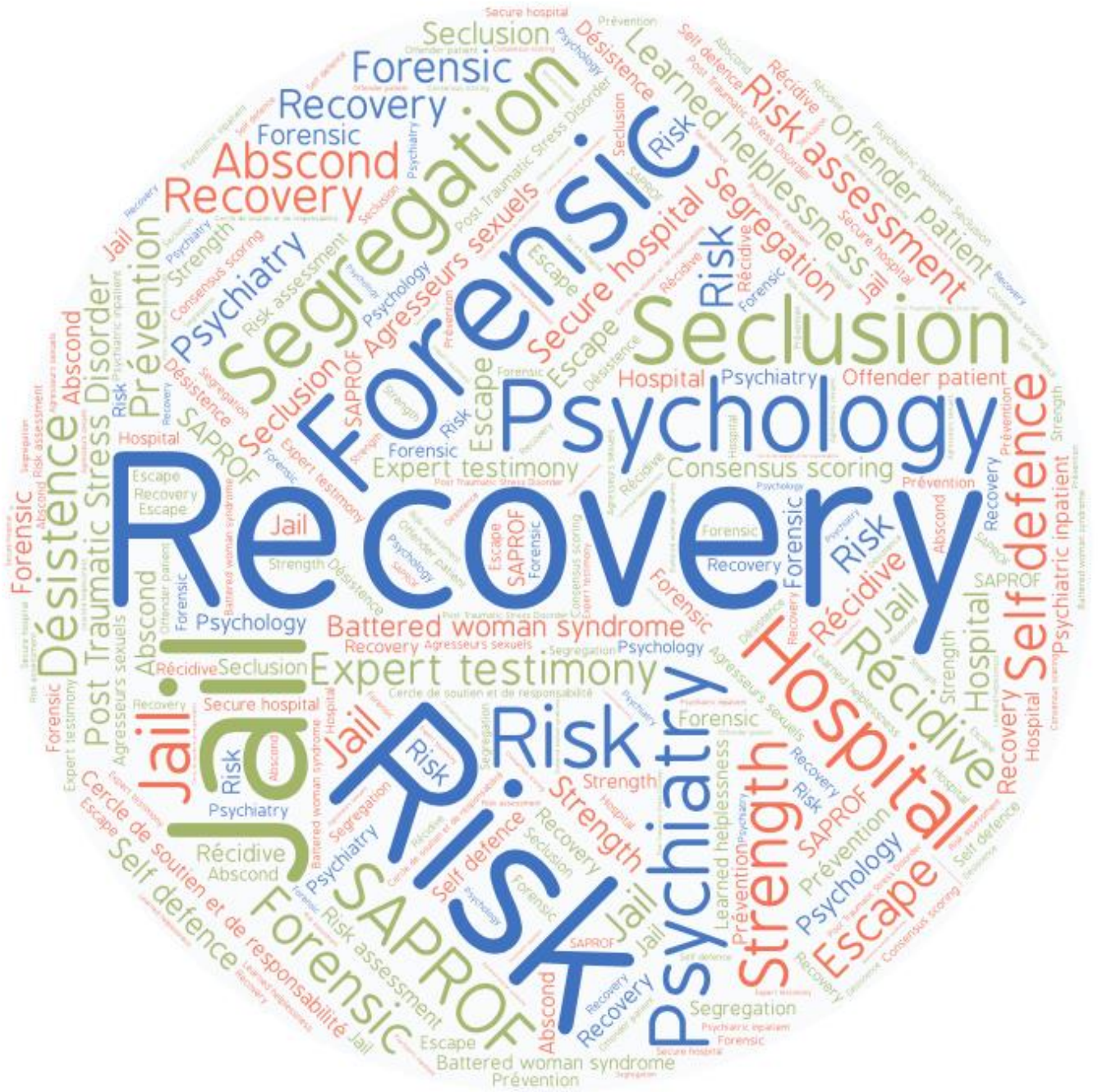
International Journal of

RISK AND RECOVERY



DECEMBER 2019 | VOLUME 2, ISSUE 2

McMaster University Library Press

EDITORIAL TEAM

Editorial Office

100 West 5th Street, Hamilton ON L8N 3K7

https://mulpress.mcmaster.ca/ijrr

ijrr@mcmaster.ca

Publisher

McMaster University Library Press

https://mulpress.mcmaster.ca

———

eISSN 2561-5645

EDITORIAL

Jail segregation today, hospital seclusion tomorrow

Gary Chaimowitz [1,2]

[1] *McMaster University, Department of Psychiatry and Behavioural Neurosciences, Hamilton, Canada*

[2] *St. Joseph's Healthcare Hamilton, Forensic Psychiatry Program, Hamilton, Canada*

Gary Chaimowitz is a Professor of Psychiatry at McMaster University and the Head of the Forensic Psychiatry Program at St. Joseph's Healthcare Hamilton. Among many roles, Professor Chaimowitz has been granted Forensic Psychiatry Founder Status. He is one of the creators the Hamilton Anatomical Risk Management (HARM) and the Aggressive Incident Scale (AIS). Professor Chaimowitz is the Editor in Chief of the International Journal of Risk and Recovery.

There has been a lot of attention given to the use of segregation in correctional facilities, sufficient that a number of class action lawsuits have been launched, and in many cases, they have been settled. Psychiatrists and psychiatry in general have mostly watched these issues play out from the sidelines. Segregation occurs in correctional facilities and few psychiatrists work in jails and prisons. Although mental health professionals watched with interest and concern, it remained an issue in correctional settings, not in our house. In the last few decades psychiatry has done a lot of work in reducing seclusion in hospitals. The tracking of seclusion, the requirements for reassessment and seclusion justification, along with improved training of staff about the traumatic effects of seclusion have helped in reducing seclusion rates and the length of individual seclusions. Psychiatry has done well in this regard and hence it would not be surprising that many may think that the issues associated with seclusion have been dealt with. This may be an error for the following reasons.

Psychiatry continues to evolve and so do our views of a whole multitude of "psychiatric" issues. There was a time in medicine where clinicians failed to recognize the impact of their behaviour on patients, and may have failed to consider the patient's experience, particularly inpatient's. Clinicians also did not recognize the impact of certain procedures on the people they cared for. It is only in the more recent years that we have begun to recognize the deleterious effects of certain clinical practices. For example, in jails inmates were segregated and in psychiatric settings they were secluded without a full appreciation of the harmful effects.

Over time most mental health professionals have come to understand that solitary confinement/segregation has harmful effects on inmates with major mental disorders. Apart from the need to place highly agitated and violent mentally ill inmates in a secure/segregated setting for a brief period of time, there are no other specific situations where one could justify the use of extended segregation for mentally ill people because of their mental illness, without the provision of active psychiatric treatment (as the vast majority of correctional settings are not clinical) [1,2]. The correctional environment has not been able to celebrate the advances that the hospital sector made in the reduction of seclusion for many reasons, including the very different systems, the physical structure, staff skillsets, and very different foci/purposes.

All the while there has been a growing consensus and increasing awareness among mental health professionals of the deleterious effects of extended periods of isolation on people generally, but certainly on people with major mental illness. Psychiatric institutions have done enormous work in reducing their equivalent of solitary confinement, namely seclusion, given the increasing understanding of the deleterious effects of this intervention. But as the lights go on around us, the question is going to be whether this is enough?

When it comes to correctional settings, there are studies that identify the psychological consequences of the isolation of solitary confinement, and more researchers have recognized the effects of solitary confinement in people with serious mental illness, exacerbating their illness, or even provoking another illness episode [3-7]. It has been argued that the research is not perfect but the signals received from what has been done has been compelling. The effects of solitary confinement are well described by a number of authors such as Grassian, Lobel, Arrigo and others [3-5]. Segregation in Canadian contexts has recently been reviewed independently [8]. The harmful effects have not only been well described in the literature over many years, but are also sufficiently well known that people have linked extended solitary confinement to the idea that it approximates some form of torture. In a U.S. case, Madrid v. Gomez, 889F. Supp. 1146, 1265 (ND Cal. 1995), the judge commented that putting mentally ill prisoners in isolated confinement is “the mental equivalent of putting an asthmatic in a place with little air” [9].

Historically, isolation from society is a form of punishment [3]. Jailing people has a punishment aspect to it. Torture has used aspects of isolation and sensory deprivation, breaking down resistance and breaking will [3]. Solitary confinement is associated with the absence of the ability to interact with others and not being exposed to the usual stimuli and experiences in everyday life [3]. The clinical view would then be that ill individuals in solitary confinement should be either treated or moved quickly to a mental health facility where assessment and further treatment could be provided [4]. Jails and prisons are considered ill equipped to manage acutely psychotic individuals.

The effects of solitary confinement are significant enough that they have been considered as cruel and inhuman treatments that can damage the person and impact their dignity [3-7]. This is in addition to the ongoing corrosive effect of solitary confinement on somebody with a major mental disorder. Several international organizations and human rights groups have described extended solitary confinement as torture [10-12]. The growing recognition that solitary confinement is cruel and inhuman captures the general view of the damaging effects and psychological harm attached to solitary confinement [12].

Numerous initiatives have been established to reduce, and in some cases eliminate, seclusion [1,2]. Any extended period of psychiatric seclusion for active mental illness when individuals pose a risk to others is closely monitored, restricted, and considered something that requires close oversight. We have learnt that many psychiatric patients have trauma histories and secluding them can reactivate and further traumatize them [11]. In correctional environments we know that many inmates including those without major psychiatric illnesses have trauma histories and are even more susceptible to the negative effects of segregation [11].

Unfortunately, major changes occur under threat or after negative events. Deaths in custody, Coroners cases, violent events, and lawsuits drive change, probably more than altruistic initiatives [2]. Notwithstanding the tremendous advances psychiatry has made in reducing seclusion, in 2020, the current state may not be enough in the future.

Seen through modern lenses, seclusion rooms in hospitals are not nice places. Even modern builds have limited light, substandard ablution and washing facilities, and few opportunities for fresh air (that even people in segregation have) [2]. Given what is now possible with architecture and technology, one may ask the question: if seclusion as we know it is necessary (and the question will be if it is really necessary), can we do a better job about how we reduce the traumatic effects of separating people from society? Perhaps when the lawyers are finished with segregation in corrections, they will turn their attention to seclusion in hospital. Or will we have the foresight to address the conditions of seclusions before the lawsuits arrive?

References

1. Annual report of the office of the Correctional Investigator 2014-2015. (accessed on December 30, 2019)
2. Annual report of the office of the Correctional Investigator 2015-2016. (accessed on December 30, 2019)
3. Grassian, S. Psychiatric effects of solitary confinement. *Wash UJL & Pol'y* 2006;22(1):325-83
4. Arrigo BA, Bullock JL. The psychological effects of solitary confinement on prisoners in supermax units: reviewing what we know and recommending what should change. *Int J Offend Therapy* 2007;52(6):622-40
5. Lobel J. Prolonged solitary confinement and the Constitution. *U Pa J Const L* 2008;11(1):115-38
6. Gordon SE. Solitary confinement, public safety, and recidivism. *U Mich JL Reform* 2014;47(2): 495-528
7. Pizarro J, Stenius VMK. Supermax prisons: their rise, current practices, and effects on inmates. *Prison J* 2004;84(2):248-64
8. Segregation in Ontario: independent review of Ontario corrections. Toronto: Queen's Printer for Ontario, 2017. (accessed on December 30, 2019)
9. Madrid v. Gomez, 889. F. Suppl.1146 1230-32 (N.D. 1995). (accessed on December 30, 2019)
10. Human Rights Watch. Written statement to the Committee on the Judiciary, Subcommittee on the Constitution, Civil Rights and Human Rights. December 9, 2014. (accessed on December 30, 2019)
11. Ayan A, Baykal T, Beynon J, Dromer C, Korur Fincancı S,Gautier A et al. (Task group participants). The Istanbul statement on the use and effects of solitary confinement adopted on 9. December 2007 at the International Trauma Symposium, Istanbul. *Torture* 2008;18(1):63-6
12. Méndez RJ (Special Rapporteur of the Human Rights Council, United Nations). Torture and other cruel, inhuman, or degrading treatment or punishment (interim report). Resolution A/66/268. 5 August 2011. (accessed on December 30, 2019)

Corresponding author

Gary Chaimowitz, Forensic Psychiatry Program, St. Joseph's Healthcare Hamilton, Hamilton ON L9C 0E3, Canada - email: chaimow@mcmaster.ca

ORIGINAL ARTICLE

Battered woman syndrome: updating the expert checklist

Graham Glancy [1,2], Marissa Heintzman [1], Adam Wheeler [1]

[1] University of Toronto, Division of Forensic Psychiatry, Toronto, Canada

[2] McMaster University, Department of Psychiatry and Behavioural Neurosciences, Hamilton, Canada

The aim of this article is to examine the current state of the battered woman syndrome (BWS) defence in Canada and propose an update to the list of factors considered by experts evaluating the applicability of the defence to individual cases. The history and current legal definition of the defence are presented, and theories relating to BWS are summarized. Factors required of expert testimony in BWS cases are presented; cases relevant to the development of the defence that highlights these assessment factors are discussed. In a subsequent section, limitations of the defence and the role of the expert are explored. The PTSD Checklist (used in clinician diagnosis) is summarized before an updated, BWS-specific expert checklist is proposed. The updated checklist proposes six elements to be considered by an expert assessing a BWS case: 1. environmental factors, 2. attempts to leave or alter the situation, 3. risk factors of the abuser, 4. risk factors of the victim, 5. triggers for violence, and 6. contrary evidence. It is hoped that using this checklist will help experts to cover all the essential elements they must consider in order to conclude that a woman satisfies the criteria for BWS. In particular, this updated checklist will help experts to prepare comprehensive testimony that addresses the five issues defined by Justice Wilson as the expert's duty to assess. In addition, this checklist will help experts present a firm foundation for a defence regarding the critical question of why the night of the offence was different from all other nights.

Key words

Battered woman syndrome, Learned helplessness, Post-Traumatic Stress Disorder, Self-defence, Expert testimony

Introduction

Battered woman syndrome (BWS) has been internationally recognized as a justification for self-defence since the 1990s. However, public acceptance of the defence is only one step toward providing women justice in a system that has traditionally favoured men. Popular understandings of the doctrine of self-defence often assume that defensive force is justified only when in response to an obvious, immediate threat. There are several reasons why this might not be the case for battered women. For many battered women, fear for their safety or their children's safety, along with trauma and victimization, drives them to use violence against their abuser outside the immediate context of a direct confrontation.

Despite being created to adapt the requirements of self-defence to include women's experiences of violence more accurately, the BWS defence is not always easily applied in practice. Many juries view the case with one question in mind: "Why did she not just leave the situation or the abusive relationship?" In some jurisdictions, there is still a legal duty to retreat: a threatened person cannot harm another in self-defence if she has a reasonable opportunity to remove herself from the situation. This stands in contrast with "stand your ground" and "castle" doctrines in some American states, whereby an individual is not required to retreat from an imminent threat but can defend himself and his property with any force necessary. Neither of these requirements supports the battered woman's position. While a man has the right to defend his family and property with lethal force, a woman must defend her reasons for not fleeing violence within the home. If she had an opportunity to flee, subsequent violence on her part might be viewed as an act of vengeance rather than an act of self-defence. Effective use of expert testimony offers juries an essential tool for navigating these challenging factual and legal dilemmas.

The following paper explores BWS in the context of Canadian law, as well as the effective use of expert testimony. In the first

section of this paper, an overview of the law of self-defence is provided to situate the historical treatment of battered women and the emergence of BWS theory. This is followed by a discussion of the key ruling that established the BWS defence in Canadian law, R. v. Lavallee, as well as subsequent judicial consideration of the BWS defence. The third section expands upon the limitations of the defence and the role of the expert in the assessment. An expanded expert checklist for the assessment of a woman regarding BWS is provided in the final section.

Overview of Self-Defence in Canadian Law

The common-law doctrine of self-defence was codified in Canada's first *Criminal Code* [1]. Although the *Code* historically included a number of provisions intended to guide the application of the defence according to circumstances (i.e. a sudden and unlawful attack vs. the use of force to defend against a disproportionate defence), the general structure of self-defence remains largely unchanged today. Recent amendments to the *Code* in 2013 replaced these statutory scenarios with a number of important contextual factors intended to guide judges and juries in applying the doctrine, although the structure of the defence itself was not changed. Section 34(1) of the *Code* currently provides that an accused acted in self-defence, and is, therefore, not guilty of an offence, if:

i. he or she believes on reasonable grounds that force is being used against him or her (or another person) or that a threat of force is being made against them or another person;
ii. the act that constitutes the offence is committed for the purpose of defending or protecting himself or herself (or the other person) from that use or threat of force; and
iii. the act committed is reasonable in the circumstances [2].

These elements were historically considered alongside an imminence (i.e. immediacy) rule, such that a self-defence argument would only succeed where there was no alternative course of action other than using force for protecting oneself. This criterion— intended, in part, to ensure that escape was not an option—was also adopted to narrow the scope of this full legal justification [3]. Evidence that a significant period of time had passed between the threat or use of force against the accused and their responding use of force could support the inference that there were other motivations at play (e.g. revenge).

Historical Treatment of the "Battered Woman" in Court

Self-defence has long been a part of Canadian criminal law. However, BWS was only first recognized as a legal justification for self-defence in Canada in the 1990s. Of course, the issue of violence against women had been considered elsewhere in the common-law world well before then.

A battered woman argument was first notably used in a Canadian criminal trial in 1911. Angelina Napolitano, a 28-year-old Italian immigrant, and mother of four, attempted to use the defence after killing her husband with an axe as he lay sleeping. Napolitano admitted to the murder, claiming it was the result of years of physical abuse and the only way she could see to escape from the life of prostitution her husband was forcing her toward [4].

The *Criminal Code* at the time had much the same requirements of self-defence as those listed above. An accused had to prove that he or she was in imminent danger with no alternative course of action available. For a variety of reasons, including differences in physical strength, battered women most often kill when they are *not* being assaulted, and, therefore, when they are not technically in imminent danger. This was the case for Angelina Napolitano. The prosecution emphasized the point that Napolitano had committed adultery, and the judge instructed the jury to keep this fact foremost in their mind since it disqualified Napolitano from claiming "wronged woman status" by the standards of the time. She was found guilty and sentenced to death.

Despite the death sentence, the public rallied in support of Napolitano. She had

been presented as a victim in her case: a poor immigrant woman, abused by her husband. An international clemency campaign was launched, propagating the idea that such an uneducated immigrant could not reasonably be expected to uphold the standards of others. Her sentence was ultimately commuted to life in prison; she served 11 years before being paroled.

Elsewhere in the common-law world, in the 1949 case of *R. v. Duffy,* the British Court of Criminal Appeal considered whether a defence of provocation applied to a woman who had killed her husband after a history of brutal abuse.[1] On the night of the offence, the deceased threatened and physically struck Ms. Duffy, preventing her from taking their child away to safety. She left the room for a while, changed her clothes, and then returned to strike her husband with a hatchet and hammer, killing him while he lay in bed. She argued that the course of abuse constituted provocation, but the defence was rejected by the jury and the Court of Criminal Appeal, resulting in her conviction for murder. In what remains a leading statement on the historical common-law defence of provocation, the Court of Appeal affirmed the following jury instruction:

> Provocation is some act, or series of acts done (or words spoken) … which would cause in any reasonable person and actually causes in the accused, **a sudden and temporary loss of self-control, rendering the accused so subject to passion as to make him or her for the moment not master of his or her mind** … A long course of cruel conduct may be more blameworthy than a sudden act provoking retaliation, but you are not concerned with blame here—the blame attaching to the dead man. You are not standing in judgment on him. He has not been heard in this court. He cannot now ever be heard. He has no defender here to argue for him. It does not matter how cruel he was, how much or how little he was to blame, except in so far as it resulted in the final act of the appellant. **What matters is whether this girl had the time to say: "Whatever I have suffered, whatever I have endured, I know that Thou shalt not kill." That is what matters.** [Emphasis added] - *R v Duffy* [1949] 1 All ER 932

The highly gendered and paternalistic nature of this jury charge aside, a strict application of this temporal requirement (i.e. how soon after abuse or provocation the woman used defensive force) remained a significant component of both self-defence and provocation throughout the common-law world (including Canada) for decades. It was only as a result of evolving clinical insight into the dynamics of gendered violence that criminal courts in Canada began to rethink its approach to the issue of when abused women use defensive force.

Theories of Battered Woman Syndrome

The term "battered woman syndrome" was first used by Lenore Walker in 1979 to describe the pattern of violence that exists in abusive relationships and the impact it has on the woman [5]. Walker described a three-step cycle of violence that defined the syndrome: tension building, acute battering, and reconciliation. It was proposed that the presence of at least two cycles of violence leads to the syndrome. Walker's theory proposed that the woman's behaviour and inability to leave the situation is due to "learned helplessness." In other words, the woman has developed such a firm belief in her partner's dominance over her that she does not believe in her own ability to escape or change her situation. This theoretical understanding has not easily mapped onto the legal doctrine, as will be discussed shortly.

In 1987, Dr. Charles Ewing made another early attempt to understand the situation and mindset of battered women who kill. In his book [6], Ewing, a psychologist and lawyer, analyzed over 100 cases. He sought to identify the kinds of abuse each defendant experienced and the characteristics of the battering relationship.

[1] Note - Provocation, unlike self-defence, only provides a partial excuse to murder. Where the defence is accepted, it reduces murder to manslaughter in recognition of the diminished moral blameworthiness of someone provoked into what is clearly an extreme use of force. Self-defence is available for a wider range of offences but is subject to the general con-straint that the use of force must be reasonable and not excessive in the circumstances.

Ewing identified seven factors of battered women who kill their husbands. A situational understanding of each case, identified by experts during trial using such factors, is the basis for a successful BWS defence today.

According to Ewing, in a violent incident ending in death, it is likely that: 1/The woman has experienced serious injuries at the hands of her spouse; 2/The frequency of battering incidents increased prior to the incident in question; 3/Life-threatening acts have occurred, often accompanied by death threats; 4/Weapons, particularly guns, are present in the household; 5/The man has abused the children. 6/ A threat to the custody, care, or lives of the children has triggered the event; and 7/The man has made a threat of retaliation if the woman were to leave, including descriptions of stalking, finding, and killing her and others.

BWS Theory Considered in R. v. Lavallee

In 1990, the Supreme Court of Canada recognized that BWS could support a self-defence argument in the landmark case of *R v. Lavallee* [7]. Ms. Lavallee was a 22-year-old woman who had been living with the victim, Kevin Rust, for several years. One evening, the couple was throwing a party and began arguing. Ms. Lavallee ran upstairs and hid in a closet but was dragged out by her hair by Mr. Rust. He allegedly handed Ms. Lavallee a gun, saying “either you kill me, or I’ll kill you.” He turned around; the gun went off. Although she claimed to be aiming above his head, Ms. Lavallee killed Mr. Rust with a single gunshot to the back of the head. At trial, Ms. Lavallee argued that she acted in self-defence. Her claim was supported by expert psychiatric evidence about the effects of ongoing physical, mental, and emotional abuse inflicted upon the accused by the deceased, all of which led to the opinion that she sincerely believed she would be killed that night. The Court accepted this argument as evidence that BWS requires a relaxation of the imminence rule in cases of domestic violence.

Specifically, the Court held that expert evidence is admissible for four main purposes: (1) to dispel stereotypes about battered women, (2) to address the ability of an accused to perceive danger from her partner (regarding the issue of whether she “reasonably apprehended” death or grievous bodily harm), (3) to explain why battered women may remain in abusive relationships, and (4) to explain why an accused may not flee and the consequent reasonableness of her belief that use of force was the only way to save her life [7]. The imminence rule has since been clarified as merely one factor to be taken into consideration where self-defence is a live issue [8]. This ruling set a precedent for future cases of its kind; women no longer had to “wait for the ‘uplifted knife’ to act in self-defence.” [9]

Selected Canadian Cases Since *Lavallee*

Canadian courts have attempted to define the parameters of a BWS defence more clearly since *Lavallee* but have struggled to apply its legal and clinical criteria. In particular, courts have considered the imminence criterion, the reasonableness of the threat perceived by the accused, and the availability of the defence in cases where the relationship between parties is not that of a battered woman and spouse.

Imminence

The case of *R. v. Irwin* [10] was decided shortly after *Lavallee*. In this case, the British Columbia Court of Appeal held that *Lavallee* would apply where there was a reasonable apprehension of death in the immediate future. However, it would not apply in a case where the accused fired the third fatal shot because he feared that the victim would recover from the first two shots and would come back in a few months to kill him. The accused’s subjective fear of retaliation in a few months was not objectively reasonable because this delay did not constitute imminent danger. The imminence criterion was more recently applied in *R. v. Z.K.* [11], where the accused had an abusive relationship with the victim, his father. In that case, the Court held that this abuse did not give rise to a reasonable apprehension of bodily harm or death on the day of the offence and rejected the self-defence claim.

Reasonableness of the Threat

In R. v. Eyapaise [12], the Court of Queen's Bench of Alberta rejected a BWS defence as unreasonable in a case where the accused was a battered wife, but the victim was not her husband. The accused stabbed the victim, a stranger after he touched her breasts several times while drinking with her. She freed herself without a struggle, then obtained a knife, and stabbed him in the neck. The Court heard that she had been the victim of abuse by men throughout her life and had once been sexually assaulted by a group of assailants. However, the Court held that her actions were not a reasonable form of self-defence, even if she feared harm to herself and felt trapped based on previous relationships because she had other options available to protect herself.

Interestingly, in R. v. Knott [13], the Court of Queen's Bench of Manitoba accepted a BWS defence in a case where a third party was present and trying to protect the accused at the time of the incident. Ms. Knott had been regularly abused by her husband and was hospitalized twice due to her injuries. She had attempted to leave the relationship twice before, but her husband always found her again. Ms. Knott was living on her own at the time of the incident when her husband and his brother showed up at her apartment. Knott's husband physically and verbally abused her throughout the day before all they went out to drink at a bar that evening. Ms. Knott did not want to let her husband back into her apartment after the bar but knew he would scream and bang on the door, disturbing the neighbours. She let him in, and the violence continued to escalate inside the apartment. The victim's brother attempted to restrain the victim, who kept trying to attack the accused. The accused first tried to fend off his attacks with a mop before eventually grabbing a steak knife and stabbing him. Ms. Knott was acquitted on evidence that she suffered from post-traumatic stress disorder (PTSD) and was fearful of escalating violence.

Relationship Between Parties

In *R. v. Malott* [14], the accused and the victim had been living in a common-law relationship for 19 years and had two children together. The accused had previously gone to the police due to physical, sexual, psychological, and emotional abuse at the hands of her husband. The police had informed the husband of her accusations because he was a police informant; this resulted in an escalation of the violence. The couple had separated a few months before the incident, the husband taking the couple's son and moving in with a new girlfriend.

On the morning of the criminal act, the victim picked up the accused and took her to a medical centre so she could acquire prescription drugs for his illegal drug trade. The accused took a gun with her and shot him to death after they arrived at the medical centre. She then took a taxi to his home and shot and stabbed his girlfriend. As in *Lavallee*, expert evidence of BWS was introduced in the trial. The Ontario Court of Appeal conceded that the accused had been subject to terrible abuse by her husband. However, the Court rejected an argument that the girlfriend of the deceased could have been viewed by the accused as an extension of her abusive spouse and as part of the source of the abuse she had suffered throughout her marriage. She was found guilty of second-degree murder; the jury recommended that she receive the lightest sentence in light of the severity of BWS.

The Supreme Court subsequently confirmed, in *R. v. Charlebois* [15], that the *Lavallee* defence was uniquely available to battered women. They refused to apply the defence to Charlebois, a male accused of shooting an acquaintance—with whom he had a history of violence—in the back while he lay sleeping. The accused claimed the victim had shown up at his house with a knife and had seen a gun the accused had previously refused to sell him. The accused was overcome with fear of retaliation by the victim, leading to the criminal incident. Following *Charlebois*, in *R. v. Bird* [16], the Saskatchewan Provincial Court held that BWS did not apply where there was no history of abuse between the parties, notwithstanding any history that the accused had been victimized by others in the past.

The Ontario Court of Appeal applied *Charlebois* to reject a *Lavallee* defence in *R. v. Currie* [17]. The Court concluded that, despite the accused's subjective fear that the victim might attack him in the future, there was no objective evidence of a threat to his safety. As a result, there was no connection between a threat to Currie's safety and his actions on the day that he shot the deceased. There was no evidentiary foundation to support the defence.

Amendments to the Criminal Code

In 2013, the *Criminal Code* was amended by the *Citizen's Arrest and Self-Defence Act* [18] to codify the *Lavallee* factors, including a history of abuse between the parties, into a statutory list of considerations relevant to a claim of self-defence by any person. As a result, s. 34(2) of the *Code* now requires courts to consider the following factors:

a) the nature of the force or threat;
b) the extent to which the use of force was imminent and whether there were other means available to respond to the potential use of force;
c) the person's role in the incident;
d) whether any party to the incident used or threatened to use a weapon;
e) the size, age, gender and physical capabilities of the parties to the incident;
f) the nature, duration and history of any relationship between the parties to the incident, including any prior use or threat of force and the nature of that force or threat;any history of interaction or communication between the parties to the incident;
g) the nature and proportionality of the person's response to the use or threat of force; and
h) whether the act committed was in response to a use or threat of force that the person knew was lawful [18].

Limitations of the Defence and the Importance of the Expert

Writing for the Supreme Court in *Lavallee*, Justice Wilson outlined some of the reasons why expert testimony is crucial to a BWS defence. She noted that the expert has the duty to address (1) the existence of complex PTSD, (2) the existence of BWS, (3) the uniqueness of the events leading to the violent act, (4) the woman's psychological state and apprehension of death or harm, and (5) reasons why the woman remained in the relationship [19]. This evidence can provide the jury with a framework to assess whether a woman's response in killing her abuser was reasonable, according to Section 34.

However, in subsequent years, there has been some disagreement as to how expert testimony should be presented. Soon after *Lavallee*, Sheehy [20] proposed that the term "battered woman syndrome" be dropped from testimony. As Schneider [21] pointed out, the term suggests "an implicit but powerful view that battered women are all the same, that they are suffering from a psychological disability and that this disability prevents them from acting 'normally.'" Others have supported this notion, arguing that expert testimony should focus on the social reality of the woman's situation—such as the batterer's control, her lack of support and alternatives, and risks of leaving—rather than her psychological reactions [22-24]. Reasons for this were supported in a study by Kasian and colleagues [25], which assessed acquittal rates by mock jurors in cases involving battered women who killed their husbands. Kasian and others found that expert evidence impacted the jurors' beliefs of guilt but only when automatism was raised by the defendant; if a plea of self-defence was entered, jurors were more likely to find a defendant guilty.

Critics of BWS point to such studies as proof of the shortcomings of the BWS defence. They argue that the legal trend to use the BWS defence disadvantages women as a group, forcing them to be portrayed in court as ultra-feminine and helpless. Acquittals are achieved by embracing victimhood [20,21]. Society imposes notions of what the "correct" behaviour is and assumes the guilt of those who do not present as such, further perpetuating the gender inequity that BWS was supposed to help solve in the court system.

The Expert Assessment

Despite this criticism, a forensic expert is sometimes retained to assess individuals charged within the existing legal system. There are several proposed ways of dealing with this reality, many of which hinge on the role of the expert. The following section expands upon Justice Wilson's suggested purpose of expert testimony in BWS cases. It provides an understanding of exactly what an expert looks for in the details of a case, including the situational factors and symptoms exhibited by the defendant, and how a clear comprehension of these details helps to understand the reasons for a violent act.

The Cycle of Violence

The first criterion is the presence of an abusive relationship. This is established by a list of the types and frequency of abuse. It is helpful to obtain collateral confirmation, including statements by others, such as friends, relatives, neighbours, colleagues and others, police records, and medical records from the general practitioner, psychiatrist, or counsellors and emergency rooms to verify this information. Without collateral information, the expert should have a high degree of suspicion about the nature of the abuse. This can be complicated by the forced isolation of the woman, such that she kept the abuse hidden. The starting point is the presence of at least two cycles of violence, as described on page two. In most legitimate cases, there are multiple instances and cycles and, in our experience, a diminishing reconciliation phase.

The PTSD Checklist

Battered woman syndrome, while not a medical diagnosis within the DSM-V, describes a pattern of behaviour and symptoms closely resembling, or at least inclusive of, post-traumatic stress disorder (PTSD). It was previously considered a form of complex PTSD [26], but this descriptor has more recently been considered merely a variant of PTSD proper.

There are a number of commonly used self-report scales [27] available as an adjunct to the clinical interview. To diagnose PTSD, clinicians may use a standardized reporting scale corresponding to the DSM-5 criteria for PTSD: the PTSD Checklist [28] (Ruggeiro et al.). In evaluating a BWS case, experts can use the PTSD Checklist criteria to determine if a woman satisfies the DSM criteria for the disorder, supporting her claim of BWS. In addition to PTSD symptoms, there may also be comorbid depressive and anxiety disorders, which should be noted and included in the formulation.

The Updated Expert Checklist

The following section will expand upon the considerations outlined above to provide an updated expert checklist for use in BWS cases. This checklist will address several factors to provide a comprehensive assessment of the woman's situation and actions, beyond the role of victim perpetuated by Walker's concept of learned helplessness. This updated checklist will explore 1/Environmental factors; 2/Attempts to leave or alter the situation; 3/Risk factors of the abuser; 4/Risk factors of the victim; 5/Triggers for violence; and 6/Contrary evidence.

Environmental Factors

An expert has a duty to help the jury answer its biggest question: why did she stay? This can be partially explained using Walker's learned helplessness theory, but a stronger tactic is to evaluate the environmental factors. These may include an examination of the support systems available to the woman.

.

Table 1. The PTSD Checklist

Factor or Symptom	Details
The experience of the traumatic event, including fear for bodily safety or of death	▪ After-effects lasting longer than four weeks
Sequelae of trauma affecting aspects of life	▪ Job performance affected ▪ School performance affected ▪ Social relationships affected
Re-experiencing of the traumatic event	▪ Intrusive memories ▪ Nightmares ▪ Night terrors ▪ Daydreams ▪ Flashbacks ▪ Physiological responses with or without stimuli
Hyper-arousal responses	▪ Anxiety reactions ▪ Crying ▪ Sleeping problems ▪ Eating problems ▪ Hypervigilance to further harm ▪ Exaggerated startle response ▪ Exaggerated fearful response
Numbing of emotions	▪ Avoidance of making things worse, whenever possible ▪ Avoidance in the form of depression, dissociation, and denial ▪ Minimization of fear or harm ▪ Decreased participation in activities ▪ Isolation from other people ▪ Other indications life is being controlled
Negative mood and cognition alteration	▪ Inability to remember some aspects of the traumatic event ▪ Negative self-esteem ▪ Negative expectations from others and the world ▪ A pervasive negative state of mind ▪ Difficulty experiencing positive emotions ▪ Distortion of self-blame ▪ Decreased interest in activities ▪ Detachment from others

Table 2. The Updated Expert Checklist: Environmental Factors

Environmental Factor	Reason
Financial difficulty of leaving	▪ The victim has a job, but the abuser controls the finances. ▪ The victim has control over finances but is afraid of repercussions if she is caught taking money. ▪ The victim does not have a job or is afraid to leave her job due to her image of herself as being talentless and unskilled that has been enforced by verbal abuse.
Presence of children in the home	▪ Victim fears ▪ The abuser will prevent children from leaving. ▪ The abuser will harm children if she leaves them behind. ▪ The abuser will take and hide children if he knows she is leaving. ▪ The abuser will win custody in court. ▪ Victim feels ▪ Social pressure to keep the family together.
Inability to access support systems	▪ Victim has ▪ Become isolated from family and friends, often at abuser's will. ▪ Limited community or government resources available to her. ▪ Lack of access to finances required to leave. ▪ Had previous difficulty reaching out for help.
No guarantee of an end to the violence	▪ Victim fears retaliation because ▪ The abuser had retaliated in the past for similar actions. ▪ The abuser has expressed threats or violence. ▪ The abuser has a proven ability and resources to locate and harm the victim or family members.

Attempts to Alter the Situation

Although the woman may not ultimately have left the situation, the expert can highlight other attempts she did make to alter her situation. An explanation of the results of these attempts can help to explain the woman's fear of further attempts or her feeling of hopelessness and resultant capitulation to the situation. It is important for the evaluator to canvas with the woman what attempts she made to change and eventually to leave the relationship. At the very least, what attempts to leave the relationship did she consider, and if she rejected them, why did she reject them. If she did make attempts to leave the relationship, it would be helpful if there is collateral information confirming this, for instance, from her family, friends, or counsellors.

Table 3. The Updated Expert Checklist: Attempts to Alter the Situation

Attempt	Result
Proposal of separation	Negative reaction/violence from the abuser.
Report to police	Abuser finds out, escalates violence.
Proposal victim takes a job to relieve financial stresses	Abuser reacts negatively, feeling threatened professionally.
Proposal of counselling	Negative reaction from abuser, persistent distrust resulting in increased isolation.

Risk Factors of the Abuser

The expert's assessment and testimony extend beyond understanding the woman's experience; the background and actions of the abuser are equally important to understanding the level of risk he presented, which adds to the woman's perception of acute danger. These factors may be found in the collateral information, which likely includes witness statements, medical records, and police records.

Risk Factors for the Victim

There are also several factors the woman may present that typically indicate the escalation of a situation, with resultant changes to her attitude and mental state, possibly helping to understand the precipitation of a violent incident. Understanding the woman's personal experience of the relationship and situation, beyond what might be visible to an outside observer, is another key purpose of expert testimony.

Triggers for Violence

Once the expert has explained the situation and the woman's enhanced ability to predict and quantify violence from her abuser, the jury can better understand why a particular incident resulted in death. Table 6 presents triggers that could precipitate violent events.

A critical factor in understanding the accused's actions in the final denouement is noted by Regehr and Glancy [19]: if the woman had been abused numerous times, why did she kill or harm her abuser on this specific occasion? In other words, why is this night different than any other night? Not all women who are battered, even repeatedly, end up killing their abusers. It is important to understand why, after repeated episodes of abuse, the woman became violent toward her abuser on this particular occasion. There may be signs of impending tragedy, resulting in an increase in the frequency and severity of the abuse (see Table 7). Even more acutely, there may be a crucial change in the quality of the abuse, such as threats of sexual assault of the children, the recent acquisition or presence of a lethal weapon, or an increase in sexual assaults.

In reviewing the literature on women who kill, some triggers emerge. It is the presence of threats related to the children that are perhaps the most critical. Understanding why a particular woman acted in this particular way at this time is

one of the most important facets of these assessments. This differentiates this woman and this occasion from the all too common patterns of abuse that do not result in the woman harming her abuser.

Table 4. The Updated Expert Checklist: Risks Factors of the Abuser

Risk Factor	Evidence
Demonstrates a lack of concern for the victim	May disrespect or ignore what is necessary for her wellbeing.
Controls aspects of the victim's life	Does not allow the victim ▪ To travel. ▪ To visit family. ▪ To attend social activities. ▪ To pursue further education. May physically or verbally sabotage victim's attempts ▪ To better self. ▪ To have a life outside of home life.
Needs to be the centre of attention	Abuser feels resentment toward ▪ Activities that occupy the victim's time. ▪ Own children and other family members for occupying victim's time. Abuser upstages other family members and close friends to maintain attention on himself.
Personality traits	Abuser may ▪ Be charming, manipulative, or seductive to get what he wants. ▪ Become hostile and mean when he fails. ▪ Have difficulty interpreting negative emotions, with multiple triggers translating into anger. ▪ Exhibit jealousy to an extreme, including jealousy of children, friends, and family.
Expresses an interest in violent topics	Items pertaining to violent behaviour are present, including ▪ Books. ▪ Internet searches. ▪ Weapons.
Personal history of violence	History of ▪ Experiencing or witnessing violence in childhood. ▪ Childhood temper tantrums. ▪ Military service, likely for long stints. ▪ Insecurity. ▪ Expressions of aggression toward women. ▪ Violence against animals. ▪ Violence against inanimate objects.
Relationship to parents	Abuser likely experienced ▪ A punitive, strict father. ▪ An inconsistent mother. ▪ Coddling or protective behaviour from mother during violent childhood episodes. Relationship with parents may have resulted in ▪ An inability to self-soothe. ▪ A belief in traditional gender roles; enforcing these roles as a way to maintain power in the relationship.

Table 5. The Updated Expert Checklist: Risks Factors for the Victim

Risk Factor	Evidence
Change in motivation	Victim stops ▪ Attending social events. ▪ Answering phone and emails. Victim quits her job.
Change in appearance	Victim exhibits ▪ A lack of care in appearance. ▪ A change in grooming habits (such as failing to wash her hair).
Social isolation	Victim may ▪ Be forced by the abuser to isolate self. ▪ Withdraw from activities to mitigate the risk of violent repercussions. ▪ Withdraw to spend more time with the abuser as he cannot handle being alone.
Learned hypervigilance	Victim may ▪ Try to watch abuser's moods. ▪ Learn to read his expressions and behaviour. ▪ Feel a heightened perception of danger. ▪ Register that this particular incident is worse than the others.
Marked passivity	Victim exhibits ▪ Difficulties in problem-solving. ▪ Depression and anxiety, leading to paralysis.
Preoccupied with relationship with abuser	Victim may unrealistically attribute total power to the abuser.
Alterations in self-perception	Victim exhibits ▪ A growing sense of shame and guilt. ▪ Self-blame. ▪ A lack of appetite. ▪ Weight loss. ▪ Persistent dysphoria. ▪ Lowered self-esteem as a result of repeated humiliation. ▪ A reduced ability to confide in others.
Altered memory	Victim experiences ▪ Amnesia or Hypermnesia (blocking out or minimizing) of traumatic events. ▪ Blocking out or minimizing traumatic events, ▪ Transient dissociative episodes. ▪ Depersonalization. ▪ Derealization. ▪ Reliving traumatic experiences.
Depressive symptoms	Victim exhibits ▪ Uncontrollable crying. ▪ Feelings of being utterly alone. ▪ Chronic suicidal preoccupation. ▪ Self-injury.
Personality changes	Victim exhibits ▪ Explosive or inhibited anger. ▪ Compulsivity or impulsivity. ▪ Extremely inhibited sexuality.
Financial situation	Victim is subject to tight economic controls, perpetuating her dependence on the abuser and reluctance to leave.

Table 6. The Updated Expert Checklist: Triggers for Violence

Trigger	Reason
Loss of income	Abuser may have lost job, resulting in ▪ Increased financial stress. ▪ A feeling of shame and failure.
Decrease in intercourse	Abuser resents ▪ Activities and relationships that occupy the victim's time. ▪ His own children, particularly a new baby, occupying victim's time.
Disparity in status	Resentment may grow due to the difference between abuser and victim's ▪ Education levels. ▪ Socio-economic backgrounds. ▪ Views of gender roles.

Table 7. The Updated Expert Checklist: Contrary Evidence

Contrary Evidence	Reason
Presence of social group or activities	Victim may try to maintain façade of functional lifestyle to ▪ Mitigate violence against her. ▪ Dissociate from her situation. ▪ Assert some element of control over her life.
Presence of control in aspects of family life	Victim may be allowed control of some aspects because ▪ The abuser likes traditional gender roles. ▪ The abuser wants to be taken care of. ▪ The abuser may check over her work anyways. Victim may conduct tasks seemingly willingly because ▪ The abuser may punish her for work he believes is done poorly.
Did not confide or report abuse	Victim may ▪ Be fearful abuser will find out she has told someone. ▪ Have previously experienced abuser finding out.
Learned Helplessness	Victim may ▪ Not be confident in the outcome of an action. ▪ Choose to develop coping mechanisms instead of pursuing escape. ▪ Be socially isolated.

Contrary Evidence

The forensic expert should approach each case with neutrality or even forensic skepticism as may a jury. In order to overcome jury skepticism, an expert must be able to explain how details of a woman's life might seem contrary to the popular concept of a battered woman. The woman may, for instance, maintain a functional lifestyle, participating in social groups or activities without anyone knowing something is wrong. She may also demonstrate control of aspects of family life. This, rather than being a sign of a confident and self-possessed woman, may be enforced by an abuser who prefers traditional gender roles, dictating particular tasks to her. The woman herself may not demonstrate any desire to escape as she has chosen to resort to coping mechanisms instead, likely afraid of the consequences of confiding in anyone or reporting the abuse.

The evaluator in such cases should perform a full psychiatric assessment. Psychological testing may be helpful. This testing typically shows a profile consistent with complex trauma. This testing may also help rule out malingering in that certain tests have validity scales, which, taken in the context of the total picture, may be of value in the assessment. It can be a complex formulation, which takes the personality of the battered woman into account, placing it in the context of the history of the abuse (if any) and the final act of violence against the violent abuser. To this end, it is important to look at possible contrary arguments before coming to any conclusions. The following table illustrates evidence a jury might see as contradictory and the possible justifications for each contradictory factor.

Conclusion

The BWS defense is an attempt to rectify the standards by which women who kill are judged in our courts. It is not as a concept, however, without criticism. The public notion of battered women and the very name of the defence itself carry a heavy stigma that can drastically affect legal outcomes. It is one of the roles of the expert to alleviate this stigma, providing testimony that contributes to a fair and balanced trial.

As shown by the legal history of BWS, the defence has the potential for change; so too must the role of the expert evolve to provide a clearer understanding of the woman's situation, actions, and mindset. Expert testimony must go beyond the declaration of an unwell victim who has learned helplessness. The above-proposed checklist provides a detailed look at the many factors that influence violent incidents involving battered women. It is hoped that these checklists will serve as a guide for expert assessment and testimony in BWS cases.

We have developed this checklist as an adjunct to assessment where the issue of a BWS defence arises. There are no definite lines between those that qualify for the defence and those that do not. However, it is important that the expert consider all the evidence available in coming to a conclusion. We have found that using this checklist helps to cover all the essential elements an expert must consider in order to conclude that a woman satisfies the criteria for BWS. In particular, this updated checklist can help experts to cover all issues comprehensively in preparation for giving testimony regarding the five issues that Justice Wilson defined as the expert's duty to assess. In addition, the final question of why the particular night was different from all other nights renders the defence not only understandable but provides a firm foundation for an affirmative defence.

Conflict of Interest: none

References

1. Criminal Code, 1892, SC 1892, c 29 (accessed on September 26, 2019)
2. RSC, 1985, c C-46, s. 34(1) (accessed on September 26, 2019)

3. Blackstone W. *Commentaries on the law of England.* Oxford, England: Clarendon Press, 2nd Ed, 1775: 184
4. Dubinsky K. Maidenly girls or designing women: the crime of seduction in turn-of-the-century Ontario. In: Iacovetta F, Valverde M (Eds). *Gender conflict: new essays in women's history*. Toronto, Canada: University of Toronto Press, 1992: 27-58
5. Walker LE. *The battered woman.* New York, NY: Harper & Row, 1980
6. Ewing CP. *Battered women who kill: psychological self-defense as legal justification.* Lexington, MA: Lexington Books, 1987
7. R. v Lavallee, 1990 1 S.C.R. 852 (accessed on September 26, 2019)
8. R. v. Cinous, 2002 2 SCR 3, 2002 SCC 29 (accessed on September 26, 2019)
9. Sheehy EA. *Defending battered women on trial: lessons from the transcripts.* Vancouver, Canada: UBC Press, 2013
10. R. v. Irwin, 1994 CanLII 486 (BC CA) (accessed on September 26, 2019)
11. R. v Z.K. 2012 ABPC 169 (accessed on September 26, 2019)
12. R. v. N.N.E., 1993 CanLII 7265 (AB QB) (accessed on September 26, 2019)
13. R. v Knott 2014 MBQB 72 (accessed on September 26, 2019)
14. R. v. Malott, 1996 CanLII 2230 (ON CA) (accessed on September 26, 2019)
15. R. v. Charlebois, 2000 2 SCR 674, 2000 SCC 53 (accessed on September 26, 2019)
16. R. v. M. L. B., 2004 SKPC 136 (accessed on September 26, 2019)
17. R. v. Currie, 2002 CanLII 44973 (ON CA) (accessed on September 26, 2019)
18. Citizen's Arrest and Self-Defence Act S.C. 2012, c. 9 (accessed on September 26, 2019)
19. Regehr C, Glancy G. Battered woman syndrome defense in Canadian courts. *Can J Psychiatry* 1995;40(3):130-135
20. Sheehy EA, Stubbs J, Tolmie J. Defending battered women on trial: the battered woman syndrome and its limitations. *Crim Law Rev* 1992;16(6):369-394
21. Schneider EM. Describing and changing: Women's self-defense work and the problem of expert testimony on battering. *Women's Rts. L. Rep.* 1986;9(3-4):207
22. Schuller RA, Wells E, Rzepa S, Klippenstine MA. Rethinking battered woman syndrome evidence: The impact of alternative forms of expert testimony on mock jurors' decisions. *Can J Behav Sci* 2004;36(2):127
23. Dutton MA. Understanding women's responses to domestic violence: a redefinition of battered woman syndrome. *Hofstra Law Rev* 1993;21(4):2
24. Martinson D, MacCrimmon M, Grant I, Boyle C. A forum on Lavallee v. R: Women and self-defence. *U. Brit. Colum. L. Rev*. 1992;25:23
25. Kasian M, Spanos NP, Terrance CA, Peebles S. Battered women who kill. *Law Human Behav* 1993;17(3):289-312
26. Herman JL. Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. *J Trauma Stress* 1992;5(3):377-391
27. Glancy GD, Ash P, Bath EPJ, Buchanan A, Fedoroff P, Frierson RL et al. APPL practice guideline for the forensic assessment. *J Am Acad Psychiatry Law* 2015;43(2):263
28. Ruggiero KJ, Del Ben K, Scotti JR, Rabalais AE. Psychometric properties of the PTSD checklist—civilian version. *J Trauma Stress* 2003;16(5):495-502

Corresponding author

Graham Glancy, Division of Forensic Psychiatry, University of Toronto, 250 College Street, 8th floor, Toronto ON M5T 1R8, Canada – email: graham.glancy@utoronto.ca

ORIGINAL ARTICLE

Clinicians' Perceptions of the Implementation of the Structured Assessment of Protective Factors for Violence Risk (SAPROF) on an Inpatient Forensic Unit

Tom Domjancic[1], Treena Wilkie[1], Shaheen Darani[1], Brittney Williams[1], Bandhana Maheru[1], Zahra Jamal[1]

[1] *Center for Addiction and Mental Health, Complex Care and Recovery, Toronto, Canada*

The Structured Assessment of PROtective Factors for Violence Risk (SAPROF) is an assessment tool that examines protective factors when assessing violence risk. There is limited research on clinicians' perceptions of the use and implementation of risk assessment tools, and this study aimed to examine the experiences of clinicians using the SAPROF in a low secure forensic rehabilitation inpatient unit in Canada. An exploratory research design was used, and five clinicians participated in semi-structured interviews. Data was analyzed using a thematic approach and three central themes were identified: "understanding of the patient from a strengths-based point of view, providing clinicians with a focus on how to help the patient, and bringing in opportunities to collaborate as a team". The findings highlight the additional value of the SAPROF as a tool in helping forensic teams to adopt strengths-based approaches to risk assessment, enhancing treatment planning, and inter-professional collaboration.

Key words

Strengths, Risk assessment, SAPROF, Consensus scoring, Recovery

Introduction

In the last decade, international attention has been given to the need to apply recovery principles, including strengths-based approaches in mental health settings [1,2]. Similarly, it has been advocated by various professionals for this same shift towards a more positive frame of reference, to be applied to mentally disordered offenders [3,4]. The recovery model has been proposed to be beneficial in forensic services, where patients are often faced with numerous challenges, such as hopelessness, social isolation, and childhood trauma [5]. Similar views were highlighted in a systematic review of qualitative studies from forensic patients on their perspectives of recovery, showing that two central themes were 'connectedness and a sense of self' [6].

Applying recovery principles in forensic mental health settings has also been shown to increase treatment motivation or engagement beyond that of enhancing quality of life alone [7]. Treatment models incorporating strengths have been developed, such as the 'good lives model', which focuses on providing rehabilitation to allow patients to fulfill goals related to their basic human needs that lead to valued outcomes [8]. This model has been applied to forensic mental health services to provide a framework for formulating treatment for forensic patients [9].

The shift towards incorporating strengths within a mental health practice has extended beyond treatment approaches to also include the area of risk assessment, as risk assessment tools have been criticized as solely focusing on factors that enhance risk rather than protective factors that mitigate risk [10,11]. In light of this perceived imbalance, a number of risk assessment tools have been developed to examine the role of protective factors in diminishing risk of future violence, including: the Short-Term Assessment of Risk and Treatability [12], the Structured Assessment of PROtective Factors for Violence Risk [13] and the Dangerousness, Understanding, Recovery and Urgency Manual Quartet [14].

The SAPROF, a Structured Professional Judgement (SPJ) tool was created to examine medium term risks (over a 6

month period) and was designed to be used in conjunction with the Historical Clinical Risk management 20 (HCR-20) [15]. The SAPROF incorporates factors that are grouped into three categories: internal (e.g., empathy, self-control), motivational (e.g., work, leisure) and external (e.g., intimate relationship, living circumstances). The factors are rated on a scale from 0-2, with a score of 0 equating to the absence of the protective factor, a score of 1 demonstrating the partial presence of a protective factor, and a score of 2 indicating the protective factor is clearly present. As recommended in the SAPROF's instructional manual, a consensus model can be used, in which coding is done by the inter-professional team following discussion to reach a score. Following scoring, the team identifies key factors, which are currently present and critical for the prevention of violent behavior from the individual, and goal factors, which are believed to be an important treatment goal and would increase their level of protection [16]. In terms of psychometric properties, the SAPROF has demonstrated good predictive validity for the prediction of recidivism in forensic psychiatric patients in short, medium and long term follow-ups, as well as after discharge [16,17]. Furthermore, the SAPROF has also shown satisfactory to good inter-rater reliability and an interactive effect with the HCR-20 [17,18].

While risk management is central to the work done in forensic mental health, there has been limited research exploring forensic mental health professionals' attitudes towards the use and implementation of risk assessment tools in formulating a risk management plan. Research has explored clinicians' perceptions of the specific risk enhancing variables, demonstrating valuable insights into which factors clinicians find risk enhancing or protective [19,20]. To find similar research examining clinicians broader insights into risk management one needs to look outside the forensic literature, where studies have shown a mix of negative and positive perceptions. A study by Clancy and Happel [21] recognized the importance of team-based communication when evaluating risk in geriatric settings. However, the clinicians commented on how a focus on documentation and completing risk assessment forms could lead to them overlooking the complex nature of the individual patient. Similarly, another study separated community health workers' interpretation of risk management policies and requirements into two categories: positive risk rationalities and critical risk rationalities. Individuals expressing positive risk rationalities discussed risk management in terms of helping to build therapeutic relationships with patients, practicing in a patient-centered manner and enhancing safety. Individuals expressing critical thoughts on risk management discussed labelling patients, limiting patient choice, and restricting service delivery [22]. Notably, research by Crocker and colleagues [23] argue that there is a need for further implementation research in forensic mental health services to bridge the gap between clinical practice and research and that risk assessment literature needs to be more widely disseminated into clinical practice [22]. To address this gap, the present study aimed to examine the utilization and implementation of the SAPROF on a forensic inpatient unit.

Methods

Setting and Context

The SAPROF was implemented with the goal of introducing a team-based method of examining the protective factors in relation to risk of violence for forensic patients on a mixed-gender, low-secure forensic rehabilitation inpatient unit located in a large Canadian city. The aim of this particular unit is to provide rehabilitation to patients with a wide range of diagnoses, who have been admitted under the auspices of a provincial review board after a finding of either Not Criminally Responsible on Account of Mental Disorder (NCRMD) or unfit to stand trial. There are 16 patients on the unit, many of whom have been identified for admission to the unit based on complexities which may include diagnostic co-morbidities, longer duration under the auspices of the provincial review board, or engagement in behaviors which

require a more extensive risk management plan. When the unit is fully staffed, it includes two members of each of the following disciplines: behaviour therapy (BT), recreation therapy (RT), occupational therapy (OT), social work, psychiatry, nursing staff, and a dedicated peer support worker. The unit's aim is to provide intensive treatment to patients, to increase their engagement in rehabilitation, and to prepare them for reintegration into the community. As a result of this staff compliment, the unit is able to offer a range of interventions such as, individualized counselling, evening and weekend programming (recreational and therapeutic) and comprehensive behavioral plans.

The SAPROF was first implemented on the inpatient unit in August 2015. Clinicians were introduced to the SAPROF by a psychiatrist working on the unit and social workers who were part of a consultation service within the broader forensic service. The individuals who provided education in relation to the SAPROF had received formal training in the tool. The initial SAPROFs were conducted with the social workers, who were paired with clinicians on the unit. In addition, an informal education session on the SAPROF was conducted on the unit and the SAPROF manual was purchased for unit clinicians to use as a reference guide to complete the scoring. Following the initial orientation, the unit occupational therapist continued providing education and assistance to other staff members scheduled to complete a SAPROF. Clinicians completed a six-month file review and collected collateral information from the patient and other care providers. The SAPROF was presented in a clinical team meeting, where all clinicians involved in the patient's care were invited to attend. Initially, it was scored by the individual completing the information gathering (chart review, patient/family interviews) and presented to the team for further discussion. Approximately a year into the implementation the team moved to a consensus scoring model. This was done to stay true to the consensus scoring model outlined in the manual and was possible as the majority of staff involved were familiar with the scoring during this time. At the time of the study, mainly allied health professionals had completed the information-gathering portions of the SAPROF, while nursing staff had received exposure through attending SAPROF team meetings and education sessions on the unit.

Participants

Ethical approval was obtained through the ethics review boards both at the hospital and the affiliated university prior to the commencement of the study. Written consent was obtained from participants, which outlined the possible risks and benefits of being involved in the study.

The clinician sample (n = 5) was recruited from all staff that had exposure to the SAPROF, either through attending education sessions, team meetings or completing SAPROF presentation. Eligible participants were identified by the research team, which totaled 30 staff members. Clinicians eligible for the study included nurses, psychiatry residents, personal assistants, behaviour therapists, recreation therapists, occupational therapists, peer support workers, and social workers. Given the small sample size and single-unit location, demographic information and professional designations were not included in the information gathered by researchers to ensure that the results remained confidential and anonymized.

Recruitment was conducted by the research students through email, which detailed the purpose of the study, procedures, risks and benefits, confidentiality of data, and participant criteria. In addition, students attended bi-weekly meetings to discuss the study and recruit participants in person. Once clinicians expressed interest the students arranged a time to meet off the unit where the interviews took place.

Procedure

A purposeful sampling technique was used as it was an effective way of utilizing limited resources and participants were recruited as they were knowledgeable about the phenomenon being investigated [24].

As the researchers included members of the team, (unit OT, unit manager, and psychiatrists) measures were taken to ensure confidentiality and the anonymity of the participants. The interviewers were student occupational therapists who were completing a research placement as part of their course requirements. Interviewers received supervision from two of the authors. Additionally, as part of the research students' course work, they received lectures in qualitative research methods and had access to faculty who specialized in this methodology.

The interviewers engaged in data collection for a period of 2 months and conducted interviews in a location off the unit as arranged by hospital administration staff. Recruitment was done through email, and interviewers periodically attended team meetings to recruit staff. To ensure the authors did not influence participation, they removed themselves from the unit, when they were informed the interviewers were attending the unit to recruit staff.

Together, the interviewers administered a semi-structured interview, which took 15-20 minutes and included thirteen questions regarding the implementation of the SAPROF on the inpatient unit. Questions aimed at eliciting participants views on the utility of the SAPROF, such as, 'Does using the SAPROF impact or change your perceptions of patients, if so how?' and 'What do you think the overall impact of the SAPROF has been?' were asked by interviewers (See interview schedule in Table 1). Interviewers were also trained by the first author to utilize neutral follow up questions if the answers given were unclear. The interviews were recorded and transcribed by the interviewers and possible identifying information was removed at this time. The data set was organized and labeled manually by the interviewers and backed up on an encrypted password-protected computer. The interviews were deleted from all devices once they had been transcribed.

The data analysis was completed simultaneously with data collection which allowed the researchers to identify when a point of saturation was achieved as repetitive patterns emerged from interview responses. Given the small final sample size, no specific software program was used for data entry or management. The texts of each interview transcript were read and codes were identified through highlighting and labeling repetitive key words or concepts from the literature, through a process known as open coding [25]. Open coding involves creating conceptual labels through comparing interactions within the data set for similarities and differences and then grouping these concepts together to form categories and sub categories [26]. Following this axial coding was used, whereby words or quotations are coded around the core emerging themes or categories [27].

Practically these processes involved having categories peer-reviewed by the interviewers and primary author. This enabled the verification of data integrity as multiple individuals were reviewing and developing the codes. The codes were revisited numerous times and double-checked for consistency and validation until all parties were satisfied with the refined codes. As this processed continued, themes and categories emerged by comparing code labels to the original transcript. These categories were used to organize and group codes. Categories were exhaustive as all relevant data was captured into the categories and were mutually exclusive, meaning that a relevant unit of data could fit into one category [25]. Several titles were created for each category and these were reviewed by the entire research team before final category titles were chosen, ensuring that they were sensitive and accurately represented the data in the categories.

Results

The participants' perceptions of the use of the SAPROF tool on the inpatient unit, yielded three unique central themes: 1) understanding the patient from a strengths-based point of view; 2) providing clinicians with a focus on how to help the patient, and; 3) bringing different perspectives and opportunities to collaborate as a team. Excerpts from the

participants are provided to demonstrate their relation to the broader themes identified.

Theme 1: Understanding the patient from a strengths-based point of view

The first theme identified reflected the strengths-based nature of the SAPROF tool and how this contributed to a clinician's understanding of the patient. One clinician described how often clinicians tended to focus on patients' deficits, particularly with individuals who had been diagnosed with personality disorders and how the SAPROF provided a valuable contrast to this line of thinking.

"…it kind of gave us a focus as a sidebar outside the tool to kind of work on. So, that was helpful and I think it was also helpful in, sometimes especially with people with personality disorders you, you focus on the negative and you focus on how they can't follow through and they don't do this and they don't do that, so it highlighted some of the really great strengths that she has… and if you can focus on someone's strengths, I think kind of twists your mind back to look at them in a positive light. Because you can get burnt out working with personality disorders really easily, so if you can kind of keep bringing up their positive aspects which you don't see on a daily basis I think…"

These individuals with the label of 'forensic patient' and 'personality disordered' associated with them, have been described by clinicians with negative connotations and lead to interactions that could be less than therapeutic [28]. Another clinician reported a similar observation on how completing a SAPROF was effective in highlighting the strengths of a patient with antisocial personality disorder and helped them alter their perception of the patient:

"…the last one I did was a client who on his diagnosis says he has antisocial traits. Reading, if you read his file, he's been quite antisocial in the past, quite violent…but in doing the SAPROF, he had so many strengths, and one of them was empathy, he scored a two on his empathy. Which, somebody with antisocial traits, generally doesn't score that high. So it kind of reframed the way that I think of this person, in terms of where is he at right now…it really kind of reframes the way I think of him, and he had a lot of strengths that weren't really shown in the day-to-day."

This excerpt illustrates the role that a strength-based tool like the SAPROF can have in combating neglect in case formulation, which can result when mistakes or misinterpretations regarding a patient are reiterated over time [29]. When describing their individual involvement in completing a SAPROF, another clinician mentioned how overtime patient strengths may be forgotten and how meeting with the patient and discussing these strengths can provide a useful reminder, *"It identified a lot of her strengths that we kind of lost sight of over time. It was an opportunity to kind of interact with her and find out how she felt"*.

Theme 2: Providing clinicians with a focus on how to help the patient

The second theme that emerged from the interviews was the effect that the SAPROF had helping clinicians to devise plans or ways that they could assist the patient in their recovery. In particular, when one clinician was asked to describe how the SAPROF was used in an inpatient context versus an outpatient team, they described its utility in helping the patient move out of the hospital. "… *I guess we use it as a tool to kind of guide where we're going to go to help people move through the system and get out. Right, so how do we, like what goals do we focus on with the strengths of the person so that they can leave the hospital and live successfully."* This notion of helping the patient progress was echoed in a similar study looking at both service users and service providers perspectives of how they define success in the forensic mental health system [30].

When asked about the overall impact of the assessment another clinician discussed how the tool helped them develop a deeper understanding of the patient based on the information gathering they were required to do when presenting the SAPROF and how this enabled them to contribute more to treatment planning:

"Well, it's definitely sort of forced clinicians to look at the clients in a different light. It helps sort of clinicians to get a deeper look into the clients that they're assigned, so like, I've become like an expert on this- these two clients that I've done, because I've really done a lot of research on them…so that sort of helps and sort of as we formulate as a team how to move forward with them, I can sort of put a little bit more into it, because of- just I've done a lot more in terms of the research"

This quote corresponds to previous research where both patients and staff have reported valuing the deeper understanding, focused beyond risk and illness, which develops as a result of treatment planning and getting to know the patient [31].

When a clinician was asked about the usefulness of the tool in treatment planning, they discussed how the scoring process was helpful in this regard:

"…someone has tons of amazing things and they then aren't so great on others, we would want to focus on those to get them up to a 2 per se…So then it was kind of like focusing on where we think we could build his strengths so that he could move through the system. So I think it's really helpful there to focus on the goals. Like what's realistic and achievable for some people."

This view of equating progress and increasing scores on protective factors is the expected direction of change when individuals are moving through the security levels in the forensic system. The articulated goal of team members is to assist in the rehabilitation of patients, so that they have opportunities to bolster their internal and motivational factors, and rely less on external factors (such as living in hospital) to manage their recovery.

When another clinician was asked about the usefulness of the tool in treatment planning, they discussed how the SAPROF could be used in the complex process of discharging an individual into the community and assisting them in their recovery:

"I think it's been helpful when they've been clinically discharged, when we know that they consider their family to be a protective factor- I guess specific things that we would make sure are a part of the discharge planning – like for example if they're really involved with their family, then making sure that the family doesn't live too far away…if they identify engaging activities, making sure that there's lots of activities planned and staffing available, and all that stuff, so that we can find things that they have identified are more helpful in recovery."

Theme 3: Bringing different perspectives and opportunities to collaborate as a team:

Several clinicians discussed the collaborative nature of the tool and how it provided new information about the patients. For example, when asked to comment on their thoughts regarding team scoring, a clinician expressed:

"I guess the collaborative nature of kind of agreeing on the score before it's kind of finalized. It was nice how, you know some of my colleagues would present information, you know in the various categories to help us kind of recognize where somebody's strength are, and then we can start to think about, you know do they have additional information that we might have missed or other examples of somebody being empathic."

Another clinician discussed their positive perceptions in relation to moving from individually scoring the assessment to a team consensus scoring model and how it encouraged other members of the team to engage in discussion:

"…It was better because, I mean, I have sort of my, my ideas of like what the score should be. But it's supposed to be consensus scoring….kind of putting my score up there, kind of skews what the team may think…I may look at it and not, not agree with it but not speak up, versus if we score it as a team everybody sort of has their input and we get the true consensus for it which is the idea of what the tool is supposed to be used for"

Two individuals commented on how, in general, the team members were usually in agreement but also reported the coming together and collaborating aided in this process:

"I find that usually we're all on the same page. A couple times we have some debates and its good because we all kind of bring our information together and then come to a consensus score.". Another clinician echoed how frequently the team agreed on what was important for the patient but that coming together to make that assessment was important:

"Everybody kind of felt the same about the person. So there wasn't like "oh like you think that's an issue, well I really don't think that's an issue". So it's like, and this particular person has like actual very definitive issues that we're aware of and she worked closely with quite a few of us, so as a team we were quite- we were able to collaborate together and make like an actual assessment that we all agreed with, so it was actually okay."

These qualitative accounts of the benefits of consensus scoring corresponded to a quantitative study examining the predictive validity of the HCR 20, which showed that consensus scoring model was more accurate than the individual ratings, highlighting the importance of conversations with colleagues in risk assessment procedures [32].

One clinician commented on how incorporating different individuals perspectives using their unique 'lens' was beneficial, stating *"my focus kind of gives me a lens to look through things and then having other people in the room looking through a different lens I think is really helpful"*. Similar findings have been shown in a previous qualitative study examining treatment planning in forensic hospitals, where it was identified that involvement by inter-professional staff was described to enhance relationships between team members and lead to favourable patient outcomes [31].

Table 1 – Semi Structured Interview Questions

The following are a sample of questions for the interview:

1. Can you describe your exposure to the SAPROF (ex. Attended training, scored, attended team meeting related to SAPROF)
2. How do you typically assess for risk of violence? What assessment tools does this involve?
    a. How do protective factors differ from risk factors?
3. Describe how SAPROF is used with your clients?
4. What are some of the protective factors within the SAPROF that you find particularly relevant for your clients?
5. How do the factors within the SAPROF relate to your discipline specific work or theories of practice?
6. Does using the SAPROF impact or change your perceptions of clients, if so how?
    a. Does it have an impact on your therapeutic alliance or rapport? If so how?
7. Describe any changes you have seen in clients following the administration of the tool.
8. Describe how information from SAPROF has been used to plan treatment.
9. What barriers do you experience when administering SAPROF?
    a. How comfortable or confident are you in gathering information for a SAPROF independently? How feasible is it?
    b. What are your thoughts on consensus scoring as a team?
    c. How do you think the use of SAPROF could be improved on the unit?
10. Do you foresee any obstacles in implementing this tool in other units? If so how could these be addressed?
11. Do you think it is worthwhile reviewing SAPROF scores after they have been completed?
12. How do you think implementing the SAPROF on an inpatient unit is different from an outpatient population?
13. What do you think the overall impact of the SAPROF has been?

Discussion

In this article, we describe the results of a qualitative study exploring the perceptions of forensic inpatient staff on the implementation and use of the SAPROF tool on a forensic rehabilitation unit. Clinicians interviewed placed value on the SAPROF, beyond the predictive ability in relation to violent recidivism, but rather as a tool that facilitated meaningful discussion between team members, developing a strengths-based approach, and focusing clinical decision making in relation to treatment planning.

A recent review of strength-based approaches in offenders with mental illness proposed that there was a need to change the perception of these individuals to an "abilities-oriented" view instead of one focused on deficits [33]. Moore and Drennan [29] have also commented on how integrating recovery-oriented practice into formulations aligns well with strength and value-based models. The participants in commenting on the use of the SAPROF discussed how the SAPROF played a role in changing their focus from solely being on patients' risk factors, to also including their strengths. Some participants specifically discussed how a strength-based approach was particularly helpful in working with individuals diagnosed with personality disorders and how strengths could often be overlooked with these individuals. This may support the use of the SAPROF on forensic inpatient units to provide a framework for strengths oriented discussions and for the integration of this information into risk management planning.

Cording and Christofferson's [34] exploration of protective factors in risk assessment described the variance between settings and how self-reflection by clinicians can be useful. They also comment that when these assessments are viewed beyond their predictive accuracy in relation to violence, other factors such as promoting collaboration, and balance in assessment, are important considerations. The interviews with staff within this study further highlighted these points, in particular, the role of the SAPROF in promoting collaboration and integrating various disciplines' viewpoints regarding a patients' level of protection. The clinicians on the unit who were involved in the SAPROF came from a variety of disciplines. Vandevelde et al. [33] discussed that despite a general paradigm shift in understanding forensic patients using a strength's based point of view, multidisciplinary teams working with forensics patients may have a different frame of reference. They also note there might be different language used to describe this shift across the professions (e.g. strengths-based, quality of life, recovery) and that there needs to be efforts to prevent confusion and loose definitions. The findings in this article can support the implementation of SAPROF on other forensic units, where the SAPROF could be used to bring together multiple disciplines to talk about the patients' strengths, in a structured, cohesive manner. Rapp & Sullivan [35] also discussed the importance of continuing to refine the concept of a strengths based approach and ensuring that organizations that promote this are practicing in this manner. The SAPROF provides a means in which organizations can demonstrate their commitment to recovery principles and strength based assessments, by ensuring that clinicians are provided time to gather, discuss, document and plan treatment based on a patients' strengths.

There were several limitations that were present during the study which must be considered when interpreting the results. Firstly, the sample size of the study was relatively small, with five of thirty eligible participants (17%) that had chosen to be involved. Factors that contributed to this included the interviewers being restricted to a short time frame for data collection and analysis. Furthermore, there were institutional changes occurring within the hospital, that the research team felt had impacted the staff's willingness to

participate in activities outside of their routine clinical responsibilities during the time of data collection. Additionally, there was another, more time consuming, research project involving staff eligible for this study that was being carried out on the unit at the same time, which may have further precluded staff from participating. It was also noted that the participants generally made positive comments regarding the tool and it is possible that staff that were already more engaged with the SAPROF chose to participate. It is possible that despite measures taken to ensure confidentiality that staff were less inclined to participate if they had negative perceptions of the tool or that this dissatisfaction was characterized by non-participation.

Future research on staff perceptions of the SAPROF could be carried out in different settings (e.g. high secure inpatient unit, or outpatient program). Studies could explore staff's perception of effectiveness over multiple points of implementation including pre-implementation, during and several times post-implementation. Future research involving a higher number of participants with multiple methods of collecting data (i.e. surveys in addition to interviews) will likely lead to collection of richer data. Lastly, involving incentives for staff participation in future qualitative studies could lead to wider recruitment.

Conclusion

This qualitative study aimed to examine the staff perceptions of the use of a risk assessment tool, the SAPROF, in a low secure forensic unit and has demonstrated value related to its strength-based nature, ability to focus clinicians on how to help their patients and has promoted team collaboration. This study has also addressed an important gap in the literature, examining how clinicians perceive the impact of the SAPROF on forensic patients and their recovery and the process of implementing this on a forensic inpatient unit.

Conflict of Interest: none

References

1. Mental Health Commission of Canada. Guidelines for recovery-oriented practice – hope. dignity. inclusion. 2015. (accessed on October 4, 2019)
2. Australian Health Minister's Advisory Council. A national framework for recovery-oriented mental health services: Guide for practitioners and providers. 2013. (accessed on October 4, 2019)
3. Ward T. Positioning mental health nursing practice within a positive health paradigm. *Int J Ment Health Nurs* 2013;22(2):116-24
4. Simpson AIF, Penney SR. Recovery and forensic care: recent advances and future directions. *Crim Behav Ment Health* 2018;28(5): 383-9
5. Dorkins E, Adshead, G. Working with offenders: challenges to the recovery agenda. *Adv Psychiatr Treat* 2011;17(3):178-87
6. Clarke C, Lumbard, D, Sambrook S, Kerr, K. What does recovery mean to a forensic mental health patient? a systematic review and narrative synthesis of the qualitative literature, *J Forensic Psychol Res Pract* 2016;27(1):38-54
7. Gudjonsson GH, Savona CSV, Green, T, Terry, R. The recovery approach to the care of mentally disordered patients. does it predict treatment engagement and positive social behaviour beyond quality of life? *Pers Individ Dif* 2011;51(8):899-903
8. Ward T. Good lives and the rehabilitation of offenders: promises and problems. *Aggress Violent Behav* 2002;7(5):513-28
9. Barnao M, Robertson P, Ward, T. Good Lives Model applied to a forensic population. *Psychiatr Psychol Law* 2010;17(2):202-17
10. Rennie CE, Dolan, MC. The significance of protective factors in the assessment of risk. *Crim Behav Ment Health* 2010;20(1):8-22
11. de Ruiter C, Nicholls, TL. Protective factors in forensic mental health: a new frontier. *Int J Forensic Ment Health* 2011;10(3):160-70
12. Webster CD, Martin ML, Brink J, Nicholls TL, Desmarais S. *Manual for the Short-Term Assessment of Risk and Treatability (START) (Version 1.1)*. Port Coquitlam, BC: Forensic Psychiatric Services Commission and St. Joseph's Healthcare,2009
13. de Vogel V, de Ruiter C, Bouman Y, Robbé, M. Guidelines for the assessment of protective

factors for violence risk *(2nd Edition)* SAPROF International, 2018

14. Kennedy HG, O'Neill C, Flynn G, Gill P, Davoren, M. Dangerousness understanding, recovery and urgency manual (the Dundrum quartet) - four structured professional judgement instruments for admission Triage, Urgency, Treatment Completion and Recovery, *Dublin, Ireland: Trinity College Dublin,* 2013
15. Robbé M, de Vogel V, Stam, J. Protective factors for violence risk: the value for clinical practice. *Psych* 2012;3(12):1259-63
16. Robbé M, de Vogel V, de Spa E. Protective factors for violence risk in forensic psychiatric patients: a retrospective validation study of the SAPROF. *Int J Forensic Ment Health* 2011; 10(3):178-86
17. Abidin Z, Davoren, M, Naughton, L, Gibbons, O, Nulty, A, Kennedy, HG. Susceptibility (risk and protective) factors for in-patient violence and self-harm: prospective study of structured professional judgement instruments START and SAPROF, DUNDRUM-3 and DUNDRUM-4 in forensic mental health services. *BMC psychiatry* 2013;13(1):197
18. Kashiwagi H, Kikuchi A, Koyama M, Saito D, Hirabayash, N. Strength-based assessment for future violence risk: a retrospective validation study of the Structured Assessment of PROtective Factors for violence risk (SAPROF) Japanese version in forensic psychiatric inpatients. *Ann Gen Psychiatry* 2018;17(1):5
19. Elbogen EE, Mercado CC, Scalora MJ, Tomkins, AJ. Perceived relevance of factors for violence risk assessment: a survey of clinicians. *Int J Forensic Ment Health* 2002;1(1):37-47
20. Sturidsson K, Haggård-Grann U, Lotterberg M, Dernevik M, Grann M. Clinicians' perceptions of which factors increase or decrease the risk of violence among forensic out-patients, *Int J Forensic Ment Health* 2004;3(1):23-36
21. Clancy L, Happell, B. Being accountable or filling in forms: managers and clinicians' views about communicating risk. *Perspect Psychiatr Care* 2017;53:38–46
22. Sawyer A, Green D, Moran A, Brett, J. Should the nurse change the light globe?: human service professionals managing risk on the frontline. *J Sociol* 2009;45(4):361-81.
23. Crocker, AG, Braithwaite, E, Laferrière D, Gagnon D., Venegas, C, Jenkins, T. START changing practice: implementing a risk assessment and management tool in a civil psychiatric setting. *Int J Forensic Ment Health* 2011;10(1):13-28
24. Palinkas LA, Horwitz SM, Green CA, Wisdom JP, Duan N, Hoagwood, K. Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. *Adm Policy Ment Health* 2015;42(5):533–44
25. Merriam SB, Tisdell, EJ. Qualitative Research: a Guide to Design and Implementation *(4th Edition)*. San Fransico: California: Jossey-Wiley, 2015:174-81
26. Corbin JM, Strauss, A. Grounded theory research: procedures, canons, and evaluative criteria. *Qual Sociol* 1990;13(1):3-21
27. Grossoehme DH. Overview of qualitative research. *J Health Care Chaplain*. 2014;20(3): 109–22
28. Boyle J, Kernohan WG, Rush, T. 'When you are tired or terrified your voice slips back into its old first place': the role of feelings in community mental health practice with forensic patients. *J Soc Work Pract* 2009;23(3):291-313
29. Moore E, Drennan, G. Complex forensic case formulation in recovery-oriented services: some implications for routine practice. *Crim Behav Ment Health* 2013;23(4):30-40
30. Livingston JD. What does success look like in the forensic mental health system? perspectives of service users and service providers. *Int J Offender Ther Comp Criminol* 2016;62(1): 208–28
31. Livingston JD, Nijdam-Jones A, Team P.E.E.R. Perceptions of treatment planning in a forensic mental health hospital: a qualitative, participatory action research study. *Int J Forensic Ment Health* 2013;12(1):42-52
32. de Vogel V, de Ruiter, C. Structured professional judgment of violence risk in forensic clinical practice: a prospective study into the predictive validity of the Dutch HCR-20. *Psychol Crime Law* 2006;12(3):321-36
33. Vandevelde S, Vander Laenen F, Van Damme L, Vanderplasschen W, Audenaert K, Broekaert E, et al. Dilemmas in applying strengths-based approaches in working with offenders with mental illness: a critical multidisciplinary review. *Aggress Violent Behav* 2017;32:71-9
34. Cording JR, Christofferson, SB. Theoretical and practical issues for the measurement of protective factors. *Aggress Violent Behav* 2017;32:45-54
35. Rapp CA, Sullivan, WP. The strengths model: Birth to toddlerhood. *Adv Soc Work* 2014;15(1): 129-42

Corresponding author

Tom Domjancic, Centre for Addiction and Mental Health - CAMH, 1001 Queen St. West, Toronto, ON, M6J 1H4, Canada – email: tom.domjancic@camh.ca

ORIGINAL ARTICLE

Comparaison franco-canadienne du développement des Cercles de soutien et de responsabilité (CSR) pour la prévention du risque de récidive des délinquants sexuels

Circles of Support and Accountability (CoSA) to prevent sexual offender recidivism: a comparison of their development in France and Canada

Ingrid Bertsch [1,2], Florent Cochez [3], Heather M. Moulden [4,5], Sébastien S. Prat [4,5], Hélène Lambert [2], Géraldine Lassagne [2], Céline Lamballais [1], Lucie Defache [6], Maud Pelletier [6], Robert Courtois [1,2]

[1] *CHRU de Tours, Centre de Ressources pour les Intervenants auprès des Auteurs de Violences Sexuelles - CRIAVS Centre-Val de Loire, Tours France*

[2] *Université de Tours, Département de psychologie, EE 1901 'Qualité de vie et santé psychologique' (QualiPsy), Tours France*

[3] *CH Charles Perrens, ERIOS - CRIAVS Aquitaine, Bordeaux, France*

[4] *McMaster University, Department of Psychiatry and Behavioural Neurosciences, Hamilton, Canada*

[5] *St. Joseph's Healthcare Hamilton, Forensic Psychiatry Program, Hamilton Canada*

[6] *Service pénitentiaire d'insertion et de probation (SPIP) du Loiret, Orléans, France*

Les Cercles de Soutien et de Responsabilité (CSR), nés il y a 24 ans à Hamilton au Canada pour répondre à l'inquiétude du public provoquée par le retour des délinquants sexuels dans la société après leur libération, se développent partout dans le monde. Ils proposent l'accompagnement de l'agresseur dans sa réinsertion sociale. Efficaces dans les pays étrangers, ces dispositifs se développent lentement en France. L'objectif de cet article est de tenter d'expliquer les freins à l'implantation des CSR en France au regard des difficultés rencontrées lors des expériences françaises passées et actuelles, mais aussi des différences interculturelles entre la France et le Canada.

There is growing interest worldwide in Circles of Support and Accountability (CoSA), which were created 24 years ago in Hamilton (Canada) in response to public concern about the reintegration of sex offenders into society after their release from incarceration. These circles support the ex-offender in the social rehabilitation process. They already exist in a number of countries, but their introduction in France is slow. The aim of this article is to explain the barriers to setting up CoSAs in France, taking into account the difficulties encountered in previous and current French experiences, and in relation to cultural differences between France and Canada.

Mots-clés

Cercles de soutien et de responsabilité ; Agresseurs sexuels ; Récidive ; Désistance ; Prévention

Key words

Circle of Support and Accountability; Sexual offenders; Relapse; Desistance; Prevention.

Les Cercles de soutien et de responsabilité (CSR) au Canada

Historique des CSR : il y a 24 ans à Hamilton...

Le premier CSR est né en 1994 à Hamilton (Canada) à partir de la nécessité d'apporter un accompagnement approprié à un auteur d'infractions à caractère sexuel (AICS), Charlie Taylor, ayant passé la majorité de sa vie en prison pour avoir agressé sexuellement plus d'une vingtaine d'enfants et dont la sortie prochaine inquiète la population et les professionnels qui le prenaient en charge. Le score à l'outil d'évaluation Sex Offender Risk Appraisal Guide (SORAG) avait fourni un risque de récidive violente ou sexuelle de 100% dans un délai de sept ans. C'est le révérend Harry Nigh sollicité par le psychologue Bill Palmer qui a proposé d'accompagner Charlie Taylor à la sortie de son incarcération avec les membres de la communauté Mennonite. Ce groupe est à la base d'un cercle de support (« Charlie's Angels group ») qui a permis la réintégration du sujet dans la communauté sans nouveau passage à l'acte jusqu'à la fin de sa vie, onze ans et six mois plus tard. C'est la naissance du premier Cercle de

soutien et de responsabilité tel qu'on les connait aujourd'hui. Charlie Taylor est resté en contact avec ses « amis », les bénévoles du cercle, jusqu'à la fin de sa vie (e.g., 1,2).

Depuis cette première expérience les CSR se sont développés dans le monde entier. Ils associent un cercle interne composé du membre principal/AICS socialement isolé à haut risque de récidive, trois/quatre bénévoles issus de la communauté, un coordonnateur qui chapote le projet et d'un cercle externe composé de professionnels de divers champs intervenants à la demande du cercle interne. En 2011, le Canada comptait 18 sites où 200 CSR étaient en cours d'exécution (https://cosa-ottawa.ca/).

Efficacité des CSR

Les objectifs des CSR répondent à deux axes forts du programme canadien les concernant : (a) « plus jamais de victimes » (c'est-à-dire la réduction du nombre de victimes à travers la diminution de la récidive des auteurs) et (b) « tout le monde compte » (c'est-à-dire des préoccupations communautaires qui visent à permettre aux AICS un accès à une vie plus équilibrée et une réinsertion sociale).

L'efficacité des CSR n'est plus à démontrer. Ils permettent :

- Une diminution significative de la récidive sexuelle (3-5) ;
- Une diminution significative de la récidive violente (5, 6) ;
- Une diminution significative de la récidive générale (3, 5, 7) ;
- Une diminution du caractère invasif et de la gravité des récidives lorsqu'elles ont lieu (4, 5).

Cette efficacité se fait par la réinsertion des AICS ayant participé à un CSR (ils sont alors appelés membres principaux) et le fait que cela favorise l'entrée dans un processus de désistance avec une augmentation de facteurs de protection (8).

Les bénévoles du CSR perçoivent une augmentation du sens de responsabilité des AICS/membre principaux et ces derniers perçoivent un soutien, des relations humaines différentes et positives qui permettent de contrecarrer l'aliénation et l'isolement qui peuvent favoriser un passage à l'acte délictuel. Pour illustration, l'un d'eux disait: "They're ordinary things, but extremely precious because that's somebody that's not giving up their time because they have to; they're giving up their time because they want to. That's incredible for them to actually sort of say, "I wanna spend time with you"[1] (9). Plusieurs membres principaux ont témoigné d'une probable récidive s'ils n'avaient pas pu bénéficier de ce dispositif (4).

Les CSR permettent également aux AICS qui en bénéficient d'avoir un meilleur feedback sur les agressions passées du fait de l'amélioration des capacités d'ajustement, du développement d'un insight relatif aux mécanismes qui sous-tendent le passage à l'acte et au total, d'une meilleure gestion de potentielles situations à risque (développement d'un plan de prévention de la rechute et de techniques de diversions) (10). On relève globalement une évolution qualitative et quantitative des capacités cognitives, émotionnelles et psychologiques des membres principaux avec une augmentation des capacités de réflexion, de résolution de problèmes, de meilleures compétences sociales, un meilleur contrôle de soi, une plus grande ouverture d'esprit, une meilleure régulation des émotions, un accroissement du locus de contrôle interne, ainsi qu'une tendance positive au développement d'une bonne estime de soi et des capacités d'adaptation (11).

Si on s'intéresse aux bénéfices pour les bénévoles, on peut déjà souligner que d'une manière générale, le bénévolat a un effet positif sur la santé mentale et psychique ; les bénévoles sont moins déprimés, plus heureux, et plus satisfait de

[1] « Ce sont des choses ordinaires, mais extrêmement précieuses, parce que voici des gens qui ne donnent pas de leur temps parce qu'ils sont obligés de le faire, mais parce qu'ils le veulent bien. C'est incroyable pour eux de dire en quelque sorte : 'Je veux passer du temps avec vous' » (traduction)

leur vie. Le bénévolat est généralement une expérience stimulante induisant un développement personnel au moyen d'une meilleure estime de soi et d'attitudes prosociales (12). En ce qui concerne le bénévolat spécifique au contexte des CSR, nous retrouvons également des effets bénéfiques (4, 12). Les bénévoles des CSR développent des capacités civiques, et améliorent leur capital social (par exemple, certains nouent une amitié avec les autres bénévoles ou les professionnels). Les CSR permettent aussi des bénéfices socio-économiques et professionnels dans le sens où ils améliorent les compétences sociales et professionnelles à travers les formations proposées (12). D'une manière générale, les bénévoles se sentent plus en sécurité au sein de la communauté. Leur croyance en la motivation des AICS à se réinsérer est plus élevée (4). Ces bénéfices sont d'autant plus marquants pour les bénévoles lorsqu'ils présentent des facteurs de protection comme une implication comprise entre une et deux heures de temps consacrées par semaine, un âge plus élevé, le développement d'une intelligence émotionnelle, une bonne estime de soi, une autonomie suffisante, un soutien des proches, un soutien entre les bénévoles ainsi qu'une bonne entente entre eux et les professionnels du CSR, une motivation associée à une certaine lucidité quant aux effets des interventions sur les comportements de l'AICS et le fait ne pas se sentir responsable des issues du CSR (12).

Du point de vue de la communauté, la possibilité d'une meilleure insertion des AICS dans la société participe activement à leur processus de désistance. Ce sont le plus souvent des personnes isolées sur le plan social, en difficulté dans les interactions sociales. Leurs faibles habiletés psychosociales sont à mettre en perspective avec l'existence de troubles anxieux, des troubles de l'attachement précoce ou des troubles de la personnalité. Le regard négatif des membres de la communauté sur eux entraine une détérioration de leur image de soi et peuvent les amener à se conformer à cette image de monstre (de « malade », de « prédateur sexuel ») qui leur est attribuée (13). Quand on les déprécie, les AICS peuvent faire de même en se réduisant à des êtres dangereux, non légitimes à réintégrer la société, et incapables de changer leur comportement (14). Les CSR permettent le rétablissement d'un lien humain, la naissance et/ou le renforcement d'une image de soi positive et entraine de fait une diminution des passages à l'acte amenant une meilleure protection des membres de la communauté (15). Les CSR participent à changer le regard que la communauté porte sur les AICS. Le fait que les AICS à haut risque de récidive soient impliqués dans un CSR renforce aussi le sentiment de sécurité des membres de la communauté (4).

L'intérêt économique de l'implantation des CSR

Les CSR n'ont pas seulement un impact positif sur les AICS pris en charge, les bénévoles ou plus globalement, la communauté, mais représentent aussi des avantages en matière économique si on prend en compte que la prévention de la récidive permet d'économiser des dépenses pour couvrir les frais de la justice, la réparation des dommages pour les victimes et le coût global pour la société. Elliott et Beech (16) comparent les bénéfices des CSR et les coûts de la récidive au Royaume-Uni. Les résultats témoignent un bénéfice net de 23 494£ par an pour 100 sujets. L'étude réalisée aux USA par Duwe (7) observe une économie estimée de 11 716 US$ par participant, soit une économie de 1,82 US$ pour chaque dollar investi. Les CSR font partie des programmes pour AICS les plus économiques.

Les CSR font l'objet d'un financement public au Canada. La « CoSA Canada » (Canadian national organization for Circles of Support and Accountability) qui est l'organisation nationale qui gère les CSR et reçoit des fonds de l'organisme de sécurité publique canadienne (Public Safety Canada) via le National Crime Prevention Strategy (NCPS) pour lutter contre la délinquance sexuelle. La CoSA Canada prend en charge le salaire du coordonnateur, la formation des bénévoles, les moyens matériels nécessaires au

fonctionnement du CSR, son évaluation, la communication de ses actions, etc. C'est parce que les CSR représentent un moyen efficace de lutte contre les violences sexuelles qu'ils reçoivent un financement, au même titre que d'autres programmes de prévention ou réduction des risques criminels.

Développement des CSR en France ?

Des expériences françaises ?

Le développement de la justice restaurative (JR) en France est favorable à celui des CSR. Ainsi par exemple l'Institut Français pour la Justice Restaurative (IFJR) qui a été créé en 2013 suite à l'organisation de la Conférence de consensus sur la prévention de la récidive et installée par la Ministre de la Justice, affirme que « les membres [de la communauté] doivent pouvoir participer à la réduction des facteurs de risque (ceux qui favorisent les comportements criminels) et, surtout, au renforcement des facteurs de protection (ceux qui évitent d'entrer dans la criminalité et encouragent le respect des lois et d'autrui), tels les mécanismes de solidarité et de soutien entre les personnes ».

Des rapports officiels préconisent l'utilisation de la JR : l'ONU en 2008, le Conseil de l'Europe en 2012 (directive 2012/29/UE) (17,18), guide traduit en français, la Conférence de Consensus en 2013 (rapport sur la prévention de la récidive en France). Des lois, permettent et organisent l'application juridique de la JR : citons la loi 15 août 2014 relative à l'individualisation des peines et renforçant l'efficacité des sanctions pénales (19) et la circulaire du 15 mars 2017 relative à la mise en place de la justice restaurative (20). Des actions de recherche proposent des recommandations pour la mise en œuvre de la JR : formulation d'une enquête de faisabilité par le Centre ERIOS (Aquitaine), amenant à des pistes de travail pour la réalisation du projet (21) et mise en place d'un programme européen « Daphné III » de financement des initiatives en faveur de la justice restaurative qui a créé le projet « circles4UE » pour implanter les CSR en Europe, comme ce fut le cas en Angleterre et en Belgique.

Malgré un contexte politique et social favorable à la mise en place de mesures de JR, il semble qu'encore peu de CSR n'aient clairement vu le jour en France, mais plusieurs initiatives sont en cours de développement. A notre connaissance, les expériences françaises passées ou actuelles sont toutes investiguées par les Service pénitentiaire d'insertion et de probation (SPIP) comme nous le montre les exemples du SPIP d'Evreux (Eure, Normandie), de Dax (Landes, Nouvelle-Aquitaine) et d'Orléans (Loiret, Centre-Val de Loire), pour la plupart en cours d'organisation. Pour l'ensemble de ces expériences, la nécessité d'apporter aux AICS une prise en charge différente est le moteur de la mise en place du CSR, souvent à l'initiative d'une poignée de conseillers pénitentiaire d'insertion et de probation (CPIP). Leur organisation (rapprochement avec un institut de JR, validation hiérarchique du projet, présentation du projet au service et aux partenaires extérieurs potentiels, organisation d'un comité de pilotage, formation des bénévoles, évaluation du membre principal (bénéficiaire) et les leviers favorisants leur création (accueil favorable du projet par les pairs et les partenaires extérieurs et motivation importante des CPIPs fondateurs des projets) sont partagés.

Difficultés dans la mise en place des CSR français

Trois difficultés principales apparaissent : *(i)* le manque d'expériences françaises passées entraine une absence de « modèle » sur lequel se baser pour mettre en place et s'assurer du bon déroulé du CSR ; *(ii)* la recherche de formateurs étrangers amène à des difficultés logistiques et des coûts ; *(iii)* la sélection du membre principal (MP) semble être une tâche difficile.

L'organisation institutionnelle française amène le SPIP à se charger de cette mission. Ceci impose : *(i)* un financement restreint, pour ne pas dire une absence de financement ; un projet de CSR peut être envisagé sans réel budget supplémentaire et sans fléchage de temps spécifique pour le salarié qui va en assurer la mission de

coordination en plus de ses autres fonctions (sans réaménagement préalable de son travail) ; *(ii)* une charge de travail supplémentaire pour les CPIPs ; *(iii)* l'accès au CSR à un MP (bénéficiaire) obligatoirement judiciarisé ; *(iv)* une séparation nécessaire et parfois compliquées des rôles de CPIPs et de coordonnateur ; *(v)* et un non-accès pour le coordonnateur comme pour l'évaluateur au dossier pénal du MP.

La nature des faits concernés amène à : *(i)* un recrutement difficile de bénévoles ; *(ii)* la crainte partagée par le coordonnateur et les bénévoles de la récidive du MP ; *(iii)* au sentiment pour les bénévoles d'une responsabilité importante au regard des conséquences possibles ; *(iv)* et enfin, aux craintes des bénévoles principalement focalisées sur l'implication demandée (en termes de temps, de qualité de relation exigée avec le MP ou encore d'éventuelles intrusions dans leur vie privée).

Comparaison France-Canada et enjeux interculturels

Différences quant à l'organisation sociale

L'organisation des actions sociales n'est pas superposable en France et au Canada. La France apparait comme un Etat providence, prenant en charge des secteurs sociaux comme la Sécurité Sociale, l'Education Nationale, les services hospitaliers qui sont davantage investis dans les pays nord-américains par la société civile (historiquement par les communautés religieuses). De fait, cela pourrait engendrer en France une moins grande culture de l'investissement individuel, voire une moins grande nécessité (22).

Alors que pour les pays nord-américains, le mot communauté implique le partage entre individus avec des valeurs, des buts ou des intérêts qui nécessite une identité ou conscience de soi commune, il est plutôt réduit en France à la simple appartenance à un secteur, un voisinage ou une ville. De fait, il existe un plus grand individualisme en France (23). De surcroit, la notion de communautarisme prend un sens péjoratif en France où elle est associée à l'idée d'intégrer un cadre plus ou moins rigide qui prendrait le pas sur l'individu et pourrait constituer une forme de menace sociale pour les autres (24). Dans les pays anglo-saxons, il existe des communautés différentes liées aux immigrations successives alors qu'en France, c'est plutôt le syncrétisme des cultures qui est prôné, devant à la fois permettre une nation unique, laïque, et en même temps, respecter la plus grande liberté individuelle. La place des communautés religieuses est aussi moins importante. De fait, ces différences sociales et conceptions culturelles de la place du sujet dans la société pourraient en grande partie expliquer les difficultés rencontrées dans la mise en place des CSR en France.

Différences quant à la place et l'implication des bénévoles

Il y aurait en France près d'un quart des français qui participeraient à des actions bénévoles formelles (au sein d'une association) et informelles (au sein de services non structurés)[4], avec un temps d'engagement moyen hebdomadaire de 2 à 5 heures. Si les motivations de ces bénévoles sont très diverses, on retrouve des tendances en fonction du genre puisque les hommes privilégient la défense des droits, le sport, la culture et les loisirs, alors que les femmes investissent d'avantage des activités éducatives, religieuses ou sociales, caritatives et humanitaires (25). Bien que les femmes soient plus sensibles et plus à même de s'investir dans des CSR que les hommes, elles ont aussi tendance à s'identifier plus facilement aux victimes et peuvent avoir du mal à dépasser les représentations péjoratives que la société attribue aux AICS. Ainsi, le sentiment d'utilité éprouvé par le bénévole qui se joue dans la rencontre avec le bénéficiaire (MP d'un CSR) peut être plus difficile à trouver (il est probable que ce soit également vrai au Canada). Les gratifications du bénévole peuvent provenir de l'investissement et de la reconnaissance du MP concernant son accompagnement. Sans retour favorable à l'égard de son implication, le risque de démotivation et de désengagement est plus important (25), surtout s'ils ne dispose pas suffisamment de qualités pré-requises. L'instauration d'un CSR demande du

temps et de la disponibilité aux bénévoles. Ils doivent en premier lieu disposer d'une certaine stabilité émotionnelle et d'une forme de résilience afin d'éviter que des interactions difficiles avec un MP, des menaces de suicide de ce dernier, des attitudes de manipulation ou encore des risques de récidive qui sont autant de facteurs émotionnellement stressants puissent contribuer à leur épuisement général. Enfin, ils doivent aussi composer avec leurs proches qui pourraient avoir du mal à comprendre leur implication d'autant qu'ils ont une obligation à respecter le secret du cercle (12). La place différente des bénévoles en France peut aussi traduire une plus grande revendication et expression de cette individualité. Le bénévolat français, moins gestionnaire que dans les pays nord-américains (26), ne s'adapte peut-être que très mal à une valorisation des actions communautaires comme l'exige l'organisation et de la philosophie des CSR.

Différences quant à la notion d'évaluation et de gestion du risque

En ce qui concerne les AICS qui pourraient en bénéficier, les limites aux projets de CSR sont peut-être à rechercher dans la spécificité et la rareté des bons « candidats » car il est préférable que le MP soit un auteur jeune, ayant déjà été condamné et incarcéré, possédant peu de ressources sociales et un risque élevé de récidive.

L'organisation des services de psychiatrie légale et des services judiciaires en France et au Canada n'est pas la même. Dans la plupart des pays anglo-saxons, l'évaluation psychiatrique et psycho-criminologique du risque de récidive des AICS est systématique en s'appuyant sur des outils standardisés, alors qu'elle demeure rare en France et encore controversée (27,28). Il est dans ces conditions plus difficiles de pouvoir identifier les besoins des sujets AICS et de mettre en place des stratégies de soin les plus adaptées (29,30).

Conclusion

Les AICS sont très mal perçus dans nos sociétés, voire rejetés et les difficultés liées à leur réinsertion après une détention augmentent le risque de survenue d'une nouvelle infraction à caractère sexuel (31,32). Les CSR qui ont fait leurs preuves en termes d'efficacité dans les pays anglo-saxons tardent à être instaurées en France. Cependant, même s'il s'agit avant tout, avec des personnes volontaires, d'augmenter le capital social d'une personne qui a commis des actes délictueux et de favoriser ainsi ses chances de désistance, plusieurs conditions sont nécessaires pour leur bonne réalisation. Il existe des expériences françaises passées et d'autres qui se développent. Elles révèlent toutes des difficultés similaires dans la mise en place ou la poursuite des CSR : un manque d'expériences antérieures (dont on pourrait s'inspirer afin de les améliorer), l'appel à des formateurs étrangers entrainant des coûts et des problèmes d'organisation et une difficulté à sélectionner les membres principaux. Ces dispositifs mettent à l'épreuve les différences interculturelles qu'il s'agisse de l'organisation sociale, de la place et de l'investissement de la société civile dans l'activité bénévole, ou encore de la capacité d'évaluation du risque de récidive dans les pratiques professionnelles françaises. Le développement des lois en France, mais aussi l'arrivée des expériences de CSR et de justice restaurative, offrent un cadre propice à leur développement dans l'avenir et les expériences récentes d'implantation offrent déjà un regard positif sur cette nouvelle manière d'envisager les auteurs, leurs victimes et leur réinsertion.

Conflit d'intérêt: aucun

Références

1. Wilson RJ, McWhinnie AJ, Picheca Janice E, Prinzo M, Cortoni F. Circles of support and accountability: engaging community volunteers in the management of high-risk sexual offenders. *Howard J Crim Justice* 2007;46(1):1-15.
2. Wilson RJ, McWhinnie AJ. Circles of support & accountability: the role of the community in effective sexual offender risk management. In: Phenix A, Hoberman HM (eds). *Sexual offending: predisposing antecedents, assessments and management*. New York, NY: Springer New York; 2016. p. 745-54.
3. Wilson RJ, Cortoni F, McWhinnie AJ. Circles of support & accountability: a Canadian national replication of outcome findings. *Sex Abuse* 2009;21(4):412-30.
4. Wilson RJ, Picheca Janice E, Prinzo M. Evaluating the effectiveness of professionally-facilitated volunteerism in the community-based management of high-risk sexual offenders: part one – effects on participants and stakeholders. *Howard J Crim Justice* 2007;46(3):289-302.
5. Bates A, Williams D, Wilson C, Wilson RJ. Circles south east: the first 10 years 2002-2012. *Int J Offender Ther Comp Criminol* 2013;58(7): 861-85.
6. Wilson RJ, Picheca Janice E, Prinzo M. Evaluating the effectiveness of professionally-facilitated volunteerism in the community-based management of high-risk sexual offenders: Part two – a comparison of recidivism rates. *Howard J Crim Justice* 2007;46(4):327-37.
7. Duwe G. Can circles of support and accountability (CoSA) work in the United States? preliminary results from a randomized experiment in Minnesota. *Sex Abuse* 2012;25(2):143-65.
8. Maruna S. Making good: how ex-convicts reform and rebuild their lives. Washington, DC American Psychological Association; 2001.
9. Hanvey S, Philpot T, Wilson C. A community-based approach to the reduction of sexual reoffending: circles of support and accountability. London, United Kingdom: Jessica Kingsley Publishers; 2011.
10. McCartan K, Kemshall H, Westwood S, Solle J, MacKenzie G, Cattel J, et al. Circles of support and accountability (CoSA): a case file review of two pilots. London, United-Kingdom: The University of West England, De Montfort University and the Ministry of Justice; 2014.
11. Höing MA, Vogelvang B, Bogaerts S. Sex offenders' process of desistance in CoSA. In: Höing M (ed). *Empowering circles: circles of support and accountability*. Oosterhout, NE: OCC De Hoog B.V.; 2015. p. 57-82.
12. Höing MA, Bogaerts S, Vogelvang B. Helping sex offenders to desist offending: the gains and drains for cosa volunteers – a review of the literature. *Sex Abuse* 2014;28(5):364-402.
13. Ward T, Maruna S. Rehabilitation. Ney Work, NY: Taylor & Francis; 2007.
14. Willis GM, Levenson JS, Ward T. Desistance and attitudes towards sex offenders: facilitation or hindrance? J *Fam Violence* 2010;25(6): 545-56.
15. Höing MA. Empowering circles: circles of support and accountability. Oosterhout, NE: Tilburg University; 2015.
16. Elliott IA, Beech AR. A UK cost-benefit analysis of circles of support and accountability interventions. *Sex Abuse* 2012;25(3):211-29.
17. Directive 2012/29/UE du Parlement Européen et du Conseil du 25 octobre 2012 établissant des normes minimales concernant les droits, le soutien et la protection des victimes de la criminalité et remplaçant la décision-cadre 2001/220/JAI du Conseil. JO Union Européenne L.315/57. (consulté le 03 octobre 2019)
18. Höing MA, Bates A, Caspers J, Goei K, Hanvey S, Pasmans V, et al. European handbook, COSA, circle of support and accountability. Hertogenbosch, Netherland: Avans University of Applied Sciences; 2011. (consulté le 03 octobre 2019; traduction par Chollier M., Cochez F.)
19. Loi n° 2014-896 du 15 août 2014 relative à l'individualisation des peines et renforçant l'efficacité des sanctions pénales. JORF n°0189 du 17 août 2014 p. 13647. (consulté le 03 octobre 2019)
20. Circulaire du 15 mars 2017 relative à la mise en œuvre de la justice restaurative applicable immédiatement suite aux articles 10-1, 10-2 et 707 du code de procédure pénale, issus des articles 18 et 24 de la loi n° 2014-896 du 15 août 2014. BOMJ n°2017-03 du 31 mars 2017. (consulté le 03 octobre 2019)
21. Cochez F, Delage A. Etude de faisabilité, étude d'adaptation et plan d'adoption pour l'implantation de CSR en France Projet Circles4EU (Daphné III, 2013-2015). 2015. (consulté le 03 octobre 2019)
22. Baste Morand L. La réparation pénale. Un embryon français de justice restaurative. *Cah Dyn* 2014;59(1):61-7.
23. Schnapper D. La République face aux communautarismes. *Etudes* 2004;400(2):177-88.
24. Thomasset A. L'Eglise et le communautarisme. *Etudes* 2005;403(9):183-92.
25. Prouteau L, Wolff F-C. Donner son temps : les bénévoles dans la vie associative. *Econ Stat* 2004;372:3-39.
26. Archambault É. Le bénévolat en France et en Europe. *Pensée plur* 2005;9(1):11-34.

27. Benbouriche M, Ventéjoux A, Lebougault M, Hirschelmann A. L'évaluation du risque de récidive en France: expérience et attitudes des conseillers pénitentiaires d'insertion et de probation. R*ev Int Criminol Police Tech Sci* 2012;65(3):305-18.

28. Jonas C, Senon J-L, Voyer M, Delbreil A. Méthodologie de l'expertise en psychiatrie. Paris, France: Dunod; 2013.

29. Benbouriche M, Vanderstukken O, Guay J-P. Les principes d'une prévention de la récidive efficace : le modèle Risque-Besoins-Réceptivité. *Pratiques Psychol* 2015;21(3): 219-34.

30. Guay J-P. L'évaluation du risque et des besoins criminogènes à la lumière des données probantes : Une étude de validation de la version française de l'inventaire de niveau de service et de gestion des cas – LS/CMI. *Eur Rev Appl Psychol* 2016;66(4):199-210.

31. Wilson RJ, McWhinnie AJ, Wilson C. Circles of Support and Accountability: an international partnership in reducing sexual offender recidivism. *Prison Serv J* 2008;138(178):26-36.

32. Courtois R, Humeau H, Bertsch I, Mozas ECL, Baudin G, Potard C. Élaboration d'une échelle des représentations sociales négatives concernant les auteurs de violences sexuelles. *Ann Med Psychol 2019, in press*

Corresponding author

Ingrid Bertsch, CRIAVS Centre-Val de Loire, CHRU de Tours, 37044 Tours cedex 9, France– email: i.bertsch@chu-tours.fr

International Journal of Risk and Recovery
EST 2007

REVIEW ARTICLE

Absconsion from forensic psychiatric institutions: a review of the literature

Danielle Campagnolo [1], Ivana Furimsky [2,3], Gary A. Chaimowitz [2,3]

[1] McMaster University, Health Sciences Program, Hamilton, Canada

[2] McMaster University, Department of Psychiatry and Behavioural Neurosciences, Hamilton, Canada

[3] St. Joseph's Healthcare Hamilton, Forensic Psychiatry Program, Hamilton, Canada

Background: Absconding from mental health units is referred to as a patient leaving without permission and can have significant consequences for the patient, family, community, and institution. The varying definitions of absconsion involve breaching security of an inpatient unit, accessing grounds or community without permission, gaining liberty during escorted leave or being absent for longer than permitted from authorized or trial leave. While considerable literature exists on absconsion from acute psychiatric units, there is a paucity of literature specific to forensic absconsions, despite inherent differences between patients and systems. Forensic patients are offenders who are found unfit to stand trial, or not criminally responsible on account of mental disorder. The literature indicates the absconding rate within the forensic population is expected to be low, based on the fact that the level of security in forensic units is higher than general psychiatric units. Despite the rates being considered low, the outcomes of absconding in this population can potentially be serious, thus the exploration of factors surrounding these incidents is essential. Purpose: To review the literature regarding absconsion from forensic psychiatric institutions. This review will identify potential risk factors and motivations of forensic patients that have absconded. Methods: Electronic database and hand searches were conducted to locate articles pertaining to absconding specific to forensic psychiatric institutions published from 1969-present. Search terms included "abscond", "escape", "AWOL", "runaway", "psychiatric inpatient", "forensic institution", & variants. All full-text articles meeting inclusion & exclusion criteria were appraised for qualitative themes, limitations, and assessed for risk of bias using appropriate CASP Checklists. The review is structured following the PRISMA checklist and framework. Results: A total of 19 articles meeting literature review criteria were identified. The majority of the articles were of retrospective case-control design (n=12). Three systematic reviews were found on absconsion that included analyses from both forensic and general psychiatric populations. Definitions for absconding were omitted or varied making comparisons between studies difficult. Much research compared demographic, static and dynamic factors. History of previous absconsion, scores on validated risk-of-violence assessment tools, substance-use disorder, acute mental state, and socio-environmental factors were consistently noted as risk-factors. Four distinct motivations for absconding emerged: goal-directed, frustration/boredom, symptomatic, and accidental. Overall, the literature suggested forensic absconsion was a rare event of short duration with low risk to the public and few re-offending incidents. Conclusions: There is a paucity of literature on forensic absconsions. A consistent definition of absconsion and use of standardized reporting protocols across forensic programs would be beneficial in order to be able to compare data on absconding events. Also, prospective studies should be undertaken to better understand the motivations and dynamic risk factors of forensic patients who have absconded and would help inform a forensic absconsion risk assessment protocol.

Key words

Abscond, escape, forensic, secure hospital, psychiatric inpatient, offender-patient

Acronyms

HCR-20- Historical Clinical Risk Management-20, LARA-Leave/Abscond Risk Assessment, PCL-R- Psychopathy Checklist-Revised, EMR- Electronic Medical Record

Introduction

Absconsion of patients from forensic mental health units can have significant consequences for the patient, hospital, and greater community [1-11]. Absconsion can be defined as an unauthorized leave of absence from mental health inpatient services. Within the literature, however there is no standard definition of

absconsion used. Definitions can include instances of breaching the security of an inpatient unit, accessing hospital grounds or the community without permission, fleeing from staff while on community outings, being absent for longer than permitted, or failure to return from an authorized or trial leave [1-6,8,9,11-14]. Regardless of the circumstances surrounding the event, the potential for serious outcomes exists.

Absconsion from forensic mental health units can compromise a patient's safety and result in suicide or serious self-harm [1,5,8,15] with the risk of suicide being elevated immediately upon return of the patient to the unit [2,8,16]. Substance and alcohol use are also commonly reported during absconding with over 50% of absconders in one study reporting use on leave [2,4,7-9,11,14]. There is risk of exposure to the environmental elements since many patients do not have a home to seek shelter [1,15]. Absconsions can lead to distrust in psychiatric services by families who expect the hospital to keep patients safe. The reputation of the forensic hospital and its processes can be put under scrutiny by a community expecting adequate management of patients who may pose a danger within a community or are at risk for violence [1-11,17]. In absconsions from forensic institutions, police are notified which may precipitate media attention, exacerbating both the situation and stigma [2,5,18,19].

Within forensic psychiatric institutions, patients are under much higher security due to potential risk for violence [1,13,17]. This level of security may decrease overall rates of absconsion, however also results in a lack of autonomy related to treatment, heightened perceived stigma, and isolation of patients from the hospital and community [1,13,20-22,24]. Lengthy durations of stay in hospital in comparison to non-forensic patients is a unique source of stress, making forensic rehabilitation and motivations for absconsion more complex [4,6,9,11,21-24].

However, for nearly all forensic patients some form of leave is a fundamental part of their rehabilitation [17,20,21,23]. Clinical teams realize the risk of absconsion exists when granting this leave [23]. However, lack of evidence on absconsion specific to the forensic population, makes clinical decision-making and identifying patients at high risk of forensic absconding more difficult. The purpose of this literature review is to evaluate the state of literature in relation to absconsions from forensic mental health units. It will aim to identify risk factors and motivations highlighted in the literature that can help inform decision-making in granting leave.

Methods

Searches of electronic databases were conducted to locate articles pertaining to absconding specific to forensic mental health patients published from 1969-present. The following databases were searched: Ovid, MEDLINE, PsychINFO, CINAHL, PubMed and Web of Science. A hand search was also conducted of Google Scholar, the Web, and relevant publications' reference lists. The following search terms were used with variants in parentheses: "Abscond" (absconding, absconder, absconded), "Escape", "Elope", "AWOL", "AWOP", "Runaway" (at large), "Psychiatric Inpatient" (Patient, Resident, Absconder, Offender, Offender-Patient), "Forensic Institution" (Special Hospital, High-Security Psychiatric Hospital, Forensic Hospital/Ward, Secure Hospital). Included publications were in English. Initially, the search timeframe was set from 2007 to present with November 20th, 2018 being the last date searched. However, due to the low quantity of articles (n=10), the timeframe was adjusted to include relevant publications from 1969. The search excluded theses or other grey literature and only literature published in peer-reviewed journals was included. Full-text articles meeting criteria were appraised for qualitative themes, limitations, and assessed for bias using CASP Checklists [25]. The review was guided by the PRISMA checklist and Explanation and Elaboration document [26]. Figure 1 illustrates the different phases of the literature review.

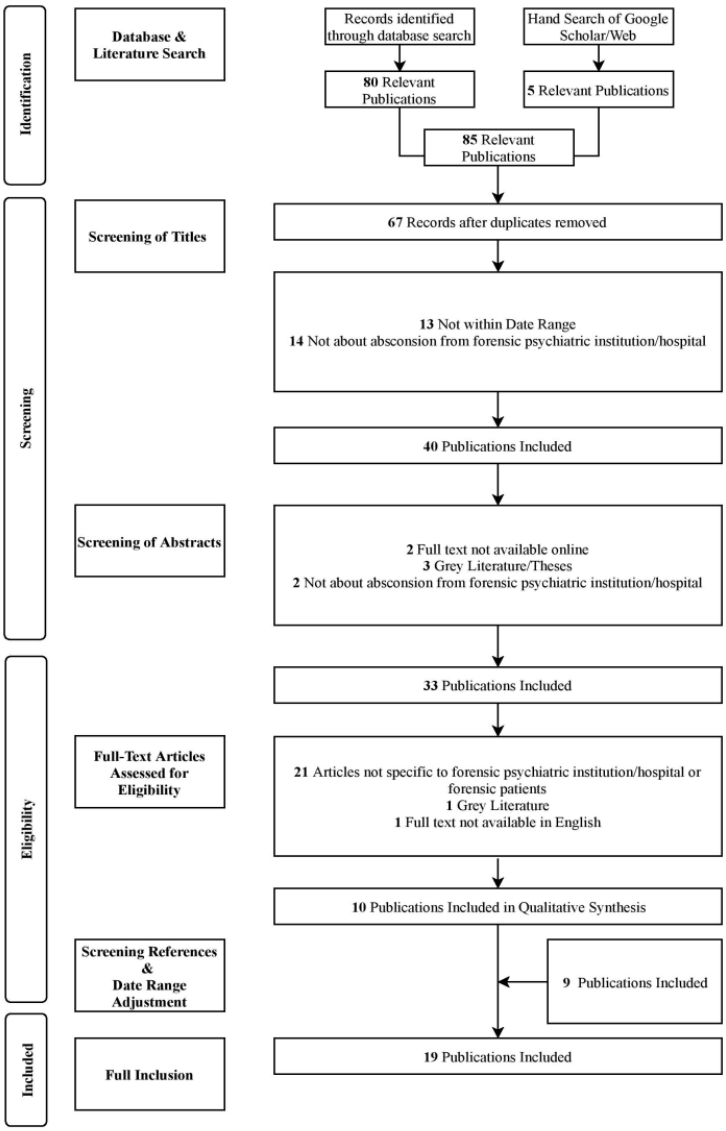


Figure 1. Literature Review Process

Results

A total of 19 full-text articles met the criteria for this literature review. The majority of the articles were published between 2009-2018 [4,7-14,23]. Eleven of the studies were conducted in the United Kingdom [2,3,5,-7,12-14,19,23,28], three in the United States [10,18,27], three in Canada [4,9,11], and two in Australia [1,8]. A summary of the characteristics and results of each study is included in Table 1. The majority (n=12) were of retrospective design [2-8,10,11,18,27,28]. Only one included a prospective cohort following forensic psychiatric patients over a two-year follow-up for absconding incidents [14]. Another included an A-B prospective study design evaluating the effectiveness of a risk-assessment tool [9].

Three systematic reviews were found on the subject of absconsion; all included articles from both forensic and general psychiatric institutions [1,12,13]. Remaining studies involved qualitative observation of clinician decision making, and a description of an absconsion protocol [19,23].

Definitions of Absconsion

There was no consistent definition of absconding used within the literature on forensic mental health units (Table 1).

Table 1. Study Characteristics (table formatted following Bowers et al., 1998 and according to Moher et al., 2009)

Study	Place	Study Design	Population	Comparison Group	Intervention	Absconding Definition	Absconding Rates	Outcomes Analyzed
Morrow et al. 1969	USA	Retrospective Case-Control	State maximum-security building for male psychiatric offenders 1956-1966; 40 patients who attempted to escape from building	Unselected security-building admissions over 5 years, and to 80 non-escapees	Chart Review	"Escape episode"	Not reported	Characteristics of escape behaviour, comparison of escapees/non-escapee groups on background characteristics. Composite scoring index developed
Cooke et al. 1978	USA	Retrospective Case-Control	Forensic Psychiatric Center; Elopement group (n=37); 30 patients with data available. Cross Validation sample (n=49); 34 with data available	Random sample 130 non-absconding controls from same population	Chart Review	"elope"; undefined	86/572 admissions over study period; 15%	MMPI profiles (Depressive & Paranoia Scales) compared between elopers and non-elopers; any statistically significant differences weighted into prediction tool
Huws et al. 1993	U.K.	Retrospective Case-Control	English Special Hospitals over 13-year period; 66 incidents involving 62 absconder-patients during study period. (n=32 from within hospital; n=30 while on trial leave)	Non-absconders during same period (n=4571) for within hospital & discharged patients for trial leave absconders	Chart Review	unauthorized absence from hospital, outside working party, rehabilitation or compassionate leave from hospital, or deliberate evasion of staff whilst outside hospital	"rare"; 36 over 13 years out of population of 4909; rate for absconsion from trial leave not reported	Predictors of absconding, planning, security measures of Special Hospitals, and the details of the absconsion outcome (offending & danger to the public)
Dolan et al. 1994	U.K.	Retrospective Case-Control	Escaped patients from regional medium-secure forensic unit over 7-year period; 27 patients; 31 escape episodes	Random sample 238 non-escape controls from same population	Chart Review	Escapes: one or more individuals who breached the security of the unit and subsequently attempted to abscond	3.5% incidence among those admitted	Frequency, characteristics of incident, escapee profile, and outcome of escapes; determining characteristics for future risk assessment
Gacono et al. 1997	USA	Retrospective Case-Control	Maximum security forensic hospital over 10-year period; 18 patients with escape history	18 non-escapee matched controls	Chart Review	“escaped”; undefined	Not Reported	PCL-R scores, psychotic diagnosis, neuroleptic medications, & index offenses compared

Study	Place	Study Design	Population	Comparison Group	Intervention	Absconding Definition	Absconding Rates	Outcomes Analyzed
Brook et al. 1999	U.K.	Retrospective Case-Control	Maximum Security English Special Hospital 1985-96; Absconders (n=36)	Random sample 150 non-absconding patients	Chart Review	Unauthorized absence from hospital, from an authorized excursion, or breach of physical security of the hospital	36 episodes across study period; rates per outing only available for last 4 years of study (0.5, 0.17, 0.13 and 0.17)	Absconder characteristics, outcome of episode, comparison between non- and absconder groups (demographics, clinical risk factors, previous absconding)
Moore 2000	U.K.	Retrospective Case-Control	Sample of absconders and escapees from 3 English high-security hospitals between 1989 and 1994; 43 incidents of unauthorized absence (30 absconsion, 12 escape, and 4 failure to return) by 45 patients	Absconsion: Total number of outings; Escape: number of hospital residencies per year	Chart Review	Any unauthorized absence from: the hospital, rehabilitation trip, an outside working party, leave of absence, trial leave	Not Reported	Characteristics of absconding & escape, risk patterns using multi-modal analysis, historical, cognitive, and emotional predictive factors; motivations categorized
Moore & Hammond 2000	U.K.	Retrospective Case Design	Patients of English Special Hospitals (Ashworth, Broadmoor, & Rampton) and those on trial leave 1989-1994; 44 known absconders during study time period	5,133 admission entries to three hospitals excluding absconders and those discharged during study time period	Chart Review	See Moore, 2000 [2]	Not Reported	35 predictor variables compared between absconding and non-absconding groups through series logistic regression analyses; predictive strength of variables and model evaluated
Nichols et al. 2007	U.K.	Qualitative Review of Absconding Pack Intervention; and case series analysis (n=2)	Two medium secure hospitals. Patients are predominantly mentally disordered offenders	One incident prior to implementation documented	Absconsion pack containing patient background details & risk assessment factors; one incident following its introduction	Vaguely "unauthorised patient absence from secure hospitals" including escapes, failure to return from leave, and absconsion	"rare"; not reported	Statistics on absconsion from secure hospitals, current state of social work policy, recommendations; development of an ‘absconsion pack ’

Study	Place	Study Design	Population	Comparison Group	Intervention	Absconding Definition	Absconding Rates	Outcomes Analyzed
Lyall et al. 2010	U.K.	Qualitative Non-Participant Observational	Data collected from observation of ward rounds of medium secure forensic unit over 15-month period; Leave discussed on 96 occasions; risk of absconding on 12	Content of 116 discussions of 18 patients analyzed	Naturalistic observation of weekly ward rounds from two clinical teams	'running away'; undefined	N/A	How leave decisions are reached by clinical teams: factors considered, nature of discussions, and two emerging themes when deciding on leave (risk vs humanity and issues of power and responsibility)
Stewart et al. 2011	U.K.	Systematic Review	English, peer-reviewed literature on absconding from acute mental health wards and forensic units, between 1960 and 2009. 75 empirical papers meeting criteria	Open-door wards & mixed wards effect on absconding	Locked- door wards effect on absconding	Patient being absent from the ward without official permission (AWOL); variations in the time period a patient could be absent before declared an absconder (1-72 hours)	Not Reported; Rate of absconsion increased as level of security decreased. Differences in services and the characteristics of patients (forensic vs general psychiatric) not controlled for.	Synthesizes literature on door-locking policy's effect on absconsion. Increased security negatively associated with absconsion but highly associated with negative outcomes, exploration of alternatives to door-locking
Hearn et al. 2012	U.K.	Review of the Literature	Papers relating to absconding risk assessment from medium and low secure mental health and forensic care units in the UK	Previous risk assessment methodologies, HCR-20, and current absconding interventions	Analysis of absconding risk factors	A patient who gains liberty during escorted leave of absence outside perimeter of the unit/ hospital by getting away from supervision of staff.	Not reported, noted lack of consistency across studies	Prevalence, characteristics, socio-environmental factors, and interventions for absconding, outlines the LARA
Mezey et al. 2015	U.K.	Retrospective Case-Control	Medium & low secure forensic psychiatric inpatient units of two NHS Trusts over 5 years; 54 patients responsible for 77 incidents (cases); 13 escape cases (12 patients)	64 absconding cases (42 patients)	Chart Review	Escape: breach of the secure perimeter of the hospital/unit; Abscond: taking unauthorised liberty outside perimeter, breaking away from staff or failure to return	Escapes: 0.04 per 1000 bed days Absconds: 0.26 per 1000 bed days; Total rate of unauthorised leave: 29 patients per 1000 admissions per year	Comparison of patient characteristics, risks, circumstances and outcomes of cases, and motives between escapee and absconder groups
Cullen et al. 2015	U.K.	Prospective Cohort	135 forensic psychiatric inpatients (medium & low secure wards) over 2-year follow-up; 27 patients responsible for 56 absconsions during study period	108 non-absconder patients	Incidents of Absconsion	Absent from hospital without permission (i.e., failure to return from leave, escape, and absconding whilst on escorted leave)	20% of population studied	Demographic, clinical, treatment-related, and offending/behavioural factors from EMRs & census of treatment teams used for predictive risk scale (low PPV)

Study	Place	Study Design	Population	Comparison Group	Intervention	Absconding Definition	Absconding Rates	Outcomes Analyzed
Wilkie et al. 2014	CAN	Retrospective Case-Control	Forensic patients within a large psychiatric hospital in Toronto (medium & minimum security); 57 patients responsible for at least one incident (n=102) from hospital within previous 24-months	57 matched non-absconder control group with no previous history of absconsion	Chart Review	Any unauthorized absence from hospital: breaching the security of inpatient unit, accessing hospital grounds/community without permission, or absent for longer than permitted	14.4% over two years	Characteristics of absconders; outcomes of event and motives; significant differences between of patients with and without absconding incidents used to identify factors predictive of absconding (HCR-20, PCL-R)
Simpson et al. 2015	CAN	A-B prospective design for Leave Application Form	Forensic program at a large urban psychiatric hospital in Toronto over 42-month study window; 86 patients responsible for 188 incidents of absconding	Compared and matched (on age, sex, and security level within the hospital) to non-absconder controls	Leave Application Form integrating HCR-20 risk indicators, nature & purpose of leave, risks & benefits of granting leave, and rehabilitative goals	See Wilke et al. 2014	Absconding rate decreased 33% ($p < .05$) Prior implementation: 17.8% During implementation: 13.8% Post-implementation: 12.0%	Rate, characteristics, motivations of absconding events prior to and following new policy; comparison between absconders and non-absconders during study period (HCR-20, length of stay, substance use)
Scott et al. 2017	AUS	Retrospective descriptive audit	High Security Inpatient Services (HSIS), Brisbane over 12-year study period; forensic and general psychiatric units; 27 AWOP incidents between 2003-2015 (14 patients)	Total Episodes of Day Leave	Chart Review	Critical incidents during leave: breaches of the conditions of leave (fleeing staff), failure to return from leave by the designated time or AWOP; criminal offending, harming others/self-harming on leave	1 in 1710 incidence of AWOPs relative to total day leave episodes across 12 years	Characteristics of critical incidents, outcomes of (harm, re-offense, returns), predictors (history of absconding)

Amongst studies that provided a definition of absconding, there were variations in time-periods a patient could be absent before being deemed an absconder [1,3,4,6,7,13]. In addition, most studies classified both failures to return from leave and escape as absconsion [6,10]. One study differentiated between escape and absconsion [7] and only one clearly differentiated between absconding, failure to return from leave, escape, and attempts [1,12,13]. Three studies did not include definitions at all [18,23,27].

Static Risk Factors

History of previous absconsion or attempts was found to be significantly associated with future absconding incidents in many studies [2,4-9,14]. Those who abscond are likely to be young, Caucasian, male, and diagnosed with a psychotic disorder, compared to non-absconders [1,5,13,18]. A history of alcoholism, unemployment, and being an older sibling was characteristic of some absconders [10]. Some studies looked at scores on commonly used violence risk assessment tools. Higher risk scores on the HCR-20 were noted in three studies as being a good predictor of absconding behaviour [4,9,11]. Higher PCL-R scores of absconders and escapes were also associated with a higher risk of absconding [4,11,27].

Dynamic Risk Factors

Absconding was also found to be significantly associated with dynamic factors such as patients' acute mental state or recent stressful events such as death/loss or transitions in care (usually from lower to higher security) [4,11,14,25]. Furthermore, in the year prior to absconding, absconders were more likely to be involved in property damage, verbal aggression, self-harm, substance abuse and to be non-compliant with treatment [3-5,9]. Absconders were more likely to have a comorbid substance use disorder and problematic personality traits/disorder than personality disorder alone [9,11].

Motivations to Abscond

Only four studies to date have included explicit analysis of specific motivational factors [4,6,9,11]. Two commented on particular subgroups of absconders: opportunity makers and opportunity takers [2,4]. Opportunity takers make up the majority of absconders, meaning those who make use of circumstances or chance events where impulsivity, fear of transfer, revoking of parole, amount of money in possession, and difficulties in accepting detention are associated with increased risk [2,4]. Opportunity makers, by contrast, engineer situations in which they can abscond, and absconsion was often goal-oriented and planned, especially with those from higher security wards [2,4-6]. Researchers identified four distinct motivations of absconding behavior: goal-directed, frustration/boredom, symptomatic/disorganized, and accidental [4,9, 11]. Frustration/boredom and goal-directed behaviours account for the vast majority of incidents [4,11]. These patients often exhibited higher HCR-20 scores, difficult behaviors, absconding ideation and voicing of discontent to staff, and upcoming or recently unfavourable Review Board hearings in the weeks prior to absconding [4,9,11]. When individuals returned, it was at their leisure, they minimized the situation, externalized blame, or defended behavior [4]. Goal-directed individuals are those with a desire to abscond in order to complete a specific goal which they were likely to have voiced to staff [4,9]. Symptomatic/disorganized absconders appeared to act in response to auditory hallucinations or delusional beliefs [4,9,11]. Active symptoms of illness, notable instability, medication changes, missed medication and stating of psychotic beliefs with absconding ideation preceded incidents [4,9]. Accidental absconders were those who lost track of time or met situations beyond their control resulting in a report of absconsion [4,9,11].

Characteristics of Absconding Incidents

Incidents of absconding from secure hospitals were found to be rare and acts of violence during absconsion were infrequent [1-4,6,8,11,12]. Incidents occurring in low-security units appeared to be higher compared to medium or maximum-security units [3,5,7,13]. Most absconding incidents occurred from individual or community trips outside the hospital [3-5,8, 13]. The number

of escorts had little impact on reducing the risk of absconding [2,5,14]. In most cases, only one patient absconded, but there are several reports of patients absconding together [2-5,7].

Timing of Absconding

Some studies observed that most incidents occurred during warm weather from May to September and in holiday months such as December when patients wished to be close to loved ones [4,10]. One study noted absconsion took place primarily during the afternoon/evening, weekends or times with lower staff level [6]. Two studies indicated that absconsions tended to occur in clusters suggesting a "copycat" or "contagion" effect during times of ward stress [5,6]. There is disagreement over whether length of stay is related to absconsion risk. Three studies confirmed significant time lapses between the date of admission and first absconsion episode [4,9,28]. One study noted that the longer a patient has been known to staff and not absconded; the less likely staff may be to expect absconsion, increasing the risk [28]. This is inconsistent with previous research, which hypothesized no relationship, or that risk of absconsion is highest earlier in inpatient stay when patients are unsettled or resentful [7,10,28]. Because of conflicting data about timings of absconsion, focusing instead on motivations behind observed trends may be more useful in assessing risk than the static factor of length of stay [4,6,7,9,10,14,28].

Outcomes of Absconsion

Forensic absconsion is rare, with locked doors and high secure units correlated to the lowest rates, but with overall rates increasing [1-8]. Studies focused on the duration of absconding events and circumstances of the return, (see Table 1) and in most cases the duration was short, the majority of patients were returned within 24 hours, and all absconders were eventually found [1-6,8,11,12]. A recent study noted the median absconding duration of only 4 hours [11], and one noted most patients were caught within minutes by hospital staff [5]. Between suburban and urban hospital settings, it may be easier for absconders to evade detection and gain access to the wider community in a metropolitan city [4,11,26]. Police were involved in the patients' recapture usually without incident, and in some cases, the patients returned voluntarily, although this was less likely in escapees [5,7]. The ultimate level of public endangerment posed by those who absconded is low, with few patients reoffending during absence [2-4]. An Ontario forensic institution found that despite higher HRC-20 scores and substance-use disorders among the 57 patients responsible for 102 absconsions over 2 years, only one incident of minor violence and very few other illegal behaviours occurred [4]. Three English maximum-security hospitals had very low rates of absconding from thousands of rehabilitation outings over a five-year period, all with minimal risk to the public [2]. Huws et al., reported 11 cases of offending from 36 AWOPs over 13 years, and with only two serious offences (rape and manslaughter) [3]. Several studies noted negative outcomes for absconders: self-harm during leave, elevated risk of suicide upon return, and substance abuse during leave [1-4,8,15]. Beyond public safety risks, re-offense, and patient harm, other outcomes included slowed patient rehabilitation, the reputational risk to the hospital, affects on the legal status of the patient, and perpetuation of stigma towards patients [1-11,18].

Table 2: CASP Checklists

A. Completed CASP qualitative risk of bias checklist tool

	Clearly stated research aims?	Is a qualitative methodology appropriate?	Was the research design appropriate to address the research aims?	Was the recruitment strategy appropriate to the research aims?	Was the data collected in a way that addressed the research issue?	Relationship between researcher and participants adequately considered?	Have ethical issues been considered?	Was data analysis sufficiently rigorous?	Clear statement of findings?	How valuable is the research?
Lyall et al. 2010	Y	Y	Y	Can't Tell	Y	Can't Tell	Y	Y	Y	Moderate
Nichols 2007	Y	Y	Y	Can't Tell	Y	Y	Y	N	Y	Very

B. Completed CASP case-control risk of bias checklist tool

	Did the study address a clearly focused issue?	Appropriate method to answer their question?	Were cases recruited in an acceptable way?	Were controls selected in an acceptable way?	Was exposure accurately measured to minimise bias?	Were the groups treated equally?	Have authors taken account of potential confounders?	Do you believe the results?	Can the results be applied to the local population?	Do results of study fit with other available evidence?
Brook et al. 1999	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Cooke et al. 1978	Y	Y	Can't Tell	Y	Y	Y	Can't Tell	Y	Y	Y
Dolan et al. 1994	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Gacono et al. 1997	Y	Y	Can't Tell	Y	Y	Y	Y	Y	Y	Y
Huws et al. 1993	Y	Y	Y	Y	Can't Tell	Y	Y	Y	Y	Y
Martin et al. 2018	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Mezey et al. 2015	Y	Y	Y	N	Y	Y	Y	Y	Can't Tell	Y
Moore & Hammond 2000	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Morrow et al. 1969	Y	Y	Can't Tell	Y	Y	Y	Y	Y	Y	Y
Scott et al. 2017	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Wilkie et al. 2014	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

C. Completed CASP cohort risk of bias checklist tool

	Did the study address a clear issue?	Cohort recruited in acceptable way?	Exposure accurately measured minimising bias?	Outcome accurately measured minimising bias?	Have the authors identified all important confounding factors?	Have they taken account of confounders in the design /analysis?	Was the follow up complete and long enough?	Do you believe results?	Can the results be applied to the local population?	Do the results of this study fit with available evidence?	Are there implicat-ions of this study for practice?
Cullen et al. 2015	Y	Y	Y	Y	Y	Y	Y	Can't Tell	Can't Tell	Y	Y
Simpson et al. 2015	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

D. Completed CASP systematic review risk of bias checklist tool

	Did the review address a clearly focused question?	Did the authors look for the right type of papers?	Do you think all the important, relevant studies were included?	Did the review's authors do enough to assess quality of the included studies?	If the results of the review have been combined, was it reasonable to do so?	Can the results be applied to the local population?	Were all important outcomes considered?	Are the benefits worth the harms and costs?
Cochrane		Y	Can't Tell	Y	N	Can't Tell	Y	Y
Hearn et al. 2012	Y	Y	Can't Tell	Y	Y	Can't Tell	Y	Y
Stewart et al. 2010	Y	Y	Can't Tell	Y	Y	Y	Y	Y

Discussion

Within this review, the use of an a priori protocol, defined research question, objectives, and scope reduces bias in selection [29]. The major limitation in this review was the scarcity of data on absconsion within the forensic population, prompting date range adjustment to include as many relevant studies as possible. Inconsistent definitions of absconsion made it difficult to draw comparisons between studies, as well as inconsistent reporting of rates, comparison groups, and settings (see Table 1). CASP is seen generally seen as an appropriate tool for qualitative risk of bias assessment, however, it appears to be inferior to others in terms of sensitivity [25,30]. Studies were all found to be of qualitative value to include in a review of the literature, individual article limitations were examined, and all were found to be of low risk of bias as per CASP guidelines (see Table 4 A-D).

Despite its rarity, cases where patients were gone for extended periods, used hospital and police resources, did commit offenses, or had negative outcomes themselves reaffirms palpable risks and consequences of absconsion [1-6,8,12,19]. These outcomes derail rehabilitative goals and demonstrate the negative consequences for absconders as well [1-4,8,9, 11,14,15]. The absence of an overwhelming number of adverse incidents may help relieve the public's beliefs about safety concerns [2,8,9,18]. To reduce negative outcomes of absconsion an "absconding pack" given to police may improve response time and streamline the recovery process [12,19]. While primarily proof of concept, this study encourages increased standardization in forensic patient data collection [19].

The deficiency in volume and quality of literature on the topic of absconsion from forensic institutions may reflect the rarity of such incidences, resulting in smaller sample sizes and difficulties in producing comparisons. The small sample sizes or discrepancy between sizes of control and absconding groups in individual studies affects the significance of results measured in case-control and cohort studies and the ability to assess risk factors [5,28]. Attempts were made to minimize confounding factors and bias in some studies by having a control group, matched comparison group of non-absconders, or other comparison group, though appropriate matching criteria were difficult to discern and inconsistent across studies [2,3,5-8,10,11,18, 27,28]. The past 10 years have seen an increase in forensic absconsion literature, possibly attributable to negative media responses to increasing rates or recent high profile absconsions prompting interest in better risk management and increased pressure for understanding of outcome risks and motivations as mentioned in some studies [2-4].

Most research conducted was retrospective in nature. Due to incomplete EMRs and biased clinician recall, many retrospective studies were operating with incomplete data and particularly limited in exploring dynamic risks [2,3,5,7]. Selection bias was evident when outcomes were not available for several absconders, or for attempts, especially considering history of absconding being a stable predictor [2,4-9,14,18]. Limitations of retrospective analysis based on EMRs is further compounded by the fact that there exists no evidence of systematic documentation for absconding episodes across forensic institutions over time. While retrospective studies attempted to discern absconder profiles, characteristics, and motivations many noted these were based off incomplete records [2,3,5-8,10,11,18, 27,28]. Refinement of record-keeping of incidents may assist in the better extrapolation of risk factors [5,19]. A standard debriefing protocol for patients who have been returned could further inform motivations and strengthen therapeutic relationships [4,5,9].

Given that risks and factors have been established from retrospective studies, more prospective studies should be undertaken. These should incorporate a standardized definition of absconding from forensic institutions and conduct in-depth analysis of motives and characteristics on

larger forensic sample sizes to replicate the significance and clinical utility of risk factors previously identified in retrospective literature.

Additionally, literature reviews pooled both forensic and general psychiatric populations in their analyses [1,12,13]. It is imperative to study forensic populations separately; there are differences between forensic patients and general psychiatric patients and the systems through which they receive rehabilitative treatment, that impacts how we analyze absconsion from these settings and development of appropriate risk tools [16,23,29]. General psychiatric patients may be admitted voluntarily or involuntarily depending on clinical presentation, while criminal history and serious mental illness are inherent for admittance to a forensic psychiatric facility [12,23-25,27]. The forensic patient also experiences the unique stresses associated with the forensic system, such as decreased autonomy, increased length of stay, Review Board hearings, revocation of liberty, and heightened security and stigma due to their criminal offenses [11,22-24,27]. Ultimately these clear differences between the two settings that warrant separate investigations into factors associated with absconsion from these two distinct populations, and a review of forensic-specific literature is warranted [1,12,13].

One of the biggest gaps is in risk assessment. At present only one qualitative study has contributed to the understanding of clinician decision making in granting forensic leave however the researcher's own influence needed to be reviewed for observation bias and reporting bias being the sole observer [23]. These leave decisions tend to be unstructured, with absconding risk and current mental state rarely referenced explicitly, and time constraints predisposing conversations to brevity [23]. Despite attempts, overall, there still exists no "thorough, well designed, rigorously carried-out trials of interventions to reduce absconding" valid for forensic populations [9,12,15]. Two studies that were analyzed explored tools incorporating validated and widely used violence risk and psychopathy assessment scales such as the HCR-20 and PCL-R that showed utility in predicting absconsion, so further analysis of these scales' absconsion predictivity would be valuable [4,9,12].The LARA is based on a review of violent risk assessment and absconsion literature, but the tool has not yet been tested for validity/reliability and is not specific to forensic settings [12]. The LARA could be refined for forensic use, although it would need to be tested prospectively [12]. Prospective analysis of an empirically-derived Leave Application Form to assist clinical teams in leave decisions showed a 33% decrease in absconding following implementation in one population [4,9]. Future cross-referencing of this form's validity in different settings would aid in confirming its reliability and shows promise for evolving into a standardized forensic tool [9]. In addition to EMR review, interviewing patients about past absconsions to further discern motivational risks to be incorporated into a tool would be valuable [9,12]. Ultimately literature is starting to emerge but any proposed risk assessment tools are in very early stages.

Statistical risk prediction of absconsion is inherently problematic due to the low volume of forensic absconding events, and risk assessment based on static and demographic factors may not be appropriate [12,28]. While compared in nearly all retrospective chart reviews, demographic factors may be time and context-specific, or the offender patient population at one institution may be skewed depending on the type of surrounding community from which patients originate [12,28]. History of absconsion, recent PCL-R, and HCR-20 remaining steadily predictive across studies may be related to consistent motivations [1,4,6,9,11,27]. Clinical interventions may affect observed findings for factors such as definite psychopathy and record of physical violence being negatively associated with absconsion, as clinical teams may impose additional restrictions on those who have high-risk diagnoses or violent behaviour [13,14]. These patients may thus present as lower risk since they have fewer opportunities to abscond, rather than these

characteristics actually representing low-risk.

Retrospective studies have thoroughly established static factors, and several acknowledge the potential weight of motivational factors, yet very little has been done to actually evaluate motivational factors as this data is difficult to obtain retrospectively [4,11,12,14,25]. Recent stressful life events and clinical events should be carefully monitored in patients in the context of their relationship to potential motivators since they may increase frustration, be indicative of boredom, precede goal-oriented behaviour, or aggravate symptoms of mental illness prompting accidental or symptomatic absconsion [3-5,9,11,12,14, 25,27]. Clinicians acknowledge the time spent without leave on a ward is frustrating and contributes to a negative rehabilitative environment, boredom, and despair for patients facing long hospitalizations alongside the revocation of their autonomy compared to other psychiatric settings [1,4,6,7,9,11]. Substance use is unsurprisingly a predominant subtype of goal-directed motivation [4,7]. Future prospective analysis should also consider incorporating patient and staff interviews alongside medical record review following absconsion to better discern patient motives.

Behaviours that are strong predictors for absconsion in forensic settings could be potentially targeted with appropriate preventative interventions [4,7]. For instance, if substance abuse is both a motivator and risk factor for absconsion, an inpatient program for patients targeting substance use disorders could prove effective [4,7]. Although the most straight forward method of reducing absconding would seem to be to increase hospital wide security, locking ward doors and reducing leave, such measures do not stop absconding altogether and need to be balanced against potential negative consequences such as a volatile ward environment, depression associated with lack of freedom, and negative acute mental states [4,11,13,14,25].

Finally, several studies suggested ensuring adequate staffing levels and relational security, increasing positive relationships with the clinical team, and improving the education of staff themselves on risks and precipitators to absconsion in order to better detect their presence, would aid in creating a cohesive, transparent, rehabilitative environment for patients [4,6,9,23].

Conclusion

Ultimately, there is a deficit in forensic-setting literature and inconsistency in many areas of interest on absconsion. While a rare event of ultimately low risk to the public, there is a need to develop a consistent definition of absconsion and use standardized reporting for incidents and outcomes across forensic settings. Prospective studies with patient interviews centered on absconder motivations and acute mental state should be undertaken so as to rely less on static risk factors and retrospective data. Development of a validated forensic absconsion risk assessment tool based on evidence, and preventative measures targeting motivations will aid in reducing risk.

Conflict of Interest: none

References

1. Muir-Cochrane E, Mosel KA. Absconding: A review of the literature 1996-2008. *Int J Ment Health Nurs* 2008;17(5):370-8
2. Moore E. A descriptive analysis of incidents of absconding and escape from the English high-security hospitals, 1989–94. *J Forensic Psychiatr* 2000;11:344–58
3. Huws R, Shubsachs A. A study of absconding by special hospital patients: 1976 to 1988. *J Forensic Psychiatr* 1993;4(1):45-58
4. Wilkie T, Penney SR, Fernane S, Simpson AIF. Characteristics and motivations of absconders from forensic mental health services: A case-control study. *BMC Psychiatry* 2014;14(1): 91

5. Brook R, Dolan M, Coorey P. Absconding of patients detained in an English Special Hospital. *J Forensic Psychiatr* 1999;10(1):46-58
6. Dolan M, Snowden P. Escapes from a medium secure unit. *J Forensic Psychiatr* 1994;5(2): 275-86
7. Mezey G, Durkin C, Dodge L, White S. Never ever? characteristics, outcomes and motivations of patients who abscond or escape: A 5-year review of escapes and absconds from two medium and low secure forensic units. *Crim Behav Ment Health* 2015;25(5):440-50
8. Scott R, Meehan T. Critical incidents during leave from an Australian security hospital - A 12-year audit. *Psychiatr Psychol Law* 2017; 24(1):47-60
9. Simpson AIF, Penney SR, Fernane S, Wilkie T. The impact of structured decision making on absconding by forensic psychiatric patients: Results from an A-B design study. *BMC Psychiatry* 2015;15:103
10. Morrow WR. Escapes of psychiatric offenders. *J Crim Law Criminol* 1969;60:464–71
11. Martin K, McGeown M, Whitehouse M, Stanyon W. Who's going to leave? an examination of absconding events by forensic inpatients in a psychiatric hospital. *J Forensic Psychiatr Psychol* 2018;29(5):810-23
12. Hearn D, Ndegwa D, Norman P, Hammond N, Chaplin E. Developing the leave/abscond risk assessment (LARA) from the absconding literature: an aide to risk management in secure services. *Adv Ment Health Intellect Disabil* 2012;6(6):280-90
13. Stewart D, Bowers L. Absconding and locking ward doors: Evidence from the literature. *J Psychiatr Ment Health Nurs* 2011;18(1):89-93
14. Cullen AE, Jewell A, Tully J, Coghlan S, Dean K, Fahy T. A prospective cohort study of absconsion incidents in forensic psychiatric settings: Can we identify those at high-risk? *PloS One* 2015;10(9):e0138819
15. Bowers L, Jarrett M, Clark N. Absconding: a literature review. *J Psychiatr Ment Health Nurs* 1998;5(5):343-53
16. Crammer JL. The special characteristics of suicide in hospital in-patients. *Br J Psychiatry* 1984;145(5):460-3
17. Wilson CM, Crocker AG, Nicholls TL, Charette Y, Seto MC. The use of risk and need factors in forensic mental health decision-making and the role of gender and index offense severity. *Behav Sci Law* 2015;33(1):19-38
18. Cooke G, Thorwarth C. Prediction of elopement of mentally ill offenders using the MMPI. *Correctional Psychologist* 1978;5(2):151-57
19. Nichols T. Absconding from secure units: a review and description of an 'absconding pack' implications for wider use. *J Ment Health Train Educ Pract* 2007;2(2):22-7
20. Mezey GC, Kavuma M, Turton P, Demetriou A, Wright C. Perceptions, experiences and meanings of recovery in forensic psychiatric patients. *J Forensic Psychiatr Psychol* 2010;21(5):683-96
21. Simpson AI, Penney SR. The recovery paradigm in forensic mental health services. *Crim Behav Ment Health* 2011;21(5):299-306
22. Bettridge S., Barbaree H., Psych C. The forensic mental health system in Ontario. CAMH. 2008. (accessed on October 2, 2019)
23. Lyall M, Bartlett A. Decision making in medium security: Can he have leave? *J Forensic Psychiatr Psychol* 2010;21(6):887-901
24. Sharma A, Dunn WR, Kennedy HG. The virtual institution: cross-sectional length of stay in general adult and forensic psychiatry beds. *Int J Ment Health Syst* 2015;9(1):25
25. Critical Appraisal Skills Programme. CASP Appraisal Checklists. (accessed on October 2, 2019)
26. Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group. Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. *PLoS Med* 2009;6(7): e1000097
27. Gacono CB, Meloy JR, Speth E, Roske A. Above the law: Escapes from a maximum-security forensic hospital and psychopathy. *J Am Acad Psychiatry* 1997;25:547-50
28. Moore E, & Hammond S. When statistical models fail: problems in the prediction of escape and absconding behaviour from high-security hospitals. *J Forensic Psychiatr Psychol* 2000; 11(2):359-71
29. Rowley J, Slack F. Conducting a literature review. *Manag Res News* 2004;27(6):31-9
30. Hannes K, Lockwood C, Pearson A. A comparative analysis of three online appraisal instruments' ability to assess validity in qualitative research. *Qual Health Res* 2010;20(12):1736-43

Corresponding author

Ivana Furimsky, Forensic Psychiatry Program, St. Joseph's Healthcare Hamilton, Hamilton ON L9C 0E3, Canada – email: ifurimsk@stjosham.on.ca