

**Submission
No 13**

SENTENCING OF CHILD SEXUAL ASSAULT OFFENDERS

Organisation: The Royal Australian and New Zealand College of Psychiatrists
Date Received: 02/05/2014

30 April 2014

Mr Tony Grant MP
Chair
Joint Select Committee on Sentencing of Child Sexual Assault Offenders
Parliament of New South Wales
Macquarie Street
SYDNEY NSW 2000

By email to: childsexualoffencescommittee@parliament.nsw.gov.au

Dear Mr Grant

Re: Amending RANZCP submission to Joint Select Committee on Sentencing of Child Sexual Assault Offenders

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) wishes to amend our submission made on 25 February 2014 to the Joint Select Committee on Sentencing of Child Sexual Assault Offenders.

The RANZCP has received further advice on the issues covered in the submission from our membership and seeks to amend the document to reflect this advice. The RANZCP also requests that this amended submission replace the existing submission on the Committee's webpage.

The amended submission is attached to this email. If you would like to discuss this matter, please contact Dr Anne Ellison, General Manager, Practice, Policy and Projects via

[REDACTED]

Yours sincerely

[REDACTED]

Dr Murray Patton
President

Ref: 3577

Introduction

The Royal Australian and New Zealand College of Psychiatrists welcomes the opportunity to respond to the *NSW Joint Select Committee on Sentencing of Child Sexual Assault Offenders*. This submission is divided into topic areas that reflect Terms of Reference (a) and (b), which are of most relevance to psychiatrists.

- a. Whether current sentencing options for perpetrators of child sexual assault remain effective;*
- b. Whether greater consistency in sentencing and improving public confidence in the judicial system could be achieved through alternative sentencing options, including but not limited to minimum mandatory sentencing and anti-androgenic medication.*

The areas covered in this submission includes

- information on sexual assault offenders and paedophilia
- the role of forensic psychiatrists in treating sexual assault offenders
- the different types of treatment used in this group
- the ethics of mandatory treatment
- the role of government in coordinating treatment services for sexual assault offenders

Key issue

The RANZCP does not support any proposals that include mandatory or compulsory biological treatments for child sexual assault offenders, as is suggested in Term of Reference b. The RANZCP's Code of Ethics states that psychiatrists shall seek valid consent from their patients before undertaking any procedure or treatment (The Royal Australian and New Zealand College of Psychiatrists 2010). Psychiatrists' involvement in the prescription of medication as set out in the Terms of Reference would therefore be unethical.

Sexual offenders and paedophilia

1. Child sexual assault offenders are a diverse group of people - not all child sexual offenders have a paedophilic disorder, which is a specific type of sexual deviant or paraphilic disorder. For a diagnosis of paedophilic disorder there must be at least six months of sexual fantasies, urges or behaviours towards a prepubescent child (aged 13 or younger). If the individual has acted on these urges, the child or children must be at least five years younger than the offender, who must be at least 16 years of age. The fantasies, urges or behaviour must cause the offender distress or the satisfaction of the paedophilia has entailed personal harm, or risk of harm, to children (American Psychiatric Association 2013).

2. Child sexual assault offenders may be opportunistic, may have severe personality dysfunction or a co-existing psychiatric disorder, or could be acting under the influence of alcohol and other drugs.
3. Prevalence of child sexual abuse is difficult to determine accurately. Because of the criminal sanctions against it, and the young age and dependent status of the child there are likely to be a number of unreported incidents (Fleming JM 1997). In Australia, the percentage of those who have ever experienced some form of sexual abuse, based on a range of studies, was estimated at 5.1% in males and 27.5% in females (Andrews G 2002).
4. The focus on child sexual assault offenders should be on treatment and rehabilitation which minimises the risk of re-offending – this is where the forensic psychiatrist has a role. Treatment of sexual deviance can take several forms, including biological and psychosocial.

Assessments and the role of forensic psychiatrists

5. Forensic psychiatrists may be trained in the assessment and management of sexual deviant disorders. The scope of their role in the issue of child sexual assault offences can come in two main forms: in providing expert opinion during legal proceedings and in a clinical capacity offering therapeutic treatment, including pharmacological treatment for child sexual assault offenders particularly if their offending relates to a mental health issue.
6. Individualised assessments of child sexual assault offenders are crucial to understanding the best course of treatment for these patients. Ensuring that each person is properly assessed will help understand their prospects for rehabilitation, and in turn, their likelihood of re-offending. Better rehabilitation ultimately means less risk to the community.
7. Another reason that individualised assessments are important is so that psychiatrists can properly assess the risks of these offenders and undertake a proper bio-psycho-social treatment plan which can be tailored to the needs of the patient.
8. Greater funding is needed to enable dedicated forensic psychiatry services for child sexual assault offenders, ensuring appropriate medical assessment and biological treatment options are offered where indicated, in order to augment currently offered psychological treatment. Augmentation with biological treatments has the potential to significantly reduce rates of further child sexual assault offending and protect children from future sexual harm where the person is engaged in treatment.

Biological treatments

9. The research base on effective treatments for sex-offenders is limited, as it is difficult to conduct trials on this cohort. However, available research does suggest that biological treatments are probably more effective than psychological treatments *alone* in treating sexual compulsion. Effective biological treatments to prevent sexual deviance can include options with minimal side effects, such as Selective Serotonin Reuptake Inhibitor (SSRI) medications, where studies have demonstrated their ability to reduce the frequency and severity of deviant fantasies (Greenberg D 1997).

10. More potent options include anti-androgen medications, which lower the level of testosterone. The most widely studied agent in sexual offenders is cyproterone. Studies have reported reductions in deviant sexual arousal in 300 men (Laschet U 1975). Studies have shown that anti-androgens can be effective in reducing re-offending post treatment (Thibaut F 2010). Further, a large study of 22,181 sexual offenders found that biological treatments, including hormonal medication showed larger effects in reducing sexual offender recidivism than psycho-social interventions alone (Lösel F 2005).
11. Cyproterone is the only anti-androgen subsidised under the Pharmaceutical Benefits Scheme in Australia for the treatment of sexual deviance. However a wide range of other hormonal treatments are available for judicious off-label prescribing in the Australian context.
12. While studies show that anti-androgens reduce recidivism in paedophiles, the issue remains of who is going to identify who needs the treatment. Evidence also shows that biological treatments such as anti-androgens are most effective when coupled a comprehensive package of care and psychological treatments.
13. Any proposals that involve the prescription of anti-androgens should involve endocrinologists, as these are drugs that influence the endocrine system.
14. Anti-androgens are drugs with significant potential physical side effects, including osteoporosis, cardiovascular disease, metabolic abnormalities, and gynaecomastia (Grubin D 2010). They are not drugs which treat mental illness; they decrease libido and thus decrease the likelihood of an individual acting on a sexual deviance (such as paedophilia).

The ethics of mandatory treatment

15. The RANZCP has serious ethical concerns about any proposed legislative changes that direct a medical practitioner to prescribe a drug which may have limited therapeutic benefit for some patients and have significant potential side effects.
16. The RANZCP's Code of Ethics states that psychiatrists shall seek valid consent from their patients before undertaking any procedure or treatment (The Royal Australian and New Zealand College of Psychiatrists 2010). Psychiatrists' involvement in the prescription of mandatory anti-androgens as set out in the Terms of Reference would therefore be unethical.
17. The prescription of anti-androgenic medication is a clinical decision and relies on medical knowledge and specific knowledge of the patient in question. There are strict controls on the use of anti-androgens, and there are very clear reasons why access is limited, usage is defined and responsibility for appropriate prescribing is left in the hands of medical professionals.
18. Mandating the prescription of anti-androgens has the potential to shift the doctor's focus from the best interests of the patient to one of public safety (Grubin D 2010). Further, consideration must be given to what happens when a person on a mandated course of anti-androgens is non-compliant with oral medication, or if the medication does not work for a particular individual. It is unclear whether any psychiatrists would be willing to be involved in mandated prescribing.

19. The Belgian Advisory Committee on Bioethics developed a list of conditions that should be met when considering treatment without consent for child sexual offenders (Belgian Advisory Committee on Bioethics 2006). While the RANZCP does not support hormonal treatment without consent, the list of conditions is instructive for the Select Committee when considering this issue (Belgian Advisory Committee on Bioethics 2006).

Psychological treatments

20. The mainstay of treatment provided for child sexual assault offenders in Australia and New Zealand is psychological treatment in the form of Cognitive Behavioural Therapy. These therapies are provided in custodial and community settings through Corrective Services NSW.
21. Corrective Services NSW does not routinely publicise sexual recidivism rates for child sexual assault offenders who have participated in psychological sexual offender treatment.
22. However, an evaluation of Corrective Services NSW Custody-Based Intensive Treatment (CUBIT) program found that well-implemented cognitive behavioural treatment could have positive side-effects on offending behaviour, potentially reducing recidivism rates in NSW (Woodrow A 2011).
23. One can estimate the effectiveness of psychological treatments from large-scale analyses drawn from international data. In the largest meta-analysis of 9,454 sexual offenders (Hanson RK 2002; Hanson RK 2009), the sexual re-offence rate was lower for the psychological treatment groups (12.3%) than those who did not receive psychological treatment (16.8%) (Hanson RK 2002).
24. Corrective Services NSW should regularly publish or make available to clinicians the recidivism rates for child sexual assault offenders who have participated in psychological sexual offender treatment. Doing so could provide valuable data on what treatments work for child sexual assault offenders and could inform treatment options and further research into the area.

Coordination of services

25. The role of government in the treatment of child sexual assault offenders must be considered. Clarification is required on which agencies would ensure that offenders stay on a mandated course of anti-androgens, and, if such a proposal was to be implemented, whether this responsibility would lie with the Corrective Services NSW or the NSW Ministry of Health.
26. The treatment of child sexual assault offenders is a shared responsibility between the justice sector and the health sector. Having a single arm of government deal with child sexual assault offenders is problematic, as the issue is multi-factorial and takes in scope justice, health, and mental health. If proper assessments and treatment of child sexual assault offenders is going to be effective, genuine cross-agency collaboration must take place.
27. Cross-agency collaboration is crucial to ensure that this patient cohort can be treated ethically and appropriately. However, care must also be taken to ensure that this information sharing does not erode patient confidentiality in any way. Good clinical

practice depends on patients feeling confident that whatever information they reveal will not be improperly used, and psychiatrists shall not do anything to undermine this confidence. If information must be obtained by other sources, psychiatrists shall seek to divulge only what is necessary in a given situation (The Royal Australian and New Zealand College of Psychiatrists 2010).

References

- American Psychiatric Association (2013). Diagnostic and statistical manual of mental disorders, 5th edition. Washington DC, American Psychiatric Press.
- Andrews G, G. B., Corry J (2002). "Child sexual abuse revisited." Medical Journal of Australia(176): 458-459.
- Belgian Advisory Committee on Bioethics (2006). Opinion no. 39 on hormonal treatment of sex offenders. Belgium, Federal Public Service: Health, Food Chain Safety and Environment
- Fleming JM (1997). "Prevalence of childhood sexual abuse in a community sample of Australian women." Medical Journal of Australia(166): 65-68.
- Greenberg D, B. J. (1997). "Treatment of the paraphilic disorders: A review of the role of selective serotonin reuptake inhibitors." Sexual Abuse: A Journal of Research and Treatment (9): 349-361.
- Grubin D, B. A. (2010). "Chemical castration for sex offenders: doctors should avoid becoming agents of social control." British Medical Journal(340).
- Hanson RK, B. G., Helmus L, Hodgson S (2009). "The principles of effective correctional treatment also apply to sexual offenders in a meta-analysis " Criminal Justice and Behavior **36** (9): 865-891.
- Hanson RK, G. A., Harris AJR, Marques JK, Murphy W, Quinsey VL, Seto MC (2002). "First report of the Collaborative Outcome Data Project on the effectiveness of psychological treatment of sex offenders." Sexual Abuse: A Journal of Research and Treatment(17): 169-194.
- Laschet U, L. L. (1975). "Antiandrogens in the treatment of sexual deviations of men." Journal of Steroid Biochemistry (6): 821-826.
- Lösel F, S. M. (2005). "The effectiveness of treatment for sexual offenders: A comprehensive meta-analysis." Journal of Experimental Criminology (1): 117-146.
- The Royal Australian and New Zealand College of Psychiatrists (2010). Code of Ethics.
- Thibaut F, D. F., Gordon H, Cosyns P, Bradford J (2010). "Guidelines for the biological treatment of paraphilias." The World Journal of Biological Psychiatry(11): 604-655.
- Woodrow A, B. D. (2011). ""Effectiveness of a sex offender treatment programme: A risk band analysis."." International journal of offender therapy and comparative criminology (55): 43-55.