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EDITORIAL

Evidence-based practice in the evaluation and treatment of sexual offenders

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This editorial addresses evidence based medical practice in forensic psychiatry and particularly in the field of paraphilia. John Bradford is a Professor in the Department of Psychiatry and Behavioural Neurosciences, McMaster University. He is an Emeritus Professor at the University of Ottawa where he was a founder of the Royal Ottawa Institute of Mental Health Research. He is a Founder of Forensic Psychiatry, granted by the Royal College of Physicians and Surgeons of Canada. Abdullah Alqahtani is an Assistant Professor and Consultant Psychiatrist at King Fahd University Hospital, Imam Abdulrahman Bin Faisal University, Dammam, Saudi Arabia. He is currently completing a clinical fellowship in forensic psychiatry at McMaster University - St. Joseph's Healthcare Hamilton. Andrew Olagunju is an academic psychiatrist with a Senior Lecturer position at the College of Medicine, University of Lagos, Nigeria. He is also completing a clinical fellowship at McMaster University - St. Joseph's Healthcare Hamilton.

One of the significant shifts in medicine in the last two decades is the introduction of evidence-based practice, characterized by the integration of clinical expertise with best available evidence from systematic research in making a clinical decision [1,2]. Given the pressure to adopt this approach in all medical disciplines, evidence-based practice is in vogue in medicine and a hot topic in forensic psychiatry. For instance, analogous to evidence-based practice, psychiatric expert testimony is required to be objective and scientifically based, and the Supreme Courts of Canada and USA in relevant case laws have established a scientific basis for the reliability of psychiatric expert evidence [3].

The US Supreme Court held that the minimum requirement for admissibility of scientific evidence (and the weight once admitted) be based on its scientific validity as described in *Daubert* [4]. In a similar case, the Canadian Supreme Court, in *R. v. Mohan*, noted that four factors control the admissibility of expert evidence: relevance, the necessity in assisting the trier of fact, the absence of any exclusionary rule, and the proper qualification of the expert [5]. Given the preceding decisions, there is an apparent burden to show that the theory or technique underlining evidence is tested, peer-reviewed, has a known error rate or standard of reference, and is generally accepted within the scientific community [4,6,7]. In fact, it is often said that an expert opinion is only as good as the factual foundation on which it is premised [7]. This puts the responsibility on the forensic psychiatrist witness to be aware of the evidence-based practice in their roles within the criminal justice system and those interfacing with the civil mental health system.

As simple as it might sound, there are caveats on how evidence-based medicine applies to forensic psychiatric practice because "one medicine or rule for all" does not always hold [8]. This is because some aspects of forensic psychiatric practice have a stronger scientific basis compared to others, and clearly fit the definition of evidence-based medicine. A "stand-alone" application of evidence-based practice to all aspects of forensic psychiatry, especially when it is devoid of clinical judgment, can be counter-intuitive, too reductionist, over-dependent on clinical trials, and would not fit all the complexities of medico-legal cases [7,9]. The assessment and treatment of sexual offenders provide a good example of a strong scientific basis

and meet the definition of evidence-based medicine in many respects, as defined by Sackett et al. [10].

When dealing with a sexual offender, the criminal justice system needs scientific evidence regarding the diagnostic criteria for paraphilia, the risk of recidivism, and the possible treatments that would mitigate that risk. All of these areas have been the subject of considerable research and would fit the definition of evidence-based medicine [1,10]. In this editorial, we model evidence-based practice by parsing the best available evidence for the assessment and treatment of sexual offenders while highlighting some limitations. We also revisit the issue of the complementarity of clinical acumen and knowledge derived from empirical research in forensic psychiatry.

Evidence-Base Practice in Assessment and Diagnosis of Paraphilia

When assessing a sexual offender, it is important to highlight the psychopathological characteristics of the individual's sexual behaviour in order to understand why it deviated from the norm. Studies related to human sexuality have provided an understanding of "anomalous psychosexual phenomenon," while evidence-based forensic psychiatric practice has specifically allowed refinement of diagnostic assessments and nosology of the paraphilias. For example, the successive revisions of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), now in its fifth edition, led to the historical delisting of homosexuality and modification in the diagnosis of paraphilia as new scientific evidence emerged [11].

According to the DSM-5, paraphilia is characterized by recurrent, intense sexual urges, fantasies, or behaviors that involve unusual objects, activities, or situations and cause clinically significant distress or impairment in social, occupational, or other important areas of functioning [11]. The paraphilias consist of exhibitionism, fetishism, frotteurism, pedophilia, sexual masochism, sexual sadism, transvestic fetishism, voyeurism and paraphilia not otherwise specified (this includes telephone scatalogia; necrophilia; partialism; zoophilia; coprophilia; klismaphilia and urophilia). Although by definition, all of the paraphilias can be diagnosed with only the presence of deviant sexual fantasies, clearly the behavior of some paraphilias require physical contact with an adult or child, or an animal in zoophilia and a corpse in necrophilia. In the other paraphilias, the behavior does not require contact with another person. The former group is regarded as the "hands-on" paraphilias, while the latter group is regarded as the "hands-off" paraphilias. This classification is not to be confused with victimization, whereby clearly the victims of voyeurism, exhibitionism and telephone scatalogia, for example, can be traumatized by the experience. When considered as a group of diagnoses in psychiatry, there are only a small number of the paraphilias that would clearly fit the definition of being sexually violent, and sexual violence is mostly related to "hands-on" paraphilias. That said, there is considerable comorbidity between the paraphilias, with significant crossover in any given individual between "hands-on" and "hands-off" paraphilias [12].

The phenomenon of comorbidity emphasizes the need for a careful diagnostic evaluation. This type of assessment is based on the pathognomonic feature of all paraphilias or sexual deviations, which is deviant sexual arousal [13]. This then formed the basis for the objective measure of sexual arousal, which would then define the sexual preference of the individual and allow for objective diagnosis of the paraphilia or sexual deviation. Deviant sexual preference, in theory, drove deviant sexual behavior and this was responsible for sexual offending in the majority of cases.

The objective measurement of sexual arousal in a laboratory setting also provided an independent measurement of the reported sexual preference by the sexual offender or persons suffering from a paraphilia. This is made possible by the measurement of penile tumescence in a laboratory setting as an objective measure of sexual preference [14]. This objective test formed a fundamental basis to the comprehensive assessment of sexual offenders. Although there is no complete stand-

ardized approach to the evaluation of sexual offenders in specialized centers, a typical approach includes a forensic psychiatric diagnostic and evaluative clinical examination, a detailed psychiatric history, mental status examination to diagnose associated psychiatric conditions and general medical conditions. In addition, specific assessment for deviant sexual behavior consists of sex hormone profile, a variety of sexual questionnaires, and objective measures of sexual interest such as penile tumescence testing or visual reaction time [15]. The sex hormone profile consists of free and total testosterone (Free T and Total T); follicle stimulating hormone (FSH); luteinizing hormone (LH); estradiol; prolactin; and progesterone. The sex hormone profile is essential to form the diagnostic basis for conditions affecting sexual endocrinology that may be associated with paraphilias, such as Klinefelter syndrome. It also establishes the baseline readings for pharmacological treatment intervention. The sexual questionnaires are usually self-report questionnaires measuring overall sexual performance, drug and alcohol usage, sexual drive measures, general measures of impulsivity, measures of aggression, quantitative and qualitative measures of sexual fantasy, a detailed sexual behaviors inventory, some measure of deception, and measurement of cognitive distortions. Physiological measures of sexual preference complete the overall comprehensive assessment [15]. Despite the scientific basis to penile tumescence testing (penile plethysmography – PPG), there has been a considerable amount of criticism, and to a certain extent controversy, about using these techniques to make a diagnosis, as well as their use in forensic settings. The main issue is the lack of standardization of the procedures used and the lack of a standardized stimulus set. Another area of criticism for PPG testing is the lack of consensus as to the appropriate content and method of delivery of each stimulus; the usual delivery is a videotape, slides and audiotapes.

Evidence-Based Practice in Risk Assessments

Sexual offense recidivism risk is calculated through risk assessment instruments such as the Static 99 [16], and often Psychopathy is measured through the Hare Psychopathy Checklist [17]. The importance of sexual arousal testing is emphasized by deviant sexual preference being amongst the strongest predictors of sexual offense recidivism [18]. Although a full discussion of risk assessment and risk assessment instruments is beyond the scope of this paper, the Hare Psychopathy Checklist forms an important part of the evidence-based practice in the assessment of sexual offenders as it forms an important part of the prediction of future sexual offense recidivism. The concept of psychopathy has developed historically and is the product of extensive clinical research [18]. The concept as operationalized in the Hare Psychopathy Checklist (PCLR) has proven to be the most reliable means of identifying psychopathic traits [17]. It also has become the most important tool in assessing psychopathy in forensic psychiatric situations such as risk assessment but is also proved to be one of the most important measurements in the prediction of recidivism [18]. The performance of other risk assessment instruments for predicting sexual offense recidivism have also been significantly researched and have significant predictive validity [16, 18]. The extensive recidivism studies, particularly looking at violent sexual offenders, have participated in the evidence-based testimony in Dangerous Offender hearings in Canada and in Sexually Violent Predator hearings in the United States.

Evidence-Based Practice in Treatment of Sexual Offenders

The pharmacological treatment of sexual offenders is based on well-established studies on the neurobiology and neuropharmacology of sexual behavior in both human and animal subjects [19]. In fact, the neurobiology and neuropharmacology of sexual behavior is far better understood compared to the neuropharmacology and neurobiology of major psychiatric disorders such as Mood Disorders and Schizo-

phrenia [19]. Historically, surgical castration was widely used as an intervention to treat sexual offenders, and various studies reported dramatic decreases in sexual offense recidivism based on this intervention. Pharmacological treatments have been developed using the same principle of intervention, that is, the reduction of total and free testosterone in the endocrine system, significantly reducing sexual drive and consequently sexual behavior, including deviant sexual behavior. The pharmacological treatments provided a reversible intervention compared to surgical castration. Pharmacological intervention includes three main categories: Selective serotonin reuptake inhibitors (SSRIs); Hormonal agents such as medroxyprogesterone acetate (MPA) and luteinizing hormone-releasing hormone (LHRH) agonists (leuprolide acetate and goserelin acetates are the most commonly used); and Antiandrogens (cyproterone acetate (CPA) is the most widely used) [19].

In addition to the neuropharmacology and neurobiology of these pharmacological agents being well understood, it has also formed the basis of a treatment algorithm for the pharmacological treatment of the paraphilias and sexual offenders [19]. This algorithm starts with all persons requiring treatment receive psychological treatments in the form of cognitive behavioral therapy and relapse prevention treatment (level one). This is followed by various levels of pharmacological treatment starting with selective serotonin reuptake inhibitors (SSRIs), a non-hormonal treatment and the least intrusive of pharmacological interventions (level two). Next is hormonal (MPA) or antiandrogen (CPA) treatments given orally (level three); this is followed by a combination of an oral antiandrogen (CPA) or hormonal therapy (MPA) given in conjunction with an SSRI (level four). This has been followed by intramuscular antiandrogen (CPA) or hormonal (MPA) treatment (level five). Finally, there is LHRH agonist treatment resulting in a pharmacological castration using leuprolide acetate or goserelin acetate (level six). The decision to move from one level of the algorithm through to the next level, and ultimately to level six, is based on a severity scale.

Limitations

Evidence-based practice can impose some limitations on forensic psychiatry. Scientific validity is a necessary but not sufficient precondition in determining if the evidence is admissible in court. Presumably, evidence-based medicine will inform the court as to the scientific validity of the evidence, while admissibility and adjudication of a case in point rests with the court. It is also not clear how much of patients' best interests as well as physician education play into evidence-based practice. In the same vein, a pragmatic use of clinical trial evidence seems essential to ensure the validity of the therapies used; for example, no randomized controlled studies of the efficacy of SSRIs in the treatment of the paraphilias have been published to date.

Recommendation

The science underpinning assessment and treatment of sexual offenders continues to evolve, and forensic psychiatric professionals are expected to be cognizant of this recent scientific evidence. Despite the complexities of medico-legal cases, the evidence-based practice remains an essential tool to continue to improve medical knowledge of sexual offenders.

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REVIEW ARTICLE

Relationships Between Patient-Level Factors and Criteria for Fitness to Stand Trial

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In Western criminal justice systems, proceedings may be halted if an individual is deemed mentally unfit to stand trial. As a prerequisite to adjudication fitness to stand trial can be evaluated through structured or unstructured assessments. Previous studies suggest limited use of structured assessments in clinical practice. Few studies have looked at the success of unstructured measures of psycholegal abilities, and fewer still have investigated the influence of individual variables on criteria for fitness to stand trial. The purpose of the present study was to examine the relationship between variables relevant to opining fitness as determined by previous research and the criteria for fitness to stand trial. The study yielded significant correlations between the three criteria for fitness to stand trial and the following variables: impaired mental status during assessment, presence of intellectual disability, nature of index offence, socioeconomic status, and all unstructured measures of psycholegal abilities. These results suggest that unstructured clinician assessment of fitness to stand trial can be successful at determining fitness and fulfillment of the three underlying criteria, and further clarify the role of specific symptoms on opinions of unfitness. Future directions for research in the areas of structured professional judgment and fitness restoration are discussed.

Key words

Fitness to Stand Trial, Competency to Stand Trial, Criminal Code of Canada, Structured Professional Judgment, Assessment

Introduction

In Canada, court proceedings may be paused if there is sufficient evidence to indicate that the accused may be mentally unfit to stand trial. Under section 672.23 of the Criminal Code of Canada (herein referred to as the Criminal Code), an individual is presumed to be Fit to Stand Trial (FST) unless the issue of fitness is raised by the Crown Attorney (prosecution), the Judge, or the Defence lawyer [1]. The accused person is considered to be Unfit to Stand Trial (UST) if he or she is unable to meet the criteria outlined in section 2 of the Criminal Code [1], which specifies that:

> s. 2: "unfit to stand trial" means unable on account of mental disorder to conduct a defence at any stage of the proceedings before a verdict is rendered or to instruct counsel to do so, and, in particular, unable on account of mental disorder to (a) understand the nature or object of the proceedings, (b) understand the possible consequences of the proceedings, or (c) communicate with counsel.

An individual's state of fitness to stand trial is thus related to the individual's mental status and the impact of his or her mental functioning on his or her ability to fulfill the criteria outlined above. This does not mean that a mental disorder is indicative of unfitness; it must be that the individual is impaired on one or more of the above criteria as a result of the mental disorder. Consequently, the presence of a mental disorder is necessary but not sufficient to determine unfitness. However, if the individual does meet one or more of the criteria outlined in s. 2 of the Criminal Code, the Judge may conclude that he or she is UST or Incompetent to Stand Trial [IST] for the American standard [2], and his or her legal proceedings will be suspended until fitness is restored.

However, the Criminal Code is unclear on how to evaluate these criteria so as to determine fitness. Over the last thirty

years, numerous studies have attempted to assess the relationship between patient-level factors (demographic information, psychiatric information, criminal history information, and psycholegal information) and findings of fitness to understand how better to determine fitness.

The majority of studies on demographic factors have left the field unclear, as have the studies on criminal history. The most consensus in the field has been in research related to psychiatric factors, where it has long been clear that those found UST are more likely to have a history of psychiatric symptoms or diagnoses [3]. Part of the reasons for the lack of consensus is that these studies assess fitness using structured assessment measures, though it is clear from the research that clinicians use unstructured assessment measures, thus leaving a gap between empirical research and clinical practice [3,4]. However, of the limitations posed by the literature, the most striking is that very minimal research (with no research occurring in Canada) has been conducted on the influence of the accused's psycholegal abilities as measured by clinicians in an unstructured manner on fitness determinations. An extensive literature review was conducted by the authors of this paper prior to commencing the study detailed below [3].

The aim of the present study is to expand upon the limited research on how specific variables impact determinations of fitness to stand trial, and to resolve many of the above inconsistencies, particularly in addressing the variance of how psycholegal abilities are measured. This is done by focusing on what information clinicians actually rely upon in their evaluations: questions based on their own clinical and diagnostic experiences and knowledge, not on standardized measures or checklists. Few studies have looked at the success of unstructured measures of psycholegal abilities, and fewer still have investigated the influence of relevant variables on individual prongs of fitness to stand trial. The goal of the present study is to examine the relationship between relevant variables and each criterion of fitness to stand trial in a real-life sample in order to better understand how the clinician's interpretation of the accused's answers leads to a determination of fitness. Secondly, this study attempts to address some of the previous methodological issues such as sample bias and statistical limitations.

Methods

The study consisted of a retrospective file review that included 51 patients consecutively referred for an assessment of fitness to stand trial at a psychiatric facility in a large Canadian city in 2014. This sample represented all fitness assessments for the forensic catchment area, thus minimizing sample bias or referral bias from a particular court or jurisdiction. The following study received ethics approval from the institutional research ethics board in July 2015. The study included files from both inpatient and outpatient assessments. Files were coded by two trained raters under the supervision of a co-author and clinical forensic psychologist. The coders met regularly to ensure coding was completed accurately.

Materials

Materials reviewed included discharge summaries from all previous hospital admissions, the most recent criminal record provided by the local police department, previous and current fitness report(s), detention centre records (both previous and at the time of assessment), any notes provided from other consultations, notes from the index fitness assessment, and any email correspondence that was also included in the files, such as from lawyers or mental health providers. Data from the following sections of the report were coded: Identifying Data, Sources of Information, Background History, Mental Status Examination, Fitness to Stand Trial Assessment, and Opinions and Recommendations.

Variables

Variables were coded within the following categories: Demographic Information, Psychiatric Information, Fitness Assessment, and Criminal History. With respect to demographic factors, this study expanded on the current literature by coding for variables that represented changes in

home configuration and financial status, as well as variables about immigration status and if the accused has any children. In accordance with other studies, the present study included variables for gender, age, race, level of education, employment status, home configuration, financial/income status, and family history. With respect to psychiatric factors, this study included a wide range of variables, including psychiatric history, number of previous psychiatric admissions, comorbidity, and codes for primary, secondary, and tertiary diagnoses. Information was also gathered about all aspects of the Mental Status Examination including mood, affect, thought content, presence of nonsensical phrasing, thoughts of harm, paranoia, presence of hallucinations, and level of aggressiveness during the assessment. With respect to criminal factors, the present study coded for prior criminal history, including information about convictions, charges, and prior incarceration. It expanded upon the index offence, coding not only the nature of the offence, but also details about the victim, intoxication of the accused, level of injury in the offence, and whether or not a weapon was used. For the purposes of this study, psycholegal abilities were coded based on the psychiatrist's summary of the individual's answers to the questions posed during the assessment. There are seven psycholegal abilities that mimic those assessed by the standardized measures but are far more open-ended when assessed in an unstructured interview setting [3].

Ability on each of these questions was coded as *Yes* or *No*, as per the fitness report outlined by the psychiatrist. The other psycholegal variable of interest was location of the assessment. Fitness assessments were conducted either on an inpatient admission basis, on an in-person basis through the outpatient Fitness Clinic, through a secure video assessment, or on an outpatient basis at a detention centre.

Results

Fifty-one assessments of fitness to stand trial were ordered by the court to the forensic psychiatry program in 2014. Four files were removed due to an inconclusive finding during the assessment (e.g. neither Fit nor Unfit). Five files were removed because of their limitation to the administration of a Treatment Order, and as such did not include much of the required data. Of the remaining forty-two files, five files were reviewed by both raters to establish and evaluate interrater reliability (IRR). IRR was excellent, with kappa values ranging from .84 to .93. The mean estimated kappa was .90. Data were analysed and treated for missing values, outliers, and normality assumptions.

With respect to analysis, the type of correlation statistic calculated depended on the nature of the data. For continuous variables, the Pearson r correlation was calculated, as well as for categorical, dichotomous variables as r approximates Phi when both of the variables each have two possible values. For correlations that involved categorical variables that have an unequal number of possible values—for example, when one is dichotomous and one is trichotomous—the Cramer's V correlation was calculated, a statistic that is used to measure the strength of association between two categorical variables.

A standardized fitness assessment test was used for only one file, consistent with the rationale of the study and the previous research. The other forty-five cases used an unstructured assessment interview to evaluate the aforementioned psycholegal questions. In addition, the group distribution between those found FST or UST and those able to fulfill or not able to fulfill the respective criteria is almost identical, which is consistent with the rationale underlying the hypotheses.

Sample Description

The total number of files used for descriptive purposes was forty-two (N = 42). Thirty-six subjects (85.7%) were judged to be FST and six subjects (14.3%) were judged to be UST. There were thirty-five males and seven females, which is representative of the larger Canadian forensic psychiatric population. The mean age of the total sample was 36.86 years, with a standard deviation of 12.58. A plurality of the sample was Caucasian/White (47.8%) and a majority of the sample was single

(76.1%). Seventy-four percent (73.8%) of the sample was unemployed (n = 31), 2.4% were students (n = 1), 4.8% were on disability (n = 2), and 7.1% were retired (n = 3). Forty-three percent of the sample lived alone (n = 18, 42.9%) at the time of the assessment order, and received some form of welfare or disability funding (n = 26, 61.9%). Four files were missing information on home configuration, and ten files were missing information on finances. Just under half of the sample (n = 20, 47.6%) was previously employed and receiving income from employment prior to the Fitness to Stand Trial Assessment.

A minority of the sample had a family history of mental illness, substance abuse, or criminal activity. Schizophrenia was the most prevalent primary psychiatric diagnosis (40%). Thirty-eight percent of the sample had a comorbid diagnosis, the most prevalent being Substance Abuse Not Otherwise Specified (NOS). In only 28.6% of the cases was a secondary psychiatric diagnosis made, followed by only 7.1% having a listed tertiary psychiatric diagnosis.

For the three criteria outlined in s. 2 of the Criminal Code, 85.7% of the sample (n = 36) was able to understand the nature and object of the proceedings, 83.3% of the sample (n = 35) was able to understand the consequences of the proceedings, and 85.7% of the sample (n = 36) was able to communicate with counsel. These percentages are consistent with the percentages of people found FST versus UST stated above.

Over half (57.1%, n = 24) of the sample had previous general convictions and 33.3% of the sample (n = 14) had previous general charges. Fifty percent of the sample (n = 21) had previous violent convictions and 21.4% of the sample (n = 9) had previous violent charges. Less than 10% of the sample (9.5%, n = 4) had previous sexual convictions and 2.4% of the sample (n = 1) had previous sexual charges.

Demographic Factors

Table 1 shows the significant Cramer's V correlations between demographic variables and all three criteria for fitness to stand trial. There were no significant correlations found for the following variables: age, gender, race/ethnicity, marital status, level of education, home configuration at the time of order, home configuration before the order, financial/income status at the time of the order, changes in home configuration, or changes in financial/income status, family history of mental illness, or family history of substance abuse.

Table 1: *Relationship between Demographic Variables and the Three Fitness Criteria*

Demographic Variable	Nature and Object **	Consequences ***	Communicating ****
Employment Status	V = .51*	V = .51*	V = .51*
Prior Financial/Income Status	V = .52*	V = .52*	V = .52*

Note: *$p < 0.05$. ** Understanding the nature and object of the proceeding; *** Understanding the Consequences of the proceedings; **** Communication with counsel

Psychiatric Factors

Table 2 shows the significant Cramer's V correlations and the significant Pearson's r correlations between psychiatric variables and all three criteria. Presence of nonsensical phrases was significantly negatively correlated with the fulfillment of all three criteria. Mood and the three criteria showed strong Cramer's V correlations, such that those with a normal or stable mood were able to fulfill the criteria. With respect to specific criteria, affect was significantly positively correlated with under-

standing the nature and object of the proceedings and communicating with counsel, such that appropriate affect made it more likely to be able to fulfill the aforementioned criteria. Thought content and understanding the consequences of the proceedings showed a strong correlation as well, suggesting that normal thought content was more likely to be indicative of someone's ability to understand the consequences. Finally, intellectual disability was very strongly negatively correlated with understanding the consequences of the proceedings such that a presence of intellectual disability makes it more unlikely for someone to understand the consequences of the proceedings. There were no significant correlations found for the following variables: number of previous psychiatric admissions, history of child abuse, previous psychiatric admissions, substance abuse, primary psychiatric diagnosis, secondary psychiatric diagnosis, tertiary psychiatric diagnosis, capability to consent to medication, comorbidity, presence of hallucinations during assessment, presence of thoughts of harm to self or others, presence of paranoid feelings, or aggression.

Table 2. Relationship between psychiatric variables and the three fitness criteria

Psychiatric Variable	Nature and Object **	Consequences ***	Communicating ****
Nonsensical Phrases	r = -.42*	r = -.36*	r = -.42**
Mood	V = .51*	V = .45*	V = .51*
Affect	r = .31*	----------	r = .31*
Thought Content	----------	V = .50*	----------
Intellectual Disability	----------	r = -.44**	----------

Note: *$p < 0.05$. ** Understanding the nature and object of the proceeding; *** Understanding the Consequences of the proceedings; **** Communication with counsel

Criminal Factors

For criminal variables, the nature of the index offence was strongly correlated with understanding the consequences of the proceedings ($V = .42$, $p < 0.05$), such that those who were accused of committing a violent offence were able to understand the consequences of the proceedings. Previous sexual convictions were found to be strongly negatively correlated with understanding the nature and object of the proceedings, and communicating with counsel ($r = -.33$, $p < 0.05$). The presence of previous sexual charges was negatively correlated with understanding the nature and object of the proceedings and with communicating with counsel ($r = -.38$, $p < 0.05$), but positively correlated with understanding consequences of the proceedings ($r = .35$, $p < 0.05$). However, these results should be interpreted with caution as there was an outlier effect with the variables that were found to be significant in these analyses. When the data was analyzed, it appeared that small cell numbers could have skewed the results we obtained, as there was only one individual with a previous sexual charge, and only four with previous sexual convictions. There were no significant correlations found for the following variables: previous general convictions, previous general charges, previous violent convictions, previous violent charges, previous incarceration, victim gender, level of injury, or relationship to the victim.

Psycholegal Factors

Table 3 displays the significant Pearson's r correlations between the psycholegal abilities, the three criteria, and the final opinion of fitness. There were no significant correlations found for location of assessment.

Table 3. Relationship between the psycholegal abilities, the three criteria and the final opinion of fitness.

Psycholegal Variable	Nature and Object **	Consequences ***	Communicating ****
Knowledge of Charges	r = .75**	r = .68**	r = .75**
Description of Events	r = .53**	r = .45**	r = .53**
Identification of Roles	r = .88**	r = .79**	r = .88**
Description of Roles	r = .90**	r = 1.00**	r = .90**
Definition of Pleas	r = .63**	r = .79**	r = .63**
Understanding Outcomes	r = .90**	r = 1.00**	r = .90**
Definition of Legal Terms	r = .77**	r = .90**	r = .77**
Nature and Object **	r = 1.00**	r = .91**	r = 1.00**
Consequences ***	r = .91**	r = 1.00**	r = .91**
Communicating ****	r = 1.00**	r = .91**	r = 1.00**
Final Opinion of Fitness	r = -.81**	r = -.91**	r = -.81**

Note: *$p < 0.05$. ** Understanding the nature and object of the proceeding; *** Understanding the Consequences of the proceedings; **** Communication with counsel.

Discussion

The goal of the present study was to evaluate the use of unstructured measures of psycholegal ability as a valid measure of fitness to stand trial, and to investigate the relationships between specific variables and the three criteria outlined in the Canadian Criminal Code. These two distinctions are crucial because while existing research has looked at the role of various factors on final opinions of fitness to stand trial, few studies have analyzed the role of those factors on specific prongs of fitness or looked at measures of psycholegal ability beyond standardized assessment. The results of the present study support the main hypothesis regarding the use of unstructured measures of psycholegal ability as tools for fitness assessment. All seven psycholegal abilities outlined above showed significant positive correlations with the respective criteria for fitness, which supports the notion that these unstructured questions successfully assess the ability to understand the nature and object of the proceedings, the ability to understand the consequences of the proceedings, and the ability to communicate with counsel. The results further support the role of specific symptoms and variables in opinions of fitness to stand trial and the three prongs.

Demographic Factors

The results indicate significant correlations between employment status and all three criteria, as well as between financial status prior to the time of assessment and all three criteria. That the other demographic variables were not correlated is desirable, as otherwise it would indicate a bias if demographic information was used to determine someone's ability to fulfill a given criterion. The demographic relationships could be due to a number of things, one of which could be a confounding variable. Many individuals who were unable to fulfill the relevant criteria suffer from a psychiatric disorder that may increase the likelihood that someone is unable to find employment, thus also leading them to a lower financial status prior to assessment. In the current study the majority of the group that was able to fulfill the three criteria was unemployed at the time of their assessment, suggesting that something (perhaps a psychiatric disorder or a lengthy pre-trial detention) led to their inability to find employment. Furthermore, even though a third of the data were missing on the financial status variable, the majority was receiving income from employment at the time before their assessment, suggesting that those who were previously employed

may have suffered circumstances that led to their loss of employment and subsequently, their involvement with the criminal justice system. Thus, these results should be interpreted with caution.

Psychiatric Factors

No significant correlation was found between presence of psychotic disorder (or any specific disorder) and any of the three psycholegal criteria and this reflects the important distinction made in the Criminal Code (1). The presence of a mental disorder is necessary to be opined UST, but it is not sufficient on its own. The mental disorder must impact those abilities outlined in the Criminal Code. Thus, the fact that the specific symptoms of mental illness (e.g. impaired mood, nonsensical phrases) are significant in determining ability, and not the disorder itself, is commensurate with the standard outlined in s. 2 of the Criminal Code. Significant results were found for mood, affect, thought content and nonsensical phrasing during assessment, suggesting that indicators of impaired mental status are associated with the likelihood of someone being found unable to fulfill the relevant criteria. These findings support the distinction outlined above.

With respect to disorders, though a specific psychiatric diagnosis was not found to be correlated with any of the criteria, presence of an intellectual disability was found to be negatively correlated with ability to understand the consequences of the proceedings. This result regarding intellectual disability is consistent with the findings of Gay et al., in that intellectual disability was related to unfitness [5]. However, the specific psycholegal criterion it impacts upon is different. Gay et al. found that understanding the nature and object of the proceedings (referred to as factual understanding in the American fitness standard) was influenced by the presence of an intellectual disability, whereas the present study found that understanding the consequences of the proceedings was influenced by this disability (5). It may be that understanding the consequences of the proceedings requires an ability to understand the nature and the object of those proceedings. Therefore, intellectual disability impacts one's ability to appreciate the consequences, and inability to appreciate one's own legal situation results in findings of unfitness.

Criminal Factors

As with previous research, there was a significant correlation between the index offence and understanding the consequences of the proceedings, suggesting a link between the severity of crime and appreciating possible outcomes, in particular when the index offence is violent [6]. This could be a result of underestimating the sanctions associated with the crime or even malingering by the accused. An accused individual who is charged with a violent offence may believe it is easier to feign unfitness, and future research could analyze the prevalence of malingering in fitness assessment, as little research has been done in this area. However, it is promising that few criminal variables are correlated with determinations of fitness under s. 2 of the Criminal Code, as this suggests that bias is not playing a role in such determinations.

Psycholegal Factors

With respect to the psycholegal abilities correlated with understanding the nature and object of the proceedings, the strongest correlations existed for Identification of Roles, Description of Roles, and Understanding Outcomes. The nature of the proceedings is represented by the identification and understanding of key roles in the courtroom, whereas understanding the outcomes represents the object of the proceedings. The other psycholegal abilities all showed strong, positive correlations with this prong as well, likely because the knowledge of one's charges, the ability to describe said charges, and the ability to define pleas and legal terms all contribute greatly to the understanding of the nature of the proceedings.

Concerning the psycholegal abilities that measure understanding the consequences of the proceedings, the strongest correlations exist for Description of Roles, Understanding Outcomes, and Definition of Legal Terms. The Understanding Outcomes

ability exhibits a perfect correlation, which supports the notion that understanding the consequences of pleas such as guilty and not guilty indicates an understanding of the consequences of the entire proceedings. The Description of Roles ability also exhibits a perfect correlation, and this is in line with what this ability tests, which is an understanding of how the system and its key players work for and against the accused, which is related to the potential consequences of the proceedings. Finally, the Definition of Legal Terms is strongly positively correlated with this criterion as well, and this may be because terms such as Oath and Perjury come with their own outcomes and consequences (particularly perjury), and this relates to the criterion of understanding the consequences of the proceedings as a whole.

With regard to the psycholegal abilities that measure communication with counsel, the strongest correlations exist for Identification of Roles, Description of Roles, and Understanding Outcomes, but it is important to note that all of the abilities are correlated strongly with this prong because ability to communicate pertinent information to counsel encompasses all of these abilities. However, the two Roles abilities may be strongly correlated because this prong measures the accused's communication with his or her counsel, and these abilities assess the identification and understanding of who represents which side and how defence and prosecution will conduct their case. It is important to note that the correlations for communication with counsel are identical to those for understanding the nature and object of the proceedings. This could perhaps be due to the variables measuring the exact same ability from a theoretical perspective. However, it may also be because the ability to understand the nature and object of the proceedings is an explicit ability, requiring the accused to communicate with counsel about the actions of the individuals in the courtroom, whereas understanding the consequences of the proceedings is more implicit and can be fulfilled without being able to expressly communicate that knowledge.

Limitations

Though the results of this study generally support previous findings, and some suggest new developments with respect to fitness assessments, several limitations exist and caution should be exercised when forming conclusions. The study was limited to a small sample size and the groups used in analyses were unequal. Studies in this field usually collect files across a range of a few years to amass a large enough sample and equal enough groups (e.g. 100 files) as there are generally more FST individuals than UST individuals. Although steps were taken to correct for these issues statistically, this could have affected the results. However, the current sample is comprised of all referrals across multiple jurisdictions for an entire year, and in this way, is representative of the population.

The results are also limited by the variation in data collected in the files. Files varied in the information provided with respect to questions asked in the assessment, the legibility of the rough notes from the fitness assessment, the detail in the individual's background history, as well as how detailed the individual's criminal history was. The manner in which some of the variables were coded also limited the ability to make conclusions. The dimensions of mood, affect, thought content, nonsensical phrasing, and demographics were all coded categorically, sometimes simply as Yes or No or Present or Absent. Some of these limitations were in part due to the lack of specificity, or comprehensive historical information. While some would suggest that the assessment should not focus on the accused's background, it can be argued that knowing which factors an individual brings with them to an assessment helps to inform possible restoration. Finally, the results of the study support the use of unstructured measures of psycholegal ability, however, there was no comparison group of accused assessed with standardized instruments, which would be an interesting future study.

Conclusion

The present study has provided the field with interesting developments regarding factors that affect specific prongs of fitness, as well as factors that affect the overall opinion of fitness. In particular, this study is among the first of its kind to look at the relationship between the criteria for fitness and individual variables, especially in Canada where the codified fitness standard is relatively new in comparison to other jurisdictions. In sum, the study supports the use of unstructured measures of psycholegal ability when assessing fitness and provides support for the criteria outlined in the Criminal Code and the factors that clinicians use to inform their decision. Factors include impairment in mental status, relevant psychiatric history, nature of index offence, and all unstructured measures of psycholegal abilities. To our knowledge, this study is among the first to evaluate unstructured measures of psycholegal ability as well as among the first to assess the relationship of specific variables to specific criteria for fitness to stand trial.

Conflict of Interest: none

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ORIGINAL ARTICLE

Anti-libidinal medication among sex offenders: a descriptive study from a specialized outpatient unit in Bordeaux (France)

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Enhancements in the treatment of sexual offenders have been taking place for over four decades. The development of pharmacological therapy has helped to reduce the risk of re-offense and has demonstrated its utility in combination with psychotherapy. However further studies to demonstrate the efficacy of these therapies are required. We conducted a retrospective study in a unit, Erios, that provides care for sexual offenders (court ordered treatment or voluntary treatment). Among the 224 patients who were seen in the Erios unit over the past 15 years, we identified 23 patients who had received anti-libidinal treatment (ALM) at some point in their care. The results, obtained from 22 files, indicate that 16 patients presented no evidence of deviant fantasy or behavioral relapse under medication. This study also highlights the comorbidities and offers a perspective regarding the improvement in prescribing this type of pharmacological therapy.

Key words

Anti-libidinal treatment, Antiandrogen treatment, Sexual Offenders, cyproterone acetate, criptorelin embonate, GnRH analogues, Recidivism

Introduction

The use of anti-libidinal medication (ALM), along with psychotherapy, is often considered in the treatment of sexual offenders [1-3]. In 2014, the *Haute Autorité de Santé* (*HAS*, French national authority for health, an independent public authority of a scientific nature) noted the absence of any framework or study to evaluate the efficacy of anti-libidinal medication in the treatment of paraphilia [4]. Anti-libidinal treatment has been used for more than 40 years, mainly in North America [5-7]; outcome for different treatments has been studied in the literature to a limited degree [8]. Approximately 10 years ago, some of these medications obtained marketing authorization for use in France [4]:

- cyproterone acetate, in April 2005 in France for a “reduction of sexual impulses in paraphilia in association with psychotherapeutic care”. It is used for its antiandrogen action. The maximum daily dose is 200 to 300 mg.
- triptorelin embonate, in August 2007 in France for a “major reversible reduction of testosterone levels in order to decrease sexual impulses in adult male with severe sexual deviances”. It is used for its inhibitory action on the gonadotropin hormones. The recommended dosage is 11.25 mg injection every 12 weeks.

Others GnRH analogues medication are used but outside of marketing authorization (approval from the French Drug Agency; such as triptorelin pamoate, leuprorelin and goserelin).

In France, anti-libidinal treatment may be offered to a patient sentenced by a court, or may be requested by the patient themselves. The conviction of the court does not specify the type of treatment to be used (pharmacological, psychotherapy...), and the options are left to the discretion of the clinical team. The judge orders care if a psychiatric assessment ordered by the court has previously specified that care was indicated. Even though the order of care is made, the convicted person has to consent to treatment, especially medication, and cannot be treated against his/her will; if

he/she refuses all care, a custodial sentence can be ordered by the judge [9].

Whether the pharmacological treatment is given at the request of the patient, or following a treatment order from the court, it is important to know the limitations that the patients and clinical team have encountered, and what the outcomes were. A better knowledge of this therapy is needed to enhance its use. The aim of the study is to provide an overview of the cases where an anti-libidinal treatment was prescribed to individuals convicted for a sexual offense.

Material and Methods

We conducted a retrospective study, selecting the files from the Erios unit at the Charles Perrens Hospital in Bordeaux. The Erios unit has three components: Criavs Aquitaine, a resource center for the professionals providing care to sex offenders in Aquitaine; Inter-CD, a mobile care team for the sex offenders incarcerated in the penitentiary establishments in Aquitaine; and Dispo-33, an outpatient unit for sex offenders who were sentenced to a court ordered treatment in Gironde territory.

To be included in the study, the patient had to be a male aged 18 years or more, who was seen in consultation at least once at our outpatient unit (Erios Dispo-33), between January 2001 and February 2016. These patients must also have received an anti-libidinal medication (ALM) sometime during their medical care (at Erios or outside, before or after his follow-up within Erios unit).

We obtained the consent of the participants to consult their files for the purpose of this research study. When the subject was incompetent to consent to treatment, we obtained the consent from their substitute decision maker. The conduct of the study followed the local regulation of research ethics.

From these files we gathered socio-demographical data (gender, age, relationship), history of childhood abuse, psychiatric conditions, the time of the initiation of the ALM, the statement made by the patients regarding benefits and side effects of the treatment, and the criminal records pre and post initiation of the treatment.

Results

Among the 224 adult males who were seen in the Erios unit since 2001, 23 patients (10.27%) received ALM sometime during their care. Not all the information researched was available in each case. Some of the data detailed below are summarized in the Table 1.

Socio-demographical and personal data

The average age was 44 (from 19 to 85 years old) and 74% were between 30 and 60. Only 18% were living with a partner at the time they received the ALM (n=3/17). Among the subjects 39% (n=9/23) were declared legally incompetent to care for themselves (which in French legislation relates mainly to the incapacity to manage property), and had a substitute decision maker.

Regarding childhood history, 25% declared that they had suffered from sexual violence during their childhood (n=4/16).

Criminal records and legal dispositions

Almost two thirds (61%, n=14) had sexually reoffended (re-offense being considered from a clinical viewpoint and not only a legal one). Prior non-sexual offenses were found in 19% (n=4, out of 21 completed); these individuals were mostly sex offenders of female adult victims (75%, n=3).

According to their legal dispositions, 65% (n=15) were subjected to a treatment order whereas 35% (n=8) no longer or never had a treatment order in place. The latter were considered to have voluntarily requested treatment.

Among the patients undergoing a treatment order (n=15), about half of them (n=8) requested the ALM be mentioned in the health-care certificate provided by the psychiatrist; then, the patient provides the cer-

tificate to his probation officer, as evidence of regular psychiatric follow-up.

Clinical and criminological aspects

The sexual offenses that were the origin of the request for treatment (either spontaneous or on treatment order) were hands-on offenses in 83% of the cases, involving minor victims (57%, n=13) or adult victims (26%, n=6). The rest of the individuals (17%, n=4) were hands-off offenses (child-pornography on the internet, exhibitionism, voyeurism with breaking entry).

Eight patients (35%) did not present with any diagnostic criteria for paraphilia and 15 patients (65%) suffered from at least one paraphilia. Among 20 diagnoses with paraphilia, pedophilia was the most frequent (70%), followed by exhibitionism (15%), voyeurism (10%) and fetishism (5%). Among the individuals who have a diagnosis of pedophilia (n=14), their sexual orientation was noted as homosexual (57%, n=8), heterosexual (21.5%, n=3) or bisexual (21.5% n=3).

Psychiatric comorbidities were identified in 91% of the patients (n=21); this includes the lifetime comorbidities after the initiation of ALM. It was found that patients suffered from mood disorder (n=9), intellectual disability (n=8), hypersexuality (n=8), alcohol use disorder (n=5), autism spectrum disorder (n=2), schizophrenia (n=1), and severe personality disorder (n=1).

Anti-libidinal treatment

The period between the first information about ALM provided to the patient and the first dose taken was available from 20 files. This period was approximatively 2 months for two thirds of the patients (n=13), corresponding to the pre-treatment evaluation (including laboratory testing) and to the time that the patient took in order to consent for the treatment. For one third of the patients (n=7), this period was much longer and varied from 13 to 60 months (up to 5 years). Among these 7 patients, 72% (n=5) reoffended (sexual offence) between the first piece of data and the initiation of ALM.

Regarding the patients who stopped taking an ALM, we collected relevant information for 11 of them (3 patients had interrupted their follow-up and no information was available regarding their care; 9 patients continued to receive treatment). The average duration of ALM treatment among these 11 patients is 42.9 months. The duration of the treatment differs whether the decision of ending the treatment was a medical decision (58 months) or a patient decision (24.8 months).

The reasons why ALM was stopped are known for only 10 patients. In about 50% of cases, it is the acknowledgement of a stable full remission of the sexual deviance that resulted in stopping. The other reasons for ending treatment included the patient's exclusive request (n=2), an incarceration (n=2), and the end of court ordered treatment (n=1). Among the patients who were undergoing a court ordered treatment, 75% decided to continue ALM (n=6 out of 8). One patient whose ALM was stopped because of the remission of his deviant fantasies asked for a reintroduction of the treatment a few months later due to the resurgence of these symptoms.

Among the patients whose ALM treatment was ongoing (n=9), 7 patients received ALM without interruption since its initiation and the average duration of ALM treatment was 67.57 months (from 18 to 131 months).

Regarding tolerance of the ALM and its potential side effects, 13 patients (57%) did not report any complaints. The most frequent side effects reported were asthenia, hot flushes, pain, headaches, dizziness, weight increase, cognitive disorder and depressive syndrome (which was attributed to the initiation of ALM and responded well to antidepressant).

Regarding compliance to the medication, it was noted that 6 patients presented poor adherence to oral treatment (cyproterone acetate) and 3 other patients unexpectedly stopped their injection therapy (triporeline embonate).

Table 1 – Summary of the socio-demographical, clinical and criminological data

Re-offense prior to being started on ALM	**14/23 (61%)**
Treatment order in place	**15/23 (65%)**
Most recent sexual offense	
Hands-on	20/23 (87%)
- *minor victim*	*13/20 (65%)*
- *adult victim*	*6/20 (30%)*
- *minor and adult victims*	*1/20 (5%)*
Hands-off	3/23 (13%)
Diagnosis of paraphilia	**15/23 (65%)**
Psychiatric comorbidities	**21/23 (91%)**
Delay initiation ALM	
About 2 months	13/20 (65%)
From 1 to 5 years	7/20 (35%)
Cessation of treatment	**11/20 (55%)**
Reason for stopping the treatment	10/11 (91%)
- *Improvement of symptoms*	*5*
- *Patient's exclusive request*	*2*
- *Incarceration*	*2*
- *End of the court ordered treatment*	*1*
Average duration	43 months
- *When stopped by doctor*	*58 months*
- *When stopped by patient*	*25 months*
Concommitant use of Antidepressant medication	**9/22 (41%)**
SSRI	5
Other	4
Compliance	
Poor adherence to oral ALM	6
Unexpected interruption injectable ALM	3
Side effects reported	**10/23 (43%)**
Behavior while taking ALM	
Re-offence while decreasing dose (oral ALM)	1
Persistent inappropriate behaviour while in institution	3
Meet a minor without offence (breach probation terms)	2

Concomitant use of antidepressant medication

The information about a concomitant use of an antidepressant medication was found in 22 files. It appeared that 9 patients received an antidepressant medication; 5 patients received Selective Serotonin Reuptake Inhibitor (SSRI: escitalopram, sertraline) and 4 patients received a different antidepressant medication (venlafaxine, mirtazapine), Information related to whether the patients under ALM benefited from taking the treatment was available in 20 files: 15 patients expressed an "improved well-being", "relief" and "safety"; 12 acknowledged a decrease of their deviant fantasies; and 4 mentioned a decrease of their hypersexuality (described as problematic by themselves).

along with the ALM. In all the cases, the indication was explicitly because of the presence of a mood disorder (the treatment was not added to improve the effect of the ALM in terms of controlling the paraphilic behaviour).

Clinical and criminological outcomes

Clinical assessment and outcomes were available among 22 files. No re-occurrence of the deviant fantasies or behavioural relapse were found in 16 of the patients. One patient (presenting with homosexual pedophilia) reoffended on cyproterone acetate while the dose was decreased for discontin-

uation of the treatment. Three patients presented with persistent behavioural disorders sexual in nature (these were patients with severe comorbidities and living in a mental health institution). In 2 cases, the individuals did not commit any hands-on offenses, however they entered in contact with a minor, prohibited by the court order (breaching the terms of their probation).

Discussion

Optimizing the treatment and follow-up of the individuals who committed a sex crime is important. The implementation of pharmacological treatment can help to significantly reduce the rate of reoffending. Based on our study, it seems that more health education is required for sexual offenders, to demonstrate the benefit of anti-libidinal treatment.

The rate of the patients, followed at the Erios unit, who have received ALM is 10.27%. Unfortunately, there is no information regarding the number of patients informed about this therapeutic option, how many patients refused to receive the treatment after being informed, and how many did not have good indications or had contraindications according to the physician's assessment. The formal marketing authorization of cyproterone acetate in 2005 and triptorelin embonate in 2007 did not increase the annual average number of ALM prescriptions in Erios unit.

In this study, the typical profile of the patients who received ALM was male, between 40-50 years old, single, subject to a court ordered treatment, had already reoffended, and presented with homosexual pedophilia in association with psychiatric comorbidities (depression, intellectual disability and/or hypersexuality). The main treatment regimen was a GnRH analogue (with antiandrogen in the initial phase) for 3 and a half years. These patients mainly expressed a positive experience, without any serious adverse effect or difficulties during follow-up. It is not surprising that this profile represents the most frequent paraphilia among our population (n=8, 35%), as they are the people that reoffend the most and appear to have difficulty controlling their deviant sexuality [4,10].

Most of the patients were referred after being convicted for sexual assault on court order, however the assessment conducted at the request of the court was not made available to us in 74% of the cases. It would have been interesting to know the appointed physician of the court's recommendations in terms of treatment, and how the judge finally ruled his/her decision.

We were unable to gather additional data related to the additional therapeutic strategy that the patients underwent. Indeed, psychotherapy is necessary and is often performed without any concomitant medication. However, Erios Unit is not the only place where psychotherapy is provided for sexual offenders. In addition, there is no consistent practice, and different types of psychotherapy are used, which makes it difficult to thoroughly assess its benefit. The only information we can provide is that 6 patients treated with ALM have participated in group psychotherapy sessions at Erios Dispo-33.

Only 65% of our sample had a clear diagnosis of paraphilia; which means that in 35% of the cases, the anti-libidinal treatment was given with no formal diagnosis for its treatment. However, these were often recidivists and despite the lack of a formal diagnosis of paraphilia, ALM showed some efficacy in the majority of our sample. This lack of diagnosis may have been due to certain difficulties in making a diagnosis, and the lack of insight or shame of patients who do not reveal their problems. In addition, 6 individuals in our sample had sexually offended adults and could have been qualified for the diagnosis of paraphilic coercive disorder; a disorder that was initially suggested to be part of the DSM 5 but finally did not get included in the new classification [11].

Psychiatric comorbidities are found at a high frequency in our sample. The fact that 39% of the patients benefit from legal protection and/or live in a psychiatric institution speaks

to their inability to function on their own, which may be explained by the presence of additional mental health disorders. Although hypersexuality is not a clear psychopathological concept and may refer to sexual compulsion, sexual addiction, etc., among the patients who have expressed symptoms that refer to a hypersexual behaviour (35% of the sample), half of them felt relieved by receiving ALM. This demonstrates that a thorough psychosexual assessment could be useful when dealing with sexual offenders.

There was some discrepancy in terms of the delay between providing ALM information and the patient's consent to begin ALM. One group of patients quickly accepted ALM while another group thought for a long time and then accepted it after committing another sexual assault. This is likely something that should be explored in therapy with the "one time" sexual offender. It also must be emphasized that no matter what legal framework of care, the prescription cannot be initiated without the patient's consent as it remains an ethical issue. When there is a clear indication for treatment by ALM but a refusal from the patient, we recommend to have the patient sign a refusal to consent to ALM treatment in order to create a sense of responsibility in his/her own care.

Treatment with GnRH analogues medication, the fifth-level (out of six) of the therapeutic strategy (according to the recommendations of the Force Task of the World Federation of the Biological Psychiatry Associations), concerns the majority of our patient sample (n=18, 79%). However, we did not check whether they actually met the criteria for this fifth-level before ALM ("*Aim: control of paraphilic sexual fantasies, compulsions and behaviours with an almost complete suppression of sexual desire and activity; High risk of sexual violence and severe paraphilias; Sexual sadism fantasies and/or behaviour or physical violence; No compliance or no satisfactory results at level 4*") [2]. Of note, none of them were in the sixth-level therapeutic strategy (combination of GnRH analogue and cyproterone acetate). We hypothesized that some patients, actively involved in their care, chose the injectable form rather than daily oral medication for convenience. We consider now having a deeper look in these criteria and see how they apply to our population and how if influences our practice.

The main limitations of this study are related to its small sample, to the lack of information in the files and the lack of objective outcome measures. This is also an uncontrolled study. In spite of its limits, we hope that this study will contribute to a better knowledge of the use of ALM as a therapeutic strategy for sexual offenders.

Conflict of Interest: none

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ORIGINAL ARTICLE

The reform of Italian forensic psychiatric hospitals and its impact on risk assessment and management

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Italy has a strong history of deinstitutionalization. It was the first country to completely dismantle psychiatric hospitals in order to create small psychiatric wards closer to the community (i.e. in general hospitals). Nevertheless, it took the nation nearly 40 years to complete the process of closing all forensic psychiatry hospitals. Deinstitutionalization however, was not fully addressed by the first wave of Italian psychiatric reform. This paper describes the establishment of new facilities replacing old forensic hospitals, formally known as Residences for the Execution of Security Measures (REMS). REMS are a paradigm shift in terms of community-based residential homes, and are mainly focused on treatment and risk assessment, rather than custodial practices. The use of modern assessment tools, such as the Aggressive Incident Scale (AIS) and the Hamilton Anatomy of Risk Management (HARM), is crucial in order to objectively assess the clinical cases and are consistent instruments that form part of the treatment plan. A preliminary analysis of data from the first 2 years of activity, focusing on severely ill patients who have been treated for more than 12 months, is described for two REMSs in the Lazio region, close to Rome. Encouraging results suggest that further research is needed in order to assess clinical elements responsible for better outcomes, and to detect follow-up measures of violence or criminal relapse post discharge.

Key words

Forensic psychiatric hospitals, deinstitutionalization, detention security measures, Italian psychiatric reform, Hamilton Anatomy of Risk Management (HARM), Residences for the Execution of Security Measures (REMS)

Introduction

It has been nearly 40 years since the Basaglia Law, also known as 180/1978 Law, was approved in Italy. This law led to the dismantling of all psychiatric hospitals; a definite landmark in Italian and psychiatric history (1,2). Similarly, another wave of reform, beginning in 2008, led to the closure of all 6 Forensic Psychiatric Hospitals (Ospedali Psichiatrici Giudiziari, OPGs) located across Italy. Along with this, was the establishment of new small-scale residential facilities called REMS (Residences for the Execution of Security Measures), designed to perform intensive and highly specialized mental health care to better meet the needs of mentally ill offenders.

In May 2014, the 81/2014 Law established the deadlines and all of the procedures considered necessary for the final dismantlement of forensic psychiatric hospitals by March 2015. This second wave of deinstitutionalization completed the work of the first wave, and fully established community treatment as the primary method of psychiatric care in Italy.

The Basaglia reform in 1978 did not extend its reforming principles to individuals suffering from a mental disorder, who committed a criminal offense and required psychiatric treatment in forensic hospitals. Those individuals were consequently left out of the medical and intellectual debate that arose. This group was kept under the same derelict conditions that the 180 Law aspired to eradicate. It seemed that the demand of preserving community protection trumped reform drives.

The law laid the foundation for a novel therapeutic approach to mental illness,

that favored extensive community treatment over hospitalization. But it did not address the framework of the Detention Security Measures, which outlines the process of internment in forensic hospitals. Starting from 1978, 6 forensic hospitals survived, preserving the characteristics of both asylum and prison, and complying with social obligations for cure and custody.

Over the years, the discrepancies between the different treatments provided to patients who did not commit crimes, versus patients who did, gradually increased. The Forensic Psychiatry population was poorly studied with little epidemiological data available on quality of health care provided (3–5). The heavy use of custodial staff led to uneven observations of offending behaviors, and impeded the development of strategies to monitor and prevent them. A lack of constant cooperation with mental health community-based teams further weakened the therapeutic project.

Additionally, the lack application, of the geographic catchment principle, resulted in patients being treated far from their homes, relatives, and doctors. This led to deficient and unsatisfactory discharge programs due to the lack of social support and therapeutic planning.

The stagnation that the OPGs (forensic psychiatric hospitals) have experienced over the past decades, along with rare occasions of cooperation and collaboration with Mental Health Departments and Universities, partially set back the access to more recent acquisitions and practices.

However, on March 31st, 2015, the reform process concluded; two more years were necessary to complete the transition period but by February 2017, 569 inpatients had been admitted to REMS throughout Italy.

The entire therapeutic path of mentally ill offenders still remained under judiciary control, with Judges' ruling both on its length and its development, as well as defining the level of intensive care required, and sentencing patients either to REMS or other residential settings according to a highly subjective interpretation of the legal indications.

To overcome any prolonged length of stay of patients within the forensic setting, the reform stated that the maximum length of the Detention Security Measure (i.e. the maximum internment in REMS) could not exceed the maximum detention provided by the Penal Code (i.e., the Italian Criminal Law) for that specific crime.

The introduction of temporal limits, along with community proximity and small-scale numbers, are all key features intended by the legislator to guarantee a therapeutic journey aimed at rehabilitation and social reintegration.

The REMS are small residences with a 20-person capacity. Here, mentally ill offenders undergo the same pharmacological and therapeutic approach as any other psychiatric patient, and where health care more than custodial necessities determines the nature of treatment.

As of July 2015, with the new allocation planned nationwide, the Lazio Region became the second largest forensic psychiatry center in Italy, with 81 beds and specific focus on violence risk assessment and management.

So far, Mental Health Departments in Lazio have had 110 forensic patients admitted since their implementation; the 1st REMS has been in Subiaco («Castor») in July 2015, then a second one in Palombara Sabina («Merope»), in Fall 2015, and a 3rd REMS has been established in Spring 2016 again in Palombara Sabina («Minerva»). The aim of our paper is to describe how the adoption of the Aggressive Incident Scale (AIS) along with the Forensic Version of Hamilton Anatomy of Risk Management (HARM-FV), as primary tools in violence risk assessment [6,7], have improved our daily practice guiding the evaluations within a team environment and granting a constant assessment of our rehabilitation program's efficacy, monitoring and redirecting our therapeutic intervention.

Rehabilitation and risk assessment in REMS

As the new Law has clearly demanded, REMS facilities have been established with the specific aim of psychiatric treatment and rehabilitation. Consequently, REMS have been the first units in our Department to structurally employ Psychiatric Rehabilitation (PR) therapists and include PR interventions as an integral part of the treatment team and program.

Therefore the clinical assessment of forensic patients routinely consists of the following: 1) a mental status examination performed by a psychiatrist, 2) a psychological assessment undertaken by clinical psychologists using clinical examination and psychometric tools, 3) a psychosocial evaluation of social needs in terms of financial resources, family support and social inclusion by a social worker, 4) a functional assessment obtained through clinical examination; and functional scales and measurement by PR therapists. Measurements of psychopathology, personality traits, and level of functioning are regularly obtained through the Italian versions of internationally validated rating scales, tests, and interviews including: the Brief Psychiatric Rating Scale (BPRS) [8,9], the Minnesota Multiphasic Personality Inventory Ver. 2(MMPI-2) [10], the Millon Clinical Multi-axial Inventory 3rd Ed. (MCMI-III) [11], the Personality Inventory for DSM-5 (PID-5) [12], the Scale for Personal and Social Functioning (FPS) [13] , and the Scale for Specific Level of Functioning (SLOF) [14,15] . Cognitive assessment is performed through the Wechsler Adult Intelligence Scale 4th Ed. (WAIS-IV) [16] and the Repeatable Battery for the Assessment of Neuropsychological Status Update (R-BANS) [17] ; while specific psychopathological dimensions are addressed and measured by specific scales, tests or interviews, such as the Barratt Impulsiveness Scale (BIS-11) [18,19] for impulsiveness, the Columbia Scale for Suicidal (C-SSRS) [20] for suicidal behaviors, the Psychopathy Check List – Revised (PCL-R) [21] for psychopathy, and the HCR-20 V3 [22].

Concerning the assessment and management of the risk of violence, REMS have established the regular use of AIS and HARM-FV as new instruments for the whole Department of Mental Health since the outset, with possible future extension to other Community Services or Psychiatric Intensive Care Units.

The routine use of HARM-FV during the early phase of admission has demonstrated impressive usefulness in defining most of the treatment plans for violent and non-violent offenders. In fact, reporting and analyzing Current Risk Factors from the HARM-FV Present Section, makes it easy to underline which psychopathological conditions and behavioral problems are to be addressed first, and in which way. For instance, when Mood or Psychotic Symptoms are assessed as “severe” (“needing improvement” in the newer version), the physician has a clear indication for introducing or adjusting antipsychotic, or mood stabilizing pharmacological treatments. At the same time, when Impulse Control, Attitude/Cooperation or Anger Management (the last two being features of the newer version) are considered an issue in the current status of the offender, the treatment plan is oriented to include the patient in individual or group psychotherapy, or in Social Skills Training (SST) programs focused on anger management or cooperativeness.

REMS utilized multiple psychopharmacological interventions, most commonly being second generation antipsychotics and mood stabilizers. Adjunctive therapy to the pharmacological interventions included: individual and group psychotherapy, psychological interventions, and psychoeducation. Specific focuses within these therapies included DBT for personality disorders, cognitive therapy for psychosis, and SST for better control of anger, impulsivity and violence. There was also a behavioral program in place to grant gradual access to privileges by virtue of constant rule adherence.

Effects of psychiatric rehabilitation on risk indexes

Since the implementation of the REMS, 46 patients have been admitted to REMS Castor, and 41 to REMS Merope, (REMS Minerva has had 23 patients, but they were not included in this study). In this study, we only considered patients with a diagnosis of Schizophrenia Spectrum Disorder (DSM-5 criteria) , including Schizoaffective Disorder, and treatment-resistant Schizophrenia, assessed according to Kane criteria [23, 24] . We did include the patients suffering from Antisocial Personality Disorder as a comorbid condition. Exclusion criteria were: the presence of DSM-5 diagnosed Moderate to Profound Intellectual Disability, or the presence of Antisocial Personality Disorder alone with no association with Disorders of the Schizophrenia Spectrum or other major psychiatric disorders. A further 3 patients were excluded because they did not complete the initial assessment period following transfer to other correctional or rehabilitation facilities on the order of judicial authority. At the end of the recruitment period, 80 patients were included in this study.

The evaluation of each current risk factor at baseline is reported in Table 1, where each degree of class according to the HARM scale (a 4-point Likert scale from none to severe) is expressed in terms of frequencies.

Evidently, some factors are considered more problematic in the forensic population at baseline, with more than 50% of patients presenting a “moderate” or “severe” risk (in red in Table 1). These results support clinical experience where it was observed that forensic patients are commonly unaware of their psychiatric conditions, frequently present comorbidly with substance abuse, often demonstrate scant participation in the rehab program in the beginning and most have inadequate social support, hampering the treatment plan.

Table 1 - Severity of HARM Risk Factors (RF) at baseline (*n: 80*)

	None	Mild	Moderate	Severe	None/Mild	Moderate/ Severe
Rule Adherence	21.25%	33.75%	31.25%	13.75%	55.00%	45.00%
Illness Insight	0.00%	13.75%	36.25%	50.00%	13.75%	**86.25%**
Mood Symptoms	17.50%	33.75%	38.75%	10.00%	51.25%	48.75%
Psychotic Symptoms	33.75%	21.25%	23.75%	21.25%	55.00%	45.00%
Social Support	13.75%	25.00%	33.75%	27.50%	38.75%	**61.25%**
Impulse Control	26.25%	28.75%	30.00%	15.00%	55.00%	45.00%
Program Participation	17.50%	28.75%	32.50%	21.25%	46.25%	**53.75%**
Substance Abuse	36.25%	8.75%	27.50%	27.50%	45.00%	**55.00%**
Med Non-Adherence	51.25%	22.50%	20.00%	6.25%	73.75%	26.25%
Antisocial Attitude	28.75%	30.00%	27.50%	13.75%	58.75%	41.25%

Aggregated frequencies >50% are reported in red

The early phase of the REMS intervention is focused on increasing Illness Insight through individual and group psychotherapy, as well as psycho-educational programs, as soon as the clinical acuteness has been sufficiently stabilized. Substance abuse is another key target of psycho-educational interventions, psychotherapy, and pharmacological anti-craving strategies. Individual and group therapy and social play activities, are oriented in granting greater inclusion and increase participation to rehab programs, as well as improving social competencies and attitudes. Finally, joint interventions with Community Mental Health Teams are proposed to enhance financial and social fragility. Figure 1, summarizes REMS intervention addressing specific Risk Factors of aggressive behaviours as conceptualized in the HARM-FV tool.

Of the 80 patients included in the study, 37 received consistent treatment for more

than 12 months. This completed the treatment sets created to target clinical needs, as determined by baseline evaluations, such as the HARM profile.

Clinical data from BPRS confirm the general trend of improvement after 12 months, as shown in Table 2, with a statistically significant mean difference in Total score (7.32), Negative Affect (1.46), Positive Symptoms (1.51), and Expanded affect (2.35).

Surprisingly, no significant improvement was reported for the Disorganization scale, whereas no significant worsening was reported for the Negative Symptoms scale. Matched pair t-test and Wilcoxon signed rank test were used in the JMP© 13.2 Software from SAS Institute Inc. to assess the statistical significance of the mean difference.

Figure 1 - Manual interventions performed in REMS addressing specific RF for violence

HARM Risk Factor	Individual/ group interventions
Illness Insight	Cognitive therapy for psychosis [25]
Medicine Non-Adherence	INTE.G.R.O. Psycho-educational program [26]
Program Participation	Group CBT [27]
Substance abuse	Individual DBT and Group Skills Training [28]
Impulse Control	SST for Schizophrenia [29]

Table 2 - BPRS total and subscales mean scores after 12 months of admission

	Total score	Disorganisation	Negative Affect	Positive Symptoms	Expanded Affect	Negative Symptoms
Baseline	63.46	9.84	15.65	12.78	9.70	7.43
12 months	56.14	8.76	14.19	11.27	7.35	7.54
Mean difference	**7.32**	1.08	**1.46**	**1.51**	**2.35**	-0.11

Figures in red are reported p-values <0.001

The summary of HARM re-evaluations at 12 months is represented in Table 3, where improvements from the baseline are also represented in terms of overall and paired differences from the total (n=80) or paired counterpart (n=37) at baseline, considering the frequency of moderate/severe attributions alone.

Statistical significance tests have also been performed in order to consider the frequencies of moderate/severe attributions that are different from the baseline, but no statistical significance has been demonstrated through the Chi-square and Fisher's exact tests for categorical variables.

Despite the lack of statistical significance, there was an evident overall trend in improvement for all of the Risk Factors except Social Support. For the individuals that were scored moderate/severe risk, it is noted that 9 (out of 10) risk factors are reduced. The greatest improvement in terms of paired difference was found in Psychotic Symptoms and Substance Abuse (21.62%), Impulse Control, Program Participation and Mood Symptoms (-18.92%). The following factors reported a reduced frequency of moderate/severe risk evaluation: Antisocial attitude (16.22%), Illness Insight (-16.22%) and Rule Adherence (-13.51%) reported. Little to no improvement was found in Medication non-adherence and Social Support.

Table 3 - Severity of HARM Risk Factors at 12 months and difference from baseline

	None	Mild	Moderate	Severe	None/Mild	Moderate/ Severe	Difference	Paired difference
Rule Adherence	27.03%	35.14%	24.32%	13.51%	62.16%	37.84%	-7.16%	-13.51%
Illness Insight	5.41%	21.62%	40.54%	32.43%	27.03%	**72.97%**	**-13.28%**	-16.22%
Mood Symptoms	18.92%	37.84%	29.73%	13.51%	56.76%	43.24%	-5.51%	-18.92%
Psychotic Symptoms	40.54%	32.43%	10.81%	16.22%	72.97%	27.03%	**-17.97%**	**-21.62%**
Social Support	16.22%	21.62%	32.43%	29.73%	37.84%	**62.16%**	0.91%	**0.00%**
Impulse Control	21.62%	48.65%	13.51%	16.22%	70.27%	29.73%	**-15.27%**	**-18.92%**
Program Participation	16.22%	43.24%	24.32%	16.22%	59.46%	**40.54%**	-13.21%	**-18.92%**
Substance Abuse	32.43%	29.73%	32.43%	5.41%	62.16%	**37.84%**	**-17.16%**	-21.62%
Med Non-Adherence	56.76%	27.03%	10.81%	5.41%	83.78%	16.22%	-10.03%	-8.82%
Antisocial Attitude	21.62%	45.95%	21.62%	10.81%	67.57%	32.43%	-8.82%	-16.22%

Figures in bold are considered more critical at baseline (moderate/severe frequency >50%). Red applies when moderate/severe frequency is still >50% at the 12-month follow-up, and green when it falls <50%.

Discussion

The introduction of modern and scientific assessment tools for violence assessment and management in REMS has allowed psychiatric attitudes towards forensic patients to change significantly, from a mainly custodial practice to a more clinical and predictive one, with focus on risk factors for violence relapse. The predictive validity of HARM has already been ascertained and demonstrated [7] across different cultures and countries [30]. However, in order to confirm the predictive validity of HARM in an Italian context, further research in Italy is needed to compare clinical assessment to follow-up data after discharge from REMS.

Our study shows that evaluating risk factors for violence is effective and crucial in the treatment planning for a forensic unit. This can be done through a comprehensive toolbox of instruments that focus on those factors playing a role of violence recidivism in psychiatric offenders, such as the HARM. As a reduction of psychiatric symptoms is crucial in forensic patients, a specific focus of intervention is devoted to positive and disorganizing symptoms, especially when connected with violent recidivism. As pointed out by Table 2, although there is significant reduction in the global severity of symptomatology (BPRS total score), the reduction in positive symptoms remains subtle. This may be explained by the comorbid drug use and possible period of treatment non-compliance and treatment-resistant Schizophrenia. Our study indicates that even when some symptoms persist, such as auditory hallucinations, delusions, disorganized speech, and no major clinical improvement is noted, their level of risk can nevertheless be assessed as reduced by the clinicians who considered some risk factors as being managed on the HARM tool (Table 3).

At the 12-month follow up mark, clinicians generally tend to assess reduced severity for most of the HARM risk factors, especially those considered more problematic at the outset. Substance abuse and program participation reported an impressive reduction in those who scored severely or moderately at risk. Illness insight reduced the proportion of more critical patients to 72%, which still represents a critical issue for the majority of forensic patients. The aspect that is almost completely unaffected by treatment is Social Support, one of the limitations of the REMS model. Indeed, the majority of interventions are more oriented to social inclusion in terms of increased sociality rather than greater social equality or accessibility to social roles. In practice, this means that many forensic patients who are clinically stable but economically fragile cannot directly access external vocational therapy programs or job training. This is a direct consequence of reform that has ensured stronger clinical attitudes, but less funding for increasing opportunities in a socially vulnerable context.

Our study model did not take into consideration the relative role played by specific

interventions or by other clinical elements such as personality traits (antisocial or psychopathic for example) and impulsivity. Further research is needed to develop a more complex model in which personality profiles, impulsivity and likelihood of violence are examined within the setting of REMS interventions.

This is the first study in Italy to evaluate the role of the HARM assessment tool in a forensic context. Here we present preliminary results on the experience of forensic de-institutionalization and the introduction of the REMS model in Italy.

Conflict of Interest: none

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LETTER TO THE EDITOR

Réinsertion des auteurs d'infractions à caractère sexuel : réflexion et échanges avec un responsable d'une communauté d'Emmaüs en région Centre-Val de Loire (France)

Rehabilitation of sexual offenders: perspectives and testimony of the manager of an Emmaüs community in the Centre-Val de Loire region (France)

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Cher Editeur,

Les personnes accueillies dans une communauté d'Emmaüs représentent une population très diverse au sein de laquelle il peut y avoir des auteurs d'infractions à caractère sexuel (AICS). Ces communautés offrent théoriquement à toutes personnes, y compris celles qui ont des antécédents judiciaires, la possibilité de les rejoindre pourvu qu'en échange, elles puissent travailler pour faire vivre la collectivité. Nous proposons d'aborder cette question à travers trois vignettes brèves.

Illustration clinique

Monsieur Hervé M., âgé de 40 ans, a déjà été condamné à plusieurs reprises, pour défauts de titre de transport, vols, violence sur mineur de 15 ans, menaces de mort et actes d'intimidation commis contre les personnes exerçant une fonction publique et récemment pour une infraction à caractère sexuel. Il est suivi pour une schizophrénie et présente des hallucinations cénesthésiques importantes (il est notamment persuadé qu'il y a des femmes qui essaient de « lui tripoter le sexe quand il va pisser »). Ces dernières années, il a alterné des hospitalisations en service de psychiatrie et des périodes où il a « repris la route », vivant soit comme sans-domicile-fixe (SDF), soit dans des communautés d'Emmaüs à travers toute la France. Sa résidence la plus stable est une clinique de psychothérapie institutionnelle en région Centre où il est actuellement hospitalisé. Il a commis une agression sexuelle sur une femme dans un train et est en attente d'être jugé, mais l'expertise psychiatrique a retenu l'existence d'un trouble psychique ou neuropsychique ayant aboli son discernement ou le contrôle de ses actes (au sens où l'entend l'article 122-1, alinéa 1, du Code Pénal) du fait d'une recrudescence des symptômes psychotiques au moment des faits.

Monsieur José C., âgé de 58 ans, vit dans une communauté d'Emmaüs depuis l'âge de 20 ans - au retour du service militaire, après avoir connu une période de dépendance à l'alcool et s'être retrouvé à la rue sans aucune ressource. Il a fait récemment un voyage en Thaïlande avec un « compagnon » de la communauté qui a réussi à le convaincre de l'accompagner, et qui lui y va apparemment tous les ans. Sur place, Monsieur C. s'est senti déstabilisé par rapport à une perte totale de ses repères habituels, isolé et démuni face à une langue étrangère, incapable de communiquer en anglais. Il a recommencé à consommer de l'alcool pour lutter contre son angoisse alors qu'il était abstinent depuis près de 30 ans. C'est dans ce contexte qu'il explique avoir entendu des voix qui lui disaient qu'il n' « est qu'un alcoolo et un pédéraste », alors qu'il jure n'avoir rien fait aux enfants en compagnie des-

quels il était. Il a été rapatrié dans un contexte d'état psychotique aigu, mis sur le compte des effets secondaires d'un antipaludéen. Cette situation n'a été abordée qu'au niveau du service des Urgences qui l'a reçu et n'a pas fait l'objet d'investigation policière ou judiciaire. Mais il semble qu'il n'avait aucun antécédent judiciaire et c'est sans doute la personne qu'il accompagnait qui elle fait du « tourisme sexuel » régulièrement.

La situation d'Antoine D., âgé de 20 ans, invite à mettre en valeur cet aspect étayant de la communauté. Il a été incarcéré adolescent pour des faits d'agressions sexuelles commis en famille d'accueil. Avant cette incarcération, il suivait péniblement un parcours scolaire classique sur l'insistance de ses parents. Il présente les symptômes d'un retard de développement précoce tant sur le plan moteur que psychique. Très carencé affectivement, il sollicite un étayage et un accompagnement important. Sans solution d'hébergement à sa majorité, il a intégré la communauté d'Emmaüs en sortant de détention. La communauté l'a accompagné progressivement vers une formation professionnelle qui doit à terme l'amener à quitter la communauté puisqu'il ne pourra plus y travailler. C'est face à l'imminence de cet éloignement du groupe qui le soutient, qu'Antoine a agressé de nouveau sexuellement une adolescente. Il a été réincarcéré et transféré vers un service d'hospitalisation psychiatrique en milieu pénitentiaire.

Les communautés d'Emmaüs

Les personnes présentées dans ces trois vignettes ont chaque fois bénéficié de la prise en charge de la communauté d'Emmaüs. Ce type de communauté de vie peut accueillir une population très hétérogène au sein de laquelle il peut y avoir des auteurs d'infraction à caractère sexuel (AICS) ou plus largement des personnes avec des antécédents délictueux ou criminels. Certains des résidents peuvent aussi souffrir de troubles psychiques si ceux-ci sont suffisamment stabilisés et ne contrindiquent pas la vie en collectivité. Ces communautés offrent théoriquement à toute personne la possibilité de les rejoindre pourvu qu'en échange elle puisse travailler pour faire vivre la collectivité. La compétence n'est pas nécessairement requise, car le travail est adapté aux possibilités de chacun.

Dans une partie de sa maison qui était trop grande pour lui, l'abbé Pierre (prêtre catholique et député de Meurthe-et-Moselle, département français de la région Grand Est) crée en 1949 une auberge de jeunesse internationale qu'il appelle « Emmaüs ». C'est l'origine de la communauté Emmaüs et de ses « compagnons » qui vont vraiment s'organiser au cours de l'hiver 1954 qui sera très rude et porter assistance à des personnes dans le besoin dans un contexte de pénurie de logements après la seconde guerre mondiale. Ce mouvement associatif qui se veut neutre sur le plan religieux et politique s'étendra au fur et à mesure dans plus de 40 pays à travers le monde. Les communautés d'Emmaüs ont pour but d'accueillir toute forme d'exclusion sociale et d'offrir un lieu de vie à des personnes qui ont besoin de se reconstruire socialement sans jugement de ce qu'elles sont ou de leurs origines. Depuis 2009, sous l'influence de Martin Hirsch, Haut-commissaire aux solidarités actives contre la pauvreté, elles disposent d'un statut reconnu par l'État et les « compagnons d'Emmaüs » bénéficient d'un revenu de solidarité active.

Le responsable d'une communauté d'Emmaüs en région Centre-Val de Loire que nous avons rencontré se défend de gérer un organisme de réinsertion, même s'il reconnaît que la communauté contribue au bien-être des personnes qu'elle accueille et vise dans la mesure du possible à leur réinsertion sociale. Cette réinsertion n'est pas un objectif posé comme tel avec des moyens spécifiques pour y parvenir et la communauté ne veut pas se situer dans une volonté de prise en charge individuelle de ses membres, mais seulement dans une entraide de tous ceux qui le demandent. Il explique qu'il gère une communauté de 50 places avec un agrément d'hébergement social de 46 chambres et des allocations personnelles de 340 € par personne. Le cadre et les règles sont simples en apparence : le

compagnon accueilli n'est pas interrogé sur son passé et peut demeurer dans la communauté autant de temps qu'il le souhaite, à condition qu'il contribue à la faire vivre par son travail et qu'il respecte les règles de vie commune. Il se vit par nécessité comme un gestionnaire, voire un chef d'entreprise qui doit aussi se préoccuper du maintien et développement de sa communauté. Il veille d'abord au bon fonctionnement collectif, au maintien d'une certaine sérénité entre tous, à l'équilibre des groupes ou catégories de personnes spécifiques (comme par exemple les familles avec enfants jeunes, les couples, les très jeunes adultes, les « sortants de prison », les personnes étrangères issues d'un même territoire géographique, etc.), à tous les facteurs qui peuvent contribuer à la stabilité de son organisation et à sa longévité. Il insiste pour souligner que l'équilibre communautaire reste toujours fragile tant sur un plan socio-économique que des interactions sociales entre membres de la communauté.

Cette communauté d'Emmaüs a une grande « longévité » et certains « compagnons » choisissant d'y demeurer parce qu'ils y avaient trouvé un cadre contenant, stable et serein. De fait, le responsable de la communauté dit devoir faire face à des défis que lui et son équipe de direction ne s'étaient pas posés antérieurement comme le vieillissement de certains de ses membres ou compagnons qui vivent là depuis des décennies, mais qui ne peuvent plus justifier d'y rester en contrepartie du travail qu'ils apportent. C'est pour cela qu'il a développé un projet de « pension familiale » de 24 places en lien avec la Direction départementale de la cohésion sociale et l'Office public de l'habitat à loyer modéré (OPHLM). Ce projet prévoit de réserver deux tiers de places pour les personnes retraitées et un tiers pour des personnes en situation de vulnérabilité psychologique. Ces personnes auront en commun le fait de ne plus pouvoir participer à l'équilibre économique de la communauté, du fait essentiellement de leur âge. De manière officieuse, il s'est autorisé à dire qu'il s'agissait pratiquement d'un projet d'établissement d'hébergement pour personnes âgées dépendantes (EHPAD).

L'accueil d'AICS dans une communauté d'Emmaüs

Cette communauté d'Emmaüs accueille des personnes âgées de 50 ans en moyenne. Beaucoup d'entre elles ont des difficultés des compétences psychosociales : difficultés dans la mise en place de leur socialisation et maturation sociale, conséquences traumatiques d'évènements vécus, parcours délictuels associés à des formes de désocialisation, etc. L'équipe de direction de la communauté a passé un accord avec le service pénitentiaire d'insertion et de probation (SPIP). Cela lui a permis aussi de poser « ses limites » et par exemple de ne pas accueillir une personne condamnée pour pyromanie du fait du risque pour la communauté, ni de violence aux enfants du fait de l'accueil de familles de manière occasionnelle. Elle entretient également des liens avec le centre médico-psychologique de son secteur (CMP) pour faciliter l'accès aux soins, mais sans se substituer à la personne accueillie et sans se préoccuper de son suivi. La communauté dit ne pas souhaiter basculer dans une forme complète d'assistanat. Elle soutient par exemple des activités individuelles extérieures en remboursant la moitié des frais engagés, organise quelques activités internes (parfois sous forme de séjours), mais ne souhaite pas se substituer à la vie sociale que ses membres doivent organiser ou non pour leur propre compte. Les personnes accueillies après avoir étaient condamnées doivent demeurer une minorité (accueil d'une personne à deux par an, en fonction des places). L'accompagnement que la communauté Emmaüs souhaite faire ne devrait être que générale et non spécifique, même si dans la réalité, certains des « compagnons » qui s'installent vont mettre en place des relations privilégiées et recevoir aussi une aide plus personnifiée. La communauté accueille une assistante sociale qui tient des permanences et peut avoir recours à une juriste pour s'occuper de la régularisation de certains papiers via une association de regroupements des différentes communautés. Elle a développé des liens avec l'association « Entraide ouvrière » (aujourd'hui dénommé « Entraide et Soli-

darités ») locale avec des possibilités de passerelle vers leurs unités d'accueil sans passer par le « 115 » et réciproquement quand ils ont des personnes qu'ils accueillent depuis longtemps.

Conclusion

Les auteurs d'infractions à caractère sexuel (AICS) ont besoin d'avoir des lieux de vies qui peuvent les accueillir. Ils ne sont pas si nombreux, surtout en cas de violences intrafamiliales. Ces personnes AICS vont alors cumuler des difficultés multiples : faibles ressources financières, faible niveau d'étude et de formation, auxquelles seront associées des difficultés de réinsertion sociale à la sortie de détention, qu'il s'agisse du problème de logement ou de l'accès à l'emploi et des difficultés familiales liées aux violences et à l'incarcération [1-3]. Ces difficultés peuvent représenter autant de facteurs de risque de récidive de l'acte délictuel ou criminel pour lequel ils ont été condamnés. En ce sens, l'accueil dans une communauté de vie peut représenter une forme de « protection » par la dimension contenante qu'elle représente ou simplement les interactions sociales qu'elle permet [4,5]. Mais, encore une fois, le maintien de ce cadre favorable aux AICS qui n'ont pas d'autres solutions d'hébergement ou de lieux de vie n'est possible que si l'équilibre communautaire est préservé. L'intérêt d'un individu ne doit pas mettre en péril celui de l'institution et des personnes qu'elle accueille.

Si on retient une possibilité d'étayage et de contenance des personnes AICS par les communautés d'Emmaüs, la régulation et réhabilitation sociale qu'elles permettent se rapprochent de ce qui est mis en place dans le cadre des cercles de soutien et responsabilité (CSR) qui se développent progressivement en France, dans la logique plus large des Good life model [6]. Mais malgré les choix militants qu'elles font, ces communautés ne sont donc pas une garantie totale contre la reprise d'une carrière délinquante criminelle. Elles offrent uniquement ce qu'elles peuvent offrir, à savoir l'intégration dans une communauté de vie et un retour au sein de la société tout en y vivant relativement en marge. En ce sens, elles peuvent participer à une forme de désistance [7].

Conflit d'interêt: aucun

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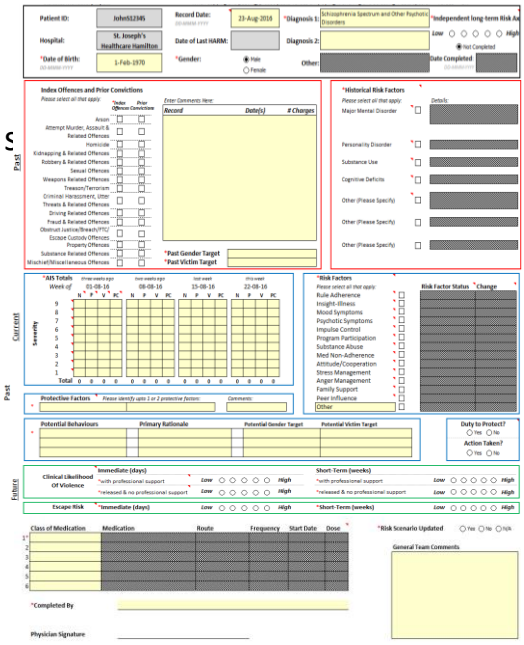

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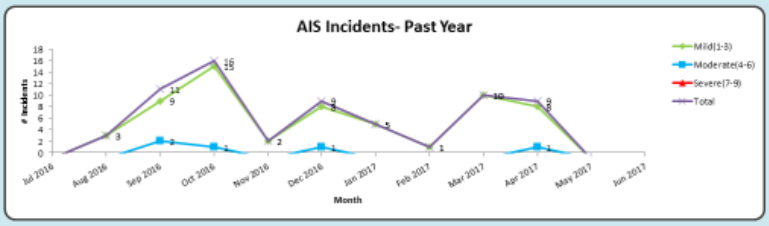

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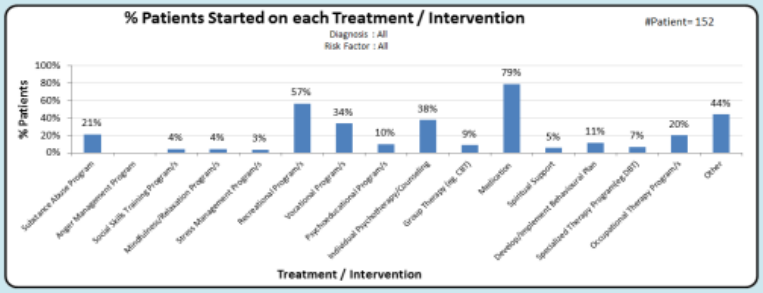

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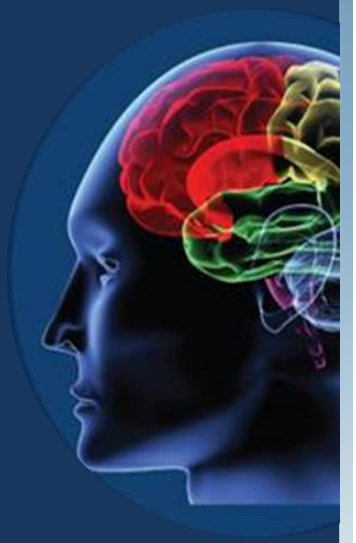

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