



Assessment and Management of Specific Populations

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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.

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