Which role can the General Practitioner (GP) play in the follow-up of sexual assault offenders who leave prison: a systematic review.

Van Vlaenderen Elise, KU Leuven

Promotor: Prof. Keygnaert Ines, UGent

Co-promotoren: Dr. De Schrijver Lotte, UGent

Master of Family Medicine

Masterproef Huisartsgeneeskunde
Academiejaar: 2023 – 2024

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ABSTRACT

Background: Sexual assault is defined as engaging in sexual activity with a person who does not consent or who is considered incapable of consent. To address the issue of sexual assault effectively, it is crucial to not only focus on the victims but also on the offenders. After serving their prison sentences, sexual assault offenders require appropriate follow-up and support to prevent recidivism and promote their successful reintegration into society. The aim of this study is to perform a systematic review on which role the General Practitioner (GP) can play in the follow-up of sexual assault offenders who leave prison.

Methods: This systematic review is performed according to the guidelines recommended by the Preferred Reporting Items of Systematic reviews and Meta-Analyses (PRISMA). Also, some informative websites have been used in writing this article. PubMed (Medline), Embase, Web of Science and Google Scholar were systematically searched for relevant articles. The Critical Appraisal Skills Program (CASP) checklist was used to assess the quality of the included studies.

Results: 25 articles were included in this review. We divided results into the following themes: '*Risk factors for recidivism and the scales to estimate these risk factors', 'Solutions or methods to prevent recidivism and the effects of these therapies', 'Conditions and difficulties for adequate guidance', 'Available assistance in Belgium for perpetrators of sexual violence', 'What role can the GP play in the follow-up*?'. First, the risk factors that contribute to the recurrence of criminal behavior, particularly focusing on sexual offenses, are discussed, as well as the tools used to assess these risks. Next, the individual, relational, community, and societal elements that influence recidivism are discussed along with dynamic and static risk factors. In addition, various therapeutic interventions aimed at preventing relapse are discussed, highlighting the importance of tailored approaches, and addressing underlying psychological issues.

Additionally, the challenges associated with offenders' reintegration into society, emphasizing the need for specialized treatment programs and community support, are explored. In Belgium, initiatives such as the COSA project provide guidance and support to people involved in sexual offenses.

Finally, the potential role of GPs in supporting offenders post-release is also discussed.

Conclusion: General Practitioners (GPs) could play a significant role in the post-release follow-up of sexual assault offenders due to their accessibility and trusted patient relationships. However, more research is needed to assess the effectiveness of GP involvement and identify barriers to collaboration with other professionals. Raising awareness among society and GPs about the importance of follow-up care for offenders is crucial, along with providing additional training for doctors. Communication skills training for dealing with both perpetrators and victims of sexual violence should be integrated into medical education. GPs should also be familiar with relevant legislation regarding sexual assault. Regional guidelines and agreements could facilitate cooperation between care providers and ensure comprehensive support for offenders during rehabilitation.

SAMENVATTING

Achtergrond: Seksueel geweld wordt gedefinieerd als het aangaan van seksuele activiteiten met een persoon die daar geen toestemming voor geeft of die niet in staat wordt geacht om toestemming te geven. Om het probleem van seksueel geweld effectief aan te pakken, is het van cruciaal belang om niet alleen te focussen op de slachtoffers, maar ook op de daders. Na het uitzitten van hun gevangenisstraf hebben plegers van seksueel geweld passende follow-up en ondersteuning nodig om herval te voorkomen en hun succesvolle re-integratie in de samenleving te bevorderen. Het doel van dit onderzoek is om een systematische review uit te voeren over welke rol de huisarts kan spelen in de follow-up van daders van seksueel misbruik die de gevangenis verlaten.

Methoden: Deze systematische review wordt uitgevoerd volgens de richtlijnen die worden aanbevolen door de Preferred Reporting Items of Systematic reviews and Meta-Analyses (PRISMA). Er zijn bij het schrijven van dit artikel ook enkele informatieve websites gebruikt. PubMed (Medline), Embase, Web of Science en Google Scholar zijn systematisch doorzocht voor het vinden van relevante artikels. The Critical Appraisal Skills Programme (CASP) checklist werd gebruikt om de geselecteerde studies te beoordelen.

Resultaten: In deze review zijn 25 artikelen opgenomen. We deelden de resultaten in in volgende thema's: *'Risicofactoren voor recidive en de schalen om deze risicofactoren in te schatten', 'Oplossingen of methoden om recidive te voorkomen en de effecten van deze therapieën', 'Voorwaarden en knelpunten voor adequate begeleiding', 'Beschikbare hulp in België voor plegers van seksueel geweld', 'Welke rol kan de huisarts spelen in de opvolging?'*. Eerst worden de risicofactoren besproken die bijdragen tot de herhaling van crimineel gedrag, met name gericht op zedendelicten, evenals de instrumenten die worden gebruikt om deze risico's te beoordelen. Vervolgens wordt ingegaan op de individuele, relationele, gemeenschaps- en maatschappelijke elementen die herval beïnvloeden, samen met dynamische en statische risicofactoren. Daarnaast worden verschillende therapeutische interventies belicht die gericht zijn op het voorkomen van terugval, waarbij het belang van op maat gemaakte benaderingen wordt benadrukt en onderliggende psychologische problemen worden aangepakt.

Ook worden de uitdagingen onderzocht die gepaard gaan met de re-integratie van daders in de samenleving. Hier wordt de nadruk gelegd op de behoefte aan gespecialiseerde behandelingsprogramma's en gemeenschapsondersteuning. In België bieden initiatieven zoals het COSA-project begeleiding en ondersteuning aan mensen die betrokken zijn bij zedendelicten.

Ten slotte wordt ook de potentiële rol van huisartsen bij het ondersteunen van delinquenten na de vrijlating besproken.

Conclusie: Huisartsen zouden een belangrijke rol kunnen spelen bij de follow-up van daders van seksueel geweld na de vrijlating, vanwege hun toegankelijkheid en vertrouwde patiëntrelaties. Er is echter meer onderzoek nodig om de effectiviteit van de betrokkenheid van huisartsen te beoordelen en belemmeringen voor samenwerking met andere professionals te identificeren. Het vergroten van het bewustzijn onder de samenleving en huisartsen over het belang van nazorg voor daders is van cruciaal belang, samen met het bieden van aanvullende training voor artsen. Training in communicatievaardigheden voor het omgaan met zowel daders als slachtoffers van seksueel geweld moet in het medisch onderwijs worden geïntegreerd. Huisartsen moeten ook bekend zijn met de wetgeving rond seksueel geweld. Regionale richtlijnen en overeenkomsten kunnen de samenwerking tussen zorgverleners vergemakkelijken en zorgen voor integrale ondersteuning van daders tijdens de revalidatie.

BACKGROUND

Sexual assault is generally defined as engaging in sexual activity with a person who does not consent or who is considered incapable of consent.[8, 12] Acts that are subject to criminal penalties vary by culture and region. These acts include, but are not limited to, sexual assault, incest, rape, pedophilia, and designing and visiting sites of child sexual abuse (CSA).[10,13]
Unfortunately, sexual crimes are not uncommon in society. Sexual crime is a pervasive international problem, and its prevalence is relatively high. The prevalence of rape is comparable to that of child sexual abuse, with most studies reporting a prevalence of 15%. Research on the prevalence of sexual crimes is often based on official statistics, which are known to be underreported.[12, 13]

In Belgium 64% of the Belgian population, between the ages of 16 and 69, have been victims of some sort of sexual violence. But only 4.5% of those victims file a complaint with the police. The prevalence of sexual misconduct and sexual violence is therefore extremely high. This issue pertains to all ages and all levels of society. Everyone is vulnerable to sexual violence: old or young, poor or rich, white or black, man or woman. For acute sexual violence, victims in Belgium may seek assistance from the Care Centers following Sexual Violence. However, due to the lack of area-wide coverage currently in Flanders, it is not readily accessible to every victim. Furthermore, numerous helplines and chat systems exist for victims of non-acute sexual violence. In contrast to the victims, there is even less outpatient/residential assistance available for the perpetrators. Although this is very important in combating sexual violence.[30, 31]

Sexual assault is a serious crime that has a significant physical, psychological, and social consequence for the victims. In order to address the issue of sexual assault effectively, it is crucial to not only focus on the victims but also on the offenders. After serving their prison sentences, sexual assault offenders require appropriate follow-up and support to prevent recidivism and promote their successful reintegration into society. [11, 12, 13]

Several studies have already been conducted studying the risk factors of sexual violence recidivism and how to treat them through specialized therapy. Yet, few if any studies have been done that examine the role of the General Practitioner in the follow-up of convicted sexual abusers leaving prison.

The aim of this study is to perform a systematic review on which role the General Practitioner (GP) can play in the follow-up of sexual assault offenders who leave prison.

METHODS

This systematic review was carried out in accordance with the guidelines recommended by the Preferred Reporting Items of Systematic reviews and Meta-Analyses (PRISMA).[1]
First, the inclusion and exclusion criteria for selecting articles were defined (Table 1). Second, the appropriate keywords were chosen according to the aim of this article. Table 2 provides the search terms. PubMed (Medline), Embase, Web of Science and Google Scholar were searched for records related to 'What role can the GP play in the follow-up of sexual assault offenders who leave prison?'. Google Scholar was used as a search engine because the other databases yielded too few results. A search was also conducted through Prospero for ongoing reviews regarding the subject. The data search ended the 14th of October 2023.

After having removed the duplicates across the different databases, the articles were screened by title and abstract. Also, the reference lists of the selected systematic reviews were manually cross searched for additional relevant data. In addition, some informative websites were used to collect relevant data. The evaluation of the articles was conducted by a single reviewer, namely myself.

The Critical Appraisal Skills Program (CASP) checklist was used to assess the quality of the included studies (see Table 3). One reviewer assessed the quality of the included articles. Only studies of moderate to high quality were incorporated.

After thoroughly reading the selected articles, the relevant information for our article was extracted and then based on those results a subdivision was made into 5 themes:

1. Risk factors for recidivism and the scales to estimate these risk factors.
2. Solutions or methods to prevent recidivism and the effects of these therapies.
3. Conditions and difficulties for adequate guidance.
4. Available assistance in Belgium for perpetrators of sexual violence.
5. What role can the GP play in the follow-up?

Table 1: Inclusion and exclusion criteria

INCLUSION CRITERIA	EXCLUSION CRITERIA
Studies on both rapists and child molesters	Studies that look at sexual offenders from religious aspect
Studies that investigate different treatments, risk factors of recidivism	Studies that investigate the neurobiological dysfunction of sexual offenders.
Primary research, systematic reviews, meta-analyses	Studies that only investigate the effectiveness of a risk–need–responsivity (RNR)-based intervention
Language: English	Studies on sexual offenders of animals
Published between 2005-2023	

1. Liberati, A., Altman, D. G., Tetzlaff, J., Mulrow, C., Gøtzsche, P. C., Ioannidis, J. P. A., … Moher, D. (2009). The PRISMA statement for reporting systematic reviews and meta-analyses of studies that evaluate health care interventions: Explanation and elaboration. PLoS Medicine, 6(7).

Table 2: Search methods

DATABASE	SEARCH TERM	NUMBER OF SEARCH RESULTS
PUBMED	((**perpetrators of sexual violence) AND (follow-up)) AND (general practitioner)**	2 results
	(perpetrators of sexual violence) AND (general practitioner)	15 results
	(sex offenders) AND (general practitioner)	9 results
	((sexual offenders) AND (general practitioner)) AND (follow-up)	3 results
	(**child molesters) AND (general practitioner)**	2 results
	(child molesters) AND (follow-up)	46 results
EMBASE	**follow-up prison child abusers' OR (('follow up'/exp OR 'follow up') AND ('prison'/exp OR prison) AND ('child'/exp OR child) AND abusers)**	6 results
	physical AND ('follow up'/exp OR 'follow up') AND ('child abuse'/exp OR 'child abuse') AND ('correctional facility'/exp OR 'correctional facility')	3 results
	sexual AND follow AND up AND ('child sexual abuse'/exp OR 'child sexual abuse') AND ('correctional facility'/exp OR 'correctional facility')	5 results
	sexual AND follow AND up AND ('child sexual abuse'/exp OR 'child sexual abuse') AND prison	15 results
	physical AND 'follow up' AND ('child sexual abuse'/exp OR 'child sexual abuse') AND prison	2 results
WEB OF SCIENCE	**child abusers (All fields) AND prison (All fields) AND follow-up (All fields)**	6 results

GOOGLE SCHOLAR	**follow-up after leaving prison " child abusers"**	263 results (year 2017-2022)
	psychological follow-up child abuser	1 result (year 2017-2023)
	physical follow-up child molester	3 results (year 2017-2023)
	Effectiveness of sexual offender treatment	5 results (year 2017-2023)

RESULTS

The flow diagram of our search strategy is illustrated in Figure 1. The systematic search following the guidelines of PRISMA identifies 373 unique articles in total. Of these 373 articles, we excluded 344 records, based on their title and abstract. Thus, 41 publications underwent a full-text review. In total, 25 articles are included for qualitative synthesis.

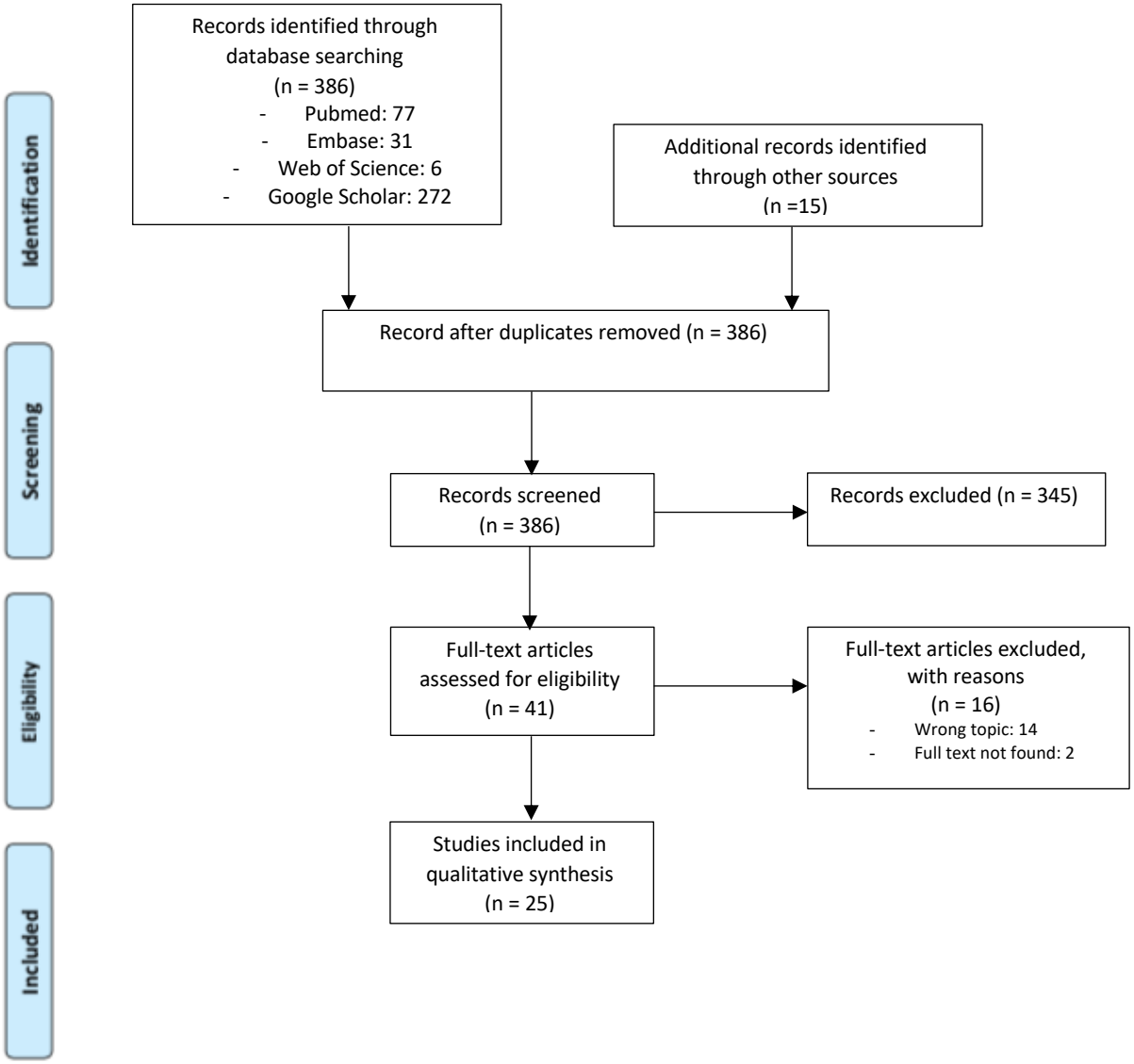


Figure 1. PRISMA Flow Diagram of selected studies

Table 3: Critical appraisal using the Critical Appraisal Skills Programme (CASP) Checklist for qualitative research

STUDY	**CASP-questions**										**Quality rating**
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	
Bates et al.	X	X	X	X	X	?	X	X	X	X	H
Nilsson et al.	X	X	X	X	X	X	X	X	X	X	H
Beggs et al.	X	X	X	X	X	?	/	X	X	X	M
McKillop et al.	X	X	X	X	X	X	/	X	X	X	H
Harkins et al.	X	X	X	X	/	/	/	X	X	X	M
Zara et al.	X	X	X	X	X	?	X	/	X	X	M
Culling et al.	X	X	X	X	X	X	X	X	X	X	H
Olver et al.	X	X	X	X	?	?	X	X	X	X	H
Lindegren et al.	X	X	X	X	X	X	X	X	X	X	H
Bingham	X	X	X	X	X	X	X	X	X	X	H
Cortoni et al.	X	X	X	X	X	X	/	X	X	X	H
Willis et al.	X	X	X	X	X	X	?	X	X	X	H
Barroso et al.	X	X	X	X	X	X	?	X	X	X	H
Collins et al.	X	X	X	X	X	/	?	X	X	X	M
Buttell et al.	X	X	X	X	X	X	X	X	X	X	H
Gilligan et al.	X	X	X	X	X	/	?	X	X	X	M
Lösel et al.	X	X	X	X	X	X	X	X	X	X	H
Pomp et al.	X	X	X	X	X	/	/	/	X	X	M

X=yes; /=no; ?=cannot tell.

H, high; M, moderate; L, low.

Table 4: Details of included studies.

TITLE	AUTHORS	YEAR	COUNTRY	PATIENT CHARACTERISTICS/STUDY INFORMATION
Intra- and extra-familial child sexual abusers and recidivism in Sweden: A 10- to 15-year follow-up study.	Nilsson, T., Carlstedt, A., Baudin, C., Jakobsson, C., Forsman, A., & Anckarsäter, H.	2014	Sweden	- N= 193, all men (intra-familial n= 143, extra-familial n= 50) who were convicted, from 1993 to 1997, for sexual crimes against a minor under 15 years old - 15 years follow-up
The psychology of criminal conduct.	onta, J. L., & Andrews, D. A.	2017	USA	- Overview of the theoretical context, major knowledge base of the psychology of criminal conduct, the eight major risk/need factors of criminal conduct and examine prevention and rehabilitation
Treatment gain for sexual offenders against children predicts reduced recidivism: A comparative validity study	Beggs, S. M., & Grace, R. C.	2011	New-Zealand	- N= 218, all men who completed a treatment program for sexual offenders against children - Released between 1993 and 2000 - Mean follow-up period 12,24 years - VRS:SO and SGAS scales used for risk assessment
Effectiveness of sexual offender treatment and reintegration programs: Does program composition and sequencing matter?	McKillop, N., Hine, L., Rayment-McHugh, S., Prenzler, T., Christensen, L. S., & Belton, .	2022	Australia	- N= 2407, all men - Released prison between 2010-2017 - Mean follow-up period 4,8 years
Fighting child sexual abuse: prevention policies for offenders.	Di Gioia, R., & Beslay, L	2018	EU	- Data from child sexual abuse prevention initiatives and programs
Assessment, management, and treatment of sex offenders: What is known, what is controversial, what needs further investigation.	Zara, G., Farrington, D. P., Freilone, F., & Lösel, F	2020	Italy	- Description of the advances in scientific and clinical evidence in the understanding of sexual offending - Treatment findings are explained, along with an introduction about which treatment pro- grammes work more efficiently, which are promising, and which do not seem to work, and why.

Table 4 (continued)

TITLE	AUTHORS	YEAR	COUNTRY	PATIENT CHARACTERISTICS/STUDY INFORMATION
*In*forming the prevention of child sexual abuse: comparing convicted offenders and minor-attracted persons	Culling, H.	2018	New-Zealand	- 3 groups of adult men (n_1= 21, n_2= 19, n_3 = 24) - Goal of the study: exploratory study that compares MAP with group of convicted child sex offenders
A Pilot Study of the Swedish Sexual Offender Treatment Program	Lindegren, S.	2022	Sweden	- N= 99, all men - Goal of the study: Is there change in criminogenic needs after participation in Swedish Sexual offender treatment program? - Mean age= 39 years
Sex Offender Treatment in Georgia: An Exploratory Analysis of the RNR Model and Provider Perceptions.	Bingham R.	2019	Georgia	- Qualitative study - 14 interviews - Goal: Provide insight as to whether sex offenders in Georgia are receiving treatment that meets the needs of the offenders
Sex as a coping strategy and its relationship to juvenile sexual history and intimacy in sexual offenders.	Cortoni, F., & Marshall, W. L.	2001	Canada	- N_1= 29 rapists, n_2= 30 child molesters, n_3= 30 violent nonsexual offenders - Mean age= 36 years - Purpose of the study was to test the hypothesis that sexual activity functions as a coping mechanism for sexual offenders
The quality of community reintegration planning for child molesters: Effects on sexual recidivism.	Willis, G. M., & Grace, R. C.	2008	New Zealand	- N= 81 - All men who completed the 32-week prison-based treatment program at the between 1990 and 2000
Are Juveniles Who Have Committed Sexual Offenses the Same Everywhere? Psychometric Properties of the Juvenile Sex Offender Assessment Protocol–II in a Portuguese Youth Sample.	Barroso, R., Pechorro, P., Ramião, E., Figueiredo, P., Manita, C., Gonçalves, R. A., & Nobre, P.	2020	Portugal	- N= 141 male adolescents who had been convicted of a sexual offense - Goal: examine the psychometric properties of a Portuguese version of the J-SOAP-II (Juvenile Sex Offender Assessment Protocol–II)

Table 4 (continued)

TITLE	AUTHORS	YEAR	COUNTRY	PATIENT CHARACTERISTICS/STUDY INFORMATION
Community Intervention with Sex Offenders: Do Dynamic Risk Factors Change with Treatment?	Collins, E., Peters, L., & Lennings, C.	2009	Australia & New Zealand	- N= 33, all men, who had commenced the program from August 1996, and had dropped out of, or completed treatment up to early 2007 - Mean age= 44,2 years -
Exploring levels of moral development among sex offenders participating in community-based treatment.	Buttell F.	2008	USA	- N= 77, all men, arrested in Tuscaloosa County, Alabama, and ordered by the court into a community-based sex offender treatment program - Mean time in treatment= 22 months
Community Supervision of the Sex Offenders: An Overview of Current and Promising Practices.	Gilligan L, Talbot T.	2000	USA	- Goal: To provide an overview and discussion of emerging practices and lessons in communities across the country in the management of sex offenders under community supervision.

We divided results into the following themes:

1. Risk factors for recidivism and the scales to estimate these risk factors.
2. Solutions or methods to prevent recidivism and the effects of these therapies.
3. Conditions and difficulties for adequate guidance.
4. Available assistance in Belgium for perpetrators of sexual violence.
5. What role can the GP play in the follow-up?

Risk factors for recidivism and the scales to estimate these risk factors.

In included articles, two types of approaches are used in the division of risk factors for recidivism. First, there is the division according to four levels: individual, relational, community and societal. The risk of recidivism can be approached at these four levels.
At the individual level, factors like age, education, income, substance use, and history of abuse are identified as potential risk factors for relapse into criminal behavior. [3, 8, 11, 13, 15] Also, the impact of hypersexuality is a significant clinical problem and a potent predictor of relapse in sexual crimes.[2, 12] Moreover, the concept of locus of control is important, noting that individuals who attribute their behaviors to external factors are at an increased risk of relapse.[12] Cognitive distortions, encompassing beliefs that blame or justify offending behaviors, are highlighted as cognitive patterns that may contribute to recidivism. Empathy deficits are discussed too as a prevailing theme among sex offenders, particularly concerning their lack of compassion or sympathy for their victims.[2, 10, 11, 12]

The relational level explores how a person's closest social connections, including peers, partners, and family, can exert considerable influence on their conduct.[8] Social needs emerge as a critical theme. There is the challenge faced by released sex offenders in establishing social support networks. Furthermore, the discussion extends to attachment issues, pointing out that problematic intimate relationships can serve as risk factors for relapse in sexual crimes.[2, 11, 12, 13] Loneliness is also consistently associated with sexual recidivism.[11] Relationship disruptions, often causing distress, are explored as potential triggers for seeking solace in risky behaviors, particularly in the realm of sexual conduct.[10]

Community factors, encapsulating the settings where social relationships unfold such as schools, workplaces, and neighborhoods, are considered as contributors to or buffers against recidivism.[3, 8, 13,15]

Additionally, societal factors, ranging from cultural norms to broader social policies, are acknowledged for their role in fostering an environment conducive to criminal behavior.[8]

Secondly, a distinction is made between dynamic and static risk factors. Dynamic risk factors underscore the importance of targeting changeable elements in offender treatment programs. Stable dynamic factors such as sexual interests, distorted attitudes, intimacy deficits, and self-regulation problems are identified as potential intervention targets. Acute dynamic factors, which change rapidly and may precipitate recidivism, include negative mood, substance abuse, anger, hostility, and victim access.

Static risk factors, derived from an individual's offense history, encompass the number of prior convictions for sexual offenses and early onset of offending.[2, 4, 5, 7, 10, 11, 12, 13, 14, 15]

Above mentioned dynamic risk factors are aligned with the "Central Eight" classification, comprising antisocial history, personality patterns, pro-criminal associates and attitudes, substance abuse, family/marital deficits, deficits in school/work, and deficits in leisure/recreation.[4, 12]

For the individual, relational and dynamic risk factors, there is a possible role for the GP, which will be discussed further in the discussion.

Various scales are constructed for estimating the risk of recidivism, such as the Violence Risk Scale Sexual Offender version[5, 11], Standard Goal Attainment Scaling[5], STABLE 2007[9, 11], Sex Offender Needs Assessment Rating (SONAR)[9], Static-99[9, 13], and SOTIPS[11]. These scales serve as valuable tools for comprehensive risk assessment, offering insights into psychological and behavioral aspects that inform treatment decisions, guide prevention efforts, and contribute to effective policy making. The overarching idea is that a nuanced understanding of these risk factors and their integration into treatment plans, is crucial for the treatment of sexual abusers.[9]

Solutions or methods to prevent recidivism and the effects of these therapies.

There are a variety of solutions and methodologies geared toward the prevention of recidivism, offering nuanced insights into the effects of therapeutic interventions. The fundamental premise is that tailoring effective supervision methods and treatment strategies requires an in-depth understanding of the unique risk and needs of each offender.[13]

The RNR (Risk-Need-Responsivity)[4, 9, 12] model takes center stage as a pivotal framework underlying many offender rehabilitation programs. It places a significant emphasis on risk management and the proactive prevention of recidivism.

In contrast, the Good Lives Model (GLM), classified as an intensive treatment approach, distinguishes itself by prioritizing the enhancement of offenders' lives. The GLM revolves around accentuating individual strengths and values, including life, education, play, work, independence, inner peace, friendship, community, spirituality, happiness, and creativity.[2, 15, 21]

Substantiated by numerous studies, the potency of cognitive-behavioral therapy (CBT) demonstrating its pronounced impact on reducing recidivism.[2, 6, 9, 11, 12, 13] CBT, characterized by the restructuring of attitudes towards sexual behavior, the cultivation of empathy for victims, comprehension of the consequences of abusive behavior, and the management of sexual obsessiveness, stands out for its substantial efficacy in producing reductions in recidivism among treated offenders compared to untreated ones.[9, 13]

Critical elements for therapeutic success are meticulously examined, encompassing the frequency, duration, and quality of the therapeutic alliance.[12] Early reintegration planning during incarceration emerges as a strategic imperative[6], with the allocation of the most intensive treatment resources directed towards high-risk offenders.[7] The correlation between self-esteem enhancement and goal attainment, coupled with reductions in deviant arousal, is underscored as a noteworthy factor in the rehabilitative process.[7]

Numerous strategies are discussed in the literature that reduce the risk of recurrence. Thus, proactively addressing dynamic risk factors is a critical strategy to prevent future offending.[10] Also, the introduction of the Relapse Prevention Model adds a layer of sophistication, merging behavioral and cognitive components to equip individuals with anticipatory and coping skills.[2, 10] Furthermore, a particular focus on empathy enhancement within sex offender treatment programs is important, recognizing its importance in treatment of attachment issues and empathy deficits.[10, 11]

Medical interventions, especially physical castration, are then scrutinized. There is a warning that a reduction in sexual drive, a potential outcome of such interventions, does not necessarily translate into a behavioral transformation.[13] Therefore, a combination with behavioral therapy is always necessary.[16]

The pre-treatment evaluation is also mentioned as essential. Risks and needs are examined through a careful examination of the perpetrator's social and sexual history. After this, treatment ideally proceeds in two separate phases, namely the active phase and the maintenance phase, each tailor made to the results of the pre-treatment evaluation.[13] It is the maintenance phase in which the GP can play a role. This will be discussed later.

To set up a successful treatment, a large number of stakeholders must be involved, such as the police, psychologists, lawyers, judges and family members. They can be considered as it were, community-oriented interventions.[17] This collective effort aims to support community monitoring plans and helps identify potential risk factors, providing a holistic approach to offender reintegration and risk reduction.[18, 19]

Conditions and difficulties for adequate guidance.

There are several conditions and challenges associated with the successful reintegration of individuals with a history of sexual offending.

First, therapists must be specialized in addressing/treatment of[2, 12] participants' sexual self-regulation. The personal style and ability to establish a therapeutic alliance is a very important element in delivering effective treatment. An empathetic, respectful yet resolutely challenging therapeutic approach is recommended, avoiding aggressive confrontational methods. The therapist's experience working with sexual abusers positively influences therapy outcomes.[7]

Subsequently, the treatment of sex offenders is inherently complex. Given the varying risks and heterogeneity of the offender population, there is a need for different intervention programs. Characteristics of the offender, such as age, persistence and risk level, have a significant impact on treatment participation, completion and success.[9] Therefore the combination of tailored treatments with reintegration programs is very important. Also, immediate support after release from custody is crucial. After all failure rates are highest during this period.[6]

In addition, the type of treatment (group versus individual) and the place where the therapy takes place (community or prison) play an important role in the success of the therapy.

It turns out that, treatments that include at least partially individualized modules, are more effective.[9] On the other hand, having different types of perpetrators in the same group can be useful to prevent collusion. Nevertheless, caution is advised with standardized 'one size fits all' treatments.[2, 9, 20]
After all, research shows that treatment interventions are most effective when they are tailored to the offender's abilities, skills, and learning styles.[2]
Furthermore, treatments provided in the community tend to be more effective than those provided in prison.[9]

No less important is the internal responsiveness of the sex offenders. It concerns the motivation of the perpetrator to participate in treatment. This is crucial and so depends on the perpetrator's willingness to change.[7, 9, 20] Positive approaches aimed at improving skills, developing prosocial attitudes and increasing self-esteem are proposed to maximize the benefits of maximize treatment. So, it turns out that preparatory programs before treatment can reduce resistance to treatment and increase motivation.[7]
A factor in treatment that should not be underestimated, is denial. Denial is a common response among sex offenders and is seen as a dynamic process. Effectively addressing denial is important in the treatment of sex offenders.[9]

In addition, social acceptability contributes to the prevention of inappropriate behavior. But the existence of sex offenders in communities suggests that social influences, acceptability concepts, and fear of judgment are not sufficient to prevent offending.[10]

Taking the foregoing into consideration, lack of trust, poor treatment experiences, negative interactions with therapists, training of therapists and difficult access to treatment (distance, private transport) are indicated as potential barriers to perpetrators' success.[13]

An important observation is that individuals who underwent therapy, had about half the relapse rate of those who did not. In addition, a ten-year follow-up research demonstrates that rapists generally have a higher risk of relapse than child molesters.[2, 5, 9, 13] This suggests a greater need for intensive treatment for rapists.

Available assistance in Belgium for perpetrators of sexual violence.

What services are available in Belgium to assist perpetrators of sexual violence? The University Forensic Center's (UFC) social map[25] offers a comprehensive overview of organizations across different provinces in Belgium. It outlines the conditions for initiating therapy and provides brief explanations of how the therapy process works. Examples of these services include Fronta, Forensic Ambulatory Support Team, FINIS, I.T.E.R., and CAW.

Additionally, Belgium has been participating in the international COSA project for several years, primarily in Brussels and Antwerp. The COSA circles, relying on a pool of volunteers, have demonstrated long-term success in reducing relapses among individuals they guide. The project aims to support perpetrators of sexual offenses in their societal reintegration, ensuring a prevention of inappropriate behavior. Importantly, COSA offers free coaching for individuals involved in sexual offenses.[22,24]

The Flemish strategic plan for assistance and services to detainees and internees[23] is undergoing revision and is expected to be completed by 2025. The revised plan will give specific attention to target groups, including perpetrators of sexual violence. Recognizing the importance of preventing relapses and protecting potential victims, the plan emphasizes the necessity of investing in the guidance of perpetrators of sexual violence, even within the prison system. There are considerations for initiating COSA guidance within prisons and exploring multidisciplinary approaches to care, all aimed at reducing recidivism rates among individuals involved in sexual offenses.

What role can the GP play in the follow-up?

In the studies that have already been conducted, little or no research has been done into what the role of a general practitioner can be in the follow-up and guidance of perpetrators of sexual violence who leave prison. The studies mainly concern specialized guidance by therapists trained in that specific subject. However, the GP can also play an important role in this. The role of the GP will be discussed below.

DISCUSSION

This systematic review explores various facets of sexual violence, encompassing its definition, prevalence, and the multifaceted challenges associated with addressing this pervasive issue.

A crucial aspect of this review is the exploration of the potential role of General Practitioners (GPs) in the follow-up of sexual assault offenders' post-release. Let's look at this role from the 7 areas of competence according to the CanMeds roles: the medical expert and decisionmaker, the communicator, the collaborator, the manager, the health advocate, the scholar and the professional.[26] These competencies will be discussed separately depending on the possible role that the GP can play in the follow-up.

The GP as the medical expert and decisionmaker. GPs can play a crucial role in the follow-up of sexual assault offenders who leave prison by providing comprehensive healthcare services. These services may include regular check-ups, screenings for sexual transmitted infections and mental health assessment. The Health Advocate competency role is also part of this. The GP recognizes the psychosocial, economic and biological aspects that influence the patient's health. These aspects are also risk factors for recidivism, making them essential to recognize.

The GP as the communicator. The step of consulting your GP is much more accessible than going to a psychiatrist or psychologist. The GP also already has a relationship of trust with the patient, or this can be built up in a short time. Because the GP knows their patients well, they can intervene more quickly when things are not going well on an individual and/or relational level. This is because the GPs are trained in communicating appropriately with the patient and in adopting an empathetic attitude. It should be noted here that with the increase in group practices, where patient can be seen by multiple doctors, this communication aspect must be viewed in a more nuanced manner. Because building a relationship of trust is so important, an agreement must be made within the group practice that the patient is always seen by the same doctor. This must be done in consultation with the patient. After all, the patient has the right to choose his own healthcare provider. Yet, this hopping from one doctor to another, indicates a lack of motivation, an important factor in preventing recidivism, as discussed in the results.
A second point of nuance is that, during their training, doctors are provided with tools during their training to communicate appropriately with victims, although here also, this communication is still a challenge. But GPs are certainly not trained properly in dealing with the perpetrators.

The GP as the collaborator. The directing role the GP can play in the multidisciplinary treatment of the perpetrator is very important. The general practitioner mainly plays a role in adequately referring the patient to the various organizations that exist and in the follow-up during that guidance. They can actively participate in case conferences and contribute their medical expertise to inform the development of individualized treatment plans and risk management strategies. This is especially important in the maintenance phase.[13]

The GP as the manager. This management competency should enable the doctor to organize his/her work in such a way he/she can spend sufficient time in listening adequately to the patient and to provide appropriate help. This "help" also includes the administrative tasks of referring to and consulting with paramedics in connection with the patient.

The GP as the scholar. The GP has always to evaluate his personal learning needs and has always to gain insight into the methodology of clinical and scientific research. Since knowledge about follow-up of sexual assault offenders is not assumed to be present among GPs, further training in this matter will be necessary.

Finally, the GP as the professional. The GP provides patient care in an honest and ethical manner. In other words, the doctor always has to adhere to the professional, ethical and legal codes to which he/she commits. This also means adhering to his/her medical confidentiality.

Many concerns can be made.

Some important side notes must be made on the paragraph above.
First, when the CSA takes place in the home environment, which is the case with incest, an additional problem may arise here. In this case, the whole family can be involved. Because the GP is mostly the "family practitioner", it becomes difficult to treat or provide psychological support to the entire family (brothers, sisters of the victim, partner of the offender…). Referral to a family therapist seems then most appropriate.
Second, the perpetrator and the victim can also, regardless of the problem of incest, both be patients of the same GP. Both, doctor and the two patients involved, must decide whether they are comfortable with the doctor treating them both. Both parties have the right to either terminate or enter a relationship.[28] If the GP feels capable of treating neutrally both perpetrator and victim and perpetrator and victim have no problem with this, then this should be possible. If the latter is not the case, the GP can refer the perpetrator to a GP who has received further training for this.
A final but not unimportant comment concerns the question "What if the perpetrator commits again a sexual offense during his treatment?". Legally, the GP has the right to remain silent, and has no obligation to speak. When both perpetrator and victim are receiving guidance from the same GP, and the perpetrator commits another sexual offense against the victim and the victim confides in the GP about this, it is the task of the GP to first motivate the victim to take the necessary legal steps him-/herself. If the victim does not dare/ cannot do anything him-/herself, the GP may waive his professional secrecy and report the offense. This must happen in consultation with the victim.[32] The GP will have to make a difficult decision between, on the one hand, abrogating professional secrecy and so maybe damaging the relationship of trust with the perpetrator and, on the other hand, not reporting the offense and so endangering the relationship of trust with the victim.

Not all competency roles necessary in this matter, are taught in medical lead-ups. A recent study also shows that general practitioners are already swamped with work.[27] Therefore, it seems useful to provide additional training of all GPs who are interested in this matter. This will ensure a pool of doctors to refer to if necessary. This can be compared to the organization of the LEIF doctor training in the context of end-of-life guidance.[29] It should this time focus on training and education in relation to sexual abuse. Knowledge about the existence of this pool is also important here.

The GP will sooner be able to play an important role in the maintenance phase rather than in the acute phase. After all, in the acute phase, the focus must be on intensive therapy provided by well-trained therapists, as discussed in the results.

Finally, there is not an appropriate or sufficient offering of specialized offender support in every region. The offer is too limited, especially for the high-risk group. Access to regular care is not always easy for sex offenders. This is because it is often thought that all sex offenders have a high risk of recidivism. The latter is not always the case. It has been scientifically proven that only am minority reoffends and that with targeted evidence-based offender therapy, this group can be reduced even further. A tailormade treatment can be proposed through risk assessment with the right instruments. In this way, an adapted offer can be available for each offender who returns to society.30 After all, entering treatment is a condition for granting conditional release. It is in our interest that all sex offenders are treated. Having the perpetrator treated in the acute phase by a psychiatrist and therapist and calling the GP for follow-up, may be an option here. Guidelines and agreements at regional level should then guide this collaboration between the professionals involved.

Limitations

This systematic review on the role of General Practitioners (GPs) in the follow-up of sexual assault offenders faces certain limitations that need careful consideration.

Firstly, the prevalence of sexual crimes is often underestimated due to underreporting. This raises concerns about the validity of conclusions drawn from official verdicts.[12] Additionally, a significant gender bias exists in the samples of existing studies, primarily including male subjects, and thereby limiting the representativeness of findings to the broader population.[10]

Moreover, the absence of prior studies examining the specific role of GPs in the post-prison follow-up of sexual abusers highlights a crucial gap in the existing research. While insights are drawn from studies related to the guidance of sexual abusers, the direct examination of the GPs role is notably lacking.

Further research is needed to address these limitations and increase understanding of GPs and their role in the prosecution of violent offenders. Therefore, the impact of GP involvement on readmission rates, mental health outcomes and successful community integration, should first be studied.

Comprehensive research should explore the specific knowledge and skills that clinicians need to meet the complex needs of this population. Understanding the skills required for effective intervention is essential to optimizing GPs' contribution to offender rehabilitation.

There is also lack of studies on the hindering and/or facilitating factors between GPs and other professionals involved in the prosecution of violent offenders. Exploring these dynamics is important in developing a multifaceted approach to offender rehabilitation.

This study indicates the importance of identifying the risk factors of recidivism and working on them during therapy supervised by well-trained therapists.

The already existing authorities are also discussed.

Future studies should investigate the sustained role of GPs in providing ongoing support and monitoring to offenders beyond the initial post-release period.

Addressing these knowledge gaps through rigorous research endeavors is crucial for the development of evidence-based practices and policies in the follow-up of sexual assault offenders by GPs. A comprehensive understanding of these dynamics will contribute to more effective strategies for the rehabilitation and reintegration of sexual assault offenders into society.

CONCLUSION

The systematic review highlights the potential role of GPs in the follow-up of perpetrators of sexual violence after their release from prison. It emphasizes the accessibility of the GPs and the trust-based relationship GPs have with patients, suggesting that they can play a directing role in multidisciplinary treatment and risk management strategies. However, further research is needed to assess the effectiveness of GP involvement and explore barriers to collaboration between GPs and other professionals. Addressing these gaps is crucial for improving offender rehabilitation and reintegration into society.

Sensitizing society and GPs to the problem of follow-up for perpetrators by GPs, is also still an underdeveloped area. Doctors must become aware of the fact that they can also play a role in this area. Society must also be aware of the idea that the GP can play an important role in preventing recidivism, provided that they have completed additional training for this purpose. It lowers the threshold for both perpetrators and victims.

As mentioned in the discussion, future GPs are not trained in communication skills with perpetrators of sexual violence. This is a vacuum in the medical education that needs to be filled. Although attention is paid to training in communication with victims of sexual violence, these communication skills need to be trained even more intensively, given the delicate nature of this problem.

Given that in the event of sexual assault, the GP is confronted with a patient who has committed a criminal act, the GP must be well informed about the relevant legislation.

Finally, regional guidelines and agreements could streamline cooperation between different care providers and ensure that perpetrators receive comprehensive support during their rehabilitation process.
The legal system also can play an important role in reducing recidivism. Emphasizing and legally requiring appropriate supervision as a condition for conditional release, can promote successful reintegration of offenders. If the risks of recidivism have been properly identified with the right instruments, appropriate treatment can be possible for every offender (released early or not).

ACKNOWLEDGMENTS

I would like to thank Prof. Keygnaert Ines, dr. De Schrijver Lotte, dr. De Bliquy Melissa and Annemieke Servaes for their contributions.

CONFLICT OF INTEREST

None.

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