can prescribe them rather than imposed by a court of justice and offered to

offenders instead of being compulsory. Of course prescription of such medications in legal settings (courts, prisons, forensic hospitals, accommodation provided by probation) presents with ethical challenges that will be addressed below.

It is therefore evident that in order to move medication prescribing for sex offenders (we slowly abandon the term “chemical castration”) further from being used as a punishment, and although the opinion of the legal community remains important, it has to be considered within the remit of the medical profession. Psychiatrists traditionally were more involved than other healthcare professionals as medication prescribing in this case focuses on the reduction of sex drive. One should distinguish first whether the treatment of sex offenders with medications is an accepted psychiatric practice. In countries that forensic psychiatry exists as a specialty, prescription of medications to manage sexual arousal and behaviours (at least initiation and stabilisation of treatment) falls within its remit. In other countries, usually any psychiatrist can be advised regarding appropriateness for a specific sex offender. In all cases, the opinion of an endocrinologist should be sought if anti-hormonal medications are considered.

In summary, the use of medications to manage sexual arousal in legal settings should only be considered for offenders that are prone to benefit and offenders that voluntarily opt in for it and only after careful consideration and consultation with psychiatrists and endocrinologists. Such prescription should not affect the outcome of any legal proceedings (including sentencing, parole, etc.) as if this was the case true freedom of choice would cease, as is in cases of offenders that opt to take it to affect justice outcomes. It also needs to be in context of an ongoing psychotherapeutic programme rather than isolated attempt to reduce sexual preoccupation or recidivism.

4.5 Use of Medication to Manage Sexual Arousal in Forensic Psychiatry

Forensic psychiatry, as described in the first chapter of this book, is the psychiatric subspecialty that aims to identify, assess and treat individuals who are mentally unwell at any point within the criminal justice system. The prescription of medications to treat sex offenders with problems in managing their sexual arousal and sexual behaviours can seem at first somewhat different from mainstream practice in that “sex offender” and “sex offence” are neither clinical terms nor diagnoses. In this case, it seems as if a clinical solution is expected for criminological issues. Many subsequently argue that the role of doctors in prescribing medications for sex offenders is dubious for two reasons: firstly, there is a fine line between treatment and punishment, and, secondly, such treatment shifts the focus from the patient’s best interests to that of the public (Grubin and Beech 2010).

It is therefore necessary to clarify that when (forensic) psychiatrists treat sex offenders, they do not treat the offending behaviour per se (this is the job of the criminal justice system) but the psychological and physical effects of the problematic arousal that can also be associated with offending. Hence, the reduction of offending should be the by-product of treatment rather than its focus.

One of the problems in defining the role of the psychiatrist in the treatment of sex offenders is the lack of clarity of what constitutes a treatable clinical problem (it would be unethical for a doctor to prescribe medications for a societal problem). The obvious response would be a diagnosis of disorders of sexual preference. The existing diagnostic systems DSM-5 (Diagnostic and Statistical Manual of Mental Disorders, fifth edition; American Psychiatric Association, 2013) and ICD-10 (International Classification of Diseases, 10th revision; World Health Organisation, 1992) provide definitions for sexual deviancy that focus on the unconventional nature of the drive rather than its psychological or physical characteristics (Grubin and Beech 2010). In this case, it is difficult to justify treatment with medications as they are not useful in amending the content of the drive (psychological therapies are/can be). When the focus is the debilitating manifestations of the deviant drive, such as the frequency of the fantasies/urges, the intensity of them or the inability to control arousal and sexual behaviours, then the role of biological therapies (such as medications) is clearer.

Another difficulty pertains to the restriction of medical practice if psychiatrists were to treat only specific diagnoses. Rösler and Witztum advocate, for example, that long-acting GnRH analogues together with psychotherapy are effective in controlling paedophilia, voyeurism and exhibitionism. They recommend further research in the form of controlled trials before concluding on the efficacy of pharmacotherapy for other paraphilias (Rösler and Witztum 2000). It is apparent that more controlled trials are needed to investigate the efficacy of all treatments available for each diagnosis, and this could advance clinical practice and update guidelines. However, we should also consider whether offenders that are not having a diagnosis of a disorder of sexual preference (which is more common than not) should be eligible for treatment with medications (and this should also be tested with clinical trials). Should, for example, offenders that are hypersexual or find it difficult to manage their sexual arousal and behaviours be considered for medications (Grubin 2018)? It is perhaps important to clarify that the target of treatment with medications in sex offender populations is not only specific diagnoses but also modifiable debilitating symptoms and problematic sexual behaviours. Of course explicit evidence-based scientific and ethical guidance should make the appropriate provisions.

The principles of prescribing medications to manage sexual preoccupation, deviancy and sexual arousal in prisons and in forensic psychiatry hospitals or indeed in the community are the same; the place should not restrict the options. Comparable are also the ethical issues that the prescriber should consider before such prescription, starting by whether there is a clear medical (rather than social) reason to prescribe such powerful pharmaceutical agents. Such issues will be discussed below.

The offender, no matter the place, should have a thorough psychiatric, physical, psychosocial and criminological assessment prior to any prescription of medications. As already described above, such assessments will reveal any physical health problems associated with increased sexual drive (e.g. brain injury, endocrine conditions, neurological conditions and syndromes, substance side effects) but also details about possible psychopathology, including comorbid mental illness,

personality disorders, developmental disorders, intellectual difficulties, organic disorders, paraphilic disorders (DSM 5) or disorders of sexual preference (ICD-10) and substance misuse disorders.

4.5.1 Medical Responsibility and Legal Obligations

Similar to any medical treatment, the focus is the best interests of the patient. The psychiatrist has to be competent in assessing and treating sex offenders but also has to be transparent about the treatments available and act with integrity. His role in this case is to assess the sex offender and if appropriate to provide him/her with information and options regarding available interventions. The offender (patient from the perspective of the psychiatrist) will choose freely whether to have any of the therapies provided. The role of the psychiatrist is to empower the offender/patient to reach decisions about his/her care.

It falls within the medical responsibility of the psychiatrist to explain that as with most medical interventions, absolute success cannot be guaranteed when treating sex offenders with medications or indeed any other interventions. Prescriber and offender need to be clear that not all that take the medications are benefited; some develop side effects, and some will reoffend despite all good intentions. It is the responsibility of the psychiatrist to inform the offender of all interventions available and seek informed consent (will be covered in detail below). It is also the prescriber's responsibility to monitor for benefits and side effects and safeguard the offender's physical and mental health but also to discontinue treatment if it is no longer beneficial or if it becomes harmful. One of the grey areas in prescribing medications for the management of sexual arousal is the duration of treatment. The principle is that medications are provided until it is no longer necessary. This means that potentially treatment can be lifelong. In that case, provisions should be made for the treatment and monitoring to continue being available.

Of course all other generic medical responsibilities are applicable such as the competence of the prescriber, updating knowledge and further developing skills, being transparent about the lack of robust evidence of who will benefit and who will not from the treatment, providing individualised care, confidentiality, considering the least restrictive alternatives first (unless otherwise indicated), educating about the need for psychometric validation of outcome measures, etc. The General Medical Council of the UK focuses on four domains to describe the responsibilities of doctors (https://www.gmc-uk.org/-/media/documents/good-medical-practice%2D%2D-english-1215_pdf-51527435.pdf). The first one is "knowledge, skills and performance" (make the care of your patient your first concern; provide a good standard of practice and care; keep your professional knowledge and skills up to date; recognise and work within the limits of your competence). The second involves "safety and quality" (take prompt action if you think that patient safety, dignity or comfort is being compromised; protect and promote the health of patients and the public). The third focuses on "communication, partnership and teamwork" (treat patients as individuals and respect their dignity; treat patients politely and

considerately; respect patients' right to confidentiality; work in partnership with patients; listen to, and respond to, their concerns and preferences; give patients the information they want or need in a way they can understand; respect patients' right to reach decisions with you about their treatment and care; support patients in caring for themselves to improve and maintain their health; work with colleagues in the ways which best serve patients' interests). And the fourth is on maintaining trust (be honest and open and act with integrity; never discriminate unfairly against patients or colleagues; never abuse your patients' trust in you or the public's trust in the profession).

Some of the most significant professional, legal and ethical focus points when considering prescribing medication for the management of sexual arousal and behaviours are:

1. The offenders' right to treatment. Offenders have the right to access appropriate treatments for all their medical and psychological problems during incarceration (or hospital detention). Depriving them from treatment they wish to have is equally unethical as imposing it. However, we need to keep in mind protection of offenders from "overzealous" prescribers that support prescribing for reasons over and above the offenders' wellbeing and prognosis (Yaki 1985).
2. The clinicians' duty to treat once a problem is diagnosed and where treatment is available. Here, we need to be careful that the state does not impose treatment they consider effective without the offender's consent. The clinicians' duty to treat does not supersede the offender's right to treatment when treatment can cause side effects, has impact on the offender's physical or mental health or is intrusive. This is more applicable to somatic treatments such as medications, as with psychotherapy the patient/offender needs to be willing to actively participate and benefit from it (Yaki 1985).
3. The coercion of inmates, as coercion in prison is so likely especially if a treatment is linked with freedom or privileges. This could be resolved by keeping medical treatments confidential and records available only to the treatment team and not to the criminal justice system (Yaki 1985).
4. The coercion of the physician: Research on the public views regarding chemical castration has revealed that the majority believe chemical castration is an acceptable management option for sex offenders, especially in order to reduce recidivism (Sedkaoui and Mullet 2016). Law makers have reacted to these views and to high-profile cases and created legislation for the treatment of sex offenders. Clinicians found their practice confined between public opinion and legislation on the one hand and their professional obligations to their patients on the other hand. The clinician should act with their patient in mind, and patient-centred care should dictate his/her professional ethics. He/she should prescribe only treatments that (s)he believes will be helpful and only to patients that (s)he believes that may benefit from it (Yaki 1985).

As autonomy, informed consent, free will and coercion are important ethical considerations when prescribing medication to sex offenders, especially in

environments like prisons that are considered inherently coercive, we will discuss in detail in the next section.

4.5.2 Free Will or Coercion?

The subject of free will and informed consent is very important, and it requires that the individual was presented with and understood all information needed to make a decision about the prescription of the medications and also that (s)he volunteered to take specific medications.

It is therefore necessary, and in fact an obligation of the healthcare provider, that all relevant information about medications is given to the individual in a language understandable to them and they are given the opportunity to ask questions and time to consider their options before communicating their decision. Relevant information includes the potential benefits as well as side effects, the risks involved in the treatment and information on what could be potential effects of not taking the treatment including information about alternative options. The MMSA candidate will also need to be aware of the fact that not all long-term effects of medications are known due to lack of research in the topic.

The subject of “volunteering” to take medication is a bit more controversial than the information component of informed consent. Using it as a condition for parole, or to influence parole, or as a restriction for conditional release can be seen as a form of punishment or coercion than a treatment, hence unacceptable, and one could argue against human rights. But how coercive can be offering medication to a sex offender that committed serious sexual crime(s) or received a lengthy prison sentence? Can free will and voluntary consent be achieved in this matter? Some offenders, for example, may believe (or made to believe) that taking MMSA voluntarily indirectly influences criminal justice decisions; that would not be completely absurd.

There is a debate among clinicians and scholars of whether the bioethics principle of autonomy is compromised on occasion that MMSA is proposed. Of course where offenders request medications because they feel uncomfortable (or indeed they are suffering) with their sexual preoccupation, there are no major ethical concerns. Similarly, on occasion that the healthcare provider (independently of the criminal justice system) introduces the discussion about MMSA with offenders that sexual preoccupation has taken over their lives to the extent that they cannot function in everyday life demands or cannot attend psychological interventions and other interventions due to their preoccupation, ethical concerns are minimal and match those pertinent to all medical interventions. It is in cases of medication prescribing that the offenders feel or indeed they have no choice that ethical concerns rise.

Lai (2014) in her dissertation focusing on the ethics of the use of androgen deprivation therapy for child sex offenders very eloquently discussed issues around autonomy, fully voluntary consent and valid consent. She argued that a starting point should be considering whether the intervention proposed could be beneficial for the particular individual (of course one should keep in mind and be transparent with the offender that the intervention may fail to alleviate their increased or

inappropriate sexual preoccupation or indeed decrease the preoccupation and desires but fail to increase the person's autonomy). In order to determine if it is appropriate to offer medication to a sex offender, one should establish that "the treatment is not cruel, inhumane, degrading or wrong; the treatment serves the best interests of the offender and the offender gives his informed consent" (Lai 2014). Lai adopted Beauchamp's (2010) three requirements for valid consent (and subsequently autonomous decision): intentionality, understanding and voluntariness. Intentionality means that if the offender communicates that he wishes to take medications to manage his sexual arousal, he must plan to undergo the treatment, i.e. has the intention of taking the medications. The second requirement implies that the offender must have "appropriate" understanding of what the intervention entails. They are not expected to be experts but have knowledge and understanding of potential benefits and risks of the intervention. It is the healthcare provider's obligation to provide the offender with information or the resources to gather all essential information. The final requirement is voluntariness, that the offender is "free from the control of external sources or their own internal states that deprive them of self-directedness" (Lai 2014; Beauchamp 2010). Lai, in agreement with other researchers in the field (Douglas et al. 2013), concludes that in order for androgen deprivation therapy to be respectful of the person's autonomy, it must fulfil two requirements. The first is that it cannot be offered with any incentive (or indeed threat), and the second is that it must be offered only to offenders that have the potential to benefit from it (in the form of recidivism reduction or subjective feelings and engagement with other therapies) (Lai 2014).

In cases that the present autonomy of the offenders cannot be guaranteed, there still may be a place for medication prescribing. An example is offenders that cannot have full capacity to be autonomous due to their overwhelming and irresistible sexual thoughts and urges that render them captives. If medication prescribing is based on the principle of benevolence, it can—on occasion—be temporarily justified (to lessen the hold sexual preoccupation has on the offender) keeping in mind that in the long term it protects the offender's right to autonomy (Douglas et al. 2013; Lai 2014; Sedkaoui and Mullet 2016).

To add to the argument, instead of incarceration and psychological therapies being the only options available to a sex offender in order to be rehabilitated and enhance his opportunities for an offence-free life, if there is a better (or equally effective) approach, it would be inappropriate for this approach not to be offered (Douglas et al. 2013). In any case, the offenders must decide for themselves. What any healthcare system should do is provide the options and explain to offenders that qualify for such interventions the potential benefits and risks. Each offender then can decide for themselves which intervention they would choose.

Making medication for sexual drive and behaviours available in prisons at any point during imprisonment may be a step towards empowering sex offenders to take medications for the own benefit rather than in order to convince the justice system of their commitment to not reoffend. Of course, such intervention has to be free from incentives or threats in order to be entirely voluntary. Keeping medical records confidential and healthcare providers separate from the criminal justice system

could help. A point for consideration is that such medication prescription cannot be a stand-alone treatment, but prisons should also invest in concurrent psychotherapeutic approaches that could be extended beyond the prison walls once the person is released. It also has to be adequately monitored to ensure the offenders do not experience major side effects, they are taking the correct dosage and they are not reversing the effects of medications by taking testosterone supplements (as such actions may put their physical and mental health at risk).

4.5.3 Other Complexities

Compared to the general population where prevalence of personality disorders is between 2% and 11%, prevalence rate for personality disorders in sexual offending populations varies between 33% (Fazel et al. 2002) and 94% (McElroy et al. 1999). Cluster C personality disorders seem to be more prevalent in child molesters, while Cluster B is more prevalent in rapists. Research has also shown that maladaptive personality traits play a key role in sexual recidivism especially when combined with deviant sexual interest (Hanson and Morton-Bourgon 2005), perhaps through common problematic coping mechanisms (e.g. impulse control, urge management). It is therefore important to consider problematic personality traits when planning any interventions and for sex offender programmes to also target such traits.

Sex offenders with intellectual disabilities also present with diagnostic and treatment challenges. To start with, the prevalence of sexual offending in individuals with intellectual disability is not clear, as is not the prevalence of intellectual difficulties in offenders that committed a sexual offence. Studies of individuals with learning disability estimate that about 4% were convicted of sexual offences, 17% had been in contact with the police and 41% engaged in “sex-related” challenging behaviours (McBrien et al. 2003), while at least 6% had severe sexual aggression (Thompson and Brown 1997). Such high rates can be due to a plethora of reasons including less elaborate planning, higher visibility and factors that have to do with arrest and conviction of individuals with intellectual disability. Methodological issues though affect the generalisability of research findings and the ability to make conclusions with certainty. Research has shown that the sexual recidivism rate for offenders with intellectual disability is higher than that of offenders without the disability (6.8 times at 2 years follow-up and 3.5 times at 4 years follow-up) and that they reoffend quicker than those without a disability (Craig and Hutchinson 2005). Most evidence for effectiveness of treatments on recidivism is based on non-disabled offender populations, and there are no randomised controlled trials on the effectiveness of pharmacological or non-pharmacological interventions for sex offenders with intellectual disability. Subsequently, offenders with IQ of 79 and below are not consistently offered such treatments. At present, only adapted CBT approaches (adapted in terms of content but also of recommended longer duration of 1–2 years) have been applied successfully to sex offenders with intellectual disability (ID) (outcome was recidivism reduction).

4.6 Juvenile Sex Offenders

Juvenile sex offenders are a difficult group to study and treat, mainly due to its heterogeneity. Their offending is usually not specialised, and quite rarely they are exclusively sexual offenders. Additionally, their backgrounds differ as their motivations for offending, their sexual preferences and their life experiences (childhood maltreatment, behavioural disorders, etc.) also differ (Worling and Långström 2006).

Crime statistics from 2011 show that the US juvenile arrests counted for 14% of all forcible rapes (Snyder and Mulako-Wantota 2013). However, research on the presence of sexual deviation in juvenile sex offenders is sparse and of variable quality.

Research has shown that deviant sexual behaviours frequently have onset in late adolescence or early adulthood. And although some will not persist into adulthood, some offenders' behaviours will not only persevere but also escalate (from noncontact sexual behaviours to rape) (Thibaut et al. 2016).

Risk of reoffending is also difficult to establish as most juvenile sex offenders will not go to reoffend or will perpetrate nonsexual offences (Worling and Långström 2006). Risk factors for reoffending include deviant sexual interests, attitudes supportive of sexual offending, high-stress family environment and problematic adolescent-parent relationship, history of sexual assault, impulsivity, sexual preoccupation, victim access, poor social skills, cognitive distortions and also failure to complete treatment programmes (Worling and Långström 2006; Thibaut et al. 2016).

Risk of recidivism is a major concern for all sex offenders, and although for juvenile sex offenders research has found it to be lower than their adult counterparts (range from 7% to 30%, although rarely exceeds 15%), it merits the attention of clinicians and law makers (Thibaut et al. 2016). Incarceration alone cannot resolve the problem and reduce recidivism. Hence, programmes specialised for juvenile offenders are critical.

Similar to research on treatments for adult perpetrators of sexual crimes, high-quality research on treatment specificity and efficacy for juvenile sex offenders is scarce. The same research methodology and quality constraints apply here. Treatment offered involves mainly residential and community programmes that are based on CBT principles, social learning theory and relapse prevention. These programmes apart from individual and group CBT offer psychosocial education, family system and multimodal and multisystemic treatments. In cases of children or female adolescent offenders, they also offer specialised work on their sexual history. Main goals for such treatments include: to help the juveniles to take responsibility of their actions; directly address interfamilial, interpersonal and extrafamilial factors that play a role in their offending and break the offence circle; educate them (and their families) and make them aware of their own triggers, maladaptive behaviours and cognitive distortions; and empower them to identify behaviour controls and devise a relapse prevention plan (Thibaut et al. 2016).

Medication also plays a role in the treatment of juvenile sex offenders, although most medications that are used in adults are not licensed for use in juveniles.

Similarly to adult populations, no controlled studies have been conducted involving treatments with medications of juvenile sex offender populations. Evidently, caution and careful planning is necessary when considering hormonal treatments for young offenders that undergo puberty, as their body already undergoes changes (dependent on hormonal levels) in order to fully develop. The American Academy of Child and Adolescent Psychiatry made the recommendation that anti-androgens are not prescribed to anyone under the age of 17 and its use is reserved for the most severe cases (Thibaut et al. 2016).

SSRIs have been used extensively to treat a range of conditions in children and adolescents, including depression and obsessive compulsive disorder. They require close monitoring not only for the presence of side effects but also as they may increase suicidality to anyone up to the age of 24 years. SSRIs however have no effect on hormonal levels and hence have been used also to treat juvenile sexual deviant behaviours with good effects (mainly though decreasing symptoms such as preoccupation, urges, deviant obsessions, impulsivity and aggressiveness) (Thibaut et al. 2016).

Anti-androgen treatments have also been used in juvenile sex offenders, despite the lack of controlled trials. There are a few case reports and case series on the use of CPA, MPA and gonadotropin-releasing hormone agonists (GnRHa) with good effects (Thibaut et al. 2016). Lack of research on anti-androgen effectiveness and potential adverse outcomes in juvenile sex offender populations (alongside lack of research on length of treatment), as well as the complexity of prescribing hormonal treatments for a population that anyway is undergoing age-related hormonal changes, makes their use limited. The World Federation of Societies of Biological Psychiatry recommends that when anti-androgens are deemed necessary for juvenile sex offenders, a specialised paediatric endocrinologist takes over the prescription process and responsibility of regular monitoring (Thibaut et al. 2016). As with the adult sex offender populations, in cases that pharmacological interventions are considered appropriate or necessary, they should never be given in isolation and should always be part of a comprehensive treatment plan including psychological therapies and psychosocial interventions. The duration of treatment needs to be regularly evaluated.

Prescription of medication for sexual arousal in juvenile populations carries the same fundamental ethical concerns as in adult populations, with the addition of considerations of the effects any medication may have on their normal growth and the development of secondary gender characteristics. Informed consent should always be sought from the young persons and depending on their age from their parents or caregivers as with the prescribing of any medications, according to legal and ethical regulations.

4.7 Female Sex Offenders

Female sex offenders are not adequately studied. Part of the issue is the small numbers of known female perpetrators worldwide. The 2006 and 2013 Uniform Crime Reports found that female offenders committed about 10.5% of all sexual offences

(prostitution excluded) (FBI 2006; Blasko 2016). The FBI (Uniform Crime Reports) also found that in 2016 2.7% of all adult arrests for rape were females (an increase from 1% in 2006) and 7.8% of the arrests for all other sexual offences (it was 6% in 2006) (FBI 2016). This can be due to a number of reasons including that such crimes are usually underreported or under-prosecuted. The media have their own role to play in this alongside public and cultural misconceptions that females cannot be perpetrators of sexual crimes (unless through coercion by male perpetrators). Research has shown that despite the horrific nature of some sexual crimes perpetrated by females, they remain unprosecuted. Ramsey-Klawnsnik (1990) in his research found that despite the sadistic nature of his female participants' crimes (burning, biting, beating, pinching genitalia/breast of children during sexual assaults), the majority were not prosecuted (Ramsey-Klawnsnik 1990).

An explanation for the low persecution and conviction rates can be the public perception that sex offenders are exclusively males. This may influence the juries' decisions about guilt or innocence in such crimes. It may also influence the ability of the victims to report such crimes. Similarly, clinicians and scholars have argued that in cases of young boys that have been abused by adult women, there is hesitation to report it sometimes due to normalisation of such abuse by the society. For example, the victims feel pressurised to feel proud to have had a much older sexual "partner" or believe this to be a normal way to initiate their sexual lives. In other cases, they may feel shameful and lost with regard to who they should speak in order to be taken seriously (Knack et al. 2015). Likewise, adult male victims may feel embarrassed to report sexual victimisation by females.

Another explanation can be that female perpetrators are harder to be revealed as they choose their victims from their immediate family (their partners, children, relatives) and social circles or they choose professions that bring them close to children and adolescents (children/adolescents they care for/look after/teach) and they usually perpetrate the sexual assaults as part of their caring activities (e.g. baby changing) (Vandiver 2006; Blasko 2016).

Apart from those female sex offenders that act on their own, there are also perpetrators that act with a male accomplice. In such cases, females may serve an auxiliary role, mainly to facilitate access to potential victims (Vandiver 2006).

Research on 471 adult registered female sexual offenders has shown that victims were usually known (82% of the cases) (Vandiver and Kercher 2004). Oliver (2007) agreed with previous research showing that female sex offenders could have offended from an age as young as 13 (to as old as 65) and concluded that such perpetrators were more likely to have experienced trauma in early childhood, including sexual abuse and incest (Oliver 2007; Strickland 2008).

Sexual deviancy can also be difficult to establish in female perpetrators of sexual crimes not only due to lack of tested objective measures but also the tendency to see these crimes as not sexually motivated (Knack et al. 2015). Deviant sexual arousal and behaviours have been reported in females; however, lack of research and clinically published data restricts our understanding (Cortoni et al. 2015). Even in cases that female sex offenders are convicted of their crimes, there are no specific risk assessment and management tools; hence, on occasion, clinicians use tools created

and validated for male populations. Understandably, therefore, there is a lack of research and guidance on treatment for female sex offenders.

Treatment programmes for female sex offenders were created due to pressuring need as modified versions of male ones, despite the lack of research on effectiveness and outcomes in female populations. It seems though that they promisingly cover aspects that male programmes failed to cover including trauma, sexual victimisation, relationship and intimacy skills, and apart from the mainstream approaches (CBT, family therapy, etc.), they also use experimental approaches such as drama and art therapy (Giguere and Bumby 2007). Regarding treatment with medications, there are only a couple of case reports of successful use of CPA for females with sexual aggression and compulsive masturbation; therefore, their use is limited and not evidence based.

4.8 Transgender Sex Offenders

Similarly to other populations such as juveniles and females, transgender sex offenders are understudied. There is no clear evidence on the size of the population or offending prevalence. To add to the problem, transgender populations are rather diverse, with male-to-female preoperative, male-to-female postoperative, female-to-male preoperative and female-to-male postoperative having different needs and expectedly being on a variety of hormonal agents for their gender reassignment that may affect their physical and mental health as well as their sexual functioning.

Of note is that individuals that undergo gender reassignment are often prescribed with either anti-androgens (male to female) or androgens (female to male). Similar to the medications to manage sexual arousal that were described above, anti-androgens prescribed for male-to-female transgender populations will have an effect on libido, arousal and sexual functioning. On the opposite side, androgens given to female-to-male transgender individuals may enhance sexual arousal, interest, fantasies and behaviour (Cohen-Kettenis and Gooren 1993). The population of females and males that undergo gender reassignment is hardly studied with regard to emotional impact and sexual feelings during/following treatment, with the main focus of clinical practice and research so far being physical appearance and functioning.

Research on transgender offender populations is sparse, and the existing small number of studies only focused on male-to-female transgender populations. Sexton et al. (2010) for the purposes of their research defined as a transgender offender: “an inmate in a men’s prison who: (1) Self-identifies as transgender (or something analogous); (2) Presents as female, transgender or feminine in prison or outside prison; (3) Receives any kind of medical treatment (physical or mental) for something related to how she presents herself or thinks about herself in terms of gender, including taking hormones to initiate and sustain the development of secondary sex characteristics to enhance femininity; or (4) Participates in groups for transgender inmates” (Sexton et al. 2010). They focused on the demographic characteristics of this particular population of inmates, their vulnerabilities within prison and the discrimination they suffer (including the fact that professionals and other inmates often

confuse gender and sexual identities which has an impact on the everyday life of transgender inmates). They concluded that the demographic composition of transgender incarcerated population differs from that of the rest of the adult male prison population; they are more often in ages 36–45, disproportionately of White and Black ethnic background, disproportionately incarcerated for property crimes, more often receiving a sex offender status (despite the fact that they may have not committed a sexual offence; Hunt and Mills 2012), quite often have been homeless before the crime (20% reported they were homeless before they came to prison, and 47.7% reported that they have been homeless at some point in their lives) and more often being under the care of mental health services (for problems such as depression, drug and alcohol problems or history of suicide attempts). To add to the problem of having access to gender-affirming medical care in prison, transgender populations also present with health-related challenges including overrepresentation of HIV or hepatitis C (Sexton et al. 2010).

Sexton et al. (2010) reported that in California prisons over 40% of transgender inmates have participated in sex work while in prison (prisoners' own account). These prisoners also reported victimisation, either sexual (75% of California transgender prisoners reported that they have been victims of sexual crimes at some point in their lives) or nonsexual (they have experienced at least 5 times more incidents of physical violence compared to other male adult inmates) (Sexton et al. 2010). Another study found that sexual assaults are usually not isolated events, but approximately 30% of the transgender or gay men that were sexually assaulted in prison have suffered six or more of these assaults (Hunt and Mills 2012). The respective statistics from other US states are similar; however, statistics from the rest of the world are lacking. Despite the sparsity of research, it is evident that this population needs both safe placements within the prison system and also access to physical and mental healthcare.

Due to the increased recognition of the needs and vulnerabilities of the transgender populations within the criminal justice system, antidiscrimination legislation and policies have been developed in both Europe and the USA in the last decade, although this does not necessarily cover the provision of adequate healthcare (gender-affirming medical care, mental health, physical health) (Tarzwell 2006; Routh et al. 2017).

Similarly, no concise guidelines exist for transgender sex offenders that require medication to manage their sexual preoccupation. Such guidelines are much needed, especially as the hormone treatments prescribed as part of the gender reassignment can affect the emotional state, sexual feelings and also the behaviour of the individuals.

4.9 Conclusion

In the last few decades, there has been an increased interest among clinicians and academics in finding effective treatments for sex offenders. Pharmacological methods have been in the forefront of developments as they are seen a more immediate and effective solution than psychotherapeutic and sociological interventions and less ethically controversial when compared to surgical castration.

With testosterone being the hormone that plays a central role in male (and female) sexuality, it is not a surprise that it is the main target when considering treatments to reduce sexual preoccupation. There have been two major categories of medications used in the treatment of sex offenders: the SSRIs and agents influencing the production and effects of androgens (steroidal anti-androgen treatments, GnRH analogues). Despite their wide use, to date, there are no controlled clinical trials comparing the effectiveness of medications alongside that of other interventions or indeed the long-term effects of such treatments.

The principles of prescribing medications to manage sexual preoccupation, deviancy and sexual arousal in prisons and in forensic psychiatry hospitals or indeed in the community are the same; the place should not restrict the options. Comparable also are the ethical issues that the prescriber should consider before such prescription, starting by whether there is a clear medical (rather than social) reason to prescribe. Alongside the fundamental principles of autonomy, informed consent and free will, important ethical considerations when prescribing medication to sex offenders are also the offenders' right to treatment, the clinicians' duty to treat (once a problem is diagnosed and where treatment is available), the coercion of inmates (as coercion in prison is so likely especially if a treatment is linked with freedom or privileges) and the coercion of the physician to prescribe.

Making medication that reduces sexual drive and behaviours available in prisons at any point during imprisonment may be a step towards empowering sex offenders to take medications for the own benefit rather than in order to convince the justice system of their commitment to not reoffend. Of course, such intervention has to be free from incentives or threats in order to be entirely voluntary.

Initial use of medications to treat only high-risk sex offenders and only those with sexual deviancy with the aim to manage risk is slowly moving towards using medications to reduce subjective distress to the offender, reduce sexual preoccupation and enable engagement in therapy and rehabilitation. Such treatment can not only improve the offenders' life and rehabilitation but also indirectly provide public safety. One can hope that such prescribing will gradually become more accessible and medications could come to be available to all sexual offenders that have the potential to benefit from them.

References

- Aagaard L (2014) Chemical castration of Danish sex offenders. *J Bioethic Inq* 11:117–118. <https://doi.org/10.1007/s11673-014-9534-3>
- American Psychiatric Association (2013) *Diagnostic and statistical manual of mental disorders* (5th ed.) (DSM-5). American Psychiatric Association, Arlington, VA
- Bain J, Langevin R, Dickey R, Hucker S, Wright P (1988a) Hormones in sexually aggressive men. I. Baseline values for eight sex hormones. II. The ACTH test. *Ann Sex Res* 1:63–78
- Bain J, Langevin R, Hucker S, Dickey R, Wright P, Schonberg C (1988b) Sex hormones in paedophiles. I. Baseline values of six hormones. II. The gonadotropin releasing hormone test. *Ann Sex Res* 1:443–454

- Bancroft J (2005) The endocrinology of sexual arousal. *J Endocrinol* 10:411–427
- Blascroft J (2009) *Human sexuality and its problems*, 3rd edn. Churchill-Livingstone/Elsevier, Edinburgh
- Beauchamp TL (2010) Consent and autonomy. In: Miller F, Wertheimer A (eds) *The ethics of consent: theory and practice*. Oxford University Press, New York, NY, pp 55–78
- Becker JV, Murphy WD (1998) What we know and do not know about assessing and treating sex offenders. *Psychol Publ Pol Law* 4(1/2):116–137
- Berlin FS (1997) “Chemical Castration” for sex offenders. *N Engl J Med* 336(14):1030
- Blasko BL (2016) Overview of sexual offender typologies, recidivism, and treatment. Chapter 2. In: Jeglic EL, Calkins C (eds) *Sexual violence*. Springer International Publishing, Cham. https://doi.org/10.1007/978-3-319-44504-5_2
- Clark VA, Duwe G (2015) What predicts where sex offenders live? An examination of census track data in Minnesota. *Crim Justice Policy Rev* 28:488–510. <https://doi.org/10.1177/0887403415594200>
- Cohen-Kettenis PT, Gooren LJJ (1993) The influence of hormone treatment on psychological functioning of transsexuals. *J Psychol Hum Sex* 5(4):55–67. https://doi.org/10.1300/J056v05n04_04
- Cooper AJ (1986) Progestogens in the treatment of male sex offenders: a review. *Can J Psychiatry* 31(1):73–79
- Cortoni F, Sandler JC, Freeman NJ, Kozlowski K (2015) Factors related to sexual recidivism among women. In: *Breaking New Ground: Understanding and Preventing Sexual Abuse 2015 ATSA Conference*. Conference abstract. Accessed on 18 Jul 2018 from <http://www.atsa.com/pdfs/Conf2015/F-18.pdf>
- Craig L, Hutchinson RB (2005) Sexual offenders with learning disabilities: risk, recidivism and treatment. *J Sex Aggress* 11(3):289–304
- Craig LA, Browne KD, Stringer I (2003) Treatment and sexual offence recidivism. *Trauma Violence Abuse* 4:70–89
- Daley M (2008) A flawed solution to the sex offender situation in the united states: the legality of chemical castration for sex offenders. *Indiana Health Law Rev* 5:87. Accessed on 6 May 2018 from <https://mckinneylaw.iu.edu/ihlr/pdf/vol5p87.pdf>
- Douglas T, Bonte P, Focquaert F, Devolder K, Sterckx S (2013) Coercion, incarceration, and chemical castration: an argument from autonomy. *Bioethic Enq* 10:393–405. <https://doi.org/10.1007/s11673-013-9465-4>
- Fanniff AM, Becker JV (2006) Specialised assessment and treatment of adolescent sex offenders. *Aggress Violent Behav* 11:265–282
- Fazel S, Hope T, O’Donnell I, Jacoby R (2002) Psychiatric, demographic and personality characteristics of elderly sex offenders. *Psychol Med* 32(2):219–226
- Federal Bureau of Investigation (2006) *Crime in the United States, 2005: uniform crime reports*. U.S. Department of Justice, Federal Bureau of Investigation, Washington, DC
- Federal Bureau of Investigation (2016) *Crime in the United States, 2016: uniform crime reports*. U.S. Department of Justice, Federal Bureau of Investigation, Washington, DC. Available from <https://ucr.fbi.gov/crime-in-the-u.s/2016/resource-pages/downloads>
- Fedoroff JP, Fedoroff IC (1992) Buspirone and paraphilic sexual behaviour. *J Offender Rehabil* 18:89–108
- Friendship C, Mann RE, Beech AR (2003) Evaluation of a national prison-based treatment program for sexual offenders in England and Wales. *J Interpers Violence* 18:744–759
- Furby L, Weinrott MR, Blackshaw L (1989) Sex offender recidivism: a review. *Psychol Bull* 105:3–30
- Gallagher CA, Wilson DB, Hirschfield P, Coggeshall MB, MacKenzie DL (1999) Quantitative review of the effects of sex offender treatment on sexual reoffending. *Correct Manag Quart* 3:19–29
- Garcia FD, Garcia HD, Assumpção AFA, Thibaut F (2013) Pharmacologic treatment of sex offenders with paraphilic disorder. *Curr Psychiatry Rep* 15:356. <https://doi.org/10.1007/s11920-013-0356-5>

- Genetics Generation (n.d.) Introduction to Eugenics. Accessed on 5 Jun 2018 from <http://knowledge-genetics.org/history-of-eugenics/>
- Giguere R, Bumby K (2007) Female sex offenders. A project of the Office of Justice Programs. U.S. Department of Justice, Center for Sex Offender Management, Washington, DC. Accessed on 19 Jul 2018 from http://www.csom.org/pubs/female_sex_offenders_brief.pdf
- Grossman LS, Martis B, Fichtner CG (1999) Are sex offenders treatable? A research overview. *Psychiatr Serv* 50(3):349–361
- Grubin D (2018) The pharmacological treatment of sex offenders. Chapter 27. In: Beech AR, Carter AJ, Mann RE, Rotshtein P (eds) *The Wiley Blackwell handbook of forensic neuroscience*, 1st edn. Wiley, New York, NY. <https://doi.org/10.1002/9781118650868.ch27>
- Grubin D, Beech A (2010) Chemical castration of sex offenders. *BMJ* 340:c74
- Hall GCN (1995) Sexual offender recidivism revisited. A meta-analysis of recent treatment studies. *J Consult Clin Psychol* 63:802–809
- Hanson RK, Bussiere MT (1998) Predicting relapse: a meta-analysis of sexual offender recidivism studies. *J Consult Clin Psychol* 66:348–362
- Hanson RK, Morton-Bourgon KE (2005) The characteristics of persistent sexual offenders: a meta-analysis of recidivism studies. *J Consult Clin Psychol* 73(6):1154–1163. <https://doi.org/10.1037/0022-006X.73.6.1154>
- Hanson RK, Gordon A, Harris AJR, Marques JK, Murphy W, Quinsey VL, Seto MC (2002) First report of the collaborative outcome data project on the effectiveness of psychological treatment for sex offenders. *Sex Abuse* 14(2):169–194. <https://doi.org/10.1023/A:1014624315814>
- Harrison K (2007) The high-risk sex offender strategy in England and Wales: is chemical castration an option? *Howard J* 46(1):16–31. ISSN 0265-5527
- Heim N (1981) Sexual behaviour of castrated sex offenders. *Arch Sex Behav* 10(1):11–19
- Henggeler SW (2012) Multisystemic therapy: clinical foundations and research outcomes. *Psychosoc Interv* 21:181–193
- Hill A, Briken P, Kraus C, Strohm K, Berner W (2003) Differential pharmacological treatment of paraphilias and sex offenders. *Int J Offender Ther Comp Criminol* 47(4):407–421
- Hunt J, Mills AM (2012) The unfair criminalization of gay and transgender youth. An overview of the experiences of LGBT youth in the Juvenile Justice System. Center for American Progress, Washington, DC, pp 1–12. Accessed on 12 Jul 2018 from <https://www.ncjrs.gov/App/Publications/abstract.aspx?ID=267708>
- Jordan K, Fromberger P, Stolpmann G, Müller JL (2011) The role of testosterone in sexuality and paraphilia - a neurobiological approach. Part I: Testosterone and sexuality. *J Sex Med* 8:2993–3007
- Kafka MP (1994) Sertraline pharmacotherapy for paraphilias and paraphilia related disorders: an open trial. *Ann Clin Psychiatry* 6:109–125
- Kafka MP, Prentky R (1992) Fluoxetine treatment of nonparaphilic sexual addictions and paraphilias in men. *J Clin Psychiatry* 53:351–358
- Kalichman SC, Rompa D (1995) Sexual sensation seeking and sexual compulsivity scales: reliability, validity, and predicting HIV risk behavior. *J Pers Assess* 65:586–601
- Kalichman SC, Johnson JR, Adair V, Rompa D, Multhaupt K, Kelly JA (1994) Sexual sensation seeking: scale and development and predicting AIDS-risk behavior among homosexually active men. *J Pers Assess* 62:385–397
- Kim B, Benekos PJ, Merlo AV (2016) Sex offender recidivism revisited. Review of recent meta-analyses on the effects of sex offender treatment. *Trauma Violence Abuse* 17(1):105–117. <https://doi.org/10.1177/1524838014566719>
- Kingsberg SA, Clayton AH, Pfaus JG (2015) The female sexual response: current models, neurobiological underpinnings and agents currently approved or under investigation for the treatment of hypoactive sexual desire disorder. *CNS Drugs* 29:915–933. <https://doi.org/10.1007/s40263-015-0288-1>
- Kingston DA, Seto MC, Ahmed AG, Fedoroff P, Firestone P, Bradford JM (2012) The role of central and peripheral hormones in sexual and violent recidivism in sex offenders. *J Am Acad Psychol Law* 40:476–485

- Knack NM, Murphy L, Ranger R, Meston C, Fedoroff JP (2015) Assessment of female sexual arousal in forensic populations. *Curr Psychiatry Rep* 17(4):557. <https://doi.org/10.1007/s11920-015-0557-1>
- Koo KC, Ahn JH, Hong SJ, Lee JW, Chung BH (2014) Effects of chemical castration on sex offenders in relation to the kinetics of serum testosterone recovery: implications for dosing schedule. *J Sex Med* 11(5):1316–1324. <https://doi.org/10.1111/ism.12492>
- Kruesi MJ, Fine MB, Valladares L, Phillips RA Jr, Rapoport JL (1992) Paraphilias: a double-blind crossover comparison of clomipramine versus desipramine. *Arch Sex Behav* 21:587–593
- Lai MQY (2014) The ethics of the use of androgen deprivation therapy (ADT) for child sex offenders. Thesis for the degree of Master of Research. Department of Philosophy, Macquarie University. Accessed on 17 Jul 2018 from <https://www.researchonline.mq.edu.au/vital/access/services/Download/mq:44385/SOURCE1>
- Le Marie L (1956) Danish experiences regarding the castration of sexual offenders. *J Crim Law Criminol* 47(3):294–310. Article 3
- Lee JY, Cho KS (2013) Chemical castration for sexual offenders: physician's views. *J Korean Med Sci* 28:171–172
- Letourneau EJ, Henggeler SW, Borduin CM, Schewe PA, McCart MR, Chapman JE, Saldana L (2009) Multisystemic therapy for juvenile sexual offenders: 1-year results from a randomised effectiveness trial. *J Fam Psychol* 23:89–102
- Levin RJ, Both S, Georgiadis J, Kukkonen T, Park K, Yang CC (2016) The physiology of female sexual function and the pathophysiology of female sexual dysfunction (Committee 13A). *J Sex Med* 13:733–759
- Lösel F, Schmucker M (2005) The effectiveness of treatment for sexual offenders: a comprehensive meta-analysis. *J Exp Criminol* 1(1):117–146
- Mann RE, Hanson RK, Thornton D (2010) Assessing risk for sexual recidivism: some proposals on the nature of psychologically meaningful risk factors. *Sex Abuse* 22(2):191–217
- McAlinden AM (2012) The governance of sexual offending across Europe: penal policies, political economies and the institutionalisation of risk. *Punishment Soc* 14(2):166–192
- McBrien J, Hodgetts A, Gregory J (2003) Offending and risky behaviour in community services for people with intellectual disabilities in one local authority. *J Forensic Psychiatry Psychol* 14(2):280–297. <https://doi.org/10.1080/1478994031000084828>
- McElroy S, Soutullo C, Taylor P, Nelson E, Beckman D, Brusman L, Ombaba J, Strakowski S, Keck P (1999) Psychiatric features of 36 men convicted of sexual offenses. *J Clin Psychiatry* 60:414–420
- McMillan J (2013) The kindest cut? Surgical castration, sex offenders and coercive offers. *J Med Ethics* 40(9):583–590. <https://doi.org/10.1136/medethics-2012-101030>
- Meyer WJ III, Cole CM (2008) Physical and chemical castration of sex offenders. *J Offender Rehabil* 25(3-4):1–18. https://doi.org/10.1300/J076v25n03_01
- Miller RD (1998) Forced administration of sex-drive reducing medications to sex-offenders: treatment or punishment. *Psychol Publ Pol Law* 4(1-2):175–199
- Norrsgård K (2008) Human testing, the eugenics movement, and IRBs. *Nat Educ* 1(1):170. Accessed on 5 Jun 2018 from <https://www.nature.com/scitable/topicpage/human-testing-the-eugenics-movement-and-irbs-724>
- Oliver BE (2007) Preventing female-perpetrated sexual abuse. *Trauma Violence Abuse* 8(1):19–32
- Petrunik MG (2002) Managing unacceptable risk: sex offenders, community response, and social policy in the United States and Canada. *Int J Offender Ther Comp Criminol* 46(4):483–511
- Quinsey VL, Harris GT, Rice ME, Lalumière ML (1993) Assessing treatment efficacy in outcome studies of sex offenders. *J Interpers Violence* 8(4):512–523
- Ramsey-Klawnsnik H (1990) Sexual abuse by female perpetrators: impact on children. Paper presented on the National Symposium on Child Victimization, Atlanta, GA
- Rösler A, Witzum E (2000) Pharmacotherapy of paraphilias in the next millennium. *Behav Sci Law* 18(1):43–56
- Routh D, Abess G, Makin D, Stohr MK, Hemmens C, Yoo J (2017) Transgender inmates in prisons: a review of applicable statutes and policies. *Int J Offender Ther Comp Criminol* 61(6):645–666
- Scott CL, Holmberg T (2003) Castration of sex offenders: prisoners' rights versus public safety. *J Acad Psych Law* 31(4):502–509

- Sedkaoui H, Mullet E (2016) Mapping French people's views on chemical castration of child and adolescent sex offenders. *Univ Psychol* 15(3):1. ISSN 1657-9267
- Sexton L, Jenness V, Sumner JM (2010) Where the margins meet: a demographic assessment of transgender inmates in men's prisons. *Justice Quart* 27(6):835–866. <https://doi.org/10.1080/07418820903419010>
- Skett S, Winder B, Kaul A, Hocken K, Grubin D, Norman C, Faulkner J, Elliot H, Lievesley R (2016) Medication to manage sexual arousal. In: *Offender personality disorder pathway*. NHS England, National Offender Management Service, London. Available from https://www.researchgate.net/profile/Belinda_Winder/publication/322505234_The_use_of_medication_to_manage_sexual_arousal_for_individuals_in_secure_settings/links/5a6343590f7e9b6b8fd7647d/The-use-of-medication-to-manage-sexual-arousal-for-individuals-in-secure-settings.pdf
- Stein DJ, Hollander E, Anthony DT, Schneier FR, Fallon BA, Liebowitz MR, Klein DF (1992) Serotonergic medications for sexual obsessions, sexual addictions, and paraphilias. *J Clin Psychiatry* 53:267–271
- Strickland SM (2008) Female sex offenders: exploring issues of personality, trauma, and cognitive distortions. *J Interpers Violence* 23(4):474–489
- Snyder H, Mulako-Wantota J (2013) Bureau of Justice Statistics. Arrest Data Analysis Tool. Available online at www.bjs.gov/index.cfm?ty=datool&surl=/arrests/index.cfm
- Tarzwel S (2006) The gender lines are marked with razor wire: addressing state prison policies and practices for the management of transgender prisoners. *Columbia Hum Rights Law Rev* 38:167–220
- Thibaut F, Bradford JMW, Briken P, DeLaBarra F, Häßler F, Cosyns P, on behalf of the WFSBP Task Force on Sexual Disorders (2016) The World Federation of Societies of Biological Psychiatry (WFSBP) guidelines for the treatment of adolescent sexual offenders with paraphilic disorders. *World J Biol Psychiatry* 17(1):2–38. <https://doi.org/10.3109/15622975.2015.1085598>
- Thompson D, Brown H (1997) Men with intellectual disabilities who sexually abuse: a review of the literature. *J Appl Res Intellect Disabil* 10(2):140–158
- Vandiver DM (2006) Female sex offenders: a comparison of solo offenders and co-offenders. *Violence Vict* 21(3):339–354
- Vandiver DM, Kercher G (2004) Offender and victim characteristics of registered female sex offenders in Texas: a proposed typology of female sexual offenders. *Sex Abuse* 16:121–137
- Verheul R, Andrea H, Berghout CC, Dolan C, Busschbach JJV, Van der Kroft PJA, Bateman AW, Fonagy P (2008) Severity indices of personality problems (SIPP–118): development, factor structure, reliability, and validity. *Psychol Assess* 20:23–34. <https://doi.org/10.1037/1040-3590.20.1.23>
- Walker DF, McGovern SK, Poey EL, Otis KE (2004) Treatment effectiveness for male adolescent sexual offenders: a meta-analysis and review. *J Child Sex Abus* 13(3–4):281–293
- Weinberger LE, Sreenivasan S, Garrick T, Osran H (2005) The impact of surgical castration on sexual recidivism risk among sexually violent predatory offenders. *J Am Acad Psychiatry Law* 33:16–36
- Wong JS, Gravel J (2018) Do sex offenders have higher levels of testosterone? Results from a meta-analysis. *Sex Abuse* 30(2):147–168
- World Health Organization (1992) *The ICD-10 classification of mental and behavioral disorders: clinical descriptions and diagnostic guidelines*. World Health Organization, Geneva
- Worling JR, Långström N (2006) Risk of sexual recidivism in adolescents who offend sexually, correlates and assessment. In: Barbaree HE, Marshall WL (eds) *The juvenile sex offender*, 2nd edn. The Guilford Press, New York, NY
- Yaki M (1985) Medical treatment for imprisoned paraphiliacs: implementing a modified standard for deliberate indifference. *Yale Law Pol Rev* 4(1):251–282. Article 12
- Zigmond AS, Snaith RP (1983) The hospital anxiety and depression scale. *Acta Psychiatr Scand* 67(6):361–370. <https://doi.org/10.1111/j.1600-0447.1983.tb09716.x>



The Use of Polygraph Test in Clinical Forensic Psychiatry Settings

5

Nicky Collins

The polygraph has and still is often referred to as the ‘lie detector’ and has received much interest since its initial introduction in the early twentieth century. Despite many concerns regarding its underlying theory, it is widely used by 79% of adult sex offender programmes in the United States (McGrath et al. 2010). Its use in the United Kingdom however has only steadily been increasing over the last two decades. Its limited use in the UK has largely been due to extensive criticism of the tool, which has included a working party review by the British Psychological Society in 2004.

5.1 How the Polygraph Works

A polygraph test should consist of three parts as recommended by the American Polygraph Association (2011): (1) a pre-test interview, (2) an in-test data collection phase and (3) test data analysis. Nelson in 2015 clearly described the polygraph test and the purpose of the pre-test interview being to ‘*orient the examinee to the test procedures, the purpose of the test and the investigation target questions*’. It involves an interview, a review of the target questions and an acquaintance test which orients the examinee to the instrument and establishes a baseline of physiological responses to a known lie. This has been found to increase the accuracy of the polygraph test (Kircher et al. 2001). The examinees’ suitability for the test is also reviewed which includes a brief review of their health and if there are any adverse health conditions which may exclude them from taking the test on the given day, in addition to obtaining informed consent to undertake the test. The interview that is conducted can be a free narrative, semi-structured or structured interview in which the test questions

N. Collins (✉)

Broadmoor Hospital, West London NHS Trust, London, England

e-mail: nikki.collins2@nhs.net

© Springer Nature Switzerland AG 2020

A. Igoumenou (ed.), *Ethical Issues in Clinical Forensic Psychiatry*,
https://doi.org/10.1007/978-3-030-37301-6_5

(relevant questions and comparison questions) are formulated and then reviewed with the examinee before moving to part two of the test.

The second part or phase of the test is the in-test data collection and can be achieved by using any of a variety of validated diagnostic or screening test formats (American Polygraph Association 2011). Nelson (2015) described *'all screening and diagnostic polygraph techniques include relevant questions (RQs) that describe the examinee's possible involvement in the behavioural issues under investigation. Effective relevant questions will be simple, direct, and should avoid legal or clinical jargon and words for which the correct meaning may be ambiguous, confusing or not recognizable to persons unfamiliar with legal or professional vocabulary. Each relevant question must address a single behavioural issue'*.

In addition to establishing relevant questions pertinent to the behavioural issue, comparison questions are also established in the pre-test interview and together form the test questions. Most polygraph tests utilise the comparison question technique (CQT) which is unsurprisingly the most researched polygraph technique. There are two types of comparison questions: the traditional one is the Probable Lie Comparison (PLC) and the other more recent and alternative type is the Directed Lie Comparison (DLC). The use of PLCs has been a heavily criticised aspect of polygraphy by various adversaries and will be discussed later as it has been an area identified as questionable ethically. In developing the DLC questions in a polygraph test, the process is transparent and does not require the examinee to deny a common behavioural issue. Importantly, DLCs have been shown to be as effective as PLCs as summarised by Blalock et al. (2011, 2012) and in a meta-analytic study (APA 2011).

In the third phase the test data are evaluated by numerically coding the differences in reaction to RQs and CQs. The theory of polygraph testing is that responses to RQs and CQs vary significantly as a function of deception and truth-telling in response to the RQs (Nelson 2016). Nelson (2015) has gone on to liken the scoring of polygraph tests with other scientific tests in medicine, psychology and forensics, in that observable and measurable criteria are identified, scoring features are transformed into numerical values, numerical cut-off scores are established statistically and then applied, and decision policies are developed. The final score(s) then indicate deception or truth-telling to the behavioural issue(s).

The polygraph is a scientific instrument which can display a representation of certain bodily activities, such as heart rate, blood pressure, respiration and palmar sweating (Gale 1988). It is assumed that when people experience fear, they experience autonomic changes within the body (Abrams 1991). It has been reported that these autonomic changes are induced by a 'stress response' during lying and are predominantly outside conscious control (Grubin 2008). For example, fear can lead to abrupt changes in perspiration, an increase in heart rate and a change in the breathing rate (Abrams 1991). These physiological changes can be recorded and measured by the polygraph; respiratory activity is recorded via convoluted rubber tubes which are placed over the chest and abdominal area, electrodermal activity (perspiration) is recorded via two small metal plates which are attached to the fingers, and a blood pressure cuff is used to record heart rate (Krueger 2009). It is assumed that almost all people experience fear of being discovered when they lie

(Wilcox 2000). Therefore, the polygraph records autonomic responses indicative of fear during a series of questions, which in turn is used to establish whether the person is likely to be lying (Kokish 2003). Thus, the polygraph itself does not detect lying per se but instead measures the physiological arousal that may be the product of lying (Gannon et al. 2008; Lewis and Cuppari 2009).

It has been said that '*polygraph testing is neither a deterministic (i.e., perfect and infallible) observation of deception or truth-telling nor a direct physical or linear measurement of deception or truth*' (Nelson 2015).

The polygraph examination used in post-conviction settings is usually the comparison question test (CQT) (Bashore and Rapp 1993). This test includes three types of questions concerning the matter under investigation: relevant, irrelevant and comparison. Relevant questions are very specific and tap into the issue of interest (Ogilvie and Dutton 2008), whereas irrelevant questions are neutral and unrelated to the matter under investigation (Ansley 2008). Finally, control questions are designed to be unrelated to the specific incident but nonetheless emotionally provocative for innocent subjects and to which both innocent and deceptive subjects are likely to respond 'no' to (Bashore and Rapp 1993). They typically involve questions regarding a subject's general honesty or historical misdeeds (Cross and Saxe 2001). The aim of the comparison question is to encourage innocent individuals to lie and experience physiological discomfort (Gannon et al. 2008). An example would be: 'Have you ever stolen anything?' (Bashore and Rapp 1993). Since most individuals display some autonomic reactivity to almost any type of question, neutral questions are used to establish a baseline of reactivity against which to compare the strength of the reactions produced by the relevant questions (Kleiner 2002).

The CQT often consists of between 10 and 12 questions, including up to four comparison questions (Honts and Reavy 2009). However, it can also be used as a multiple-issue examination, whereby a discussion about a specific allegation or incident will be replaced with a structured interview aimed at addressing areas pertinent to risk and/or compliance.

By comparing physiological responses to these three types of questions, a decision can be made about truth-telling. The CQT premises that the questions posing the biggest threat to the examinee will elicit the strongest physiological responses. Thus, for innocent examinees it is proposed that the comparison and relevant questions share equal stimulus significance, and therefore physiological responses to relevant questions will be less or equal to those of the comparison questions (Verschuere and Ben-Shakhar 2011). In contrast, for those individuals who have something they wish to hide, the relevant questions are likely to lead to greater physiological responding compared to comparison questions (Verschuere et al. 2007). Thus, when the physiological responses, as recorded by the polygraph, show greater reactivity to control questions, the respondent is classified as Deception Indicated or Significant Responses. When the pattern of responding is greater for comparison questions the individual is classified as No Deception Indicated or No Significant Responses. Finally, if the pattern of responding to both relevant and comparison questions are equal or fluctuate significantly, then the test result is Inconclusive (Ben-Shakhar 2008; Ogilvie and Dutton 2008).

All questions constructed for a polygraph examination require the individual to respond with a 'yes' or a 'no' (American Polygraph Association 2009). These questions are formulated in the pre-test interview based on the information provided. The pre-test interview consists of: greeting the individual, providing an explanation of the procedure and instrument, obtaining the examinee's informed consent, determination of the suitability of the subject for testing, an acquaintance test to establish a baseline to a known and deliberate lie, a structured interview (to review the examinee's background and the case facts and to obtain a detailed review of each issue of concern with an opportunity for the examinee to provide their version of all issues under investigation) and a review of the test questions to be asked during the polygraph examination (American Polygraph Association 2009).

Concerns about the CQT have been documented but it is used by 35 states in the United States to monitor sexual offenders in the community (Consigli 2002). Its use has also grown in popularity in the United Kingdom, being used within high-security psychiatric hospitals as part of identifying and addressing treatment needs (Ho et al. 2013). Despite persistent criticism over its use, accuracy estimates for the CQT have ranged from 74% to 89% and 59–83% for guilty and innocent examinees, respectively (Meijer and Verschuere 2010), suggesting that it has some clinical utility. Additionally, the National Research Council (2003), reviewing 37 laboratory and 7 field studies, showed a ROC of 0.85 and 0.89, respectively. These figures led the research panel to conclude that specific-incident polygraph tests can discriminate lying from truth-telling at rates well above chance, though well below perfection.

5.2 PCSOT

It is likely that the polygraph is so extensively used owing to its ability to provide fuller and more accurate information about an offender's history, paraphilic interests (including 'unhealthy' sexual fantasies) and offence behaviour, all of which can increase the reliability of risk assessment and thus the more effective planning of treatment so as to meet the needs of the individual (Emerick and Dutton 1993; English et al. 2000; Heil et al. 2003). However, the polygraph has not been used extensively in the United Kingdom due to the view of the British Psychological Society (2004) at that point in time that it lacked a valid theoretical underpinning and had limited evidence from research in the clinical setting.

In the United Kingdom, large evaluation studies of polygraph with sexual offenders in the community have been conducted. Initially (Grubin 2006 and 2010) conducted a pilot of voluntary polygraph testing across ten English probation areas. The results found that polygraph offenders were 14 times more likely to disclose information relevant to their treatment, supervision and risk assessment, compared with a comparison group of offenders who received standard supervision without a polygraph. It was noted that taking the polygraph was voluntary and therefore raising questions about motivation of those that chose not to take the test. It has been noted that the comparison group were not robustly

matched, and the time points for recording disclosures were not adequately matched either (Gannon et al. 2012).

In order to address some of these issues, a further pilot was undertaken. In 2012 Gannon et al., evaluated a mandatory polygraph pilot of adult sexual offenders on licence and under supervision by probation. Overall, the findings '*suggest that the polygraph increases the chances that a sexual offender under supervision in the community will reveal information relevant for their management, supervision, treatment or risk assessment*'. This is the only study found that has estimated the cost-effectiveness of polygraph and been used to recommend targeting the use of polygraph with high- or very-high-risk sexual offenders.

Therapists evaluating and/or treating sexual offenders need valid, reliable information from the sex offender (Abel and Rouleau 1990). Without this, the therapist is less able to identify the precise treatment needs of the patient (Abel and Rouleau 1990) and is less able to accurately manage risk (Wilcox 2009). However, it has been suggested that sexual offenders are extremely reluctant to disclose their offending histories (Blasingame 1998), thus making risk assessment and treatment provision extremely difficult.

It is widely acknowledged that past behaviour is the best predictor of future behaviour (American Polygraph Association 2009) and that the frequency of offending, the number of prior victims and the variety of unhealthy behaviours are all empirically linked to the risk of re-offending (Serin et al. 2001). As a result, it is vital that clinicians have accurate information on the offender's sexual history. Support for the use of the polygraph is helping to achieve this aim and has been provided by English et al. (2000) using an American sample. They found that post-conviction sex offender polygraph tests often identify new crimes and high-risk behaviours which were not previously known. Further, agencies in the United States that use the polygraph for post-conviction sex offender purposes reported that it greatly enhanced the number of disclosures made by the individual and that, as a result of this, it led to better management and supervision of the individual and more appropriate treatment (English et al. 2000). Some research has been conducted in the UK (Gannon et al. 2014; Grubin 2010) which has found similar findings in relation to increased disclosures for those undertaking a polygraph and offender managers reporting an increase in supervision or changing focus in supervision as a result of the disclosure made during a polygraph.

Research has consistently shown that the polygraph increases disclosures of the number of offences (Ahlmeyer et al. 2000; English et al. 2003; Wilcox 2002), the number of victims (Wilcox 2002; Wilcox and Sosnowski 2005), the range of paraphilias (Ahlmeyer et al. 2000; Wilcox and Sosnowski 2005), the age of offending onset (Wilcox 2002) and the number of high-risk behaviours (Buschman et al. 2010; Grubin et al. 2004) when compared to admissions through clinical interviews and file reviews. Additionally, the polygraph has been suggested to be effective as a 'truth facilitator' (Grubin 2002). Individuals can reveal information regarding their sexual history at three time points: when they are anticipating a polygraph examination, during the pre-test interview or during the post-test interview (once the polygraph examination has been conducted, an interview is conducted to discuss the results)

(Krueger 2009). It is not uncommon for subjects to disclose information prior to the actual examination (Abrams 1991; Blasingame 1998), possibly owing to fear of being found 'deceptive'. Further, Grubin and Madsen (2006), using a US sample of 176 sex offenders who had undergone a polygraph examination, found that 44% of individuals reported that they were more truthful with their probation officers than they otherwise would have been. Kokish et al. (2005) also found that the polygraph accurately identified truth-telling 92% and deception 82% of the time, suggesting that it is a reliable and valid instrument for use in post-conviction settings.

Crossover sexual offences are defined as those in which victims are from multiple age groups, multiple gender groups and multiple relationship categories (Heil et al. 2003). Typically, when offence crossover is disclosed, assigned risk level increases (Gannon et al. 2008). Thus, it is important that for risk assessment to be reliable, information regarding crossover offending be obtained. Abel and Rouleau (1990) have suggested that individuals with only one paraphilia are rather uncommon and that the majority of sex offenders have multiple paraphilic interests; thus, research needs to look into ways in which to increase the disclosures of such high-risk behaviours.

Research suggests that the level of disclosures about crossover offending increases as a result of a polygraph examination. For example, Heil et al. (2003) found that prior to the polygraph only 7.2% of the sample of inmate sexual offenders had both child and adult victims; after the polygraph however this rose to 70%. In addition, English et al. (2000) reported that the individuals studied reported mixed-gender victims only 10% of the time; post-testing this increased to 29%. Thus, the polygraph may not only be useful at increasing disclosures regarding sexual history, but this information may also be helpful in increasing our knowledge and understanding of the prevalence of crossover offending. Indeed, Cann et al. (2007) conclude that at least 25% of convicted sexual offenders in England and Wales sentenced to at least 4 years in custody have engaged in some form of crossover behaviour.

The vast majority of research conducted in the field of post-conviction polygraph testing with sex offenders has been conducted in community-based samples in the United States. Indeed, research on the use of the polygraph in such settings in the United Kingdom is extremely slim. Pilot studies have taken place (Wilcox 2002; Grubin 2002; Grubin et al. 2004; Gannon et al. 2012) but these have looked at community-based samples (i.e. individuals on probation or parole) and none have considered the use of the polygraph in other settings such as mental health.

Whilst there are several types of polygraph tests, there is much evidence to validate the use of post-conviction sex offender (PCSOT) tests. The sexual history examination (SHE) obtains a fuller and more accurate account of an offender's sexual history, including the range of unhealthy behaviours in which he has engaged, the age at which these commenced and any unidentified paraphilias (English et al. 2003; Grubin 2008). The information obtained from the SHE can assist in the tailoring of treatment for the offender in addition to providing an opportunity for a more comprehensive assessment of risk (Wilcox 2002, 2009). It is widely acknowledged that sexual offenders minimise the extent of their offending, unhealthy sexual behaviours and/or fantasies (Ahlmeyer et al. 2000; Blasingame 1998; Grubin 2009).

In spite of this, without valid, reliable and detailed information pertaining to historical and current behaviours, the treatment provided is likely to be insufficient in addressing and managing risk (Abel and Rouleau 1990; Wilcox 2009). As a result, polygraph testing has been introduced to validate sex offenders self-reports (Hindman and Peters 2001) and to facilitate the gathering of historical information pertinent to risk (Emerick and Dutton 1993; English et al. 2000; Heil et al. 2003; Kebric 2009), with many therapists believing that therapy cannot be conducted adequately without the polygraph (Abrams 1991).

It is likely that the polygraph is used due to its ability to provide fuller and more accurate information about an offender's history, paraphilic interests (including deviant sexual fantasies) and offence behaviour, all of which can increase the reliability of risk assessment and promote honest disclosure (Levenson 2009). The use of the polygraph as a 'truth facilitator' is extremely important as risk assessment remains an inexact science (Cortoni 2009).

Support for the polygraph as a truth facilitator has predominantly come from studies carried out in the United States and Canada. For example, English et al. (2000) found that PCSOT often identifies unknown crimes, high-risk behaviours and a broader victim profile. Additionally, McGrath et al. (2007), using a sample of 208 adult male sexual offenders, found that during the polygraph examination, 4.3% admitted having had contact with a victim and 15.7% masturbating to offence-related sexual fantasies. It was estimated that between 60% and 80% of these disclosures were not previously known, and 96% of service providers rated such disclosures as 'helpful' or 'very helpful' in informing treatment and supervision. Finally, Hindman and Peters (2000) compared polygraphed and non-polygraphed sexual offenders on disclosures relating to male victims. They found that 30% of the former admitted to having a male sexual offence victim, compared to 17% of the latter, and the total number of victims jumped from an average of 1.25–9 per person. Clearly without the polygraph this information would have remained unknown and untreated (Levenson 2009).

As described above, research has consistently shown that the polygraph increases disclosures of the number of offences (English et al. 2003; Wilcox 2002), the number of victims (Wilcox 2002; Wilcox and Sosnowski 2005), the range of paraphilias (Ahlmeyer et al. 2000), the age of offending onset (Wilcox 2002) and the number of high-risk behaviours (Buschman et al. 2010; Grubin et al. 2004) when compared to admissions through clinical interviews and file reviews. When considering the impact of such disclosures in a high-security psychiatric hospital, the potential of the polygraph examination increases dramatically. There are currently four high-security hospitals within the United Kingdom. One of their aims is to protect the public from individuals deemed to be a high risk of harm and who are identified as suffering from a mental disorder. Due to the risky nature of these individuals, it is imperative that supervision and treatment is tailored to the specific patient and that all risk factors are identified. In addition, this is a unique setting and unique population. Whilst research in this field is limited, there have nonetheless been suggestions that individuals suffering from personality disorder and psychopathy experience general physiological hypo-responsivity, making polygraph examinations difficult to conduct (Meijer and

van Koppen 2008; Verschuere and Ben-Shakhar 2011). Additionally, mentally disordered sexual offenders routinely engage in cognitive distortions, for example, perceiving children as wanting sex with adults. These cognitive distortions are likely to reduce feelings of guilt and anxiety, resulting in reduced detection during the CQT examination (Meijer and van Koppen 2008). As a result, it is surprising that the use of polygraph examinations within high-security psychiatric settings has not yet been researched in the United Kingdom.

Despite its perception as a 'lie detector', the polygraph as a 'truth facilitator' has gained much favour in the literature. For example, Grubin (2009) suggests that the disclosures that an individual makes are much more important than whether the individual 'passed' or 'failed' the examination, as 80% of all polygraphed individuals (regardless of whether they passed or failed the examination) disclosed additional information relevant to their treatment and supervision. Interestingly, Grubin et al. (2004) suggested that most information is disclosed during the pre-test interview, well before the sensors of the polygraph are actually connected. Additionally, Grubin and Madsen (2006) found that 44% of an American sample of sexual offenders reported that they were more truthful with their probation officers as a result of the polygraph, suggesting that it can increase honesty in treatment settings. Despite consistent findings to support the view of the polygraph as a 'truth facilitator', very few studies have considered the implications of such disclosures in formulating risk and treatment provision.

5.3 Ethical Issues and Conclusion

As previously discussed, the polygraph measures physiological changes associated with deception. It is now understood that these measures do not measure deception directly, as noted by Ben-Shakhar (2008), who added that physiological changes that are recorded may also be triggered by surprise, cognitive load, loud noises and fear of being classified as 'deceptive' when in fact the participant is not. The first three of these are controlled by the polygraph examiner by ensuring that the polygraph examination is conducted in a quiet room away from distractions and that the participant is made aware of all questions that will be asked during the test. The last of these confounding variables is invariably present in some participants; however, the use of the CQT enables a baseline of physiological responding to be established so as to limit the chances of 'false-positive' (when a truthful examinee is reported as being deceptive) and 'false-negative' (when a deceptive examinee is reported as being truthful) errors (Wilcox et al. 1999). Whilst these errors may still occur, the polygraph examiner ensures that a post-interview be conducted so that the results of the polygraph can be discussed with the individual.

Another area of criticism of polygraph has been the use of PLC questions and that they are manipulative in nature (Lykken 1981; Saxe 1991). The assumption made in these criticisms is that the polygraph is measuring lies, when in actual fact it records responses to stimuli, like many scientific tests (Nelson 2015). DLCs have been considered ethically more acceptable (Honts and Reavy 2009)

and have also been found to be effective with different languages and cultures (Nelson et al. 2012).

The polygraph is not without its critics, particularly with relation to field studies. Whilst they allow us to investigate real-world examples, they falter at their inability to establish ground truth. Without having a method which is independent of the outcome of the test, we are unable to accurately judge the reliability of the polygraph examination itself (Honts and Kircher 2011). Further, it has been suggested that the ability of the polygraph in obtaining new information is more related to its intimidating effect than its accuracy (Meijer and Verschuere 2010), with Matthews (2011) suggesting that deliberate disclosures are more dependent on the motivation of the offender than the polygraph itself. Finally, Grubin (2010) has raised the issue of the impossibility of teasing out the effects of the polygraph from the effect of treatment, as it may in fact be the latter which results in increased disclosures. As a result, the polygraph is rarely used in isolation, but instead forms part of a comprehensive assessment of risk and need (Levenson 2009).

Countermeasures are of concern to polygraph examiners and are behaviours which the individual may employ during the polygraph examination so as to distort the physiological responses to comparison questions (for example, by increasing the physiological responses to comparison questions so as to appear innocent) (Honts et al. 1994). Countermeasures can involve both physical (e.g. pushing toes to the floor) and mental (e.g. counting backwards from 7) (Honts et al. 1994). In reality it is extremely difficult to alter physiological responses on all relevant questions, but nevertheless, this is a concern for polygraph examinations. By employing the use of somatic activity sensors (such as on the seat, under the arms and feet during the polygraph test), both overt and covert physical activity is likely to be detected. The literature indicates that these sensors can increase the ability of the examiners to detect and observe such attempts at faking (Ogilvie and Dutton 2008; Stephenson and Barry 1986).

Mental countermeasures are much harder to detect. Some examples of mental countermeasures that have been studied include post hypnotic suggestion or stimulant medications. There has been mixed findings as to the effectiveness of such measures (Timm 1991; Ben-Shakhar and Dolev 1996; Waid et al. 1981). Other countermeasures employed may involve sleep deprivation, physical exhaustion, meditation or mental activity.

Despite this area being of concern to polygraph examiners, little research has looked into the employment of countermeasures with contemporary testing procedures or the effect on the accuracy of the tool.

References

- Abel GG, Rouleau J-L (1990) The nature and extent of sexual assault. In: Marshall WL, Laws DR, Barbaree HE (eds) *Handbook of sexual assault: issues, theories, and treatment of the offender*. Plenum Press, New York, NY, pp 9–21
- Abrams S (1991) The use of polygraphy with sex offenders. *Sex Abuse* 4:239–263
- Ahlmeyer S, Heil P, McKee B, English K (2000) *Sex Abuse* 12:123–138

- American Polygraph Association (2009) Model policy for post-conviction sex offender testing. Accessed on 23 Dec 2010 from <http://www.polygraph.org>
- American Polygraph Association (2011) Meta-analytic survey of criterion accuracy of validated polygraph techniques. *Polygraph* 40(4):196–305
- Ansley N (2008) Irrelevant question: a descriptive review. *Polygraph* 37(1):34–41
- Bashore TR, Rapp PE (1993) Are there alternatives to traditional polygraph procedures? *Psychol Bull* 113:3–22
- Ben-Shakhar G (2008) The case against the use of polygraph examinations to monitor post-conviction sex offenders. *Legal Criminol Psychol* 13:191–207
- Ben-Shakhar G, Dolev K (1996) Psychophysiological detection through the guilty knowledge technique: effects of mental countermeasures. *J Appl Psychol* 81:273–281
- Blalock B, Nelson R, Handler M, Shaw P (2011) A position paper on the use of directed lie comparison questions in diagnostic and screening polygraphs. *Police Polygr Dig*:2–5
- Blalock B, Nelson R, Handler M, Shaw P (2012) The empirical basis for the use of directed lie comparison questions in diagnostic and screening polygraphs. *APA Mag* 45(1):36–39
- Blasingame GD (1998) Suggested clinical uses of polygraphy in community-based sexual offender treatment programs. *Sex Abuse* 10:37–45
- British Psychological Society (2004) Working party: a review of the current scientific status and fields of application of polygraphic deception detection. The British Psychological Society, Leicester
- Buschman J, Bogaerts S, Foulger S, Wilcox D, Sosnowski D, Cushman B (2010) Sexual history disclosure polygraph examinations with cybercrime offences: a first Dutch explorative study. *Int J Offender Ther Comp Criminol* 54:393–411
- Cann J, Friendship C, Gozna L (2007) Assessing crossover in a sample of sexual offenders with multiple victims. *Legal Criminol Psychol* 12:149–163
- Consigli JE (2002) Post-conviction sex offender testing and the American Polygraph Association. In: Kleiner M (ed) *Handbook of polygraph testing*. Academic Press, London, pp 237–250
- Cortoni F (2009) Factors associated with sexual recidivism. In: Beech AR, Craig L, Browne KD, Wiley J (eds) *Assessment and treatment of sex offenders: a handbook*. Wiley-Blackwell, Chichester
- Cross TP, Saxe L (2001) Polygraph testing and sexual abuse: the lure of the magic lasso. *Child Maltreat* 6(3):195–206
- Emerick RL, Dutton WA (1993) The effect of polygraphy on the self-report of adolescent sex offenders: implications for risk assessment. *Sex Abuse* 6:83–103
- English K, Jones L, Pasini-Hill D, Patrick D, Cooley-Towell S (2000) The value of polygraph testing in sex offender management: research report submitted to the National Institute of Justice. Colorado Department of Public Safety Division of Criminal Justice Office of Research & Statistics (ORS), Denver, CO
- English K, Jones L, Patrick D, Pasini-Hill D (2003) *Ann NY Acad Sci* 989:411–427
- Gale A (1988) *The polygraph test: lies, truth and science*. Sage, London
- Gannon TA, Beech AR, Ward T (2008) Does the polygraph lead to better risk prediction for sexual offenders? *Aggress Violent Behav* 13:29–44
- Gannon TA, Wood J, Pina A, Vasquez E, Fraser I (2012) The evaluation of the mandatory polygraph pilot. *Minist Just Res Ser* 14/12
- Gannon TA, Wood JL, Pina A, Tyler N, Barnoux MF, Vasquez EA (2014) An evaluation of mandatory polygraph testing for sexual offenders in the United Kingdom. *Sex Abuse* 26(2):178–203
- Grubin D (2002) The potential use of polygraphy in forensic psychiatry. *Crim Behav Ment Health* 12:S45–S53
- Grubin D (2006) Polygraph pilot report: final report. Available from www.probation.homeoffice.gov.uk/files/pdf/Polygraph%20Pilot%20Report%20-20July%202006.pdf
- Grubin D (2008) The case for polygraph testing of sex offenders. *Legal Criminol Psychol* 13:177–189
- Grubin D (2009) Using the polygraph to manage risk in sex offenders. *Assessment and treatment of sex offenders: a handbook*, p. 145

- Grubin D (2010) A trial of voluntary polygraph testing in 10 English Probation areas. *Sex Abuse* 22(3):266–278
- Grubin D, Madsen L (2006) Accuracy and utility of post-conviction polygraph testing of sex offenders. *Br J Psychiatry* 188:479–483
- Grubin D, Madsen L, Parsons S, Sosnowski D, Warberg B (2004) A prospective study of the impact of polygraphy on high-risk behaviors in adult sex offenders. *Sex Abuse* 16:209–222
- Heil P, Ahlmeyer S, Simons D (2003) Crossover sexual offenses. *Sex Abuse* 15:221–236
- Hindman J, Peters JM (2000) Polygraph testing leads to better understanding adult and juvenile sex offenders. *Fed Probat* 65:8
- Hindman J, Peters JM (2001) Polygraph testing leads to better understanding adult and juvenile sex offenders. *Fed Probat* 65(3):8–15
- Ho DK, Collins N, Vinestock M, Das M (2013) Polygraph testing of sex offenders in a high secure hospital. *Psychiatrist* 37(4):141–143
- Honts CR, Kircher JC (2011) Research Methods for Psychophysiological Deception Detection. *Research Methods in Forensic Psychology*. pp 105–121
- Honts CR, Reavy R (2009) Effects of comparison question type and between test stimulation on the validity of comparison question test. Final progress report on contract No. W911NF-07-1-0670, submitted to the Defense Academy of Credibility Assessment (DACA), Boise State University
- Honts CR, Raskin DC, Kircher JC (1994) Mental and physical countermeasures reduce the accuracy of polygraph tests. *J Appl Psychol* 79:252–259
- Kebric A (2009) Polygraph testing in sex offender treatment: a constitutional and essential tool for effective treatment. *Ariz St LJ* 41:429
- Kircher JC, Packard RE, Bell BG, Bernhardt PC (2001) Effects of prior demonstrations of polygraph accuracy on outcomes of probable-lie and directed-lie polygraph tests (Grant No.DoDPI97-P-0016). Final report to the U. S. Department of Defence. University of Utah, Department of Educational Psychology, Salt Lake City, UT
- Kleiner M (ed) (2002) Handbook of polygraph testing. Academic Press, London
- Kokish R (2003) The current role of post-conviction sex offender polygraph testing in sex offender treatment. *J Child Sex Abus* 12:175–194
- Kokish R, Levenson JS, Blasingame GD (2005) Post-conviction sex offender polygraph examination: client-reported perceptions of utility and accuracy. *Sex Abuse* 17:211–221
- Krueger J (2009) The use of the polygraph in sex offender management. In: Research bulletin 3. New York State Division of Probation and Correctional Alternatives, New York, NY
- Levenson JS (2009) Sex offender polygraph examination: an evidence-based case management tool for social workers. *J Evid Based Soc Work* 6(4):361–375
- Lewis JA, Cuppari M (2009) The polygraph: the truth lies within. *J Psychiatry Law* 37(1):85–92
- Lykken DT (1981) *A tremor in the blood: uses and abuses of the lie detector*. McGraw-Hill, New York, NY
- Matthews J (2011) Investigating disclosures made by sexual offenders: preliminary study for the evaluation of mandatory polygraph testing. *Probat J* 58(1):74–75
- McGrath RJ, Cumming GF, Hoke SE, Bonn-Miller MO (2007) Outcomes in a community sex offender treatment program: a comparison between polygraphed and matched non-polygraphed offenders. *Sex Abuse* 19(4):381–393
- McGrath R, Cumming G, Burchard B, Zeoli S, Ellerby L (2010) Current practices and emerging trends in sexual abuser management: the Safer Society 2009 North American Survey. Safer Society Press, Brandon, VT
- Meijer EH, van Koppen PJ (2008) Lie detectors and the law: the use of the polygraph in Europe. In: Canter D, Zukauskienė R (eds) *Psychology and law: bridging the gap*. Ashgate, Burlington, VT, p 262
- Meijer EH, Verschuere B (2010) The polygraph and the detection of deception. *J Forensic Psychol Pract* 10(4):325–338. <https://doi.org/10.1080/15228932.2010.481237>
- National Research Council (2003) *The polygraph and lie detection*. National Academies Press, Washington, DC

- Nelson R (2015) Scientific basis for polygraph testing. *Polygraph* 44(1):28–61
- Nelson R (2016) Scientific (analytic) theory of polygraph testing. *APA Magazine* 49(5):69–82
- Nelson R, Handler M, Morgan C (2012) Criterion validity of the directed lie screening test and the empirical scoring system with inexperienced examiners and non-naive examinees in a laboratory setting. *Polygraph* 41(3):176–185
- Ogilvie J, Dutton D (2008) Improving the detection of physical countermeasures with chair sensors. *Polygraph* 37(2):136–148
- Saxe L (1991) Science and the CQT polygraph: a theoretical critique. *Integr Physiol Behav Sci* 26:223–231
- Serin RC, Mailloux DL, Malcolm P (2001) Psychopathy, deviant sexual arousal and recidivism among sexual offenders. *J Interpers Violence* 16:234–246
- Stephenson M, Barry G (1986) Use of a motion chair in the detection of physical countermeasures. *Polygraph* 17:21–27
- Timm HW (1991) Effect of posthypnotic suggestions on the accuracy of pre-employment polygraph testing. *J Forensic Sci* 36:1521–1535
- Verschuere B, Ben-Shakhar G (2011) Theory of the concealed information test. In: Verschuere B, Ben-Shakhar G, Meijer E (eds) *Memory detection: theory and application of the concealed information test*. Cambridge University Press, Cambridge, pp 128–148
- Verschuere B, Crombez G, Koster E (2007) *The international affective picture system; a cross cultural validation study*. Ghent University, Belgium
- Waid WM, Orne EC, Orne MT (1981) Selective memory for social information, alertness, and physiological arousal in the detection of deception. *J Appl Psychol* 66:224–232
- Webster CD, Douglas KS, Eaves D, Hart SD (1997) *HCR-20: assessing the risk for violence (Version 2)*. Mental Health, Law, and Policy Institute, Simon Fraser University, Vancouver, BC
- Wilcox DT (2000) Application of the clinical polygraph examination to the assessment, treatment and monitoring of sex offenders. *J Sex Aggress* 5:134–152
- Wilcox DT (2002) *Polygraph examination of British sexual offenders: a pilot study on sexual history of disclosure testing: a portfolio of study, practice and research*. Thesis (Psych. D). University of Surrey
- Wilcox DT (2009) *The use of the polygraph in assessing, treating and supervising sex offenders: a practitioner's guide*. Wiley, Chichester
- Wilcox DT, Sosnowski DE (2005) Polygraph examination of British sexual offenders: a pilot study on sexual history disclosure testing. *J Sex Aggress* 11:3–23
- Wilcox D, Sosnowski D, Middleton D (1999) The use of the polygraph in the community supervision of sex offenders. *Probation J* 46:234–240

Part III

Ethical Issues in the Assessment, Treatment and Management of Violent Offenders and Sex Offenders in Clinical Settings



Ethical Issues Arising from the Prescription of Antipsychotic Medication in Clinical Forensic Settings

6

Harriet Hunt-Grubbe

6.1 Introduction

The physician must...have two special objects in view with regard to disease, namely, to do good or to do no harm. (Hippocratic Corpus, Epidemics, Book I, section XI)

The evolution of clinical psychiatry is a fascinating one. It is a journey that continues to develop, exploring new concepts and revisiting existing ones interchangeably. At its core lies a deep appreciation of humanity and for us to serve our profession well, this needs to remain central to how we practice. If, hidden amongst our other attributes, we lose our compassion, then we demean the very nature of what it is we strive to achieve. We lose sight of the human condition and we do our patients a grave disservice.

As clinicians we must ensure that our duty to our patients is respected and enforced. We should hold present in mind our ethical and moral duties at all times. The overriding principles of medical ethics are those of autonomy, beneficence (to seek to do good), non-maleficence (to do no harm) and a respect for justice. The issues however are complex and the principles are weighed against each other, seldom considered in isolation. As an example, the principle of non-maleficence goes hand in hand with the principle of beneficence. One is constantly balanced against the other, but because human communication is complex and context specific, balancing risk of harm against potential benefit will vary from person to person and sometimes for the same person at different times or in different circumstances. Such decision-making is further complicated by the fact that often the balance of risk and harm to an individual is only ultimately understood when viewed through a retrospective lens.

H. Hunt-Grubbe (✉)

Barnet Enfield and Haringey Mental Health Trust, London, England

e-mail: harriet.hunt-grubbe@nhs.net

© Springer Nature Switzerland AG 2020

A. Igoumenou (ed.), *Ethical Issues in Clinical Forensic Psychiatry*,
https://doi.org/10.1007/978-3-030-37301-6_6

99

If we take the principles of beneficence and non-maleficence and apply them to the practice of administering medication to patients detained against their will in secure settings, it becomes clear that the ethical dilemmas are manifold. As psychiatrists, and doctors foremost, we are in a unique position to try to ameliorate the psychological distress and suffering of those in our care. We have a number of tools at our disposal that can be employed to help treat our patients, the most potent of which in today's Western world is medication—specifically, antipsychotic medication.

Antipsychotic medication is a big player in the current climate. Prescription rates have never been higher and the toll of mental ill health never greater. The ethical principles that guide us in terms of delivery of care are central to the endeavour of prescribing treatment in the form of medication. We do this in an attempt to modify the behaviour of our patients, both in terms of ameliorating internal distress and reducing actual and potential violence. In so doing we may cause a direct risk to that patient's health.

We need to consider, therefore, with whom the responsibility lies in terms of judging the harm suffered. Equally important is determining to what extent a medication regime is deemed too risky. When, for example, is high-dose antipsychotic medication justified, and when is it malpractice? Being both mentally unwell and having committed harm to others in the wider community, our patients face significant social marginalisation. They are considered both as a risk to society and often as a risk to themselves. As forensic psychiatrists we need to be able to balance and weigh up the ethical obligations we have to the patients in our care and the ethical obligations we have to wider society in terms of management of risk. Never more apparent is this dual role than when prescribing and administering high doses of antipsychotic medication when consent to do so has been refused or revoked.

The advent of pharmacological agents designed with ever-increasing sophistication has led to increasingly optimistic predictions with regard to the alleviation of some of the distressing symptoms experienced by those suffering with severe and enduring mental illness. Whilst the expansion of the pharmacological industry offers cautious hope, it is countered with the knowledge that these medications carry a significant physical, psychological and societal burden. Ethical issues are inextricably linked to the act of prescribing antipsychotic medication, not least in terms of informed consent and capacity, but also in the face of wider societal constraints and financial ties to the pharmaceutical industry. The relationship with the industry is important to consider because it is unavoidable given the way in which research and development of new medications is carried out—the influence that the pharmaceutical industry has to potentially shape the science of psychopharmacology is great, and there is public feeling that financial ties, including recruitment incentives, serve to influence professional behaviour and thus medical care (Strous 2011). There are clear ethical problems when a treating psychiatrist accepts gifts from pharmaceutical companies, or agrees to use certain medications on the back of a financial incentive. It is likely that gifts given in the context of intensive advertising campaigns create an unconscious bias in that psychiatrist's prescribing practice. Insel states that the problem is greater in psychiatric practice than in medicine or surgery owing to the psychopharmacological focus of many pharmaceutical companies (Insel 2010).

Sales of antipsychotic medication in the Western world are huge, and they generate a large amount of income for the pharmaceutical companies. Some of this is in turn fed into further research and studies, so it is vital that prescribers are kept abreast of marketing practices and biases in therapeutic information (Strous 2011). The need to engage responsibly and ethically in the prescription and administration of these agents therefore remains of utmost importance.

6.2 The Rise of Antipsychotic Medication

Antipsychotic medication currently holds a central place in the treatment of many with psychiatric disorders and it at times tends to dominate much of what we do—certainly within secure settings where a major arm of the treatment arsenal comprises use of these agents. We can often find ourselves the deliverers of care by virtue of the drugs at our disposal—and this is where ethical mindfulness and sensitivity need to play a part in the decisions that we make.

Mental health care has historically made use of substances, both legal and illicit, with varying degrees of success. It was not however until the early 1950s that a French pharmaceutical company, investigating sedative drugs for use in surgery, discovered chlorpromazine. They found that it caused relaxation without significant drowsiness. The subsequent serendipitous discovery that chlorpromazine could also alleviate disordered thinking and behaviour was groundbreaking. It challenged the way in which mental illness was conceptualised and treated and in so doing gave psychiatric practice medical validity. Chlorpromazine paved the way for the search for other antipsychotic agents, and society became more aware about the use of antipsychotic medications and the way in which they worked.

The social impact of this was significant. Psychiatric symptoms started to be attributed to chemical imbalances rather than to any underlying psychological or emotional needs, which in part helped to reduce some of the stigma surrounding mental ill health. This was not merely a moral or spiritual affliction, a weakness of the mind—there had to be a neurobiological basis. This medicalisation of psychiatry served to swell the increase in the psychiatric drug market and fuelled research into the search for more potent pharmaceutical agents. This advancement in research helped to generate a better understanding of the pathophysiology of many mental processes. Although this understanding remains only partly understood, one thing became clear—antipsychotic medication was here to stay.

6.3 Use of High-Dose Antipsychotics and Polypharmacy in the Management of Severely Disturbed Offenders

We now prescribe antipsychotic medications to our patients with an awareness of the large evidence base that supports their use. We know that the medication can be used to good effect to reduce aggression arising from psychosis, but it is also used to try to reduce risk of future violence—something that can be very hard to

determine. Most of our patients have co-morbid psychiatric diagnoses—serious mental illness and personality disorders in combination, often compounded by longstanding substance misuse issues. This co-morbidity can help to explain why some are often slow to respond to treatment and frequently relapse. It also helps to explain why, in cases such as these, clinicians often resort to antipsychotic polypharmacy or high-dose antipsychotic monotherapy.

High-dose antipsychotic monotherapy arises when a clinician prescribes more than the recommended BNF (British National Formulary) maximum limit for one antipsychotic agent. Antipsychotic polypharmacy arises when two or more antipsychotic medications are prescribed to run concurrently. In the case of polypharmacy, the amount of medication can be determined by converting the dose of each antipsychotic medication into a percentage of the BNF maximum recommended dose for that medication and adding these together. A cumulative dose of more than 100% is deemed a high dose (College Report 2014). The reason that this is considered an issue is because at higher than recommended doses there are two major concerns—firstly, there is an increased chance that the risk–benefit ratio for the medication will be exceeded and that there will be harm caused to the patient, and secondly, the responsibility of any harm caused will be assumed by the prescriber and those that dispensed and administered it (the pharmacist and the nurse). So, is there an evidence base for going off the recommended prescribing piste, and if it is deemed a necessary route for treatment, what are the ethical considerations that need to be held in mind?

From a pharmacological perspective, there are two main reasons why higher doses of antipsychotics might be theoretically justified in some cases. The first reason is that individual patient differences in pharmacokinetics (how the body affects the medication) may lead to insufficient antipsychotic medication reaching the effect site. The second reason is that some patients have differences in their pharmacodynamics (how the medication affects the body), which might mean that higher doses of antipsychotic medication are required (College Report 2014).

We know that if psychosis is left untreated, or insufficiently treated, behaviours that manifest can be impulsive and aggressive, and these risk harm both to the patient and to others. We also know that patients can continue to behave in ways that are violent and impulsive even when the psychosis is under control. Most violence in forensic settings tends to be impulsive, and this can be mediated by antipsychotic medication (Warburton 2014). The impulsivity may arise from the psychosis itself, or may be separate to it. With the aid of neuroimaging, it has been demonstrated that at least 60% of the dopamine (D2) receptors need to be blocked by the antipsychotic medication in order for a reduction in the psychosis to be seen. At beyond 80% blockade the beneficial effect is less evident, and there is an increased (and often substantial) side effect burden. Interestingly, there is increasing evidence that in some patients with schizophrenia, symptoms do not seem to be driven through dysfunction of dopamine pathways, which would make increasing the dopamine blockade in such patients clearly futile (Taylor et al. 2015).

Not unsurprisingly, there is little evidence base to support the use of high-dose antipsychotic monotherapy or antipsychotic polypharmacy specifically to reduce

violence in the medium to long term (Goedhard et al. 2006). There is some evidence that suggests an association between prescriptions of higher antipsychotic dosage in patients who have a history of violence and who have also engaged in recent violent behaviour. Wilkie et al. found that patients with a history of aggression had a nine and a half times higher chance of being prescribed higher doses of antipsychotic medication, as did those patients who had a greater than 5-year history of antipsychotic medication prescription. Their conclusions surmised that the high-dose antipsychotic prescription related more to patients' past reputation of aggression and to prescriber differences, than to patients' current behaviour (Wilkie et al. 2001).

The current Maudsley Prescribing Guidelines reports that there is no firm evidence that high doses of antipsychotics are any more effective than standard doses. They note that in the UK, the vast majority of high-dose antipsychotic prescribing is through the cumulative effect of polypharmacy (Taylor et al. 2015). The guidelines recommend that the use of high-dose antipsychotics be an exceptional clinical practice (that is, not the norm) and that it should only ever be employed when an adequate trial of standard antipsychotic treatments, including clozapine, have failed. The main clinical rationale for prescribing combined antipsychotics is to improve residual psychotic symptoms. The guidelines however state that there is no good objective evidence that combined antipsychotics (that do not include clozapine) offer any efficacy advantage over the use of a single antipsychotic (Taylor et al. 2015).

The limited evidence base is likely a consequence of the fact that those patients requiring and receiving high dose antipsychotic medication are too unwell to take part in any clinical studies. Managing longer-term aggression and challenging behaviour is particularly complex given the multifactorial nature of the psychopathology in many cases (such as childhood conduct problems, victimisation history, social living situation and substance misuse) (Swanson et al. 2008).

As many as 30% of psychiatric patients receive antipsychotic polypharmacy at any one time (Längle et al. 2012). Current guidelines recommend that at least two trials of monotherapy be attempted, followed by a trial of clozapine prior to consideration of polypharmacy. If, as in some cases, polypharmacy is introduced as the rule and not the exception, what we see is an increase in side effect burden. High-dose antipsychotic treatment clearly worsens adverse side effect incidence and severity. The side effects of these medications are horrible and can become life-threatening. The evidence that these medications can cause harm is compelling. There are a number of published reports of clinically significant side effects such as an increased prevalence of extrapyramidal side effects, increased metabolic side effects, sexual dysfunction, increased risk of hip fracture, paralytic ileus, grand mal seizures, prolonged QTc and arrhythmias associated with antipsychotic polypharmacy (Taylor et al. 2015). This knowledge carries with it its own ethical bind. Medications used to help combat these side effects can themselves impact negatively, with anticholinergics (commonly used to help manage extrapyramidal side effects) causing, amongst other complaints, cognitive impairment. So the antipsychotic medication used to help moderate the behaviour carries risk to the patient, as does the medication used to counter this risk. What results is a constant, circular risk-benefit analysis.

What is it then that leads to high antipsychotic prescribing in the forensic population? There is often the assumption that it is a lack of response to lower doses and that the high doses are warranted in attempts to reduce the threat of future violent behaviour. Often these patients are deemed treatment resistant and their insight remains limited. In these cases, it is common for the medication to continue unabated. There is also the pressure to provide pharmacological treatment for those who are behaviourally challenging to manage, even when there is no strong evidence base to support the use of antipsychotic medication in the treatment regimen. The question to be asked therefore is what is it that we are treating—aggression predicated on historic risk, current risk or future risk? For many, it is treatment for all of the above, and sustained high-dose medication appears to be the answer.

6.4 What Ethical Issues Are Raised by the Use of High-Dose Antipsychotic Medication?

So how do we engage ethically in this psychopharmacological arena? The power that lies in the clinicians' hands is remarkable, particularly given the ability that these medications have to alter mental state and behaviour. It is clear that the ethical code underpinning this power is critical. It is no less important to understand how dopamine blockade alters the neurotransmitter balance than it is to obtain well thought through informed consent for the administration of the proposed antipsychotic medication. It has long been observed that injuries to patients may be caused by overmedication by doctors. Sometimes the disease process itself masks these injuries, and at other times they are attributed to side effects.

So, with this in mind, are we able to justify prescribing high doses of medications that we know have the ability to cause harm? If we are able to achieve a desirable outcome, by which I mean a reduction in the violent behaviour and a quietening of the patient's internal distress, then it could be argued that the treatment is justified because it is necessary (both in terms of the best interests of the patient and also in terms of reduction in risk of harm to others). However, an important question remains—is it morally right to achieve this outcome in the first place, and if it is, is it ethically acceptable to do so in this way? This is particularly relevant to ask in those that are behaviourally very challenging (for example, as a result of maladaptive personality traits) rather than those who are immediately challenging as a result of their (treatable) psychosis. The point here is that in those without clear evidence of an underlying psychotic process driving the behaviour, there is little scientific understanding of how the chemical action of the antipsychotic medication helps to moderate the behaviour. What we do know from clinical experience is that it can, and often does, help. But this is a controversial area and one that causes heated debate. It also stands to reason that in treating patients who present with challenging behaviour, outside the realm of psychosis, we are merely muting the behaviour and not treating the cause. This may be why we see long-stay forensic patients, in whom the psychosis has remitted but the challenging behaviour remains, on long-term maintenance therapy with antipsychotic medication. There

is an argument to suggest that in treating the behaviour, the patient is better able to develop their life in ways that increase their chance of discharge from hospital. There is a significant positive social impact too for reducing the level of aggression and violence that supports the rationale for prescribing high doses of antipsychotic medication, although this needs to be weighed up against the side effect burden that often ensues.

What I am saying therefore is that even if the antipsychotic medication, given against the patient's consent, causes them harm, the treatment itself may be comparatively less damaging to the patient than leaving the behaviour (whatever the underlying psychiatric cause may be) unchecked. What then arises, is deliberation about to whom the treatment is intended to benefit—society or the patients themselves? In the forensic arena, it is, more often than not, the potential risk to others that trumps any intended benefit to the patient.

Is the use of high-dose antipsychotic medication then a reasonable approach in terms of managing our patients? Does it deal merely with the expression of the aggressive behaviour? If this is the case, then it can only be ethically acceptable if it is not possible to treat the core problem from which the behaviour stems.

But we know that the side effect burden is significant when these medications are prescribed at high doses. Extrapyramidal side effects induced by antipsychotics are of significant clinical importance, not least because they have been shown to affect patients' quality of life negatively but also because they result in further stigmatisation. It is well documented that these effects reduce antipsychotic medication concordance because of this stigma, but also because of how unpleasant the side effects are for the patient. Extrapyramidal side effects can make people feel dysphoric, apathetic, emotionally withdrawn and cognitively slowed (Tandon and Jibson 2002). Other symptoms include akathisia (feelings of restlessness, inner tension and mental unease), which can be particularly unpleasant. Some studies have found that there is additionally a greater likelihood of suicidal ideation in those affected with akathisia (Seemüller et al. 2012).

With the prescription of antipsychotic medication comes an increased risk of cardiac arrhythmias and sudden death. These risks are heightened with higher doses and autonomic arousal, and also in some patient groups (for example, women, those with cardiovascular or liver disease and those also taking other drugs with cardiac effects or risky pharmacokinetic interactions (College Report 2014)). There is also evidence from two meta-analyses that reveal the higher the antipsychotic dose, the greater the effect on cognition, which gives direct support for the view that high antipsychotic dosage is detrimental to cognitive function. We know that anticholinergic agents might be required to treat the side effects, and so the detrimental effect on cognition is intensified (College Report 2014). The impact of being on high-dose antipsychotic medication is difficult to avoid, and this naturally has a detrimental effect on issues such as medication concordance.

The principle of non-maleficence is an important injunction against overtreatment, but in reality it is the *weighing up* of beneficence and non-maleficence that determines much of clinical care. Our decision-making therefore needs to be constantly considered within the context of a harm–benefit analysis (Sokol 2013).

Given that the perception of what constitutes a harm and a benefit varies on an individual basis, the principles of non-maleficence and beneficence may best be considered in light of respect for autonomy, one of the four guiding principles of medical ethics. I will explore this a little further, below.

6.5 Considering Ethics as Principlism

Some may question the need to use an ethical framework, but it makes sense to do so in order to help set our own personal codes of moral reasoning aside. They form the basis for expected standards of behaviour. What I may view as right and wrong is relative to another person's view of right and wrong. Our moral codes will likely differ, and it is the use of an ethical framework that enables clinicians to acknowledge the importance of our patients' values and principles. An ethical framework can therefore allow us to appreciate another's values, even if set apart from our own beliefs and moral code (McKinnon 2007).

The four principles plus scope approach to ethical dilemmas offers a culturally neutral and accessible framework (Beauchamp and Childress 2001), and it may be used here to aid thinking about some of the issues that face forensic clinicians when decisions about treatment regimens are being debated. The four principles comprise autonomy, beneficence, non-maleficence and respect for justice. None are seen necessarily in isolation, and conflict commonly arises between them, which allows room for ethical debate as dilemmas arise on a frequent basis.

6.5.1 Autonomy

In Kant's view, patients act with autonomy when they move towards aims and objectives over which they have ownership. This relates to prescribing practice when the patient is able to consider the medication and decide whether they consent to it or refuse it. It also applies to questioning the judgement of the clinician and querying the diagnosis. The degree to which patients in these settings can consent is however a matter for debate. Does consent to medication at times morph into assent? Knowing that an increase in leave (and hence possible increased liberty) is linked closely to your medication concordance is likely to sway your decision to agree to take the medication. Similarly, if you know that your refusal to take oral medication will result in it being forced upon you in injectable form, then you may end up agreeing to take it.

The fact that situations like these arise is due in large part to the nature of the setting. As all forensic patients are detained, legal coercion becomes part of the landscape. The forensic patient finds that their autonomous right to choose between refusing and accepting medication is limited by the treating clinician and team. If the clinician is of the view that the treatment is deemed necessary for the patient's welfare, then it will be enforced, irrespective of the patient's viewpoint. Because the

welfare of others, and society at large, needs also to be born in mind at all times, it is easy to see how further restrictions on one's autonomy can arise. You can see how easy it is for abuses of power to creep in. It is often third parties that influence and determine decisions about treatment and discharge of the forensic patient, and as a consequence, the views of the forensic patient regarding their treatment often bear less weight. Their autonomy is therefore limited.

With respect to autonomy, it could be argued that treatment methods that avoid the use of antipsychotic prescribing altogether may be preferable, for example, individually tailored psychological intervention, or occupational therapy. This avoids much of the ethical dilemma, but if the behaviour is so challenging that engagement with the therapist is futile, then we are again back at the starting blocks. There is no doubt that individual autonomy holds great weight in today's Western society. There is little that challenges the perception that personal success (and therefore power) is of paramount importance. It is interesting to consider however that this perception lies in stark contrast to the way in which non-Western societies operate, where well-being is measured as a collective. In these cultures, the ability of a community to support the health and wealth of its members is seen as its greatest strength. Individualism, and therefore autonomy, has much less importance. The strength in these cultures is in the collective.

6.5.2 Beneficence

This demands that as clinicians we act in a manner to 'seek to do good' to our patients. It is the very meaning of clinical benefit. It can however be difficult to ascertain what beneficence really entails. On the one hand it could be about making the patient feel better on an emotional level, and on the other hand, it could be about making that same patient behave better (often with the aid of medication). And if behaving better is a benefit of treatment, then does this contradict the notion of moral neutrality in medicine, that is, ensuring that we do not impose our own moral values and codes on to anyone else? This ethical dilemma is in turn weighed against the duties that the clinician has to the local community and to wider society. There is the potential here for this to become an ethical minefield.

One important aspect of beneficence is to seek the patient's willingness to accept treatment. Sen et al. have suggested that seeking consent prior to any coercive or enforced medication measure is taken, could be perceived as showing appropriate ethical concern for the patient's beneficence (Sen et al. 2007). The clinical reality however may be somewhat removed from this notion.

In recent years there has been a shift in psychiatry and medicine, away from beneficence and towards autonomy. The shift is towards honesty and authenticity, at the cost of causing potential distress to the patient. Where a clinician may once have withheld some of the truth regarding diagnosis to their patient, believing that it would cause too much distress, the thinking now is that the patient must take the lead in managing their illness, assuming they have the capacity to do so.

6.5.3 Non-maleficence

The use of sedating and powerful medication raises concerns with respect to risk of harm to patients. It is also not clear who should judge the harm suffered. It may be argued that there is merit in short-term breaches of this principle, on the grounds that the longer-term benefits outweigh the short-term distress. It is not always clear however if the harm done to the patient is always in their best interests—at times it is clearly done to meet the needs of the others (for example, the sedative effects of high-dose antipsychotic medication yields the patient less aggressive and therefore the risk of harm to others is reduced). It may also be argued that the loss of physical autonomy that the medication causes is harmful to the patient. What about medication prescribed for the prevention of violence that may happen but has not yet. Is that justified? Can that be construed as doing patients both a wrong and a harm?

6.5.4 Respect for Justice

We are required to treat people in similar ways. However, forensic patients are vulnerable to exploitation and injustice. Political pressure can be exerted in all manner of ways, particularly if the case has a significant media interest. We need to be confident as clinicians that in prescribing these medications, we are acting honestly and fairly, particularly if the medication is strongly opposed by the person receiving it. It is a matter of respect for our patients. It is about keeping in mind respect for their humanity.

6.5.5 Scope of Application of the Principles

The scope of the application relates to the duties of forensic psychiatrists and to third parties and is always a difficult tightrope to walk. The balance is more often than not shifted towards the protection of others.

6.6 Issues with Principlism

Sen et al. have argued that in cases of conflict between different principles, the principle of justice should be given greater credence (Sen et al. 2007). But do we need to consider a moral emphasis? Should we consider, rather, a different approach—one such as the World Medical Association? This method encourages the analysis of rational versus non-rational approaches to ethical decision-making. Rational approaches engage concepts of deontology, utilitarianism, principlism and virtue, whereas non-rational approaches comprise obedience, imitation, feeling or desire, intuition and habit (Williams 2005). There is a case to be made that adopting the principlism approach does not often sit comfortably with forensic psychiatry,

namely, because the principles often lie in conflict with each other but also because there are invariably issues relating to third parties that are not covered by the four principles. Lastly as others have pointed out, in forensic psychiatry there is a need to pay special attention to the principle of justice.

6.7 Informed Consent, Capacity and the Forensic Arena

A competent adult has the right to refuse treatment, even if that refusal of treatment may adversely affect them. It follows therefore that if the patient has capacity, their decision must be respected irrespective of how wise or unwise that decision may be. Lack of capacity may be temporary or it may endure over long periods of time. It may also fluctuate and thus vary. It is the dynamic and situation-specific nature of capacity that can render decision-making difficult. If someone is found lacking capacity, any subsequent decision made regarding their treatment must demonstrate that it was done so in the patient's best interests. It is also important that the methods chosen to deliver the treatment (for example antipsychotic medication) are administered in the least restrictive fashion.

The law dictates that there is a legal duty to obtain informed consent prior to starting treatment. In forensic settings there is a constant tension between care and control and between concepts of capacity and consent. The ethical importance of informed consent is that it is itself key to respecting patient autonomy. The two are inextricably linked together. It is important here to remind ourselves that the essence of autonomy lies with its roots in Kantian reasoning—where the links between autonomy and respect for persons are well established. Put simply, autonomy reflects respect for the person, which is a fundamental principle in the practices of psychiatry.

The legal and ethical foundations of health care are founded on the premise of informed consent, which itself centres on the therapeutic relationship between treating clinician and their patient. It is this patient–doctor relationship that influences the norms of informed consent and it is within the context of this relationship that treatment decisions are made. One of the key elements involved in the process of informed consent comprises information sharing that is accurate and balanced, to include the risks and benefits of not only the proposed treatment but also of the risks and benefits of having no treatment at all. This sharing of information also needs to be sensitive to the values held by the patient, as much as is possible.

Another key element that needs to be held in mind is the assessment of the patient's decision-making capability and, specifically, the ability of the patient to come to an informed, non-coerced decision. It is the remit of the clinician to undertake a clinical judgement of capacity, and this requires careful exploration of a number of factors. These include the ability of the patient to communicate their preferences, to understand and retain the information presented to them, to think through the available choices in a rational manner and to appreciate the nature of the illness and associated recommended treatment in the context of their own life and belief system. This last factor is particularly important, not least because if the

assessment of capacity does not pay consideration to the patient's ability to act in line with an authentic sense of what is right for them, then the resultant consent cannot be considered to be voluntary.

It is interesting to consider the nature of what voluntary cooperation actually comprises. There is in fact a continuum of which numerous shades of voluntarism can be appreciated, such as: active cooperation, passive cooperation, ambivalence, silent objection, irrational opposition and rational refusal. A patient may move along this continuum in either direction during the course of their illness and in the process choose to accept some treatments but not others (Cahn 1982).

In the forensic arena we struggle to obtain voluntarism with respect to informed consent. As adults we are entitled to accept or reject health care interventions on the basis of our own personal values and goals. However, this is not true for those detained against their will. Compare, for example, the psychotic patient in a secure hospital who is quite clearly less able to offer an un-coerced decision than a psychotic patient considering treatment in a community care setting, who can make such a decision. It is evident that it is the context of the situation that either supports or undermines the ability of the patient to come to a truly autonomous decision. Despite the restrictions placed on autonomy, optimal conditions for obtaining informed consent should include an informed psychiatrist, a non-technical presentation, patient familiarity, involvement of other potential informants, information repetition and attempts to ensure that the patient is as free as possible to make the choice without any unreasonable pressure. It is recommended that providing aids to those who may have cognitive impairments should also enhance the process (Applebaum 2007).

Even those that regain the capacity to consent (for example, following the remission of a psychotic episode) find that their capacity to do so is compromised by virtue of the fact that they are unable to refuse the treatment even if they wanted to. As such therefore, although optimal informed consent is considered best practice when consenting a patient to antipsychotic treatment, the process of doing so in a forensic patient is less than perfect. It would appear that the idea of using informed consent to provide assurance that the patient has neither been deceived nor coerced is something that can only really be fully appreciated outside the realm of forensic psychiatry in secure hospital settings.

The legal assumption that patients require capacity in order to be autonomous creates difficulty, not least because many forensic patients are not capacitous for long periods of time. Consider also the fact that for those non-capacitous patients, it is the mental health professionals who become the agents of control (Sen et al. 2007). This does not sit easily with most clinicians. It is further fraught with unease when the primary therapeutic relationship that the forensic patient has is with those that are responsible for the forcible administration of medication. And with the risk associated with enforced medication, the more rigorous the informed consent needs to be. Due to the impact of psychiatric disorders on cognitive functioning, there is, and arguably ought to be, a high degree of scrutiny about issues of capacity to consent to treatment, particularly if the treatment is deemed risky (Carrier et al. 2017).

The refusal to consent (albeit in a compromised manner) to antipsychotic medication whilst detained under mental health law is a common ethical tension that is

played out in forensic settings frequently. To prescribe medication in these situations, the clinician must have confidence that it will be of potential benefit to the individual receiving it. We need to ensure therefore that we have a sound knowledge of the evidence base that supports it and keep the intention of ameliorating the mental illness and contingent behaviours upmost. The ethical principles that guide us help to maintain professional integrity, but in addition to these principles, we might also consider acting in a manner that allows sensitive recognition of what that patient and their family want and then to act sensitively, both admitting and addressing our limits wherever possible (Levine and Bleakley 2012).

We need to ask ourselves whether, in enforcing the medication, we are violating our ethical principles. How do we weigh up our duty to our patient and our duty to the public? Given the arena that we work in, it is our duty to the public (and to third parties) that tends to be more heavily weighted in the decision-making process. We are duty bound to be mindful of our societal contract with the community in terms of attempting to understand, assess and modify risky behaviour in mentally unwell offenders. The use of antipsychotic medication is more often than not central to this endeavour, but we must not lose sight of those we are trying to help whilst also balancing our duty to society. Throughout history we have seen abuses of the privileged clinician–patient relationship and how easy it is for psychopharmacological agents to be harnessed by those in positions of influence to be used as a means by which to advance their own political agendas.

6.8 Conclusion

It is important that as psychiatrists we acknowledge the complexities of human nature and the manifold ways in which mental illness can present. It is equally important to appreciate and make use of the great advances that we have witnessed in recent years with regard to neurobiological understanding of many of these mental processes. As our understanding of mental illness has grown, the development of increasingly sophisticated antipsychotic medication has too. And yet it also remains necessary to acknowledge the limits of our psychiatric understanding.

The use of high-dose antipsychotic treatment regimens tends to be restricted to hospital inpatient units. We know that in not treating the symptoms of mental illness, especially when they are severe and interfere with healthy development and sustenance of emotionally important relationships, there is the potential to be devastating consequences. But, perhaps in light of growing public awareness about mental ill health, there is also a trend for antipsychotic medication to be used as a means by which to manage emotional and behavioural problems in challenging patients outside of hospital too. The use of antipsychotic medication in this way raises the question of whether the idea of drug treatment for behavioural problems is a morally acceptable one. These medications have an important and often necessary role, but there are both ethical and very real dangers associated with these medications, not least those that are prescribed in high doses and in combination.

Michel has argued that the sustained drive to seek out psychopharmacological solutions for the problems of human living constitutes an exemplification of biological reductionism. Although some may disagree with this viewpoint, it is an insight that warrants taking time to pause and reflect (Michel 2011).

With this in mind, at what point do we need to consider issues relating to personhood? What is it to have a meaningful life, alongside its responsibilities and imperfections? Who is it that determines which is held greater—one's dignity and sense of self, or one's improved function and productivity resulting from administration of medication? Some patients feel that treatment with antipsychotic medication has caused their participation in life itself to be deadened and report that their ability to engage with others has become so limited by their pathology that life itself is devoid of meaning. These are treatment decisions that require of the forensic psychiatrist a close and thoughtful ethical analysis at every turn.

It is worth here considering the views of those that oppose the use of antipsychotic medications. There has long been debate about whether these medications are used as chemical alternatives to the straight jacket. The idea that the prescription and administration of antipsychotic medication leads to covert social control encouraged the swelling of the antipsychiatry movement in the 1960s and 1970s. As a consequence, the psychiatric profession reacted by strengthening its medical and scientific credentials, and the idea of the specificity of drug treatment became a central part of that endeavour (Moncrieff 2008). Does psychiatry therefore operate as a covert measure of social control? It is not a question that is to be considered here, but it is not hard to see that as forensic psychiatrists one of the main treatment goals is to achieve behaviour that allows our patients to attain conformity with the law. Many patients however demonstrate behaviours that do not change, despite symptom alleviation, which creates further tension when society has come to expect that the outcome of treatment results in a safer place for all.

Forensic psychiatrists are called upon to practice in a manner that balances competing duties to the individual patient and to wider society. In doing so, we need to be bound by underlying sound ethical principles. We know that informed consent is fundamental to ethical practice because it is the mechanism by which patients autonomously authorise medical interventions. It is this autonomy that allows the patient control over their medical destiny—except that in forensic mental health settings that autonomy is undermined by the nature of the law that detains them. Those detained under mental health law do not have the right to refuse antipsychotic medication if it is deemed by the treating team to be necessary to manage their illness and consequent risks, and thus their autonomous right is undermined by the very legislation that keeps them in hospital.

There is a duty on us to maintain our ethical principles and hold them in mind at all times, not least because this dual relationship to patient and to society can be fraught with challenges. Take, for example, the tendency to prescribe antipsychotic medications to patients based on their previous history of risk alone. This is done in order to reduce the risk of future, potential violence to others. In terms of our ethical commitment to do no harm, can this be justified? Because our patients are guilty of

violent crime, are they less able to claim moral or legal protection? On the other hand, if this patient was undertreated and they committed a violent act against another person, could that less than optimal treatment be justified in the knowledge that they had a history of acting in a violent manner? In a world where the tendency to pathologise and codify human behaviour is becoming increasingly common, it is apparent that the need to adhere to strict ethical code in our daily practice is of the utmost importance.

References

- Applebaum PS (2007) Clinical practice. Assessment of patients' competence to consent to treatment. *N Engl J Med* 357:1834–1840
- Beauchamp TL, Childress JF (2001) *Principles biomedical ethics*, 5th edn. Oxford University Press, Oxford
- Cahn C (1982) The ethics of involuntary treatment: the position of the Canadian psychiatric association. *Can J Psychiatry* 27:67–74. Available from <http://journals.sagepub.com/doi/abs/10.1177/070674378202700113?journalCode=cpab>
- Carrier F, Banayan D, Boley R, Karnik N (2017) Ethical challenges in developing drugs for psychiatric disorders. *Prog Neurobiol* 152:58–69. <https://doi.org/10.1016/j.pneurobio.2017.03.002>
- College Report (2014) CR190. Consensus statement on high-dose antipsychotic medication. Available from <https://www.rcpsych.ac.uk/usefulresources/publications/collegereports/cr/cr190.aspx>
- Goedhard LE, Stolker JJ, Heerink ER, Nijman HL, Olivier B, Egberts TC (2006) Pharmacotherapy for the treatment of aggressive behaviour in general adult psychiatry: a systematic review. *J Clin Psychiatry* 67(7):1013–1024
- Insel T (2010) Psychiatrists' relationships with pharmaceutical companies: part of the problem or part of the solution? *JAMA* 303:1192–1193
- Längle G, Steinert T, Weisner P, Schepp W, Jaeger S, Pfiffner C, Frasch K, Eschweiler GW, Messer T, Croissant D, Becker T, Kilian R (2012) Effects of polypharmacy on outcome in patients with schizophrenia in routine psychiatric treatment. *Acta Psychiatr Scand* 125(5):372–381. <https://doi.org/10.1111/j.1600-0447.2012.01835.x>
- Levine DF, Bleakley A (2012) Maximising medicine through aphorisms. *Med Educ* 43:156–162
- McKinnon J (ed) (2007) *Towards prescribing practice*. John Wiley & Sons Ltd., New York, NY
- Michel A (2011) Psychiatry after virtue: a modern practice in ruins. *J Med Philos* 36(2):170–186
- Moncrieff J (2008) *The myth of the chemical cure: a critique of psychiatric drug treatment*. Palgrave Macmillan, Basingstoke
- Seemüller F, Schennach R, Mayr A, Musil R, Jäger M, Maier W, Klingenberg S, Heuser I, Klosterkötter J, Gastpar M, Schmitt A, Schlösser R, Schneider F, Ohmann C, Lewitzka U, Gaebel W, Möller HJ, Riedel M, German Study Group on First-Episode Schizophrenia (2012) Akathisia and suicidal ideation in first-episode schizophrenia. *J Clin Psychopharmacol* 32(5):694–698
- Sen P, Gordon H, Adshead G, Irons A (2007) Ethical dilemmas in forensic psychiatry: two illustrative cases. *J Med Ethics* 33(6):337–341
- Sokol DK (2013) “First do no harm” revisited. *BMJ* 347:f6426. <https://doi.org/10.1136/bmj.f6426>
- Strous RD (2011) Ethical considerations in clinical training, care and research in psychopharmacology. *Int J Psychopharmacol* 14(3):413–424. <https://doi.org/10.1017/S1461145710001112>
- Swanson JW, Swartz MS, Van Dorn RA, Volavka J, Monahan J, Stroup TS, McEvoy JP, Wagner HR, Elbogen EB, Lieberman JA, CATIE Investigators (2008) Comparison of antipsychotic medication effects on reducing violence in people with schizophrenia. *Br J Psychiatry* 193(1):37–43. <https://doi.org/10.1192/bjp.bp.107.042630>

- Tandon R, Jibson MD (2002) Extrapyramidal side effects of antipsychotic treatment: scope of problem and impact on outcome. *Ann Clin Psychiatry* 14:123–129
- Taylor DM, Paton C, Kapur S (2015) *Maudsley prescribing guidelines*, 12th edn. Wiley-Blackwell, Hoboken, NJ. ISBN: 978-1-118-75460-3
- Warburton K (2014) The new mission of forensic mental health systems: managing violence as a medical syndrome in an environment that balances treatment and safety. *CNS Spectr* 19(5):368–373
- Wilkie A, Preston N, Wesby R (2001) High dose neuroleptics – who gives them and why? *Psychiatrist* 25:179–183
- Williams JR (ed) (2005) *WMA medical ethics manual*. The World Medical Association, Ferney-Voltaire



The Many Faces of Surveillance: Ethical Considerations That Encompass the Use of Electronic Monitoring in Criminal and Clinical Populations

Harriet Hunt-Grubbe

7.1 Introduction

It is said that no one truly knows a nation until one has been inside its jails. A nation should not be judged by how it treats its highest citizens, but its lowest ones (Nelson Mandela)

The emergence in recent years of *technocorrections*—the melding of information technologies with the management of offenders—has offered a new perspective with regard to the supervision and risk management of offenders in the community. Ethical issues arising from the application of this technology, in particular the use of electronic monitoring via global positioning systems (GPS) are far-reaching and should alert us to the impact that endeavours such as these can have on society as a whole. The extension of electronic monitoring into clinical settings as a means of surveillance (specifically for those living with cognitive impairment and those in forensic populations) is a further reason to pause and reflect. In an area such as forensics, where the intersection between one's ethical duty to our patients and our duty to wider society can feel blurred, it is important to take the time to fully consider the implications that these technologies may have when meted out by clinicians and not law enforcement.

Beattie astutely observes that the forms of punishment employed by a society at any one moment are shaped by a variety of interests and intentions, which are more often than not conflicting. These include the framework of the law, what seems necessary in light of the apparent problem of crime, the technology available and what society finds acceptable and able to pay for (Beattie 1986). The fact that penal codes evolve within a large social and cultural context also helps to explain why

H. Hunt-Grubbe (✉)
Barnet Enfield and Haringey Mental Health Trust, London, England
e-mail: harriet.hunt-grubbe@nhs.net

methods of punishment change over time and why varying methods of enforcing the law are chosen at different times. One such method that has entered the public arena is electronic monitoring, or tagging, in the large part because of improvements in information processing, afforded by a vast expansion in technological infrastructure over recent years.

Electronic monitoring was first proposed in the USA in the 1960s. Ralph and Robert Kirkland Schwitzgebel (later known as Gabel) came up with the idea when both were graduate students at Harvard University. As psychologists, their idea was rooted in behavioural psychology and in their desire to apply operant conditioning to human social problems. The original concept focussed on a *walkie talkie* type transmitter system (using old military equipment) that could be designed to track young offenders as they moved around a city. Their thinking was that the young offenders would be rewarded for attending designated places at the right time (e.g. probation, education, home). The concept was, in fact, aimed at modifying behaviour via positive reinforcement. Owing in part to the political and economic climate at the time, the idea was not embraced with any vigour. It was indeed many years before electronic monitoring (in a more refined form) was adopted by the legal system, and when that occurred, it rapidly became used as a legal sanction—the psychological origin of the design being all but completely obscured.

Using electronic monitoring as a way by which to enhance our ability to survey others naturally raises concerns about what use the information gathered by it is put to. It follows too to question whether the technology is being utilised as a means of social control. And if it is, is there a way to moderate its deployment and ensure that it is not subject to misuse? After all, this is technology that now enables an individual's movements to be tracked and crime mapped using web-based data integration and in so doing provides a sophisticated level of information about one's location and movements. There is certainly an appetite to enforce a degree of surveillance upon those who have transgressed the societal rules that govern us and keep us safe, but what must be debated is the manner in which we do so, and discussion should ensue to ensure that we do not sleepwalk into something that is bigger than we are. In a climate where there appears to be almost constant moral panic about predators wandering our streets, does the use of technology in the form of technocorrections do us more harm, on a societal level, than good?

A case from the USA that neatly illustrates this point is that of the supervised release of business executive Martha Stewart from Alderson Federal Prison Camp in March 2005. Her release on tag brought unparalleled attention to the use of electronic monitoring. The use of electronic monitoring for Martha Stewart—someone who presented negligible risk of violence to the public and who did not require facilitation in reintegrating into her local community—was more about ensuring that she was appropriately punished by society for her crime. In this way, the monitoring served as a 'socially expedient intermediate sanction that was more punitive than traditional probation, but less harsh than incarceration' (Gable and Gable 2005). Electronic monitoring has found itself used globally now as a measure for control and punishment. Use of the technology in this way seems far removed from

the original premise of the device, where it was envisaged as a means by which to help offenders gain socially valued skills and enhance their self-esteem.

One of the many questions to consider is how to engage with this technology in a manner that serves as a positive experience both to the offender, or patient, and to the observer (be it probation officer, clinician or wider society). If the primary driver for the use of electronic monitoring is one of rehabilitation and restoration, then there surely is a strong ethical case to be made. A key reason to use this technology is to ensure that public safety remains a priority, but can this be achieved alongside positive reinforcement strategies for those subject to wearing it? The alternative vision where electronic monitoring is used purely as a punitive driver, and where it succeeds in replacing rehabilitation, and thus interpersonal contact, is far worse.

Placing the focus of the use of electronic monitoring on enhancing rehabilitative potential (as is the premise within those clinical fields that already adopt this technology) seems like a good place to start. This differs from the use of electronic monitoring in the criminal justice system where it is used as an alternative to custody, with an emphasis on its ability to act as a deterrent to further criminal activity rather than on rehabilitation—although it is acknowledged that in recent years there is an increased awareness of this and a consequent shift away from sole punitive use. There are of course countless ethical issues that arise and which need to be kept in mind. In order to attempt to address these, it is important to consider in more detail the evolution of this technology and its current widespread use within the criminal justice system.

7.2 Recent History and the Rise in Use of Surveillance in Criminal Justice Settings

The use of the technology has evolved over time. The original design patented by Ralph Schwitzgebel and William Hurd in 1964 comprised a radio-frequency transmitter/receiver system. The transceiver was strapped to a subject's body. When the transceiver activated the repeater station, a light on the map at the base station lit up, identifying the location of the device. Robert Schwitzgebel a few years later modified his twin brother's design and created a device capable of sending tactile signals and permitting two-way coded communication (Gable and Gable 2005). Although clearly ahead of their time, the brothers' design and hopes for a behaviourally mediated intervention to help manage those offenders in the community was largely ignored. The issue with their radio-frequency devices was in part the prohibitive expense, but also the primitive nature of the electronics (although appropriate for that time) and bulky design. This resulted in the devices being viewed as impractical, and by in large, the idea was abandoned.

It was not until 1977, again in the USA, that electronic monitoring was reconsidered with any real vigour. Jack Love, a state district judge in New Mexico, made a link between the use of electronic identification tags implanted under the skin of livestock, and an identification bracelet that tracked movement (which he had seen portrayed in a Spiderman cartoon). Thinking that the two could be combined to aid

his sentencing options, Judge Love subsequently persuaded a technician to construct a device that could be attached to the ankle. By 1983 the ankle device was operational, and three offenders were subsequently sentenced to wear it as a condition of their probation period (Gable 2007). The success of this spawned hundreds of further monitoring units in the USA. By 2007 an estimated 110,000–120,000 monitoring units were being deployed on a daily basis (Gable 2007).

Europe was not to miss out on this technological development, and in 1981 Tom Stacey, a British writer and penologist, was also instrumental in highlighting the advantages of remotely monitoring offenders by way of a tag. Having been incarcerated himself he was deeply opposed to the idea of prison, and the concept of tagging was touted as being the ‘ultimate community penalty’ (Nellis 2006). This was embraced by the government at the time and subsequently, not without resistance, adopted by the probation services. Figures in England and Wales reveal that about 20% of 50,000 offenders who started pre- or post-release supervision in 2004 were being subjected to electronic monitoring in 2005 (Gable and Gable 2005). By 2010–2011 more than 80,000 tagging orders were made as both community penalty orders and home detention curfews (Tully et al. 2014).

There are a number of reasons that may explain the rapid expansion in the use of electronic monitoring as a means of remote supervision by probation services. The first was the introduction in the 1980s of tougher sentencing laws, which meant that many more people were being incarcerated and often for lower-level crimes (such as drug) offences. This led, unsurprisingly, to serious issues with overcrowding in prisons. The harsher sentencing laws coincided with expansion of information processing and the technological infrastructure that supported it. This technological development saw analogue telephone networks replaced by digital ones, which in turn allowed for easier integration with more powerful and lower-cost microprocessors (Gable and Gable 2005).

The electronic monitors used in the UK today still tend to rely on radio-frequency technology rather than GPS, although we are seeing an increasing tendency to introduce GPS over the earlier radio-frequency models. The vast majority of cases, around 12,300–14,000 offenders at any one time in 2016–2017, are under curfew tagging orders. These orders are usually managed with radio-frequency monitoring—the offender wears an ankle tag and places a home monitoring unit in their residence. The unit is programmed to detect a tag within a specific range (e.g. 50–150 ft). When the tag comes into range of the unit, the unit transmits information to the monitoring centre. The location information is then reviewed by staff at the monitoring centre to check that the individual is where they are meant to be (i.e. at home, or at approved activities such as work, school or treatment) (Morse 2017). There is no way to track their movements. This radio-frequency technology is viewed by those that operate it as ‘fit for purpose, robust and very difficult to circumvent without being detected’ (Hucklesby and Holdsworth 2016). It is also a medium that supervisors and offenders alike are familiar with; the simplicity and low cost continue to make it an attractive option for many. It is also considered to provide more structure in terms of day-to-day living than the newer GPS technology. This viewpoint, however, is not without its

critics (Geohegan 2012). In 2011, the UK government launched a program to develop a hybrid model of the electronic monitor that combined both radio-frequency and GPS technology. However, the demand for the location monitoring provided by the GPS was not as high as anticipated and, amongst other reasons, the project floundered (Hucklesby and Holdsworth 2016).

The newer GPS monitors are usually small and lightweight and are also worn on the ankle. The ankle strap connects the device to the body. It is thick and incorporates optic fibres (which enables anti-tampering alarms to be integrated into the design). The GPS devices may be passively or actively monitored. In both passive and active forms of monitoring, the designs are the same and both require the use of digital telephone networks and computer software in order to review the GPS information. Signals from global positioning satellites create a map of the individual's movements. With active (real-time) monitoring, the data is transmitted every few minutes to a monitoring centre and any violations are immediately reported. With passive monitoring, the data is downloaded to the monitoring centre and then relayed once or twice daily for review (it is referred to as 'after the fact reporting' owing to it not being contemporaneous).

Both GPS and radio-frequency systems have advantages and disadvantages—the primary one with GPS being that it relies on a traceable signal, which is fine when the signal is strong, but when the signal is weak the device can become inaccurate. Situations where this is particularly evident are when underground or in thick-walled buildings. GPS is also not available in some areas of the country. Disadvantages with radio-frequency models are that they do not allow for tracking and they require specialist scanners to read and transmit data (Tully et al. 2014). It is generally considered that GPS technology is superior to radio frequency, although there remain challenges, not least the fact that reliability of operational capabilities is a fundamental tenet in order for the system to work well.

7.2.1 Use within the Criminal Justice System

In 1989 England and Wales embraced the use of electronic monitoring in a series of trials, but it was not until 1999 that it was fully integrated into the criminal justice system and from there it was slowly implemented (Hucklesby and Holdsworth 2016). It is most commonly used to enforce curfew restrictions and as a condition of bail, as a requirement of suspended sentences and community sentences and as a means of enabling early release from custody (under the Home Detention Curfew scheme). The Ministry of Justice contracts out electronic monitoring services to private companies—and has done so since the inception of this technology. This has served to divide opinion and it is likely the private sector involvement that has led to greater public scrutiny of electronic monitoring, not least when the system goes wrong and an offender commits a further offence whilst subject to electronic surveillance (Hucklesby and Holdsworth 2016). The private sector companies have been blamed by some for lacking in technological innovation and for this reason impeding the progression of GPS and new hybrid technologies in the UK (Geohegan

2012). However, there has also been concern that the GPS technologies, until more recently, were neither robust enough nor cost-effective enough to be used on a large scale (Hucklesby and Holdsworth 2016). So too has the lack of convincing evidence to support the use of electronic monitoring been raised—a finding echoed by US experts reviewing the use of the technology in tracking moderate- to high-risk offenders (Renzema and Mayo-Wilson 2005). Moreover, there have been allegations of corruption within some of the private companies, with accusations of overcharging the government (and hence tax-paying citizens) for their services. In instances such as these, private sector involvement is seen to harm the credibility of the system. Despite this however, in 2017 a number of pilot studies were launched in London (across eight boroughs) using GPS technology for those deemed to be prolific offenders. The schemes are ongoing (London Assembly 2017).

Whether the use of electronic monitoring has had a significant impact on the rates of imprisonment is also hard to discern. Certainly in England and Wales, the number of people imprisoned continues to rise, despite the use of electronic monitoring, and there is a lack of empirical support for its use. Perhaps what can be drawn from this, certainly in England and Wales, is that electronic monitoring is being used as a supplementation to existing probation services, rather than as an alternative to custody (Hucklesby and Holdsworth 2016).

The use of GPS technology for monitoring offenders is widespread in the USA and is federally mandated for the monitoring of sex offenders. In 2010 there were approximately 200,000 sex offenders at any one time under the control of correctional agencies in the USA, and of these, around 60% were being supervised by use of electronic monitoring (Bishop 2010). In 2005 Florida passed a legislation requiring that those who have offended against children be mandated to wear an electronic tag *for life* (Tully et al. 2014). This raises concerns given the paucity of evidence available to support the effectiveness of electronic monitoring in sex offenders. There is literature that highlights some of the unintended consequences associated with this widespread use, not least the fact that many sex offenders return to the community with inadequate housing arrangements or with housing restrictions in place, leading to increased risk of homelessness, unemployment and despair—factors that are associated with increased rates of reoffending (Bishop 2010).

7.2.2 Limitations of Use

It is clear therefore that using electronic monitoring as a means by which to supervise offenders following release into the community is not without its difficulties. In terms of practical issues, it can imbue a false sense of security in both those monitoring the individual and to wider society. There is often a perception that ‘someone’ is in a room with a huge map, on the lookout for movements made by all sex offenders (Bishop 2010). Clearly this is a fallacy, but one that ensures the public feels safe. Although the tracking data with a GPS device is collected constantly, the supervising officer is only notified if there is a possible violation to the probation terms (for example, if the individual enters an exclusion zone). As GPS is designed

to be used outside, it cannot offer information once they are inside a building—it can track their entry into it, but there is no way of finding out, once inside, which floor they are on or room they are in. With radio-frequency monitoring, there is no ability to track movements at all. It is also possible for the GPS ankle devices to be tampered with (they can be cut through with bolt cutters) and, more simply, for the battery to run down. It is the responsibility of the offender to charge the device. If the charge runs down, the supervising officer will not necessarily know immediately, and once there is no charge, there is no way of determining the actual location of the offender.

A further issue is that of community supervision. This is not always consistent and the volume of data generated by the monitoring system (particularly if it is a GPS) can be enormous. As a result, the information is not always reviewed and acted upon contemporaneously. For this reason, there can be time lapses between an alert notification and the response by authorities. The amount of data to review adds to the pressure on already stretched probation services, and in addition to monitoring and reviewing the data, alerts need to be responded to (including those that are inappropriately triggered) and the equipment needs to be fitted and maintained. It is unsurprising that the volume of workload has increased dramatically with the implementation of widespread electronic monitoring and it can be overwhelming.

One final point to consider are the myriad different legal issues that surround the use of electronic monitoring. Examples in the USA of where legal action has been sought include cases involving failure to respond to an alert that results in a new crime, cases involving the commission of a new crime that occurred when the GPS signal is lost, challenges to rights of privacy, concerns about the admissibility of location data points from GPS vendors and cases where an officer has deliberately chosen not to respond to a significant alert when they could have done (Bishop 2010).

So does electronic monitoring actually work in the offender population? There is commentary that would suggest that the evidence base for its use is unconvincing. In fact, best practice demonstrates that ‘the technology has little non-punitive utility unless it is integrated with other interventions’ (Paterson 2012). This is consistent with the Gable brothers’ original premise—for the process to work, there needs to be an emphasis on rehabilitation and this needs to be integral to the way in which the monitoring is delivered and utilised. The issue of course is that the policymakers in the UK have not internalised this evidence and what we see is the development of surveillance that is driven by political and commercial agendas rather than any solid evidence base. The upshot of course is that electronic monitoring is contracted out to and operated by the private sector and practised largely in isolation from other community sanctions (Paterson 2012).

The common perception that electronic monitoring will prevent crime from happening continues to perpetuate. The simple truth is that it cannot, and we should not expect it to whilst it remains used in relative isolation. If, however, its use is properly combined with community supervision, rehabilitation and law enforcement, it can be used as an adjunct to reduce the *likelihood* of further crime (Bishop 2010). The devices can only operate efficiently and accurately when there is good operational capacity and when the individual wearing it cooperates with it.

7.3 Extrapolation of Surveillance to Clinical Settings

As we know, the use of electronic monitoring is now implemented in a variety of arenas—as devices to allow parents to track their children, for people living with cognitive impairment, for monitoring of employees (for example, long-distance lorry drivers) and in the clinical domain of forensic psychiatry.

The use of surveillance in populations living with cognitive impairment, such as dementia, has been in effect for some time. Use of this technology—often termed assisted technology—carries with it a large number of ethical dilemmas, not least concerns about privacy and restriction of liberty. However, research in the area would suggest that electronic monitoring and other forms of assisted technology (such as door sensors and motion detectors) can be beneficial when used in conjunction with individualised, person-centred ethical evaluation and assessment (Godwin 2012). In the case of a cognitively impaired person suffering with dementia, wandering out of their residence may present as a risk. Where this tendency to wander results in a vulnerable person placing themselves at high risk of injury or exploitation, there is a powerful argument for the use of this technology. In the USA, it is estimated that over half of all dementia wanderers that are missing for more than 24 hours die or are seriously injured (Yang and Kels 2017).

A common response (perpetuated within Western societies) to a cognitively impaired older person with a tendency to wander is to isolate them further by moving them to a more restrictive environment (such as a retirement home). In this way we simultaneously increase their likelihood of social isolation and limit their escape opportunities. But when used appropriately, electronic monitoring can remove the need to do this (Godwin 2012). It could be argued that the use of these technologies enables preservation of autonomy, but at the cost of liberty. Surely then, is the option of utilising technology that in the short term restricts their liberty (by making others aware of the escape and thus halting it), but in the longer term keeps that person in the community rather than hospital or residential care, a sound one to make?

What becomes more difficult to disentangle in this population is the ethical concern that arises when the technology is used without sufficient interaction at the social and individual level. By way of an example, the use of a remote sensor to summon help can be viewed as a useful way in which to prioritise safety over well-being—help would indeed be summoned, but perhaps monitoring by a thoughtful carer (in person rather than by remote access) would have precluded the need for the call, provided social contact and ultimately delivered a more ethically sound alternative (Wey 2007). The idea being that in using a patient-centred model of care, the patient themselves remains a key collaborator in decisions made about their care, and in so doing, they retain their autonomy and sense of well-being. In a similar vein, there needs to be a careful balance between managing risk and ensuring respect for autonomy. Sensors attached to the front door may restrict one's liberty but prevent the risk of a patient wandering into the night in a busy city, disorientated and vulnerable. In cases as complex as these it may be necessary, as Beauchamp and Childress point out, to aim for 'attached attentiveness to needs' as opposed to a 'detached respect for rights' (Beauchamp and Childress 2001, p. 373).

If we now turn to the use of electronic monitoring in clinical forensic populations, it is evident that the ethical issues here, too, are complex and thought-provoking. Electronic monitoring was first trialled in an NHS forensic population in 2010, the devices being provided and operated by Buddi Ltd, a private company (Tully et al. 2014). Doing so created a fertile bed for ensuing ethical discussion, at both local and national levels. For any person detained under the Mental Health Act, and particularly someone held in a forensic unit where length of stay may be long and progression through the care pathway intimately related to risk, leave is an important and necessary step in their recovery. As clinicians we are aware of how the process of leave acts as an integral part of treatment, but also provides an opportunity to build upon the therapeutic alliance and to strengthen trust. It is a central part of the recovery process and, as such, clinical decision-making is informed by structural risk assessment and granting leave is not undertaken lightly.

However, whilst the clinical team may endeavour to build upon this trust, the relationship can fracture and breaches in leave do occur. Research has demonstrated that breaches in leave conditions tend to occur owing to socio-environmental factors. The factors cited comprise feelings of being trapped and confined, experiencing boredom or fear of other patients, worrying about relatives or property, poor food and the desire or need to carry out an activity or responsibility (Hearn 2015). It has also been found that breaches in leave are less likely to be planned ahead, and most tend to occur spontaneously, driven by impulsive acts, albeit influenced by some of the socio-environmental factors identified above.

Trialling the use of electronic monitoring in a forensic rehabilitation population was an attempt to try to better manage the risk associated with granting forensic patients leave both within and outside of the secure hospital site and to do so in a therapeutic manner. It was envisioned to comprise part of a comprehensive protocol for risk management and recovery. There was also an emphasis on enhancing public protection by virtue of the fact that the electronic monitoring should allow faster detection of any violation of the patients' leave conditions. Added to this was the fact that the electronic monitoring devices were designed with GPS technology and were therefore able to identify the patient's location and were delivered in real time (i.e. active transmission) (Tully et al. 2014). The drive to incorporate electronic monitoring into the forensic rehabilitation population was in part based on those few high-profile cases where patients on leave had committed further unlawful offences, which had served to undermine public confidence, quite understandably, in the ability of services to manage risk. The electronic devices used by the forensic unit were able to be set with geographical parameters (known as geofences), completely individualised for the wearer (Hearn 2015). These geofences enabled both exclusion and inclusion zones to be created. A large amount of data was required in order for the monitoring to take place. This included the patient's name, hospital ID, description, risk and danger rating, inclusion and exclusion zones, leave details (including places and times), escalation procedures, contact points and the designated hospital authority (Nova Scotia Health Research Foundation 2014). Contrary to some of the criticism levied at the researchers of this study, the patients included were all risk assessed and the decision regarding electronic monitoring made based

on that assessment. Subsequent to that, each patient was consulted and provided with information to then digest and discuss with family, friends or an advocate. Those assessed as low risk of absconion were interviewed in order to obtain informed consent prior to proceeding. Those that were unsure or declined it were allowed to continue with their leave program unchanged (as per prior to the introduction of the electronic monitors). Those however deemed medium or high risk were compelled to wear the device when on leave—the other option being the withholding of leave altogether (other than for emergencies), again, consistent with existing leave arrangements (Tully et al. 2014).

The results showed that the number of absconds (where a patient unlawfully gains liberty during escorted leave outside of the perimeter of the originating hospital by getting away from the supervision of staff) fell to zero over a 2-year period. Those that were late in returning from leave, or went missing (termed a leave violation rather than an abscond), were more easily located and returned to the unit. What is inferred from this is that the use of electronic monitoring served to help patients in not making impulsive decisions early on in their recovery, which in turn was felt to impact positively upon their overall length of stay and rehabilitation (Hearn 2015). Discussions held with patients involved in the trial were generally pragmatic, and there was recognition that they achieved greater amounts of leave in a shorter space of time. Some also stated that knowing they were wearing the device served to help them make safer decisions.

Questions arise of course owing to the fact that it was a private company that provided the electronic monitoring devices and collected the data. Issues regarding accountability, training and service quality are hard to avoid and need to be asked. From the clinician's standpoint, the technology was used in order to help inform clinical decision-making, rather than viewed as an isolated strategy in risk management. The emphasis appeared to be one of supporting and improving upon current clinical approaches, with the aim of improving patient autonomy.

Criticism of this trial has been significant, and much of the critique has comprised commentary about possible implications on patients' rights to liberty and privacy. A service user involvement group canvassed by the research team described electronic monitoring as *twenty-first century shackles*. They raised concern about private companies depriving patients of both care and supervision (Tully et al. 2014). Concern has also been raised with regard to possible breaches in patient confidentiality and questions asked about how the information is stored, communicated and used for evaluation purposes (Nova Scotia Health Research Foundation 2014). This too begs the question, who is it that owns the location data—the patient themselves, the hospital or the third party that is collecting the data?

Further issues that have come to light revolve around coercion and violation of human rights, reinforcement of stigma and fears that the overrepresented black population in secure settings would be impacted upon negatively (Tully et al. 2014). Stigmatisation is a concern given the fear that there is a real risk of increased societal condemnation of forensic patients, which ultimately has a negative impact on their mental health, treatment and recovery pathways. Others have said that the patient may be made to feel like a criminal, rather than a mental health consumer,

and that there is risk of patients experiencing increased paranoia, anger and alienation if the monitoring is not implemented in a patient-centred manner (Nova Scotia Health Research Foundation 2014). Additionally, because there is no general consensus about the impact of electronic monitoring on forensic patients, those opposing its use recommend risk assessment processes and community support be used instead—commenting that the use of this technology has no power to change behaviours or guarantee outcomes (Nova Scotia Health Research Foundation 2014). Others have raised concern that electronic monitoring has a detrimental impact on trust, and the ability to form a therapeutic alliance, and have also questioned the ability of forensic patients to give informed consent (Watson et al. 2014). So, too, has the spectre been raised of hospitals turning into prisons by virtue of them adopting a system used primarily by the criminal justice system. The dialogue about confidentiality, particularly in the realm of private companies being used to access the data, raises issues around the principles of autonomy, beneficence and justice. It is to these ethical principles that I now turn.

7.4 Ethical Considerations

The introduction of electronic monitoring into clinical settings raises a number of ethical concerns. In our clinical practice, we must ensure that our duty to our patients is respected and enforced, and we are expected to hold present in mind our ethical and moral duties at all times. Different ethical frameworks can be used to help guide our practice, and most commonly the overriding principles of autonomy, beneficence (to seek to do good), non-maleficence (to do no harm) and a respect for justice, are brought to mind (Beauchamp and Childress 2001). Many ethical issues of course are complex, and using this framework can be difficult, particularly as these principles tend to weigh against each other and are seldom considered in isolation. Some may question the need to use an ethical framework, but it makes sense to do so in order to help set our own personal codes of moral reasoning aside and to allow for deeper appreciation of another person's values, even if set apart from our own.

In considering the principle of autonomy—in Kant's view, the ability to move towards aims and objectives over which one has ownership—we see that informed consent is itself central. But this is often fraught with difficulty, given that the very nature of the forensic setting precludes fully autonomous behaviour. Forensic patients are legally coerced to remain within a specified secure setting, and it is commonly the relationship with the treating clinical team that will determine how quickly a patient is considered appropriate for leave. Given the duty that clinicians have to the welfare of others, and to society at large, risk of possible breach in leave needs to be born in mind at all times, and for this reason, clinicians are rightly cautious about granting it precipitously and without thorough and informed risk assessment. It is not hard to see how further restrictions on a detained patient's autonomy can arise and how easy it is for abuses of power to creep in. Third parties both influence and determine decisions about leave (the Ministry of Justice is required to

approve the granting of leave at each step), the consequence being that the views of the forensic patient regarding their leave progression often bear little weight.

With this in mind, it can be argued that electronic monitoring whilst on leave could provide the means by which to enhance a forensic patient's autonomy (Tully et al. 2014). Is there a way then in which to implement this technology that respects the needs and desires of our patients and, in so doing, enable them to be both protected and autonomous? Can this be achieved in parallel to the duty that needs to be upheld with regard to the safety of the public, but not at the expense of compromising personal liberty? These issues play into this complex matter of informed consent. It may not always be possible, as treating clinicians, to gather informed consent in its truest form and we need to be cognisant of the fact that in many of our patients there will be a degree of assenting to the proposed regimen, in the belief that it will serve them better in the longer term. It is well observed that the forensic patient who complies with the clinical regimen prescribed for them (either by virtue of informed consent or by agreeing to engage in the process on a more superficial level) will be more likely to progress faster through their care pathway than one who resists or subverts it. There are times too, as described in the trial above, where there is no consideration of obtaining consent, informed or otherwise—the monitoring device in this example is considered absolutely necessary in order for the patient to progress to leave in the first place (Tully et al. 2014). But how does this tie in with sound ethical principles?

We know that in order to facilitate informed consent, we need to enhance our patients' input into their care decisions, by actively collaborating with them. When we speak of autonomy we understand it to comprise both the ability to make decisions and the retention of values and beliefs that make that person who they are. In those where there is reduced decisional capacity, the ability to retain values, preferences and goals may likely remain (Yang and Kels 2017). In fostering these discussions and keeping the tenets of patient-centred care uppermost, are we not balancing principles of beneficence and respect, which in turn plays into the principle of autonomy?

When considering the use of electronic monitoring, whether in a cognitively impaired individual, a forensic inpatient or an offender, the possible positive effects must be counterbalanced by the potential loss of both privacy and autonomy. In the offender who is in the community—on licence—whose only other alternative is incarceration, you may argue that the restriction of their privacy and autonomy is far less than would be experienced were they still in custody. What this means therefore in terms of ethical consideration is that a careful weighing up of the situation may involve a necessary trade-off between infringement of personal privacy and autonomy and that of security (and the restrictions that this would entail). Making the decision however, in terms of whether the benefits of surveillance outweigh the risks to personal liberty, may often be muddled.

What we see is that this form of surveillance can allow individuals the freedom of travel (within a designated area) without the restriction of direct supervision (and, in the cases of the few, physical restraint) (Yang and Kels 2017). This can be argued to build trust and enhance autonomy, although the inherent nature of

electronic monitoring does threaten to erode privacy and dignity. Here again though, we need to remind ourselves of what these relative intrusions in privacy replace—for both the dementia wanderer and the forensic inpatient, the alternates are far more restrictive—possible placement into a home, or a return to closely monitored accompanied leave arrangements. For the offender released on license, the alternative is even more restrictive. Each decision needs to be weighed in light of the other alternative ethical infringements. And if we choose to consider things this way, can they not be viewed as potential avenues of patient empowerment?

In considering the principle of beneficence we are considering the very meaning of clinical benefit: the duty to ‘seek to do good’ to our patients. As mentioned above, if the clinical team is ensuring that the patient remains central to discussions about their care pathway (and specifically leave, with or without electronic monitoring), it can be argued that the principle of beneficence is being considered. This can feel rather vague though, and in reality, determining what beneficence actually comprises can be difficult—are we seeking to do good by attending to their emotional needs but at the expense of a potential increase in risk to others? Or are we seeking to do good by not approving leave because of our own concerns about the use of electronic monitoring and in so doing compromising the notion of moral neutrality? Who benefits the most out of it? Patient surveys of forensic patients about the use of electronic monitoring are limited. There is however research relating to the use of this technology in cognitively impaired adults and in the offender populations. Research in the USA reveals that offenders who have experienced the regime of electronically monitored home detention report it being ‘psychologically wearing and more onerous in terms of self discipline than the world of prison’ (Black and Smith 2003). Others report preferring the routine and familiarity of imprisonment, where they seek no recourse to reform and where the responsibilities of daily living are all but removed from them (Nellis 2015). We could suggest that the principle of beneficence is upheld in justifying granting leave in order to enhance quality of life. Equally we could justify not granting leave in order to preserve the risk status quo (in not granting it at all, there is no opportunity for leave to be breached). How you look at it however determines how you perceive the very nature of what beneficence is. What we have seen in recent years is that there has been a shift in psychiatry and medicine away from beneficence and towards autonomy, with the emphasis now being placed on honesty and authenticity.

The principle of non-maleficence, and the duty to do no harm, raises questions about who determines the nature or degree of harm suffered. It is not always clear if harm done to a patient is always in their best interests—at times it is clearly done to meet the needs of others, and at other times it is justified as a short-term intervention, which conversely, in the longer term may be judged as harmful. With regard to electronic monitoring, this principle can be argued either way. From the view of the clinician, attempting to facilitate leave and in so doing improving that patient’s autonomy and ultimate progression through the care pathway could be seen as adhering to this principle. The person affected by the monitoring however may view the procedure very differently, finding the constant surveillance difficult to marry with the infringements to both their privacy and liberty. Is there a point when the

moral autonomy of our patients becomes less important than the prevention of harm to society?

Finally, in addressing the need to treat everyone in a similar way, we are applying the principle of respect for justice. We know that forensic patients are vulnerable to exploitation and injustice and that political pressure can be exerted in all manner of ways, particularly if the case has a significant media interest. We need to be confident as clinicians that in treating our patients we are acting honestly and fairly, not least out of respect for another person's dignity and well-being, but also out of respect for their humanity.

Introducing electronic monitoring technologies into our hospital populations has also raised concerns about whether we are enabling a technology used predominantly in correctional environments to alter the way in which we perceive our patients. Although the use of electronic monitoring is not deemed a punishment (there is a strong focus on the rehabilitative power of enabling leave), there are also strong associations with the criminal justice system and inherent overtones of punishment. It is a system currently used by probation services as a means by which to primarily facilitate restriction and surveillance. It is undoubtedly a physically invasive technology (requiring attachment of the device to a body part) but also a psychologically invasive one (Black and Smith 2003). The use of this technology in our secure hospitals however differs from the premises that determine its use within the criminal justice system. In practical terms, the confines and security of a secure hospital are far more in line with a prison establishment, and it can be argued that the provision of electronic monitoring within a secure hospital estate in fact enables a degree of liberty not afforded to those incarcerated in prison. Whether or not the inclusion of this technology alters how others perceive those detained in secure hospitals remains a topic for further thought.

7.5 Societal Considerations

Electronic monitoring used as a tool to enhance patient well-being within clinical populations may be a step too far for many people. Most of the research that has been conducted about the use of electronic monitoring to date falls within the criminal justice arena. We know from this research, that, as a 'technocorrectional innovation', the use of electronic monitoring is shaped by what constitutes appropriate punishment within the public domain. So too is its use shaped by the manner in which this technology is consumed within our societies—a point that requires ethical deliberation given that it serves as a form of surveillance (Nellis 2015). This raises concerns about the degree to which an offender's movements are tracked and to what use the information is put. In England and Wales, there are a number of schemes in which offenders are given the choice of either electronic monitoring or intrusive supervision by police officers—in schemes run jointly by probation officers and the police. Those offenders who opt for the electronic monitoring (which operates alongside daily support given to aid compliance) report feeling more trusted and optimistic about their futures (Nellis 2015). It would also seem that the

fear of detection also proves a deterrent against committing further crime. One system, in the USA, correlates the wearer's movements with crime reports and alerts authorities if they appear to be in the location of a recent crime scene (Black and Smith 2003). The converse of this of course is that the information can be used to exonerate as well as to incriminate, dependent on the device's ability to accurately record the offender's whereabouts.

This raises an important question however in terms of who owns the information generated by the electronic monitors. One can assume that the government owns the physical satellite system, which is integral to the GPS functioning, but is there clear legislation about who owns the data once it is collected? (Michael et al. 2006). And if a private company collects and stores this information, are they obliged to divulge apparent aberrant behaviour, as detected by the monitoring device, to the police? This then leads to further questions, regarding accountability and authenticity. If the GPS provides an unreliable service, whose responsibility is it, and how do we ensure that the data collected is accurate?

It is interesting to note that augmenting or, in some cases, replacing human contact with technological surveillance is never a morally neutral decision. There will no doubt be competing financial pressures, but the use of this type of technology needs to be thought about within the context of what good the introduction of it will bear, both in societal and political terms (Nellis 2015). The concept of replacing skilled human contact with impersonal, remote monitoring is a worrying one, if it is used in isolation. We come back to the original concept of the Schwitzgebels' device—one originally designed for use as an adjunct to help encourage pro-social change in young offenders, not one merely to be used as a sanction.

For many, electronic monitoring is viewed as a better alternative to the overwhelmingly institutionalised nature of imprisonment. There are no locked doors and bars on the windows, and consequently it can be seen as a less oppressive form of control and one that is compatible with rehabilitation and better reintegration of offenders into the community. There are arguments to be made that electronic monitoring provides greater opportunity for improved rehabilitation of offenders (Black and Smith 2003). The positive aspects of it for most offenders are those of less restriction, a quicker return to family or independent living and possible employment opportunities. This can be viewed as being more conducive to behavioural change than a prison setting. However, it has also been noted that for some offenders spending time at home with family members increases intra-familial conflicts, particularly where there are no constructive activities in place to help diffuse existing tension (Black and Smith 2003).

Some offenders have stated that they find the process a more dignified way in which to be supervised and that it removes the possibility of enduring a negative face-to-face interaction with a supervisor (Nellis 2015). This last point is an experience that seems to be quite often reported. Not all supervisor contacts are beneficial or positive, and some of these interactions serve to reinforce and strengthen an offender's belief in themselves as a criminal, with limited capacity to change or to model better behaviour. We also know that many people find the experience of wearing an electronic monitor humiliating. It serves to reinforce

some cultural stereotypes and further stigmatise a population already facing significant social marginalisation. It can be seen to be a depersonalising and deeply dehumanising approach to managing offenders and those in rehabilitation (such as forensic inpatients).

Electronic monitoring has at various times been compared to an Orwellian dystopia, portrayed as an electronic ball and chain and virtual prison. This portrayal belies the fact however that measures put in place do allow a degree of choice and rely heavily on trust. By design therefore, the success of any electronic monitoring enterprise is dependent upon the cooperation and compliance of the wearer (Nellis 2006).

The ethics of surveillance in larger society raises profound questions about democracy, freedom and privacy. We live with and amongst CCTV cameras, DNA databases, ID cards, speed cameras—the list goes on. Such a variety of surveillance, both in private and public space, allows for vast amounts of data to be collected. As a society we tend to seek out technological advances that facilitate monitoring. To what use this data is put is varied. It may be used, for example, to aid understanding of specific behaviour patterns, to enable crime prevention or to refine marketeering (Nellis 2006). Who, though, holds all this data and what does this level of surveillance mean for society in general? Here, it is important to refer briefly to the work of Foucault, a keen observer of people who, above all else, believed in the freedom of people and held this belief paramount.

Foucault considered knowledge as a form of power and believed that knowledge and power could reinforce one another. Crucial to his belief was the ability to gain knowledge (and, by virtue, power) through the observation of others. It followed therefore that the more you observe, the more powerful you become (Mason 2018). He drew importance to the effect that power has on social networks and on behaviour—the ability to suppress, or stimulate—and observed how constant observation can act as a control mechanism, ultimately becoming an internalised form of coercion. Living in a surveillance society means that we, as society, become part of the fabric of it, and we see how easy it is to be caught up in technological surveillance—whether we are willing, hesitant or unknowing in our participation.

It is this surveillance potential of electronic monitoring that creates concerns about over-regulation and infringement of human rights. It should be pointed out, however, that the use of surveillance within recent society is not a new concept. Bentham's panopticon—an architectural design proposed in the nineteenth century as a means by which to observe prisoners (and other populations) from a central vantage point—provided an apt metaphor for Foucault's line of thought (Mason 2018). Observing prisoners in this manner resulted in calmer behaviour, and prisoners became more accepting of the rules and regulations. This in part stemmed from the constant threat of discipline, made possible by the power of observation. The surveillance may not be constant, but the internalised belief is that it might be. This is the principle used to good effect with electronic monitoring. Whilst the monitor is on, the behaviour tends to be well regulated. When the device is removed and the threat of discipline is reduced, it is not uncommon for aberrant behaviours to creep back in. This is consistent with the essential tenet of learning theory—that punishment does not change behaviour; it temporarily suppresses it (Gable and Gable

2005). And so it is that turning off the virtual gaze swings the power pendulum back in the other direction.

The very real problems that we face in our societies remain pressing, and for these problems to be addressed, we need to consider a practical basis upon which to apply the theorem. I suspect that it is this very desire to reach for something tangible and practical that has seen electronic monitoring become an attractive option, particularly for those in the political and commercial arenas. There are certainly powerful forces that advocate for continuous surveillance and it is important that the human element is not lost or portrayed as an unnecessary adjunct—it needs to remain central. To my mind, for electronic monitoring to work optimally the need to separate it from the ideology of punishment remains key. If the focus is on rehabilitation and social integration, rather than punishment, then the individual remains central to the process. In this way social contact and positive interventions remain a priority in terms of rehabilitation, and the technological advances can be used as important adjuncts in terms of aiding risk management.

7.6 Cost Considerations

Again, the bulk of research in this area comes from the criminal justice system. From an ethical standpoint, cost alone should seldom be a reason for the use of electronic monitoring, but it will likely always be central to decisions made with respect to policy. There is evidence to suggest that electronic monitoring has the potential to improve cost-effectiveness of correctional programs, and this has been born out in a variety of jurisdictions, including New Zealand, the USA and the UK (Black and Smith 2003). Whether it reduces the overall prison population, and cost associated with this, is less clear and it is difficult to find a general consensus about this.

The UK trial in a forensic rehabilitation population found that the costs associated with abscondment were reduced through the use of electronic monitoring, although the reduction was not found to be statistically significant, and the findings of electronic monitoring being cost neutral were termed *cautiously optimistic* (Murphy et al. 2017). The average cost per patient using the system was calculated at being £1617 compared to £1702 per patient without (Murphy et al. 2017).

In the USA, offenders are usually required to pay a fee towards the cost of the monitoring system, based on the assumption that those in the community have access to continued employment. The upside is that this furthers reduces the cost of the system and makes the process more cost-efficient. The quite obvious downside is of course that this has the likelihood of causing significant hardship to those either not able to find employment or on low incomes with high family maintenance costs (Black and Smith 2003).

The main body of literature would suggest that electronic monitoring is a comparatively low-cost venture, both as a direct alternative to prison and as a means of reducing the length of stay in custody. As such, the use of this technology will be one that continues to be keenly embraced by policymakers. Certainly, early release provides the opportunity for a more efficient and graduated return to community

living (Nellis 2015), but it needs to be born in mind that any introduction of new technology should not be based purely on financial cost. As important, if not more so, is its merit in terms of its ability to enhance the release process and subsequent reintegration into the community whilst being cognisant of risk both to the offender themselves and to wider society.

7.7 Conclusion

Electronic monitoring, and the use of ever-emerging technocorrections, brings with it ethical debate about punishment, control and care and technological change. It is an area in which informed deliberation about the profound ethical issues at play must take place across all domains in which it is used. The more recent introduction of electronic monitoring into the forensic clinical domain is one that has yet to be comprehensively researched with respect to ethical constraints, and for this reason alone it is important to continue to address the use of it in a thoughtful, considered manner.

When deploying this type of technology, ethical infringements will likely remain commonplace—of which erosion of autonomy is one of the most salient. Thought needs to be given to the manner in which these technologies may erode or augment the liberty and privacy of those wearing the devices (Yang and Kels 2017). As clinicians, we need to ensure that the trust and therapeutic alliance is maintained in order to facilitate the recovery process. There are diverging views with regard to whether the use of electronic monitoring hinders the development of this therapeutic alliance (breeding distrust and paranoia), or whether it enhances it (by virtue of granting more leave, more quickly and earlier on in the hospital stay). Whichever side you fall down on, what we do see with the introduction of this technology is the ability to think creatively about ways in which to manage the very real risks associated with some of our patients. However, the way in which the technology is utilised remains crucially important to the overall process.

In the UK, the need to address the problem of prison overcrowding led to the growth in electronic monitoring of offenders in the community in a manner that was considered to be cost-effective. There is however widespread commentary about whether this is in fact the reality. What many report is that the high number of people managed by electronic monitoring is a result of *net widening*—the extension of the use of electronic monitoring to include low-risk offenders who would not otherwise be imprisoned. This means that the low reoffending rates that some probation or police schemes report may more often than not be a reflection of the low-risk profile of the offenders, rather than the deterrent power of the technology (Gable and Gable 2005). This makes it even more difficult to ascertain whether there is any clear and consistent benefit to its use or not.

A recurrent theme in the literature is that in order for the use of this technology to be put to a positive good, it needs to be paired with meaningful rehabilitation. Conversely, since its inception, electronic monitoring has found itself used globally as a measure of control and punishment. It remains clear however that rehabilitation needs to form an integral part of this corrective technology if it is to effect a positive

change. There are no replicated, well-designed studies that demonstrate that electronic monitoring alone reduces reoffending behaviour once the monitoring is terminated (Burrell and Gable 2008). The technology used in isolation can do no more than offer us an adjunct with which to better improve our risk management strategies.

It is not difficult to see that in order to bring about social change, there needs to be a shift away from a desire to punish and a move towards creative pro-social help. The original premise of the Gable brothers was based on social learning theory, and in their own words ‘the criminal justice system may be the least likely place to develop an inspiring pro-social communication network. But it is also the place where unexpected generosity can most easily change lives’ (Gable and Gable 2005). Is this optimism hopelessly naïve? Possibly, but it is not a bad place to start.

References

- Beattie JM (1986) *Crime and the Courts in England 1660–1800*. Oxford University Press, Oxford. p470
- Beauchamp TL, Childress JF (2001) *Principles of biomedical ethics*, 5th edn. Oxford University Press, Oxford. p373
- Bishop L (2010) The challenges of GPS and sex offender management. *Fed Probat* 74(2). http://www.uscourts.gov/sites/default/files/74_2_8_0.pdf
- Black M, Smith RG (2003) Electronic monitoring in the criminal justice system. *Trends and issues in crime and criminal justice* (PDF). 254. Australian Institute of Criminology, Canberra, pp 241–260
- Burrell WD, Gable RS (2008) From B. F. Skinner to Spiderman to Martha Stewart: the past, present and future of electronic monitoring of offenders. *J Offender Rehabil* 46(3–4):101–118
- Gable RS (2007) Electronic monitoring of offenders: can a wayward technology be redeemed? In: de Kort Y, IJsselsteijn W, Midden C, Eggen B, Fogg BJ (eds) *Persuasive technology*, Lecture notes in computer science, vol 4744. Springer, Berlin
- Gable RK, Gable RS (2005) Electronic monitoring: positive intervention strategies. *Fed Probat* 69(1):21–25. <https://www.ncjrs.gov/App/Publications/abstract.aspx?ID=210867>
- Geohegan R (2012) *Future of corrections: exploring the use of electronic monitoring*. Policy Exchange, London, UK. <https://policyexchange.org.uk/publication/future-of-corrections-exploring-the-use-of-electronic-monitoring/>
- Godwin B (2012) The ethical evaluation of assistive technology for practitioners: a checklist arising from a participatory study with people with dementia, family and professionals. *J Assist Technol* 6(2):123–135
- Hearn D (2015) Other GPS uses: forensic mental health. *Probation Quarterly*, Issue 5, Electronic Monitoring. <http://probation-institute.org/other-gps-uses-forensic-mental-health/>
- Hucklesby A, Holdsworth E (2016) *Electronic monitoring in England and Wales*. Centre for Criminal Justice Studies, University of Leeds, Leeds. http://28uzqb445tcn4c24864ahmel.wpengine.netdna-cdn.com/files/2016/06/EMEU-EM-in-England-and-Wales_Briefing-report.pdf
- London Assembly (2017) GPS tags to help drive down reoffending in the capital. <https://www.london.gov.uk/press-releases/mayoral/gps-tags-to-help-reduce-reoffending-in-the-capital>
- Mason MK (2018) Foucault and his Panopticon. <http://www.moyak.com/papers/michel-foucault-power.html>. Accessed 14 Mar 2018
- Michael K, McNamee A, Michael MG (2006) The emerging ethics of humancentric GPS tracking and monitoring. In *Proceedings of the International Conference on Mobile Business*, Copenhagen, Denmark. http://ro.uow.edu.au/cgi/viewcontent.cgi?article=1384&context=info_papers

- Morse A (2017) The new generation electronic monitoring programme. NAO report by the Comptroller and Auditor General. National Audit Office, Ministry of Justice, London. <https://www.nao.org.uk/wp-content/uploads/2017/07/The-new-generation-electronic-monitoring-programme.pdf>
- Murphy P, Potter L, Tully J, Hearn D, Fahy T, McCrone P (2017) A cost comparison study of using global system technology (electronic monitoring) in a medium secure forensic psychiatric service. *J Forensic Psychiatry Psychol* 28(1):57–69
- Nellis M (2006) The ethics and practice of electronically monitoring offenders. Seminar for the Glasgow School of Social Work. <https://www.iriss.org.uk/sites/default/files/gssw-2006-02-16.pdf>
- Nellis M (2015) Standards and ethics in electronic monitoring. Handbook for professionals responsible for the establishment and the use of Electronic Monitoring. Council of Europe, Strasbourg, France. <https://rm.coe.int/handbook-standards-ethics-in-electronic-monitoring-eng/16806ab9b0>
- Nova Scotia Health Research Foundation (2014) Evidence on the effectiveness of GPS monitoring for mental health forensic rehabilitation patients. Nova Scotia Health Research Foundation, Halifax. <http://0-nsleg-edeposit.gov.ns.ca.legcat.gov.ns.ca/deposit/b10678013.pdf>
- Paterson C (2012) Commercial crime control and the development of electronically monitored punishment: a global perspective. In: Nellis M, Beyens K, Kaminski D (eds) *Electronically monitored punishment: international and critical perspective*. Routledge, London
- Renzema M, Mayo-Wilson E (2005) Can electronic monitoring reduce crime for moderate to high-risk offenders? *J Exp Criminol* 1(2):215–237. <https://doi.org/10.1007/s11292-005-1615-1>
- Tully J, Hearn D, Fahy T (2014) Can electronic monitoring (GPS ‘tracking’) enhance risk management in psychiatry? *Br J Psychiatry* 205(2):83–85
- Watson E, Madhani P, Mysorekar S, Sollitt K (2014) Electronic monitoring of forensic patients. *Br J Psychiatry* 205(6):500–501
- Wey S (2007) The ethical use of assistive technology. www.atdementia.org.uk
- Yang YT, Kels CG (2017) Ethical considerations in electronic monitoring of the cognitively impaired. *J Am Board Fam Med* 30:258–263



Assessment and Management of Specific Populations

8

Philip Baker, Sumi Ratnam, and Leah Wooster

8.1 Ethical Issues in the Assessment and Management of Transgender Forensic Psychiatry Populations

Philip Baker and Sumi Ratnam

The single biggest risk factor for violence is being male, comprising 95% of the prison population in the UK. It is on this background that forensic psychiatry has, and will always be, a field in which the primary focus will be on male service users. Much of the evidence base around risk assessment, for example, has relied upon studies of male patients and male offenders. Although for a long time the high-security hospitals had relatively higher proportions of female patients than might be expected, this reflected limited alternative provision, rather than a need for so many to be detained in such restrictive environments.

More recently, the needs of female service users within secure services have become better considered. Across mental health services, and indeed healthcare as a whole, the importance of single-sex inpatient environments has become accepted. It is almost inconceivable now that as recently as one decade ago, female patients were routinely being treated in wards together with men, despite some of these men having convictions for sexual offences and many of these women having histories including sexual trauma.

Nonetheless, it remains the case that provision for women in the forensic psychiatry services is a poor relation to what is available for men. Most NHS

P. Baker (✉) · S. Ratnam
East London NHS Foundation Trust, London, UK
e-mail: philipbaker@nhs.net

L. Wooster
Nottinghamshire Healthcare NHS Foundation Trust, Derby, UK

medium-secure units will have a variety of environments for male clients at different stages of their recovery pathways. These have developed to include wards for intensive care, acute admissions, active rehabilitation and longer-term care, as well as inpatient environments for people with severe personality disorder and learning disability. Women will often have access only to one all-purpose secure ward, with patients with very disparate needs receiving care in the one place. Such services have become, through necessity, expert at managing variety and, in many cases, skilled at providing very person-centric care within a single ward system.

It is on this background that the issue of how best to treat people identifying as transgender arises. Whilst being far from a new phenomenon, there has rightly been increased focus recently on how to best provide care for transgender people. The profile of transgender people has arguably never been higher in the media. Transgender and non-binary actors have included Laverne Cox playing Sophia in *Orange is the New Black* and Riley Carter Millington playing Kyle in *EastEnders*. There are also a number of high-profile celebrities such as Caitlyn Jenner, Kelly Malone and Ruby Rose raising the profile of transgender issues.

Sadly, the profile of transgender people in the criminal justice system has also been raised due to serious incidents that have taken place, including suicide amongst transgender women placed in male prisons. There is also an elevated risk of suicidal behaviour in transgender populations with up to an 84% lifetime prevalence of suicidal ideation and 48% lifetime prevalence of attempted suicide in England (in the rest of the world ranges from 32% to 50% depending on the country) (Virupaksha et al. 2016). The rates are reportedly higher than those for lesbian, gay or bisexual individuals.

There has been much progress in terms of enshrining the rights of transgender people in law. The Gender Recognition Act of 2004 granted full recognition to transgender people. The act allows those over the age of 18 who have changed gender to apply through a Gender Recognition Panel for a Gender Identity Certificate ensuring that their acquired gender becomes their legal gender (Gender Recognition Act 2004).

The Equality Act of 2010 protects individuals from harassment and discrimination and protection for gender reassignment applies at any stage of the transition process. It also protects those who are perceived to be transgender from harassment and discrimination. The Equality and Human Rights Commission is a statutory body established under the Equality Act, which enforces equality legislation across nine protected areas including gender reassignment (Equality Act 2010).

Section 146 of the Criminal Justice Act 2003 makes provision for hate crimes, including against transgender people. If there is evidence that an offence included a demonstration of transgender identity hostility or was motivated by such, this will be treated as an aggravating feature which must result in increase of sentence (Criminal Justice Act 2003). This came into force in 2012.

Whilst these changes in the law are undoubtedly encouraging, that has not adequately dealt with the situation of trans people who are yet to go through gender reassignment for any number of potential reasons, who find themselves subject either to the criminal justice system, or in need of inpatient psychiatric treatment including in secure settings.

There are anxieties about treating transgender women in services for women. As detailed above, the concept of single-sex environments is still relatively young. There is anxiety about the risk that transgender women who have not undergone reassignment may pose to other women. However, proven cases of this occurring appear to be extremely rare. One notable exception was Christopher Hambrook, who was sentenced to indefinite imprisonment in Canada in 2014 having been convicted of posing as transgendered in order to access a shelter for vulnerable women, where he committed sexual assaults.

There is also concern within the feminist movement about treating transgender women simply as women. This has been memorably described by high-profile and respected figures such as Germaine Greer, who commented in 2015 that “Just because you lop off your dick and then wear a dress doesn’t make you a fucking woman. I’ve asked my doctor to give me long ears and liver spots and I’m going to wear a brown coat but that won’t turn me into a fucking cocker spaniel”.

Similarly, the issue of allowing transgender women to use female facilities in public has not yet disappeared. This has had a very high profile in America, with North Carolina being the most high-profile state to enact legislation. A “bathroom bill” was enacted in 2016 requiring people to use restroom and changing facilities in accordance with the gender on their birth certificate, which could only be altered following gender reassignment surgery. In other jurisdictions, such as California, the law has taken a diametrically opposed position, with laws mandating gender-neutral changing facilities for single-occupancy public bathrooms, to ensure access for transgender people.

This issue has also arisen in the UK. Labour MP Caroline Flint expressed concern in parliament in 2016 about potential risk to women from gender-neutral environments. Whilst not implying the risk was from transgender people, her concern was that having men in such environments could increase risk to women. Thus, attempts to improve access for transgender people could have unintended negative consequences for women. However, strong opposition to Ms Flint’s views was expressed from other parliamentarians, including Maria Miller, the chair of parliament’s Women’s and Equalities Committee, who referenced the Equality Act.

Taken together, there is evidently a need to balance the rights of transgender people to be treated in a way that reflects their gender identity. Whilst in a small number of situations this could present risks, that will be a minority. Managing those situations appropriately will be a delicate and sensitive issue, but cannot be used to deny most transgender people the right to be accepted as who they are. This will be the case within secure mental health services and prisons, just as it is in other spheres of public life.

The Ministry of Justice recently undertook a review of the Prison Service’s guidelines on “the care and treatment of transgender offenders” (2016). A key conclusion was a wish to respect the self-identified gender of an individual rather than relying on gender identity certificates. With this comes location in the appropriate prison, which can also be translated to mental health services. In addition, it is recommended that risk assessment be related to the individual and not the issue of being transgender, and there is no evidence to link risk with being transgender. Care

also needs to be taken to avoid isolation in environments, and in mental health settings, this might equate to the inappropriate use of long-term segregation or seclusion. In addition, training of staff is vitally important.

Mental health services have to address this issue. There is evidence to suggest that transgender people experience high rates of emotional difficulties and mental illness. A large survey of transgender people's mental health from 2012 found very high rates of depressive symptoms, stress and anxiety in transgender people. Over half of survey respondents had felt so distressed that they had needed to seek urgent help, and more than half had self-harmed at some point. There were 84% who had thought about ending their lives and 35% had attempted suicide at least once (McNeil et al. 2012; Nuno et al. 2015). This clearly poses challenges for mental health professionals.

It is obvious that not all mental health problems experienced by transgender people will relate to their gender identity. Indeed, one expressed concern was that transgender people often experienced professionals considering their trans status as a symptom of mental disorder in and of itself (McNeil et al. 2012). However, the high rates of comorbid problems in transgender people do suggest some association between transgender status and an increased risk of mental health problems. The importance ethically of professionals being alert to mental illness and high rates of self-harm and suicidal thoughts in transgender people, without stigmatising their trans status as inherently not normal, is paramount.

It would be foolish, indeed negligent, for a psychiatrist to fail to attempt to understand an individual's problems in the context of their life experience and identity, which remains equally true for a transgender person. Spending much of your life in a gender role that is wrong for you will often take an emotional toll, and transgender people have also often struggled with bullying and misunderstanding, which again could have an impact on emotional well-being. However, it would clearly be reductionist and demeaning to assume that a transgender person's problems always relate to being trans.

Surveys have revealed that particular problems faced by trans people affecting mental health include the lengthy delay in being able to access appropriate care and sometimes difficulties in having health professionals take their needs seriously (McNeil et al. 2012). There has been a dramatic risk in the number of referrals being made to gender identity clinics in the NHS, at a time when NHS resources are under almost unbearable strain. Waiting times are now very long, often measured in years rather than months.

The Department of Health issued guidance in 2009 and 2010 regarding same-sex accommodation (DoH 2010). Hospitals have had to develop policies in keeping with this. For transgender people this means that they should be accommodated according to their presentation, including the way they dress and the name and pronouns they use. An excellent guidance document produced by the Royal Free Hospital also notes that it should not depend on the physical sex appearance of the chest or genitalia, with an expectation being that it should be possible to ensure sufficient privacy for this not to be a concern. Similarly, it does not depend on having a Gender Recognition Certificate. However, variance from this can be made where particular treatment needs require it (e.g. if a trans-man requires a hysterectomy). It

is also advised that patient history and wishes, including their own anxieties and concerns, should inform the decision.

There have been efforts to ensure appropriate treatment of transgender people specifically within mental health services through policy. Sometimes the advice can seem vague, or, to view it from a more positive perspective, offer flexibility in how to offer good individualised care. The Mental Health Act Code of Practice, for example, has a chapter relating to privacy and dignity (DoH 2017). Given that within forensic hospitals patients are always treated under the Mental Health Act, this is of particular relevance to our services. In referring to the need for gender-segregated sleeping and bathroom areas, a sentence is included noting that “consideration should be given to the particular needs of transgender patients”.

Secure services have to address the best way to manage individuals with differing care needs and differing risk profiles. Based on recent experience, we would propose that managing transgender people in need of such services need not deviate from this. However, considerable thought needs to be given as to how to assist such patients to make progress within secure services.

Our recent experience includes managing transgender women, both pre- and post-gender reassignment on a generic female medium-secure ward. We also have provided treatment for trans-men within the female service, not through a lack of sensitivity, but based on a collaborative approach taken with patients about where they feel their treatment would be best provided. Ethically, this is an interesting situation. Cis-gendered individuals can never choose which environment to receive care on or have an individualised approach taken to this in these days of single-sex ward environments. The situation for transgender people is less rigid. Specifically in forensic services, other priorities such as risk both to and from an individual must be sensitively considered and managed, within the principle of treating people in accordance with the gender role that they identify with.

One area that has been crucial is to help staff to understand these patients’ situations and to manage their own anxieties. Treating pre-reassignment transgender women on a female ward makes those unused to these clinical situations anxious. These anxieties may sometimes relate simply to inexperience, e.g. about how best to prescribe for them or how to disentangle complex psychopathology related to psychosis or personality disorder from gender issues. Where psychosis has a sexual theme, this can be particularly difficult for the inexperienced clinician, and similarly, uncertainty about body image is a core feature of emotionally unstable personality disorder. Input from specialist gender identity clinics can be difficult to access in a timely manner.

Providing good clinical care relies on strong teamwork and environments in which staff can share their experiences and emotions without feeling criticised. In anticipation of admitting transgender people to the ward, we have run sessions facilitated by experts, to help staff better understand gender identity. Staff have been encouraged to share their anxieties, which not surprisingly included fears that the patient could act in a sexually violent way towards vulnerable women on the ward. In thinking about how we have managed dynamics on the ward without transgender women, it quickly became clear that the team were already skilled in protecting patients vulnerable from others for various reasons. This would equally be possible for any issues arising between cis and transgender women.

A further issue is how to protect transgender women from victimisation based on their gender on inpatient environments, where people with disturbed mental states and severe personality pathology have to live together for prolonged periods. Bullying based on gender can arise, in the same way that inpatient units sometimes have to manage abusive racist, homophobic or religion-based behaviour of service users towards each other. Involving the local police to run sessions on hate-based crime has been helpful and relied on good existing relationships between staff and the police. Again, units are used to dealing robustly with incidents of ethnicity-based abuse and in a healthy unit do not shy away from so doing. Abuse for reasons related to gender or sexuality can similarly be assertively dealt with.

Another ethical consideration is the importance of maintaining confidentiality. Staff members must be made aware of a patient's transgender identity in order to provide appropriate clinical care and, sometimes, to manage risk situations. It is of course necessary to maintain confidentiality about this and yet, in our experience, other patients have always become aware of patients being transgender. This can arise when a service user discloses it to one peer but then information is spread unintentionally or, occasionally, maliciously. Being outed against your will is a situation that should be avoided, but a sensitive and thoughtful approach to managing this if it does occur needs to be taken, including the whole community of patients and staff if the service user agrees to this taking place.

Women's services in particular have one great advantage in approaching the issue of providing good-quality individualised care for transgender people. We are used to providing care for very different people within single-ward environments. We have had to be skilled in creating personalised care for people stuck on wards with people very unlike themselves. Harnessing this skill to provide sensitive treatment for transgender people is certainly manageable. People do not end up in secure services unless they pose a significant risk to others. Transgender people will be no different. However, it is within the remit of those working in such units to provide treatment in a way that respects someone's gender identity, and professionals in secure services should be reassured that if the service they work in is strong and effective, they will be able to provide appropriate person-centred care to cis and trans people alike.

8.2 Ethical Issues in the Assessment and Management of Offenders with Intellectual Disabilities

Leah Wooster

8.2.1 Introduction

There are ethical issues to be considered when working with people with intellectual disabilities. This group of individuals have historically been and remain vulnerable and have been denied certain rights related to their level of cognitive functioning

and understanding, and there is a perceived inability to live and think independently. These issues are magnified particularly when this group are found amongst the forensic population due to their often risky behaviour, co-existent mental health problems and the likely nature of their backgrounds given they have ended up in situations which have deemed them a danger to the public to varying degrees.

In this chapter we will discuss six important ethical issues which arise when working with people with intellectual disabilities, particularly in the context of forensic healthcare.

8.2.2 Ability to Learn

The Department of Health defines learning disability as: a significantly reduced ability to understand complex information or learn new skills, a reduced ability to cope independently which started before adulthood and has a lasting effect (DoH 2001). Let us consider a person with a learning disability who is taken into the care of forensic services. These services, by nature, apply varying levels of restrictions. People often stay in these services for years having received orders to remain in hospital when sentenced by the court.

In the UK, the court may impose a hospital order on someone instead of a prison sentence if they conclude the defendant needs medical treatment which is given in a hospital. The aim of a hospital order, as set out in the UK by the Ministry of Justice, is to “divert the convicted mentally disordered offender from punishment in the criminal justice system, and direct his care and treatment at the discretion of mental health professionals”. In applying treatment to such a case, the aim of the treatment would be to treat or prevent deterioration of a mental disorder and to reduce the subject’s subsequent risk with an eventual aim of discharging them safely into the community. In order to do so, there needs to be some capacity to learn, which all individuals have to some extent; however, this has a range of limitations in those with intellectual disabilities and this positive change may occur more slowly. If people with intellectual disabilities are being detained in hospitals with detentions which last indefinitely, then in theory their rate of learning is likely to be slower. In order to make progress through the system, they will need to demonstrate that their risk has reduced which often includes an increased insight into their offending behaviours as well as tackling the factors which led them to offend in the first place. There is a lack of evidence that people with intellectual disabilities remain in the system longer compared to their counterparts of normal intellect. In care or custody (Adshead 2000), it was argued that mentally ill offenders are detained longer in secure settings than their counterparts who have committed exactly the same offence, but do not have a mental disorder. This would also apply to people with intellectual disabilities considering their rate of learning and what is required in order to progress through the system.

One of the reasons someone with an intellectual disability might engage in law-breaking behaviour is because they may have a poor understanding of the law or be unaware of it. People with intellectual disabilities are more likely to

have been brought up in institutional care and therefore are less likely to have had a stable learning environment and opportunity to learn about and develop their own moral and ethical frameworks. So on the one hand they may lack knowledge of the law and therefore be unable to make informed decisions about their actions, and on the other hand, they may have had exposure to knowledge of the law but their understanding of it may vary. For example, someone with an intellectual disability may not know or understand the law around the age of sexual consent. They may engage in a sexual act with someone under age with a lack of knowledge of the law, rather than their actions being attributed to any paedophilic tendencies or deliberate act. Due to sentencing guidelines, once convicted they may face a long sentence despite having lacked the knowledge to make an informed decision regarding their actions. One could argue that people with intellectual disabilities in certain situations should not be liable to punishment or treated via the traditional punitive route if they did not have the capacity to understand the wrongful act. If the purpose of the sentence is to rehabilitate and educate them, then the sentence would fulfil its proposed aim, but if there is a strong punitive dimension to the sentence, for example, having received a prison sentence, then one could argue that the punitive aspect is not proportionate to the act if the act lacked intent.

The evidence for lack of theory of mind in people with intellectual disabilities is equivocal; however, there are many features of theory of mind which have been found to be lacking in autistic spectrum disorder which is often comorbid with intellectual disabilities (Craig and Hutchinson 2005). Such people may have a reduced ability to pick up on the cues which allow us to know how people are feeling emotionally and whether they want to participate. This may be particularly pertinent when considering sexual offences, as consent or lack of consent from the victim may not have registered in the mind of the perpetrator. Additionally, there may be other factors at play, contributing to their poor decision-making, such as impulsivity. In such cases, when the punishment or sentence is being served, the question should be asked as to what form of sentence should be given. If the consequence serves to deliver the message to the perpetrator that such an act is wrong and therefore acts as a deterrent to engage in such acts in the future, then this may be appropriate. However, if the situation arose again, the person would still lack the ability to “read” the person/situation and a punishment may serve the consequence of them avoiding any related scenarios, e.g. sexual or romantic relationships, in the future, which itself could be seen as limiting their quality of life. From this perspective, a purely punitive consequence could in itself be seen as unethical.

Looking at the different options for sentencing, such as community sentences, or hospital disposals, these are another way of opening these options up, reducing the punitive focus of consequences. Placements in secure hospitals or treatment in community settings allow a greater emphasis on learning and rehabilitating in relation to the element which is focused on punishing the person for what they did. However, even if someone receives a hospital order following an offence, by a court of law, then this sentence can be lengthy and the treatment and progress may take time. The length of this detention may be protracted and continue for longer than a

determinate prison sentence would. This detention in itself serves to protect the public and protect the person being detained but that detention in itself can by nature be perceived as punitive.

8.2.3 Sexual Consent/Understanding Sexual Relationships

There is some evidence that the rates of sexual offending amongst people with intellectual disabilities are relatively high. Sexual rights for people with intellectual disabilities have evolved over the decades, with a history of enforced sterilisation programmes in some countries, based on a person's label of having an intellectual disability, rather than on their own wishes and consent. The entering into force of Article 8 of the European Convention for Human Rights sought to protect people from such severe infringements.

Someone with intellectual disabilities, depending on the characteristics and level of their disability, will have varying perceptions of relationships and what constitutes a relationship. The romantic relationships of people with intellectual disabilities may develop in different ways to relationships that develop in the more traditional way due to their lower levels of independence and their encounters may be monitored by those who are responsible for them. Likewise, they may find it easier to relate to someone of a younger age because of the level of their intellectual functioning and therefore may aim for relationships with people younger than themselves who may be "under age", with varying degrees of understanding of the law around age of sexual consent. This may be seen as a natural way of seeking out relationships with someone they can relate to, as is human nature. Someone with an intellectual disability who commits a sexual offence will be viewed as such in the eyes of the law. In an alternate sense, the behaviour could be viewed as them seeking out a relationship with someone who they can better relate to than someone of their equivalent age. The act may attract a hospital order due to their intellectual disability with possible co-existing mental illness, or may attract a prison sentence. The ethical dilemma in such an instance is to what extent they should be punished for this. A hospital order would serve to treat them, educating them and enabling them to gain the understanding and experience needed to engage in legal, functioning relationships which are deemed acceptable by society, but restricting their liberties and taking away their autonomy in the process.

Some prisons in the UK have adapted rehabilitation programmes for people with intellectual disabilities, including an adapted sex offender treatment programme, which would serve the function of providing the rehabilitation required for them to live safely in society. A hospital order can be seen as less punishing and more therapeutic; however, both options, by restricting liberties and autonomy, can be deemed as punitive in nature. The dilemma remains as to what extent someone with an intellectual disability should be punished despite their lack of knowledge, intent and volition. The difficulty of treating people with intellectual disabilities who sexually offend can be considered in the context of their recidivism rates. These have been

found to be 3.5–6.8 times those of their non-intellectually disabled counterparts in studies with follow-up for 2 years or more (Baron-Cohen 2001).

8.2.4 Safeguarding

As mentioned previously in this chapter, someone with an intellectual disability is often vulnerable. Someone with an intellectual disability with a comorbid psychiatric condition is particularly vulnerable. The forensic element of their case adds another dimension to their vulnerability. By posing a danger to the public, they are liable to engage in risky behaviour, leaving themselves vulnerable to retaliation from others. Poor judgment can exacerbate this. Having been labelled as an “offender”, their liability for stigmatisation is further magnified. Some people with intellectual disabilities may present with challenging behaviour and complex mental health problems. These people may need to be brought into hospital and furthermore be detained under the Mental Health Act (“sectioned”) in order to be treated. Furthermore, if there is an aspect of their case which poses a certain level of risk to others/the public, then they may be detained in a secure (forensic) facility.

An infamous case in the UK in the last decade demonstrated the potential vulnerabilities of people with intellectual disabilities. A care home in the South West of England named Winterbourne View had people with intellectual disabilities in their inpatient care facility. An undercover journalist revealed brutal treatment of people who the state and whose families trusted to care for these individuals. Following on from this exposé came an inquiry and subsequent paper called *Transforming Care* which outlined a drive to review all people detained in inpatient care in England and Wales and for an aim towards more community-based care (DoH 2015). There was particular attention on restrictive practices amongst such people in inpatient care. Systematic reviews (“Care Treatment Reviews”) of all such cases were rolled out nationally as a result. This shocking case brought into the nation’s consciousness a need to regard people with intellectual disabilities with particular caution due to their vulnerabilities. Care Treatment Reviews shone a spotlight on each case of someone with an intellectual disability who was detained under the Mental Health Act, acting to ensure that such people were not kept in hospital too long and that they were kept in the least restrictive environment possible, as outlined by the Mental Health Code of Practice.

Historically, the rise of the industrial revolution in the UK highlighted the deficiencies of people with intellectual disabilities and their roles in society which led to housing of these people in large institutions, or asylums. This restrictive model of care was only challenged over a century later when Margaret Thatcher’s government’s white paper, *Care in the Community*, set out the closure of these large institutions and moving people back into the community. This led to an increase of the liberties of people with intellectual disabilities, moving from an asylum care model to community care, promoting independence. *Transforming Care* has seen a new wave of challenge of the detention of people with intellectual disabilities.

Detaining someone under the Mental Health Act involves the restriction of their liberties and is a decision which needs to be taken very carefully. Because of the increased level of dependence people with intellectual disabilities require, there may be a tendency for the people looking after them to adopt more paternalistic approaches when looking after them. This may either be a conscious or less conscious act, as they may evoke more parental reactions in those who are providing their care. This may inadvertently lead to more restrictive practices and a tendency to move towards increasing their liberties (e.g. discharge planning) in a slower way.

Seclusion practices are used in psychiatric facilities, particularly in forensic services, at times when patients pose risks to others. Keeping attention on such restrictive practices for people with intellectual disabilities allows objective and critical reviews. People with intellectual disabilities are less likely to be able to voice when they feel they are being treated unfairly, unlawfully or if they do not agree with the provisions of their care. For example, they may be less likely to spontaneously request a Mental Health Review Tribunal, requesting their discharge, which is an opportunity for their case to be looked at objectively. Therefore, it is important for such cases to be reviewed in a systematic way to ensure ethical and lawful care for people with intellectual disabilities detained in forensic facilities and to ensure they are detained in the least restrictive way possible. The features of intellectual disabilities such as difficulties in communication and social functioning means that their interests and liberties can be inadvertently overlooked. It is important that a robust strategy to reduce the likelihood of this happening is employed when looking after people in such restrictive settings.

An individual who is detained in secure care as a forensic patient is vulnerable in the sense that they are open to abuse of power from those who care for and look after them. These are the same people who are responsible for their detention. Forensic psychiatrists and allied professionals are agents of the state as well as professionals who are responsible for the care of their patients. This changes the dynamic of the traditional doctor-patient relationship as there is another agent to whom they have a responsibility and so the interests of the doctor do not lie exclusively with the patient. The four ethical principles which a doctor is to use as a framework for their moral practice (autonomy, beneficence, non-maleficence and justice) in this context are challenged. With a patient who has an intellectual disability, along with an additional mental disorder in many cases, this dynamic may be even more unbalanced. Their vulnerabilities due to their lack of intellectual capabilities render them even more at the mercy of those looking after them and hence more liable to their rights being abused.

8.2.5 Medication and Consent

Psychotropic medication, which is widely acknowledged, is prescribed relatively heavily amongst the forensic patient population. They are a group who are by definition more risky and medication is used as a way of managing this risk.

People with intellectual disabilities may display challenging behaviours, which are behaviours of an intensity and frequency or duration that threaten the physical safety of themselves or others. Concerns have been voiced about the overuse of psychotropic medication in people with intellectual disabilities, particularly associated with the management of challenging behaviour.

A study by Sheehan et al. (2015) of over 33 thousand adults with intellectual disabilities showed a high rate of psychotropic prescription amongst people with intellectual disabilities (49%). Challenging behaviour was a positive predictor of having been prescribed a psychotropic medication, with people with challenging behaviour more than twice as likely to receive a prescription for antipsychotics compared to those without such a record (Sheehan et al. 2015). Given the rate and intensity of prescribing of psychotropic medication amongst forensic patients, these levels of prescribing are likely to be reflected, if not intensified, in this population. Amongst detained psychiatric patients, capacity and consent are standard issues which are considered for every such patient. Capacity is a particular issue amongst people with intellectual disabilities as, as much as someone can be supported and educated to make an informed decision about their care, people with intellectual disabilities are more likely to lack capacity to make decisions and are therefore more likely to have decisions about their care made by the people who are caring for them in their detention.

When issues of prescribing for challenging behaviour in intellectual disabilities are combined with their lack of capacity and lack of consent, then one is faced with removing that person's autonomy in quite a dramatic way. The forensic psychiatrist is acting, in such a case, on the side of the public in a rather biased way. Forensic psychiatry acts, one could argue, to treat someone in order to reunite them with their liberty and autonomy in the future; the treatment in hospital is given with the purpose of rehabilitating them in order that they can live in the community with as much independence as their level of risk allows. By treating someone intensively, the forensic psychiatrist is acting to fulfil beneficence for the patient; without doing so the risk is run of perpetuating their detention and denying their liberties and autonomy. Consequently, this could be seen as going against the principle of practicing "non-maleficently". The issues which arise in relation to this when caring with someone with intellectual disabilities particularly involve the issues of capacity, consent and the patient being involved in their care.

8.2.6 Forensic Services and Integration

In the UK, people with intellectual disabilities tend to fall under the care of specialist mental health services. People who are detained in secure care settings with intellectual disabilities, furthermore, tend to be detained in specialist services—specialist forensic intellectual disability secure services. These tend to be in facilities alongside other people who are detained in "mainstream" forensic services for people with "normal" intellect. There is often some level of integration of patients; however, amongst the "community" of patients detained in such settings, there is

generally a knowledge of this difference between the two sets of patients. Along with the diagnosis of an intellectual disability comes a certain stigma. In separating them with the aim of reducing their vulnerabilities and compartmentalising their specialist care comes a perpetuation of the stigmatising label which has always existed in society. Within institutional settings, such as these, often exists a hierarchy amongst the patient group, and by highlighting these disabilities, you are automatically placing these people at a disadvantage in this hierarchical system, which by nature contains people who are prone to antisocial, aggressive behaviour. The lower down the hierarchical system, the more vulnerable they are.

People with intellectual disabilities in forensic services present with their own issues; they tend to have a different diagnostic tapestry and often have different offending profiles and furthermore require treatment (psychological, occupational and medical) which is tailored towards their needs and characteristics. Therefore, there is a strong argument for a specialist service so that people with intellectual disabilities are given the appropriate treatment and in the most timely way possible. By providing treatment in this bespoke way they are being provided with treatment which will, in theory, minimise the deprivation of their liberties. However, along with providing this bespoke service comes segregation and setting them apart from mainstream service users and therefore highlighting their differences.

In the UK, because of the niche nature of the intellectually disabled forensic group and the way commissioning works, although specialist NHS services do exist, many of the services are based in the private sector and are not geographically consistent. This puts this group at a disadvantage as they are more likely to be detained further away from their families and community teams who would ultimately be looking after them when they are discharged; discharge planning will in theory be at a slower rate. Because of the lack of proximity to these supportive sources, this may delay their progress and discharge, making their pathway into the community slower. Work is needed to build services which bring people with intellectual disabilities in secure care closer to their homes, in order to ensure they are supported to advance into care in the least restrictive environment. Scarce specialist services exist for this group in the community. People are usually looked after by community intellectual disability teams or forensic teams, with some scope for joint-working. In order to provide the most specialist support for this complex, risky and dependent group, this argument also exists for developing such specialist community services, in order to promote safe community living, fostering as much autonomy as possible, whilst preventing readmission when possible. This would also bring them in line with the services which are available for the general forensic psychiatric population, creating greater equity and justice for this group.

8.2.7 Advance Directives

A person's clarity of mind can fluctuate throughout time, and their ability to make decisions, or capacity, can be affected by numerous factors including physical or mental illness. This includes someone with an intellectual disability. People with

intellectual disabilities have varying intellectual capabilities, and although an individual's capacity to make certain decisions may routinely be impaired, different factors can further complicate this ability.

An advance directive is where an individual executes a document expressing his or her wishes as to treatment in the event that they are unable to do so and the physician acts upon the pre-stated wishes if and when the situation arises (Mason et al. 2002). They allow the voice of an individual to be heard at a time when their communication is particularly impaired or they lack capacity to make decisions about their care specified in the directive. It allows their autonomy to be preserved beyond the point of loss of capacity when important decisions are needing to be made. Advance directives are particularly pertinent in the cases of forensic psychiatry patients with intellectual disabilities. Advance directives allow such people to have a level of involvement in their care which is otherwise rather paternalistic. Advance directives can be written at a time when there is space and there are resources to do so. Such patients should be actively encouraged and supported to write them when they are able. In a group of individuals whose autonomy is so compromised due to their circumstances, tools such as advance directives can be used to empower them and for them to regain some autonomy which is otherwise seemingly so minimal.

8.2.8 Conclusion

People with intellectual disabilities are a complex group who, by the nature of their disabilities, have the potential to be vulnerable. Some of the ethical issues, which arise when working with this group in a forensic psychiatric setting, have been discussed in this chapter. Due to their cognitive deficits, the learning process involved with rehabilitating and reducing someone's risk will in theory be slower and more complex. Someone with intellectual disabilities is less likely to have a knowledge of the law, which particularly applies when considering sexual offences. This combined with difficulties in applying theory of mind makes them more liable to encounter difficulties when seeking such relationships. This leaves a quandary about the punishment element for such an offence, if someone had a poor grasp of the law when committing the offence.

Forensic psychiatrists have a dual responsibility—to both their patients and for public protection. The principles which form the ethical framework which doctors aspire are somewhat compromised when detaining and often treating someone against their will. This is further compromised when working with someone with intellectual disabilities; their level of independence and thus autonomy tends to be lower. They are liable to more restrictive practices due to the dynamic which exists between them and those looking after them and the parental responses they might inspire. Because of these complications, systematic, objective reviews of practices with this group in forensic psychiatry are needed in order to ensure safe and ethical practice where people are treated in the least restrictive way possible, promoting liberties and autonomy wherever possible. Advance directives are an example of a tool which can empower someone with intellectual disabilities in an otherwise disempowering situation.

There is an argument for specialist care for people with intellectual disabilities and forensic needs, in order to treat them in the safest and most bespoke environment

possible, in order to give them the best chance of moving on and being treated in the least restrictive setting. Whilst treating them in this compartmentalised setting, their differences are being highlighted, perpetuating the segregation of this group from society.

A fine balance exists in treating people with intellectual disabilities and forensic needs with as much humanity as possible, respecting their autonomy, whilst regarding their risk and vulnerabilities. A high level of awareness and scrutiny is required in order to continually appraise these services and care which are prone to higher levels of paternalism and restriction. Historical treatment of people with intellectual disabilities who are detained should act as reminders of the responsibility which needs to be taken by the state for the care of this group and fair and ethical treatment cannot be relied upon, with complacency.

References

- Adshead G (2000) Care or custody? Ethical dilemmas in forensic psychiatry. *J Med Ethics* 26:302–304
- Baron-Cohen S (2001) Theory of mind in normal development and autism. *Prisme* 34:174–183
- Craig LA, Hutchinson RB (2005) Sexual offenders with learning disabilities: risk, recidivism and treatment. *J Sex Aggress* 11(3):289–304
- Department of Health (2017) Code of practice: the Mental Health Act 1983. Available from <https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983>
- Department of Health (2015) Transforming care for people with learning disabilities—next steps. Available from <https://www.england.nhs.uk/wp-content/uploads/2015/01/transform-care-next-steps.pdf>
- Department of Health Guidance (2010) Eliminating mixed sex accommodation in hospitals. Available from <https://www.gov.uk/government/publications/eliminating-mixed-sex-accommodation>
- Department of Health (2001) Valuing people: a new strategy for learning disability for the 21st century. Available from <https://www.gov.uk/government/publications/valuing-people-a-new-strategy-for-learning-disability-for-the-21st-century>
- Equality Act (2010). Available from <https://www.legislation.gov.uk/ukpga/2010/15/contents>
- Gender Recognition Act (2004). Available from <https://www.legislation.gov.uk/ukpga/2004/7/contents>
- Mason JK, McCall Smith RA, Laurie GT (2002) Law and medical ethics, 6th revised edition. LexisNexis, UK, London
- McNeil J, Bailey L, Ellis S, Morton J, Regan M (2012) Trans mental health study 2012. Available from https://www.gires.org.uk/wp-content/uploads/2014/08/trans_mh_study.pdf
- Nuno N, Elizabeth P, Allan T, Ian R (2015) The RaRE research report: LGB & T mental health—risk and resilience explored. PACE—Project for Advocacy Counselling and Education, London, England
- Sheehan R, Hassiotis A, Walters K, Osbord D, Strydom A, Horsfall L (2015) Mental illness, challenging behaviour, and psychotropic drug prescribing in people with intellectual disability: UK population based cohort study. *BMJ* 2015(351):h4326
- The Care and Treatment of Transgender Offenders (2016) Policy paper. Available from <https://www.gov.uk/government/publications/care-and-management-of-transgender-offenders>
- The Criminal Justice Act (2003) Section 146. Available from <https://www.legislation.gov.uk/ukpga/2003/44/section/146>
- Virupaksha HG, Muralidhar D, Ramakrishna J (2016) Suicide and suicidal behavior among transgender persons. *Indian J Psychol Med* 38(6):505–509

Index

A

- Accreditation Council for Graduate Medical Education (ACGME), 18
- American Academy of Forensic Sciences (AAFS), 17
- American Academy of Psychiatry and the Law (AAPL), 17
- American Board of Forensic Psychiatry (ABFP), 18
- American Board of Psychiatry and Neurology (ABPN), 18
- American College of Legal Medicine (ACLM), 17
- Antidepressants, 61
- Anti-hormonal substances, 62
 - GnRH analogues, 64
 - oestrogens, 63
 - steroidal anti-androgen treatments
 - CPA, 64
 - MPA, 63, 64
- Antipsychotic medication
 - beneficence and non-maleficence, 100
 - ethical obligations, 100
 - extrapyramidal side effects, 105
 - harm-benefit analysis, 105
 - high dose antipsychotic
 - monotherapy, 101–104
 - informed consent, capacity and forensic arena, 109–111
 - long-term maintenance therapy, 104
 - medical ethics, 99
 - pharmacological agents, 100
 - polypharmacy, 101–104
 - prescription rates, 100
 - principlism
 - autonomy, 106, 107
 - beneficence, 107
 - issues with, 108, 109
 - non maleficence, 108
 - respect for justice, 108
 - scope of application, 108

- psychopharmacological arena, 104
- rise of, 101
- sales of, 101
- Anxiolytics, 61, 62
- Approved social worker (ASW), 30
- Asia, 16
- Australia
 - inpatient and outpatient care, 15
 - legal framework, 15
 - prison mental health, 16
- Autistic spectrum disorder, 142

B

- Beneficence, 107
- Bournemouth Gap*, 32
- British Medical Association, 33
- British National Formulary (BNF), 102
- British Offender Personality Disorder Pathway, 55
- Buspirone, 62

C

- Care Programme Approach (CPA), 8
- China, 16
- Community treatment orders, 31
- Comparison question technique (CQT), 86, 87
- Confidentiality
 - generic ethical issues, 33
 - specific ethical issues
 - disclosures about patients who lack capacity to consent, 37, 38
 - disclosures approved under a legal process, 36
 - disclosures in public interest, 36, 37
 - GMC, 36
 - transgender, 140
- The Criminal Justice Act 2003, 136

- Criminal justice system
 GPS, 118–120
 history, 117
 limitations, 120, 121
 police and court diversion, 7
 prisons and young offender institutions, 8, 9
 private sector involvement, 119, 120
 radio frequency technology, 118, 119
 remote supervision, 118
 ultimate community penalty, 118
 Cyproterone acetate (CPA), 64
- D**
 Denmark, legal framework and inpatient care, 15
 Department of Health (DoH), 138, 141
 Directed Lie Comparison (DLC), 86
 Donaldson v.O'Connor (1968), 18
 Dopamine, 58
The Dundrum Quartet, 9
- E**
 Egymen project, 23, 24
 Electronic monitoring
 control and punishment, 116
 cost considerations, 131, 132
 criminal justice system
 GPS, 118–120
 history, 117
 limitations, 120, 121
 private sector involvement, 119, 120
 radio frequency technology, 118, 119
 remote supervision, 118
 ultimate community penalty, 118
 ethical considerations, 125–128
 extrapolation of surveillance, 122–125
 political and economic climate, 116
 public arena, 116
 rehabilitation, 117
 social control, 116
 societal considerations, 128–131
 supervision and risk management, 115
 walkie talkie type transmitter system, 116
 England and Wales or the Health and Social Care Act of 2016, 36
 Equality Act of 2010, 136
 Ethical issues
 confidentiality
 disclosures about patients who lack capacity to consent, 37, 38
 disclosures approved under a legal process, 36
 disclosures in public interest, 36, 37
 GMC, 36
 definition, 34
 deprivation of liberty, 34, 35
 environmental factors, 34
 forensic research, 40, 41
 patient and clinicians relationship, 39, 40
 Eugenics movement, 52, 53
 Eugenics Records Office (ERO), 52
 Europe
 Denmark, legal framework and inpatient care, 15
 Germany
 inpatient care, 13
 legal framework, 13
 outpatient care, 14
 prison psychiatry, 14
 medico-legal systems, professions and service provision, 12
 Netherlands
 inpatient care, 14
 legal framework, 14
 Sweden, 14, 15
- F**
 Female sex offenders, 75–77
 Fluoxetine, 62
- G**
 Gender Recognition Act of 2004, 136
 General Medical Council (GMC), 33, 36
 Generic ethical issues, 32, 33
 Germany
 inpatient care, 13
 legal framework, 13
 outpatient care, 14
 prison psychiatry, 14
 Global positioning systems (GPS), 115
 Gonadotropin-releasing hormone (GnRH) analogues, 64, 65
 Goserelin, 65
- H**
 Healthcare system
 in Egypt, psychiatric services, 23, 24
 in Iraq
 adult population, 20
 culture of psychiatry and stigma, 20, 21
 data collection, 20
 forensic psychiatry, 22
 mental health workforce, 21

in Oman, mental health provision, 22, 23
 outpatient care, 11, 12
 in-patient care, 9–11
 High dose antipsychotic monotherapy, 102
 Human Rights Act, 31
 Hybrid model, 11

I

In-reach services, 8
 Integrated model, 11
 Intellectual disabilities
 ability to learn, 141–143
 advance directives, 147, 148
 forensic services and integration,
 146, 147
 medication and consent, 145, 146
 safeguarding, 144, 145
 sexual consent/understanding sexual
 relationships, 143, 144

J

Japan, 16
 Juvenile sex offenders, 74, 75

L

Leuprorelin, 65
 Liberty restrictions, 34, 35
 Lie detector, 92

M

Märistans, 19
 Maudsley Prescribing Guidelines
 reports, 103
 Medication to manage sexual arousal
 (MMSA), 55, 71
 Medroxyprogesterone acetate (MPA),
 53, 63, 64
 Mental Capacity Act of 2016, 4
 Mental Health Act 1983, 30, 31
 Middle East
 in Egypt, psychiatric services, 23, 24
 Hammurabi's code, 19
 in Iraq
 adult population, 20
 culture of psychiatry and stigma, 20, 21
 data collection, 20
 forensic psychiatry, 22
 mental health workforce, 21
 in Oman, mental health provision, 22, 23
 Moral principles, 29
 Multisystemic therapy (MST), 56

N

National Health Service Act of 2006, 36
 Netherlands
 legal framework, 14
 outpatient care, 14
 Non-maleficence, 105, 108

P

Parallel model, 11
 Percy Commission, 30
 Polygraph test
 bodily activities, 86
 CQT, 87, 88
 in-test data collection, 86
 PCSOT
 cognitive distortions, 92
 community-based samples, 90
 crossover sexual offences, 90
 disclosures, 89, 90
 high-secure hospitals, 91
 mandatory polygraph pilot, 89
 risk assessment, 88
 SHE, 90, 91
 treatment, 89
 truth facilitator, 91, 92
 physiological changes, 86, 87
 polygraph examination, 92, 93
 post-conviction settings, 87
 pre-test interview, 85, 88
 test data analysis, 86
 Polypharmacy, 102–104
 Post conviction sex offender (PCSOT) tests
 cognitive distortions, 92
 community-based samples, 90
 crossover sexual offences, 90
 disclosures, 89, 90
 high-secure hospitals, 91
 mandatory polygraph pilot, 89
 risk assessment, 88
 SHE, 90, 91
 treatment, 89
 truth facilitator, 91, 92
 Post-traumatic stress disorder (PTSD), 20
Principlism, 29
 Probable Lie Comparison (PLC), 86
 Psychiatric intensive care units (PICU), 7
 Psychologically informed planned
 environments (PIPEs), 9

R
 Radio frequency systems, 119
 Relational security, 10
 Relevant questions (RQs), 86

S

Selective serotonin reuptake inhibitors (SSRIs), 61, 62

Sell v U.S. (2003), 18

Sexual history examination (SHE), 90, 91

Sexual offending

- androgen deprivation therapy, 54
- antipsychotic medication (*see* Antipsychotic medication)
- California enacted legislation, 53, 54
- chemical castration, 51, 54
- cognitive behavioural techniques, 56
- community factors, 48
- diethylstilbestrol (progestational compound), 53
- electronic monitoring (*see* Electronic monitoring)
- emotions, 47
- eugenics movement, 52, 53
- female sex offenders, 75–77
- holistic approach, 56–57
- juvenile sex offenders, 74, 75
- medical interventions, 56
- medications
 - antidepressants and anxiolytics, 61, 62
 - anti-hormonal substances, 62–65
 - chemical castration, 66, 67
 - etiology, 60
 - paraphilic disorders, 60
 - psychiatric evaluation, 61
 - psychological and physiological characteristics, 60
 - surgical castration, 65, 66
 - testosterone, 59
- neurobiology
 - females, 58, 59
 - males, 57, 58
- non-pharmacological interventions, 55
- pharmacological methods, 55
- polygraph test (*see* Polygraph test)
- psychological interventions, 56
- quality of life and sexual functioning, 55
- recidivism rates, 47
- restrictions, 48
- sexual arousal
 - complexities, 73
 - diagnosis, 68
 - free will/coercion, 71–73
 - medical responsibility and legal obligations, 69–71
 - pharmacotherapy, 68
 - principles, 68
 - sexual behaviours, 67
- surgical castration, 53
- undesirable traits, 52

- therapeutic interventions, 55
- transgender sex offenders, 77, 78

Significantly impaired decision-making ability (SIDMA), 4

Sweden, legal framework and inpatient care, 14, 15

T

Technocorrections, 115, 132

TerBeschikkingStelling (TBS) hospitals, 14

Testosterone, 57, 59

Transgender forensic psychiatry populations

- advantage, 140
- anxieties, 137
- confidentiality, 140
- The Criminal Justice Act 2003, 136
- Department of Health, 138
- Equality Act of 2010, 136
- female facilities, 137
- female service users, 135
- feminist movement, 137
- gender identity, 137
- Gender Recognition Act of 2004, 136
- health professionals, 138
- mental health services, 138
- NHS medium-secure units, 135–136
- non-binary actors, 136
- pre- and post- gender reassignment, 139
- Prison Service's guidelines, 137
- privacy and dignity, 139
- risk factor, 135
- suicidal behaviour, 136
- teamwork and environments, 139

Transgender sex offenders, 77, 78

Triptorelin, 65

Truth facilitator, 91, 92

U

United Kingdom (UK)

- capacity and insight, 4
- criminal justice system, 5
 - police and court diversion, 7
 - prisons and Young Offender institutions, 8, 9
- fusion legislation, 4
- healthcare system
 - in-patient care, 9–11
 - outpatient care, 11, 12
- history, 4
- hybrid order, 5
- mental health legislation, 4
- offending behaviour, 3, 4

-
- regional secure units, 5
 - risks, 3
 - SIDMA, 4
 - United States of America (USA), 17–19, 24, 25
- W**
- Washington v. Harper (1990), 18
 - Women’s Enhanced Medium Secure Services (WEMSS), 10