Recommandations on a draft bill "reinforcing prevention and repression of sexual offences against minors".

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The CCNE was consulted by Mr. Barrot and Mr. Gaymard on the subject of a draft bill "for reinforcement of prevention and repression of sexual abuse against minors and of offences against human dignity". As a first comment, the Committee can only approve efforts by the authorities to give better protection to a particularly vulnerable category of victims. However, the draft text does call for comment and recommendations and, on this score, the Committee intends to confine itself to that which it feels to be within its purview. It is not the task of the Committee to state its views on the draft's repercussions on law and penal procedure nor on medical deontology although it may be difficult in an analysis of the subject to avoid touching upon the periphery of these issues. The primary mission of the Committee is "to give opinions on ethical problems arising out of progress of knowledge in the fields of biology, medicine, and health, and to publish recommendations on these subjects". After reviewing scientific data available at this time, CCNE has considered the ethical aspects of the text submitted to it.

The draft for examination is based on an intricacy of instruments related to law, science, and medicine. The method's complexity as now proposed is illustrated by the expression "sentencing to medical and social aftercare".

Thus we find that a penalty, an authoritarian pronouncement, is enforced through therapy.

A requirement of this nature raises a host of problems which the present report seeks to analyse.

I - Summary of scientific data

Before investigating the issue of therapeutic prospects for sex offenders, some fundamental points relating to biology and physiology need to be kept in mind to gain a fuller understanding of indications and methodology.

A - Biology and physiology

Adult male sexuality, in its dual aspects of sexual and reproductive functions, depends largely on testicular secretion of androgens, testosterone in particular. Any impediment to the normal secretion of androgens impairs both these functions : libido, and erectile capacity, and therefore both sexual activity and potential fertility. The most extreme

example of androgen secretion deprivation is surgical castration which was in fact practised at the end of the previous century on perpetrators of sexual crimes (1), and which may still be performed nowadays for severe pathological conditions due to trauma or tumours. One of the principal biological signatures of male castration is the collapse of levels of circulating testosterone (3, 4, 5).

In modern times, certain substances are used therapeutically to considerably reduce testicular testosterone production by blocking, in the pituitary gland, secretion of the hormone which stimulates testosterone production by the testes. A typical product producing this effect is a GnRH agonist(1) (8,10,14,15,16). Medroxyprogesterone acetate (MPA) is a similar substance which also slows testicular androgen production because of its anti-gonadotrophic effect (12). Other substances act by competitive binding to the receptor sites for testosterone on target organs and thus inhibiting the effects of testosterone. Flutamide and Nitulamide are typical of such inhibition at target organ level.

Finally, further substances act in both ways; cyproterone acetate for instance (6, 7, 11).

Irrespective of the mechanism followed by the substance concerned, the net result is a drastic reduction of testosterone activity in order to arrive at the desired effect.

Hormonal management is based on a few simple principles.

Fundamentally, action is antiandrogenic. The permissive action of testosterone and of dihydrotestosterone on sexual behaviour is eliminated or reduced.

It is reversible and on cessation of treatment, hormonal functions are completely restored (which naturally puts an end to castration).

Duration cannot be predicted since symptom management is the aim. Only through interruption of treatment on a trial basis can improved behaviour be demonstrated.

Consent must be given once the patient is informed of possible or probable side effects, in particular on reproduction (temporary infertility).

All the products used aim at opposing the effects of androgens, but are of a different nature and act in different ways. Some of them are steroidal antiandrogens (Cyproterone acetate), or non-steroidal (Flutamide (Eulexine), Nilutamide (Anandron), Casodex), which act primarily on androgen receptors (intra-cellular) in target cells, and have the further effect of changing the level of testosterone concentration in the blood. These levels will have to be verified during treatment and they may be lowered with Cyproterone acetate which is very antigonadotrophic, or increased with the three other substances. Another possibility is to use agonist analogs or antagonists of GnRH, which act by suppressing the function of the pituitary receptor of this peptide, the result of which is to reduce the pituitary hormone LH and consequently lower testosterone, the level of which must again be verified. For some of these substances, a long acting form is available which may continue to be effective for several months. Antiandrogens acting on receptors can be taken orally whereas GnRH derivatives generally need to be injected.

This anti-androgen effect gave some therapists the idea that such products could be used to try and prevent the authors of serious sex offences from committing renewed acts of aggression, in particular the special category of deviants, so called "pedophiles", whose preferred or even exclusive sexual objects are children. A review of the problem has been published recently (9).

This kind of treatment was initially attempted in the 70s (2). Experience acquired over the years shows that a beneficial effect is generally achieved on deviant sexual behaviour in as much as sexual fantasies are considerably fewer and individuals undergoing treatment find that the possibility of sexual activity is notably reduced. Such individuals, who are habitually plagued by fantasies and sexual compulsions, can be liberated and appeased under the

influence of treatment so that they can stand back from their obsessions and invest in other types of activity. However, it is essential to emphasise that as soon as treatment stops, so does its effects. Once treatment is suspended, anti-androgenic effects recede following a timetable which depends on the pharmacology of the substance and frequency of its administration. At this point, a resurgence of sexual offences can be expected which demonstrates the fact that *such treatment is not curative, only seeks to control symptoms, and depends entirely on a reversible inhibitory effect on androgen hormonal secretions and/or on their effect on receptors.*

That being so, the fact remains that results and undesirable side effects differ according to what substance is used. An analysis of these differences should help to achieve more rational choices with due regard to indications and means of delivery.

Cyproterone acetate

With a medium dose of 100 to 150 mg per day (2 or 3 tablets per day)(2) , in about 80% of cases it is possible to attenuate sexual obsession, fantasies, compulsions, and reduce the number of erections, recourse to masturbation, frequency of orgasm, and achieve control of sexual behaviour.

An assay of plasma testosterone levels (which should be 0.5 to 1 ng/ml) provides a very accurate marker for treatment compliance and adequacy.

Effects are not immediate when treatment begins. Up to a month or six weeks should be allowed before their onset.

Undesirable side effects should be noted :

reduction of spermatogenesis

increased body weight and asthenia at high doses,

gynecomastia in 20% of cases

loss of body hair and reduced sebum production

When treatment ceases, sexual capacity and testosterone levels return to pre-treatment levels within a month. Return to normal of spermatogenesis takes longer, about 4 to 5 months.

Medroxyprogesterone acetate

The advantage is that this is a long acting injectable drug - IM injection every 2 or 3 months. Results are roughly equivalent to those of cyproterone acetate.

GnRH agonists

Testosterone reduction achieved is extreme, bordering on ablation of circulation testosterone rates. However, unlike antiandrogens, they have no effect on testosterone receptors. It is not therefore possible to achieve a dose-to-effect modulation as one can with products like cyproterone acetate, or others which have an exclusively antiandrogen effect.

Whichever treatment is used, these methods which have in common their ultimate antiandrogen effect, are beneficial to most patients as regards sexual fantasies and compulsions. But all of them suffer from the same drawback, i.e. when treatment ceases

biological and behavioural factors revert to pre-treatment conditions with consequent risk of relapse.

B - Psychological aspects

Generalities

It would be an absurdity to attempt a description of a typical sexual offender. All kinds of personalities are to be found amongst the perpetrators of sex offences. The kind of offence is just as varied ranging from "simple" exhibitionism to sex crimes including torture.

Sweeping statements to settle the controversy of whether sexual deviancy is or is not a disease would be just as absurd since in fact, every kind of situation is encountered and every kind of psychopathology. Some sex offenders are without any doubt mentally deranged(3) . The draft bill does not concern them since an expert will declare them irresponsible and they will be dealt with in a psychiatric environment.

Once the mentally deranged delinquents are excluded, one can consider that the rest of them are thought to be responsible for their actions, and therefore for that reason subject to the rule of law.

However, perhaps progress in the understanding of what controls or inhibits recourse to violence may in future allow for a less symptomatic approach.

Psychological treatment

There are many arguments in favour of offering psychological help and not just hormonal therapy to sex offenders. For that matter, some of them spontaneously ask for such assistance. There are many possibilities : individual therapy, group therapy, family therapy, behaviourist techniques.

But such treatment only makes sense if there is a true motivation and clearly positive desire for it on the part of the person concerned. In other words, this means that it is quite useless to embark on such therapy if the individual's consent is not sincere.

Furthermore, only a few publications report temporary improvement in pedophiles' behaviour. A project at the Institut Pinel in Montreal (13) suggests that what has been called the "Canadian" style of psychotherapy brings about a reduction in the percentage of pedophilic relapses after a year of therapy, but after the second year, there is a return to initial levels.

However, it would seem perfectly logical to offer dual therapy combining antiandrogens and psychotherapeutic support.

II - Ethical considerations

1. Generalities

Issues now being considered were in part examined in two previous Opinions delivered by the Committee : one, dated 24th October 1993, is on research in the sciences of human behaviour; the other, dated 7th December 1993, relates to the prescription of antiandrogen substances to prison inmates sentenced for offences of a sexual nature.

The first point to remember is that the object of this draft bill, by means of various modalities of judicial and/or medical treatment applicable to sexual criminals and

delinquents, is essentially the *protection of children* , and more generally minors less than 15 years old. This objective could be called secondary prevention since what is involved is to make best efforts to prevent sex offenders who have already been sentenced for punishable sexual activities from reoffending once they have served their sentence.

A further objective is to help the offender since the therapy provided to him also aims to improve his chances of regaining his place in society, in his family, and at work. These two objectives must be kept in mind whilst discussing ethical aspects.

2. Treatment viewed as a sentence

This duality does not allow for the traditional relationship between physician and patient.

Since our subject is a conviction, the relationship between physician and convict must also be considered. The convict is under obligation to undergo therapy, as though it were any other kind of conviction. The only degree of freedom allowed is to choose his attending physician (subject however to approval by the coordinating physician). This is the main difficulty : treatment, if that is what it is, is undertaken without due consent. From that point of view alone, one can wonder whether in ethical terms the text does not contradict one of the fundamental principles of health care.

It is clear that there is a significant deviation from the norm when the relationship between the patient (convict) and his physician is transformed by the fact that treatment is an obligation. The only choice while the sentence is being served is acceptance or returning to prison. Furthermore, the text should therefore be more specific and state clearly that sex offenders covered by the proposed bill would, once they have served their sentence, be confronted with an offer of prolonged therapeutic follow-up. However, the Committee understands that this attitude raises for doctors the serious issue of giving long term therapy - with a risk of momentous side effects - to individuals who, as far as we know, suffer from no identifiable somatic pathology.

3. Information given to the convict

It should include very specific medical data to be given only by the attending physician, regarding beneficial effects to be expected from treatment and how long it should be continued. In particular, information must be given on the subject of impairment of procreative capacity which is now known to be reversible, except that scientifically established facts regarding long term treatment are not available.

A medical and social sentence is for a limited time. This is also the case for any form of curative medical treatment. However, as regards antiandrogens (which aim to treat symptoms), the fact is that beneficial effects fade in the weeks following termination of treatment.

It would therefore be unrealistic to hope that there might be a coincidence between term of sentence and end of treatment. Consequently, convicts must be aware that they may be required to continue therapy for long periods of time or even throughout their lifetime.

These two aspects of the problem must at some point be made known to the person concerned. It would seem that any enlightenment on treatment and its consequences is the responsibility of the physician and not of the judge. For that matter, a judge would not be competent to settle the details of medical treatment. He would only be required to decide on the principle of mandatory treatment, as is the case for instance of probation on certain conditions.

4. Confidentiality

The draft bill entails a further exception to the rule of medical confidentiality on two specific points :

there would be no obligation on the physician to inform as is the rule when children are molested. The decision would be in the hands of the practitioner.

the doctor may be called upon to inform about the convict's lack of compliance or negligence as regards treatment, and furthermore he is expected to reveal to the judge or coordinating physician that he fears a new crime may be committed.

If the physician chooses to keep silent and the patient does commit a new crime, the physician may bear sole responsibility.

5. Future uncertainties and need for evaluation

Finally, in such a complex field, it would be a dangerous illusion to entertain the notion that medical treatment or psychotherapy can certainly contain recidivism. No treatment can be considered fail-safe from that point of view.

One might well wonder also whether pronounced androgenic inhibition might not increase the risk of non sexual violence, in particular because of impotence.

As for positive effects to be expected from psychotherapy, they must be an attenuation of the risk of renewed sexual assault. A possible improvement in terms of relieving the distress of the delinquent cannot suffice.

The above serves to underline the importance of evaluation of the various modes of management (both penal and medical) for sex offenders. But it is quite clear that complex problems of methodology will arise with these evaluations.

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Recommendations

1°) CCNE approves the principle of a draft bill with the aim of improving prevention of sex offences committed against minors.

2°) The Committee underlines that the medical and social aftercare sentence is a composite and is described as both sentence and treatment. The resulting ambiguity does have an effect on the ethical scope of the text.

3°) According to article 131-32-2 of the Penal Code, a medical and social aftercare sentence is preceded by a psychiatric examination which would seem to orient mandatory therapy exclusively in the direction of psychotherapy, whereas in fact, it appears that medical treatment, in particular hormonal, is appropriate for a sizeable number of culprits, in combination if necessary with psychotherapy.

4°) According to article 131-32-1, the medical and social sentence is temporary. Consequently, mandatory therapy ceases once the sentence has been served. Yet, by its very nature, such therapy is of indeterminate duration.

5°) Automatic termination of treatment when the penalty ends may make a mockery of the objective to improve prevention. What is required therefore is to provide for the possibility of continuing therapy for a period of time which cannot be set a priori. It is not CCNE's task to define a procedure to respond to this necessity.

6°) By virtue of article L.335-35 of the Code of Public Health, the attending physician may reveal to the judge or to the coordinating physician lack of compliance by the convict of his medical treatment or alert them to behaviour which may endanger law and order or other citizens. In doing so, the obligation of professional secrecy is impaired. Nevertheless, the second set of possibilities of informing left open to the practitioner leave too much room for his personal appreciation of the situation and could lead to his being held responsible if the convict did commit renewed offences and the physician had not alerted those concerned.

In any case, it should not be necessary to approach anyone but the coordinating physician.

7°) The convict must be informed about the consequences of medical and social aftercare and of possible changes in his sexual activities and procreative capacity brought about by antiandrogen treatment.

8°) CCNE emphasises that there is still uncertainty about individual variability of response to these substances, and about whether the effects of very prolonged antiandrogen treatment are reversible. Another point of concern is lack of long-term follow-up of effects.

9°) With due regard to the complexity and magnitude of issues raised, CCNE considers that provision should be made in an article of the text for an evaluation of the proposed system as a whole so that modifications can be made if necessary. The evaluation should take place in about 2 years time.

Notes

1. GnRH is the abbreviation of Gonadotropin Releasing Hormone. LH, (women) Luteinising hormone.

2.A form of this drug which can be injected once a week is available in Germany. So far, it is not authorised for sale in France.

3. Should be included in this group the severely mentally retarded.