Legislation in Victoria on sexual offenders: issues for health professionals

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ABSTRACT

- New legislation passed in Victoria (the *Serious Sex Offenders Monitoring Act 2005*) extends the role of doctors in managing and treating sex offenders.
- This legislation is not based on a solid understanding of the research evidence on treatment of sex offenders or on their risk of reoffending.
- The legislation creates ethical and professional dilemmas for health professionals through the conflation of legal control of offenders with the medical management of disorders of sexual preference.
- There is a critical need for research and funding in this area, rather than ever more oppressive laws, if governments are to be serious about treating sex offenders, rather than simply incarcerating them.

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The Victorian State Government has introduced legislation to provide for extended supervision of some sexual offenders. The *Serious Sex Offenders Monitoring Act 2005*[1] was enacted in June 2005. It permits an order to be made providing for up to 15 years of conditional supervision and "treatment" subsequent to the expiration of a criminal sentence or parole for a range of child sexual offences and bestiality (Box).

In the second reading, the Hon. Tim Holding, MLA, Minister for Police and Emergency Services, noted that:

> The deterrent effect of ongoing supervision, reduction of the offenders' exposure to environmental risk factors and ongoing access to treatment and support will deter the commission of further offences.[2]

Reducing child molestation is an admirable goal, and anything is welcome that might decrease the serious sequelae in its victims.[3] However, we hold significant concerns that the legislation can achieve this goal. We are also concerned about its compromise of fundamental legal and ethical principles. The legislation has been adopted with remarkably little debate or comment from interested professional bodies. It is not based on research evidence, relies on faulty appraisals of risk, encroaches significantly on personal autonomy and principles of justice, and potentially places doctors in a compromising, policing role.

The international context

Jurisdictions in a number of developed countries have enacted laws directed against child molesters, which provide for indeterminate sentencing, mandated treatment, community registration and protracted supervision beyond the duration of a sentence. For instance, the Queensland *Dangerous Prisoners (Sexual Offenders) Act 2003* was designed to allow continued detention in custody and supervised release of offenders seen at high risk of reoffending. It was upheld as valid on appeal to the High Court of Australia.[4]

These laws, often described collectively as "sexually violent predator" laws, are a controversial response to the public distress and media attention accorded to reoffending by convicted sex offenders.[5] However, despite the popularity of these laws, we are unaware of any research that has yet demonstrated that they actually reduce rates of sexual offending against children.

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The Victorian Act

The Victorian Act provides for extended supervision with conditions. Among its mooted requirements are that an "assessment report" be provided by a psychologist, psychiatrist or other prescribed health service provider (a very broad definition not limited to doctors and psychologists) (s. 7). Such a report must address "propensity to commit relevant offences in the future", and previous treatment and its effects (s. 8). The standard of proof required in the Act is "a high degree of probability" (s. 11(1)). The Adult Parole Board is empowered to direct that the offender fulfil conditions, including "treatment or rehabilitation programs or activities that the offender must attend and participate in" (s. 16(3)(d)), and courts involved may take into account "whether the offender cooperated … fully, in the preparation of an assessment report" (s. 34).

These requirements are similar to international sexually violent predator laws, although the Victorian Act does provide for procedural protection, including rights of appeal, and does not go as far as some other laws which, for instance, reverse the burden of proof (ie, require that the offender demonstrate that any risk has abated, rather than the onus remaining on the court to find that the offender continues to pose a high risk).[6] The Act is modelled on New Zealand legislation enacted in 2004. The cost of enforcing its conditions on a single offender has been reported as hundreds of thousands of dollars annually.[7]

As citizens, we welcome any measure which makes our children safer, but we question whether the Victorian Act will achieve this goal. Furthermore, we believe that it flouts fundamental principles of justice, in effect providing for offenders to be sentenced twice for the same crime and making them subject to legislation retrospectively. It also raises important ethical and professional issues for doctors. It conflates the legal control of offenders with the medical management of disorders of sexual preference and, in so doing, attempts to make health professionals the agents of a

The *Serious Sex Offenders Monitoring Act 2005* (Vic)[1]

- Requires some sexual offenders against children to be subject to supervision and treatment after release (an Extended Supervision Order).
- An assessment report by a psychologist, psychiatrist or other health service provider is needed for consideration of an Order.
- This report must address:
  - propensity to commit relevant offences in the future;
  - efforts made by the offender to address the causes of sexual-offending behaviour;
  - factors that might increase or decrease any identified risks; and
  - an assessment of risk that the offender will commit another relevant offence if not subject to an Extended Supervision Order.
- A court may make an Extended Supervision Order only if it is satisfied to a high degree of probability that the offender is likely to commit a relevant offence.
- The prosecution has the burden of proof.
- Conditions of the order may include:
  - attendance, reporting and electronic monitoring;
  - notification of changes of address, name or employment;
  - conditions of residence, curfews, and restrictions on movement, associations and employment; and
  - attendance and participation in treatment and the preparation of reports.
- The Order can be made for up to 15 years and is renewable, but subject to review.
- Breach of an Order may be punished by imprisonment of up to 5 years. ◆

particularly draconian form of social control. Doctors treating patients subject to the Act may be required to report non-compliance, thus facilitating incarceration.

Will this Act make our children safer?

What is the evidence for treatment effectiveness?

Most convicted child molesters will eventually return to the community. This is why effective management of those who might reoffend is so important. Treatment of sex offenders is usually psychological, using a cognitive behavioural framework. This includes cognitive restructuring, training in victim empathy and social skills, and relapse prevention. Increasingly, treatment is targeted towards specific deficits and is individualised, although it may be delivered in group settings.[8] Its effectiveness relies on proper assessment and the use of interventions justified by well constructed research evidence, which is as yet lacking.

A number of biological treatments are also currently used. These include specific serotonin uptake inhibitors, progestagens (eg, medroxyprogesterone), anti-androgens (cyproterone acetate) and gonatodotropin-releasing hormone agonists (eg, leuprorelin).[9] These medications seem to have efficacy in reducing sexual drive, deviant sexual arousal and problem sexual behaviours. Because of their side effects, their use tends to be limited to those at higher risk of reoffending.[10]

However, the evidence base for both types of treatment of sexual offenders is poor. Study populations have been either highly selected (eg, by severity of offence or imprisonment) or heterogeneous (eg, in predilection or offending rates). Psychological treatments are rarely manualised (that is, adherent to a specified methodology) or tested for integrity by blinded external raters. For biological treatments, the evidence generally comprises uncontrolled case series with small numbers and limited follow-up. Despite the extensive clinical experience with these medications, there is only limited empirical support for their effectiveness. Until more is known of their effects on deviant arousal and sexual recidivism, any legislative mandate for such treatment is both premature and clinically unjustified. There seems little interest at government or industry level in funding studies of interventions to reduce sexual offending. This may well correlate with the ease of introducing legislation to provide correctional solutions.

Who is at risk of reoffending?

Recidivism rates for sexual offenders are far lower than is popularly assumed. A meta-analysis of recidivism studies, acknowledging their generally limited periods of follow-up and reliance on reconviction rates (which underrepresent reoffending), suggests that the overall rate of sexual reoffending is 13.4%, which is much lower than for most other types of offending, such as theft and violent crimes.[11] Knowledge is expanding about the clinical indicators of increased risk of offending, which potentially enable targeted intervention for higher risk subgroups. Currently, large amounts of public money are expended on psychological treatments that we believe are of dubious benefit or may even be detrimental, for large numbers of sex offenders who are at very low risk of reoffending. At the same time, high risk offenders often go unrecognised and effectively untreated.

We do not believe that the Victorian Act will improve this situation. The Act requires a prescribed health service provider to assess the risk of reoffending. However, the range of people who might be defined as "prescribed" providers is uncomfortably broad and not defined by expertise or skill base. In addition, we believe that the tools currently available for assessment may be inappropriate for Australian use. A range of objective risk assessment scales are used in jurisdictions in North America and the United Kingdom.[12-14] However, these scales are based on actuarial data and focus on historical variables, without taking into account significant clinical and current variables (such as motivation or response to treatment), or variables which reduce offending risk (such as the advent of physical illness or frailty).[15] The resulting estimates of recidivism risk are subject to significant error.[16] Furthermore, these scales have not been normed for Australian use, particularly for subgroups such as Indigenous offenders. Our concerns about these scales are even greater given that they are to be used in legal forums, where they are prone to manipulation and misinterpretation. It must be remembered that "false positives" will result in detention on spurious grounds. Preventive detention is odious and affects classes of people rather than individuals. Some will be detained unnecessarily.

Ethical issues and role conflict

The role of clinicians under the Act is ethically contentious. Clinicians assessing risk of reoffending will be required to determine eligibility for continued coercive supervision, rather than being called on to inform treatment. Treating doctors may find treatment is subject to lower standards of informed consent, and the voluntariness of those subject to conditions of treatment is a vexed issue. In the United States, sexually violent predator laws

have often legislated for a reduced standard of informed consent — for instance, not requiring full explanation of side effects equivalent to usual practice — and have offered indemnity to doctors treating patients under these laws.[6] These indemnity clauses reflect the fact that doctors may not necessarily be acting in the best interests of their patients.

Of course, many psychiatric interventions are less than consensual and are provided under involuntary treatment legislation. However, these *civil* commitment laws do not provide for protracted incarceration in prison for failure to comply with treatment. Similarly, one could argue that doctors involved in assessments under such laws are executing the public health duties of medicine, or that the protection of the community warrants such incursions into individual autonomy. However, in a court such arguments substantially alter the duties of beneficence and non-maleficence which are integral to the practice of medicine. Doctors acting in legal forums should not be so easily seduced by the needs of the legal system.

The dual role of treating doctors under this legislation may also have detrimental effects on the therapeutic relationship. For those in treatment, the threat of being subjected to supervision laws is quite likely to discourage candid disclosure about the magnitude and nature of thoughts, impulses and behaviours, lest these be considered incriminating. These factors reflect that treating doctors may be viewed not as independent clinicians but increasingly as agents of supervision, social control and monitoring. Although a similar situation may arise under other legislation (eg, legislation on monitoring of infectious diseases and other public health issues), to our knowledge no other legislation has been so closely linked with the goals of justice rather than patient care. This shift in the ethical basis of practice warrants careful consideration and consultation. We are not aware that this has occurred in formulating the Victorian Act.

Conclusions

The introduction of legislation in Victoria to provide lengthy post-sentence supervision of some sex offenders is likely to set the tone for similar laws throughout Australia. It reflects an international trend for laws targeted at sex offenders, many of which involve doctors and clinical psychologists in non-therapeutic goals, such as monitoring and risk management. The roles of health professionals in assessment and treatment under the Victorian Act are contentious and at odds with existing standards of ethical practice. It is preferable for clinical staff to focus on treatment rather than policing, as the latter can be adequately, and ethically, undertaken by correctional staff responsible for ensuring compliance with legal orders.

Most importantly, the possibilities for effective treatment that will reduce sexual offending have once again been neglected. In part, the Victorian Act is a response to previous misdirection of resources. Those responsible for providing programs for sex offenders all too often rely on therapists who are not clinically trained psychologists and who are frequently unsupported by appropriate psychiatric input. Instead of developing, funding and evaluating community- and prison-based assessment and treatment programs, what is offered are claims of effectiveness based on no more than a hope and a prayer. This Act, far from making our children safer, may simply allow an unsatisfactory situation to continue.

There is a critical need for funding, training and research to clarify the effect of psychological and pharmacological interventions and to determine their effectiveness in achieving a popularly desired goal. However, to embed treatment in legislation is currently both controversial and premature. It is time to stop gambling with our children's safety and to develop sound evidence-based assessment and treatment programs for sex offenders, administered by properly trained and registered clinical psychologists and psychiatrists.

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Competing interests

None identified.

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