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Treating women in clinical forensic mental health care

A guide

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Preface

In this guide we provide guidelines for treating women in (gender-mixed) clinical forensic mental health care. In the Dutch language report [*Behandelen van vrouwen: Een vak apart? Ontwikkeling van een handreiking voor het behandelen van vrouwen in de klinische forensische zorg*](#)¹ [Treating women: A profession in its own right? Developing guidelines for treating women in clinical forensic mental health care], the rationale for these guidelines from the research project we conducted is discussed in detail.

We feel it is important to emphasize that several of the guidelines can also be valuable for men admitted to forensic mental health care. Gender-responsive working means taking into account gender differences, but also being as attuned as much as possible to the individual, whether female, male, or another gender identity. Nevertheless, we felt it necessary to formulate specific guidelines for women, since most of the attention to date within forensic mental health care, both from science and practice, has been directed towards men. Research is still limited, but it shows that not all (risk assessment) instruments and forensic treatment methods are valid and / or suitable for women and that adaptations or additions are desirable. In addition, we believe that extra attention for female patients is important given their minority position within forensic settings.

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We hope that this guide can contribute to the most effective treatment of women in clinical forensic mental health care in the interest of these women, their social network (especially their children), the professionals who work with them, and society.

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¹ <https://kfz.nl/projecten/behandelen-van-vrouwen-in-forensische-klinische-zorg-een-vak-apart-het-ontwikkelen-van-richtlijnen-voor-de-behandeling-van-vrouwen-in-de-forensische-klinische-zorg>.

1. Background and aim of the guide

1.1 Background

Women in clinical forensic mental health care are a small but growing group. However, most of the tools and methods used in forensic mental health care have not yet been sufficiently studied in women or have proven less valid and / or suitable for them. A Dutch [multicenter study](#) on gender differences in clinical forensic mental health care has been running since 2012. This study shows a picture of severely traumatized women with very complex problems, for whom previous mental health treatments have often failed. Given this profile, it is not surprising that the treatment of female patients in clinical forensic mental health care is often complicated. All forensic settings in the Netherlands where women are admitted experience difficulties in the (continuity of) treatment.

In various phases of the forensic (gender-mixed) treatment, there are issues around the supervision and treatment of female patients, like how to deal with intimate relationships, biological differences (including possibly different effects of psychotropic medication) and the role of family, children and social relationships. More generally, there are questions about whether gender differences are sufficiently taken into account in diagnostics, risk assessment and treatment methods. There are also questions around the theme of gender identity and how to treat transgender patients. These questions from the field and the experienced problems in the continuity of forensic care of women in the Netherlands formed the reason for the project.

The literature reviewed in the Dutch language report ([de Vogel et al., 2023](#)) shows that there are many similarities between women and men admitted to forensic mental health care, but also relevant group differences that can be considered as specific risk or responsivity factors. These are summarized in Box 1.

Box 1. Distinguishing characteristics of women versus men in forensic mental health care

History

- Women have a higher prevalence of victimization, particularly sexual abuse.
- Women more often have a pattern of victimization in both childhood and adulthood.

Criminal history / offence characteristics

- Women were older at the time of committing the first offense.
- Women were less likely to have been convicted prior to the offense for which they were admitted to forensic mental health care.
- Women more often had familiar victims, like children or (ex) partner.
- Women were more often convicted for arson and homicide offenses (relatively often child homicide) and much less often for sexual offenses.
- Women were more often driven by relational motives (e.g., jealousy, hurt) and less often by instrumental motives (e.g., money, power, status).

Psychiatric characteristics

- Women had more co-morbidity.
- Women more often had a borderline personality disorder and depression.
- Women less often had an antisocial and narcissistic personality disorder.
- Women showed more internalizing and self-harming behavior.
- Women had a longer treatment history.
- Women had more incidents during treatment (violence towards others and self, and covert / manipulative behavior) and more often directed towards professionals rather than fellow patients.

Risk assessment

- The standardly used risk assessment tools like the HCR-20^{V3} (and FAM) can reasonably predict general recidivism, but do not sufficiently predict violent recidivism in women.

The research findings discussed in the [report](#) show that - although both women and men in forensic mental health care typically have complex backgrounds with many traumatic experiences and complex psychiatric problems - women generally have different treatment needs, and there is evidence that most current practices do not adequately address these. It is important that more attention will be paid to women in clinical forensic mental health care to provide them with the best possible treatment and prevent relapse into violent or antisocial behavior. This is important not only for these women and for society, but also for the recognition of their victims and for their social environment, especially any children. We know from research that children of mothers with a history of criminal and violent behavior are more likely to have a variety of problems, like developing mental disorders, dropping out of school, health problems, addiction, criminal and aggressive behavior. Finally, more attention for gender issues is important for professionals who work with women. Research shows that many professionals find it more complex and demanding to work with women / in gender-mixed forensic settings than with men alone and need additional support and practical guidelines. For male professionals it may be difficult because they sometimes fear of being falsely accused of sexual harassment.

1.2 Aim of the guide

The aim of this guide is to provide practical guidelines for the treatment of women in clinical forensic mental health care.

The guide is intended for professionals and organizations in (gender-mixed) clinical forensic mental health care. The guidelines in this document may also be of value to the treatment or supervision of women in outpatient forensic mental health care, the probation services or other partners. However, not all of the themes will be applicable to them and probably other themes will also be important there, for instance, children who still live with their mother.

1.3 Development of the guide

The guide was developed in six phases:



A total of 295 professionals completed the survey and 22 professionals and 11 patients (eight female, three male) were interviewed. Based on this, a draft guide was written, which was then presented in two expert meetings with professionals and one with patients, and subsequently adapted. Finally, a pilot study was conducted in three of the participating forensic settings. For a detailed description of the method and results we refer to the report ([de Vogel et al., 2023](#)).

1.4 Vision treating women in clinical forensic mental health care

Based on the literature on women in clinical forensic mental health care and the results of the research project, the following vision was formulated:

There are many similarities between men and women treated in clinical forensic mental health care, and each person must be assessed and treated individually. Thus, tailored care should be provided as much as possible. In principle, the widely used *Risk Need Responsivity model* is also valuable for women. There are some specific risk factors and characteristics for women that can be considered as responsivity factors.

It is important that treatment in clinical forensic mental health care is gender-responsive, i.e., that gender differences are taken into account as much as possible. It is important to formulate clear policies about gender-responsive working in a gender-mixed facility, and it is recommended that gender-sensitive diagnostic and risk assessment tools or additional guidelines and gender-responsive treatment programs be used as much as possible.

The following definitions are applied in this guide:

Gender	The characteristics of males and females that are socially constructed, and includes norms, behaviors and roles associated with being of either sex (WHO definition).
Gender-sensitive	Being aware of gender differences.
Gender-responsive	Taking into account gender differences.
Sex	The physical, biological characteristics that give a human a male or female role in reproduction, such as hormones, chromosomes, and internal and external organs.

2. Gender-responsive working

2.1 General principles

From the literature and our research project, a number of general principles for gender-responsive working can be formulated. We want to emphasize that many of these principles can also be valuable for men. However, these points have emerged specifically from scientific research on women in forensic mental health care.

From a synthesis of qualitative research into female service users' experiences of secure care in the United Kingdom ([Ratcliffe & Stenfert Kroese, 2021](#)), three overarching themes were found that women themselves mention as essential:

- *Safety and containment*: clear structure, expectations and information, consistency and availability, trust and cohesion;
- *Empowerment*: respect and understanding, choice and autonomy, identity and individuality, connectedness and normality;
- *Acceptance and making change*: facilitators of change, making internal change, moving on and managing transitions.

[Logan and Taylor \(2017\)](#) discuss the challenges in gender-responsive work with women with personality disorders in secure care in the United Kingdom. They emphasize the importance of practitioners' skills in understanding and managing emotions and in being able to establish and sustain a safe relationship with the women in treatment. They also explicitly mention that not everyone is suitable for this work and that a good selection of practitioners is therefore important. In addition, they discuss characteristics that an organization must meet to be able to offer good gender-responsive treatment. These can be summarized as follows:

Relevant skills practitioners for working with women in secure care:

- Being prepared and willing to accept that women exhibit harmful behavior (toward others and themselves);
- Being able to mentalize; understand the behavior of others and themselves;
- Being aware of- and able to indicate personal boundaries;
- Being able to communicate clearly and effectively;
- Taking women seriously in their change process and involving them as 'stakeholder' in their recovery process.

Relevant characteristics organizations and management for working with women in secure care:

- Good selection of practitioners;
- Clear, accessible and up-to-date operational policy on gender-responsive working (this should be available to all and adapted if needed or desired);
- Building in support for practitioners in working with women.

Two basic general principles for gender-responsive working can be formulated, as well as several principles about living climate, treatment and organizations (see Box 2).

- 1) **Trauma-informed care.** Trauma awareness is the core principle in this model with an emphasis on safety in the setting, providing adequate choices, good collaboration and connection, working from strengths and building skills. Trauma-informed care has five core principles: 1) safety; 2) trustworthiness; 3) choice; 4) collaboration; 5) empowerment ([SAMHSA, 2014](#)).
- 2) **Relational working and security.** Knowing someone well in order to be able to pick up on signals that things are not going well, showing interest, and offering support with emotional problems are important (see for instance [See Think Act](#)).

Box 2. General principles and recommendations for gender-responsive working

General principles and recommendations for gender-responsive working

General

- Trauma-informed care is the basis: 1) safety; 2) trustworthiness; 3) choice; 4) collaboration; 5) empowerment.
- Relational working and security are the norm.

Living climate

- Offer a safe environment and clear structure.
- Approach patients in a respectful manner.
- Involve the women as stakeholders in their recovery process.
- Give women as much autonomy as possible.

Treatment

- Use gender-sensitive risk assessment and diagnostic tools.
- Use evidence-based gender-responsive treatment programs.
- Take specific characteristics of women into account in the treatment program (e.g., the form and goals of trauma treatment).
- Put an emphasis on (developing) strengths / protective factors.
- Facilitate contact with child(ren) if desirable / possible and offer support in this:
 - Strengthen parenting skills if necessary or desired;
 - Examine whether there are risks to the contact with children (e.g., in case of domestic violence or offenses in which children were victims).
- Pay specific attention to:
 - *Physical health* (especially obesity, problems with sleeping); assess possible problems with somatic diagnostics and pay attention to prevention and lifestyle;
 - *Self-harming behavior*: examine the function of this behavior and what possibilities there are to stop or reduce it. Take into account - and prevent possible copycat behavior; other patients can also start showing self-harming behavior themselves by seeing or hearing about this behavior.
 - *Social and intimate relationships*: relationships are of great importance and can be both a protective factor and a risk factor / source of stress.

Organizations

- Take into account the specific skills needed by professionals for working with women in forensic mental health care (e.g., awareness and understanding of personal boundaries, respectful attitude) and select professionals accordingly.
- Acknowledge that working with women can be experienced as more complex and demanding and provide adequate support for professionals. It can be difficult for male professionals because they sometimes fear of being falsely accused of sexual harassment.
- Develop clear policies on the treatment of women (in a gender-mixed setting) which are easily accessible to everyone and can be adapted if necessary or desired.
- Offer knowledge on gender (differences).
- Offer education and coaching in dealing with self-harming behavior, including providing more insight about the nature and function (emotion regulation seems to be most common) of self-harming behavior.
- Offer education in recognizing and dealing with manipulative behavior.

2.2 Gender-specific principles

In addition to the general principles, there are issues specifically related to gender or biological factors, which are listed in Box 3.

Box 3. Gender-specific principles

Gender-specific principles

- Acknowledge gender differences and take into account biological factors; e.g., possible hormonal influence on behavior, possibly different effects of psychotropic medication, since most of the research on this so far has been conducted in male populations.
- Take into account female-specific and hormonal health problems, like problems around menstruation, menopause, endometriosis.
- Pay attention to sexual health and how it is experienced: make this a subject for discussion.
- Formulate clear policies on contraception: who is responsible, how is it organized?

One particular issue is working with transgender persons. From various literature reviews within prison and probation populations (e.g., [van Hout et al., 2020](#)), some conclusions can be drawn:

- Transgender persons are more likely to be (sexually) victimised during incarceration.
- Gender dysphoria is associated with increased suicide risk, also within correctional institutions.
- Transgender persons in correctional institutions report negative experiences during their stay; they indicate that they "feel different" and they mention that this is often used against them, both by fellow inmates and by their supervisors.

Some recommendations can be drawn from the literature that may also be of value to clinical forensic mental health care (see Box 4). It is important to emphasize that good assessment by experts is important for identifying issues surrounding gender identity. For more information on diagnostics and risk assessment in transgender individuals, see Chapter 3 *Gender-sensitive Diagnostics and Risk Assessment*. For more general guidelines see [APA \(2015\)](#).

Box 4. Working with transgender people

Working with transgender people

- Conduct assessment on gender dysphoria and possible transdiagnostic factors by experts in the field of gender (see Box 7, p. 17).
- Ensure safety within the institution as much as possible.
- Ensure sufficient privacy within the institution.
- Recognition and respectful approach towards issues around gender identity.
- Formulate clear policies about placement and facilities (e.g., sanitary facilities, clothing).
- Provide access to good medical care.
- Offer training to professionals about gender (identity).
- Pay attention to possible traumas and offer treatment.
- Be cognizant of increased risk of victimization within the institution.
- Be cognizant of increased risk of suicidality within institution.

2.3 Recommendations for gender-mixed treatment

The survey revealed a clear preference for gender-mixed treatment; of all professionals 191 (77%) indicated to prefer gender-mixed treatment. Among professionals working in a clinical setting this was even higher (85%). This preference was also expressed in the interviews with both professionals and patients. From the research project and literature, the following advantages and disadvantages of gender-mixed treatment can be reported:

Advantages of gender-mixed treatment

- It provides the best preparation for resocialization; it creates a treatment environment that is comparable to that in society;
- It clarifies specific treatment opportunities;
- It creates a more positive atmosphere in the hospital, with male patients showing more empathic behavior and less aggressive, intimidating behavior;
- It offers an opportunity for women to gain positive experiences with men.

Disadvantages of gender-mixed treatment

- There is risk of re-traumatization (of note: this is also possible in groups with only women). Especially risky in case:
 - A woman resides as the only woman in a gender-mixed ward;
 - Presence of men with a history of sexual offending;
 - Women with serious trauma-related mental health issues and/or who are not able to indicate their boundaries adequately;
 - Women with a history of prostitution (risk of repetition within the setting).

In addition, it was mentioned that placing only women together also has disadvantages, for instance, possible 'copy cat behavior', particularly of self-harming behavior. Furthermore, conflicts between women are often experienced by professionals as more complex and less visible.

There is widespread recognition that creating an optimal treatment climate in groups where male and female patients are treated requires more energy and effort from professionals.

It is up to each setting to make its own choices, but from the literature and the current project, the following recommendations or conditions for gender-mixed treatment, including supervising intimate relationships can be formulated (see Box 5). Again, several of these recommendations could just as easily apply to groups where only men or only women reside, and it should be noted that various forms of intimate relationships may exist.

Box 5. Recommendations for treatment in gender-mixed forensic mental health settings

Recommendations for treatment in gender-mixed forensic mental health settings

General:

- Safety in the institution should be ensured as much as possible; including sufficient skilled staff, safety in building (e.g., lighting, lock on room).
- It is important to strengthen the resilience of women in a male-dominated environment.
- Expert professionals who have knowledge about gender differences.
- Provide supervision in contacts / intimate relationships.
- Emergency measures must be possible in case of risky situations, (e.g., transfer of a patient).
- Formulate clear policies on:
 - Options for intimate contact / intimate relationships;
 - Contraception (responsibility, organization);
 - Pregnancy.
- Facilitate treatment options specifically for women, for instance, women's discussion or therapy group, relaxing activities ('ladies night') and separate sports times. Mentioned relevant themes for a discussion group are: motherhood, sexuality, trauma, questions around menstruation, contraception, pregnancy, menopause, healthy lifestyle etc.
- Sufficient privacy, facilities and specific products for women, for example, hygiene products.

Living group

- Make an analysis of the most suitable composition of a gender-mixed ward (e.g., offense type, trauma history, prostitution history).
- Formulate clear policies about the desired ratio of women to men in a gender-mixed ward; always at least two women in a gender-mixed ward.

Intimate relationships

- Prohibiting intimate relationships is not realistic and intimate relationships can have positive effects. However, it is essential to closely supervise and support patients in relationships. In the case of an intimate relationship:
 - Make clear agreements with those involved (including how often and where they can see each other, clarity about contraception) and ensure that everyone is familiar with these agreements.
 - If desired, provide couples therapy / system therapy or supervision and regularly monitor and discuss how the relationship is going.
 - Conduct regular risk assessment for intimate partner violence if necessary / desired (e.g., in case of a history of partner violence by one or both partners).

3. Gender-sensitive diagnostics and risk assessment

3.1 Gender bias

Gender bias is a construct that refers to beliefs, attitudes, and/or predispositions that involve preconceived and stereotypical ideas about the roles, abilities, and characteristics of women and men ([APA, 2018](#), p. 31).

Gender bias is considered a potential risk in (forensic) assessment processes, both in instrument items, and in the way these instruments are applied. To illustrate, in the *Psychopathy Checklist-Revised* (PCL-R), item 1 *Glibness/superficial charm* literally describes 'macho men' as indicator for coding the item which is obviously difficult to code for women.

It is important for professionals to be aware of the possibility of gender bias in diagnostics and risk assessment and to realize that other risk factors and protective factors may be important to women, or that they have a different meaning or value. It should be noted that there may also be gender bias towards men. For instance, depression, anxiety and trauma-related complaints are less easily recognized in men compared to women.

3.2 Guidelines for diagnostics

General guidelines

The [APA \(2018\)](#) has formulated guidelines for girls / women:

Psychologists strive to assign diagnoses to girls and women only if and when diagnosis is necessary, use unbiased assessment tools, and bring to bear an understanding of the history of misuses and gender biases and diagnoses and assessment. (p. 15)

Guidelines Psychopathy Checklist-Revised

There are specific guidelines for coding the PCL-R for women (Smith et al., 2021, pp. 437-454). The authors provide tips on how to ask questions during the interview and discuss points of interest for studying the file. General guidelines are:

- Use examples that are more appropriate for women.
- Reflect and show empathy in order to uncover information.
- Pay attention to defensive style or if the woman seems to be taking on a victim role.
- Pay attention to indirect, subtle behavior and obfuscating language. For example, for coding item 1 *Glibness/superficial charm*, they state that "although men will present as a confident (even arrogant), slick and smooth 'used car salesman', in females look for a demure, 'damsel in distress'." (Smith et al., 2021, p. 452)
- Pay close attention to discrepancies what is in the file and what the woman tells herself.

Trauma

Examining the history of traumatic events and assessing trauma-related complaints should be an important part of forensic diagnostics.

3.3 Guidelines for risk assessment

It is important to take into account that most risk assessment instruments have not been sufficiently studied in female populations or have not proven to be valid or suitable with them, and it is therefore recommended to be cautious in drawing conclusions about recidivism risk in women. From the research to date, it can be concluded that unstructured clinical assessment often leads to an underestimate, and actuarial instruments, on the contrary, to an overestimate of risks. Dynamic risk factors (e.g., impulsivity) seem to predict better in women than historical risk factors. Furthermore, research has shown that a summation of risk factors or protective factors does not predict well, but that a consensus coding of low, moderate, or high, does. Thus, discussing the factors with each other seems to be valuable (see for discussion of gender-sensitive risk assessment [de Vogel et al., 2019](#); [de Vogel 2023](#)).

Risk assessment in general

For instruments that assess the likelihood of relapse to crime in general (e.g., the *Level of Service instruments*), international research has found fairly good results in terms of predictive value for women. These have generally been conducted in populations of ex-prisoners/ probationers and not in forensic mental health care.

Risk assessment violence

The two most commonly used risk assessment instruments in Dutch clinical forensic mental health care, the *Historical Clinical Risk Management-20 Version 3* (HCR-20^{V3}) and the Dutch language HKT-R have been found to be less valid for women than for men. For the HCR-20^{V3}, recent [Dutch research](#) has found a reasonable predictive value for general recidivism, but a moderate predictive value for violent recidivism. The START yielded the best results in this study (but also lower than typically found for men). Both the HCR-20^{V3} and the START can be used, but interpreted with great caution, especially when important decisions need to be made.

The Female Additional Manual (FAM) as a supplement.

The [FAM](#) is an additional risk assessment tool for females to the HCR-20^{V3} for assessing violence toward others and self. The risk factors included in the FAM are:

- Prostitution
- Parenting difficulties
- Pregnancy at young age
- Suicidality / self-harm
- Covert / manipulative behavior
- Low self-esteem
- Problematic child care responsibility
- Problematic intimate relationship

The FAM is likely to be particularly valuable for clinical use (increased understanding of risks, risk management guidelines) and for the prediction of risky behaviors such as self-harming behavior. Dutch research showed that the FAM did not provide any additional predictive value for violent recidivism after discharge compared to the HCR-20^{V3} ([de Vogel et al., 2019](#)).

Protective factors

It is also important to look at protective factors, especially as this can provide guidelines for treatment. Within the [Dutch multicenter study](#), the SAPROF was found to predict recidivism less well for women than for men. Possible (additional) relevant protective factors for women are:

- Positive social relationships
- Intrinsic will to change and feeling that this can be achieved (sense of agency)
- Children / motherhood
- Economic independence
- Self-confidence

Risk assessment partner violence

It is important to consider specific risks within clinical forensic mental health care, for example, partner violence in case of intimate relationships within forensic mental health care. Use validated instruments (e.g., the B-SAFER), but again, keep in mind that most instruments have only been studied in male populations.

Risk assessment sexual violence

A large Canadian study in 739 women ([Marshall et al., 2020](#)) who have sexually offended concluded that the STATIC-99R was not a significant predictor and is therefore not suitable for use with women. Little is known about other sex offender instruments like the STABLE for women. Overall, there is little knowledge about risk factors and no validated risk assessment instruments for women who have committed sexual offenses. Thus, it is recommended to be reserved in assessing recidivism risk of sexual offenses in women and be very cautious in drawing conclusions about it.

Box 6. Recommendations for gender-sensitive diagnostics and risk assessment

Recommendations for gender-sensitive diagnostics and risk assessment

Gender-bias

- Be aware of the possibility of gender bias in diagnostics and risk assessment.

Guidelines for (forensic) diagnostics in women

- Use general [APA \(2018\)](#) guidelines.
- Use additional guidelines for interviewing and coding the *Psychopathy Checklist-Revised* for women ([Smith et al., 2021](#)).
- Assessing trauma (related symptoms) is an important part of diagnostics.

Risk assessment

- There is overlap in risk factors, but take into account that for women other risk factors and protective factors may be important, or that they have a different meaning or value than for men.
- Take into account that most risk assessment tools have proven less useful or are insufficiently studied in female populations; be careful in drawing conclusions.
- *Violence*. The commonly used HCR-20^{V3}* has moderate predictive value for violence. The HCR-20^{V3} and START can be used for women but should be interpreted with caution. The [Female Additional Manual \(FAM\)](#) can be used as an additional tool for assessing violence towards both others and oneself. The FAM may be valuable for clinical use (increased insight, risk management guidelines), but does not provide additional predictive value to the HCR-20^{V3}.
- *Sexual violence*. There is little knowledge about risk factors and no validated risk assessment tools for women who have committed sexual offenses. Be very cautious in drawing conclusions about the risk of sexual recidivism.

* In the Netherlands, the HCR-20^{V3} is one of the mandatory tools to use with forensic patients with the tbs-order (mandatory treatment order).

3.4 Guidelines for diagnostics and risk assessment with transgender persons

In daily practice, there are questions about the use of risk assessment instruments in transgender persons (usually in the case of a trans woman). Hardly any research has been done on this, making it difficult to draw clear conclusions. For now, the following recommendations apply, based on the scarce research and experiences from practice (see Box 7).

More generally, it is important to emphasize that good diagnostics are important to identify problems related to gender identity. Several instruments are available to assess gender dysphoria, including the Utrecht Gender Dysphoria Scale (UGHS) or the revision Utrecht Gender Dysphoria Scale - Gender Spectrum (UGDS-GS). Typically, a formal classification is required to initiate a transition pathway. An important theme that is still largely lacking in the reviewed literature is good, distinctive diagnostics, also considering the possible overlap with mental disorders. Are there transdiagnostic factors? More research is needed.

There is currently hardly anything known about the value of risk assessment instruments with trans women (see for example, [Jumper, 2021](#)). For now, we recommend taking into account the gender identity at the time of the offense. If the trans woman identified as male at the time of the offense, it seems of little value to score the (Historical factors of) the FAM, since these stem from research on women. The FAM dynamic factors may be valuable, but only for risk management guidelines. Regarding risk assessment for sexual offenses, we follow the recommendation for transgender persons as formulated by the original authors of the SSA (see Box 7).

Box 7. Recommendations for diagnostics and risk assessment with transgender persons

Recommendations for diagnostics and risk assessment with transgender persons

- Structured assessment by experts in the field of gender is needed to classify gender dysphoria (and possibly transdiagnostic factors).
- Violence risk assessment: be careful to use the FAM when a trans woman identified as male at the time of the index offense; possibly use only for risk management guidelines (especially the dynamic factors).
- Sexual violence risk assessment: *Static-Stable-Acute* may only be used if person was biologically male at the time of the sexual offense or if the transition from female to male was generally acknowledged.

4. Gender-responsive treatment

In the United Kingdom and North America, several gender-responsive treatment programs have been developed, particularly for substance abusing women in prison and usually given by peers (experienced and trained prisoners). Research so far show promising results, that is, a reduction in mental health problems, relapse in substance abuse and offending behavior ([van Voorhis, 2022](#); see for references the report [de Vogel et al., 2023](#)). No gender-responsive treatment programs exist yet in the Netherlands and adaptations for use in Dutch clinical forensic mental health care are probably needed, as well as research into its value for female forensic psychiatric patients.

We can learn from the potentially effective components of such gender-responsive treatment programs (see Box 8).

Box 8. Gender-responsive treatment

Gender-responsive treatment

- Trauma treatment aimed at increasing resilience, indicating boundaries, preventing revictimization. Self-confidence, self-efficacy, coping and social relations are aspects that have proven to be especially important for women.
- Empowerment: financial independence, choice of profession, control, autonomy.
- If child(ren): strengthening parenting skills, fulfilling mother's role.
- Specific attention for the role of social and intimate relationships and sexuality.
- Psychoeducation (e.g., about the relationship between trauma and substance abuse).

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A comprehensive bibliography can be found in the final report.

Information on Dutch multicenter study of gender differences in forensic mental health care: <https://www.researchgate.net/project/Gender-differences-in-forensic-psychiatric-patients>

The Dutch language tools HCR-20^{V3}, HKT-R en FAM are available via: <https://www.forensischezorg.nl/beleid/risicotaxatie-instrumenten>

The English language FAM is available via: https://www.researchgate.net/publication/355131623_Female_Additional_Manual_Additional_guidelines_to_the_HCR-20_V3_for_assessing_risk_for_violence_in_women