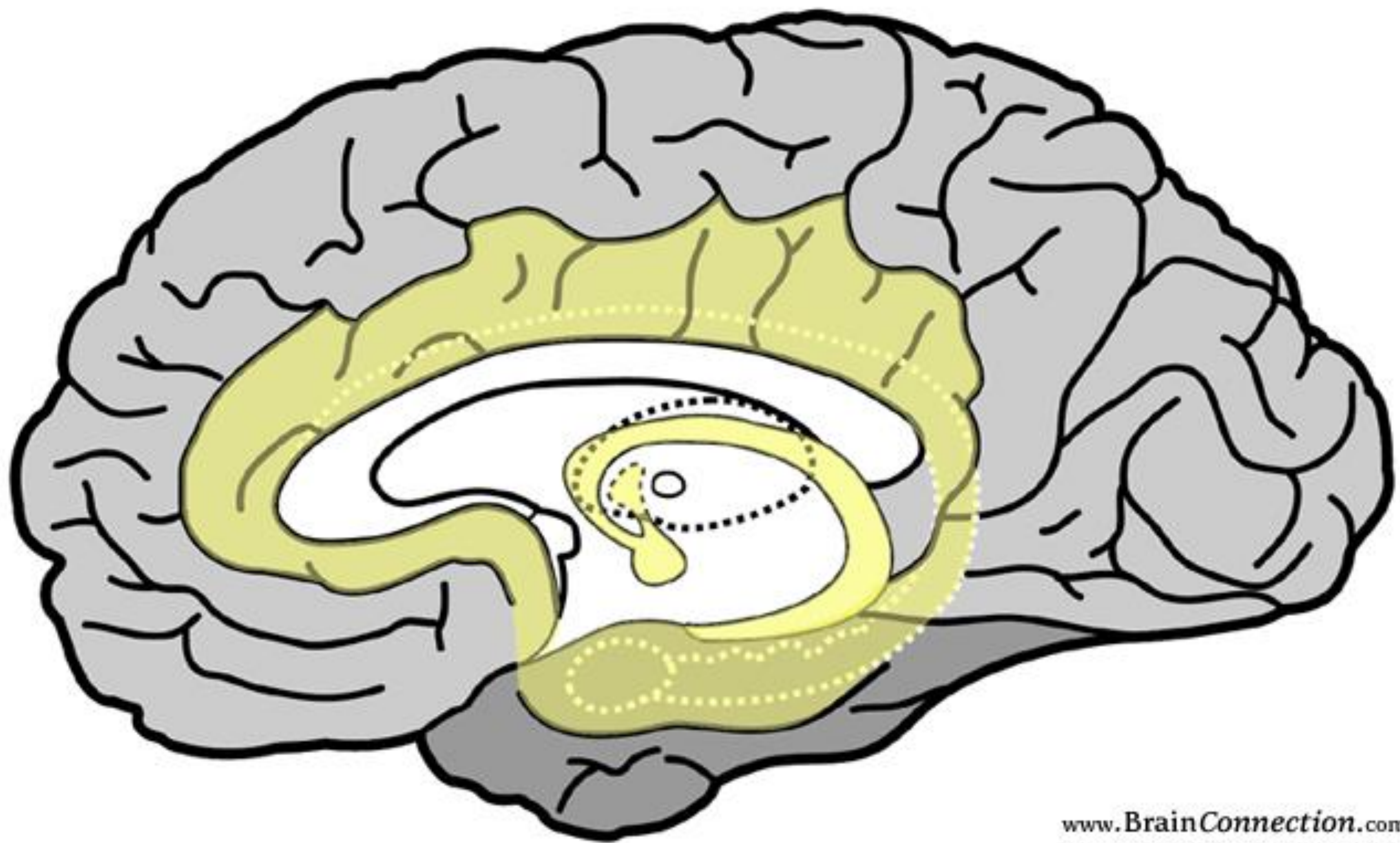
# Medication and Sex Offenders

don.grubin@ncl.ac.uk

# The fundamentals

- sex drive is biological
- no one chooses their sexual arousal patterns
- difference between arousal and control of arousal
- difference between sexual arousal and sexual interest
- attitudes & beliefs, emotional state, self-management, influence sexual behaviour
- the most important male sex organ is:


www.BrainConnection.com
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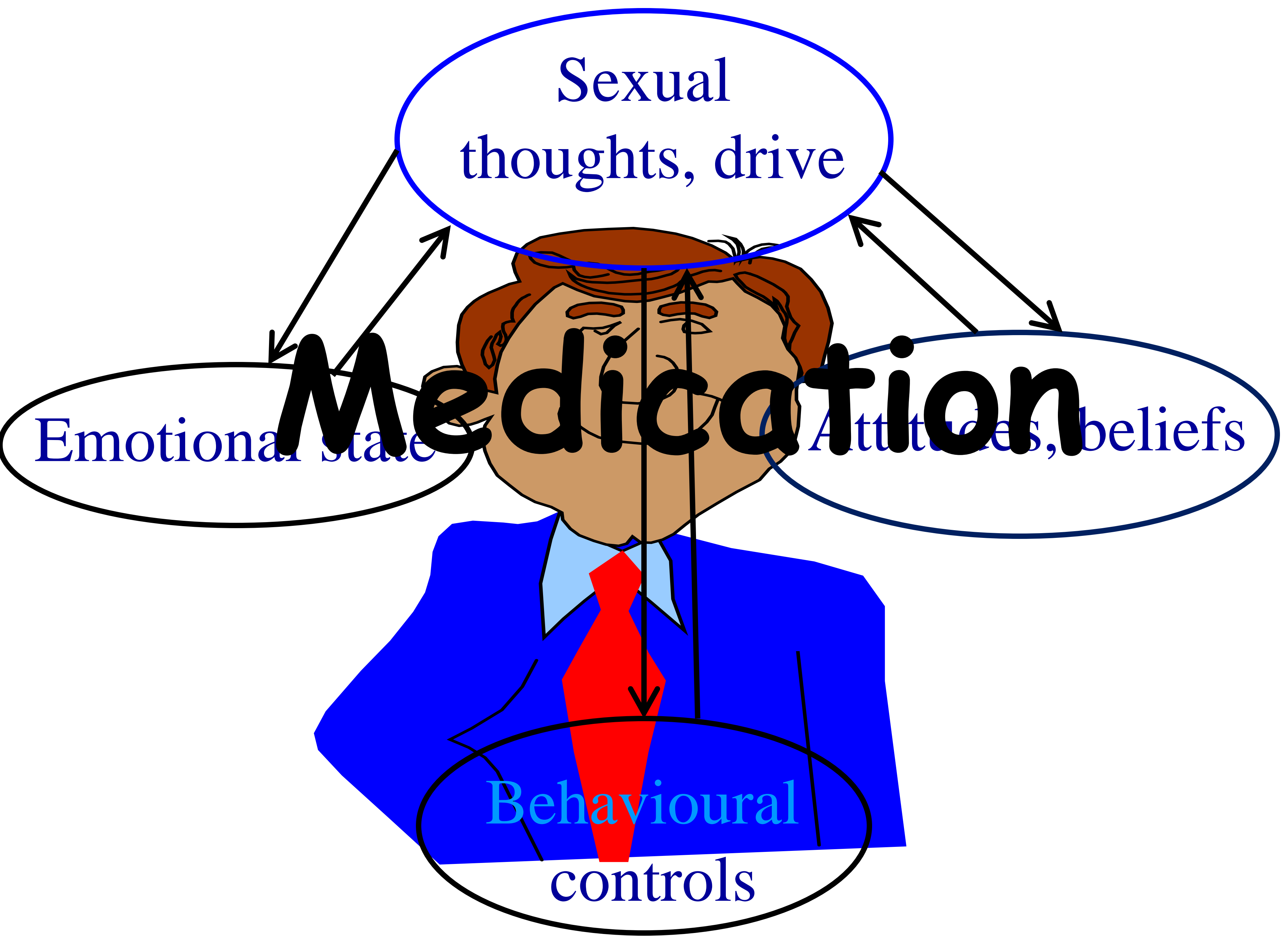
Sexual thoughts, drive
Emotional state
Medication
Attitudes, beliefs
Behavioural controls

# 2008
# NATIONAL PSYCHIATIC SEX OFFENDER ADVISORY SERVICE

a network of psychiatrists with an interest and expertise in treating sex offenders

# National Psychiatric Sex Offender Advisory Service: Aims

- improve psychiatric infrastructure
  - quantity
  - quality (expertise)
  - non-offenders
- prescription and treatment protocols
- facilitate referrals
- data collection

# The Basic Principle

We are treating a medical indication . . .

. . . risk reduction is a useful side effect

# Medical Management of Sexual Arousal (MMSA) - 2016

- 7 clinics in prison (based on Whatton pilot)
  - transfers if current prison cannot/will not assess
  - all security levels
  - also advice
- in community, incorporated into PD consultation clinics
  - but no funding; currently case by case basis
  - prevention

To reiterate this is primarily a health intervention, with secondary gains for criminal justice.

OPD Pathway

We do have a fundamental disagreement as to whether or not this approach to managing sex offenders is primarily a health matter with the criminogenic offending management coming second. Our view, that it is not primarily health, is supported by the very description of the treatment in that we are describing the meds used as Meds to manage sexual arousal. An approach which is intended to reduce criminogenic behaviours.

NHS health & justice commissioning

# The research questions

- does medication 'work'
- what are the long term effects of anti-androgens
  (what we know is based on elderly men)
- can sexual preference be changed
- just what is a paraphilia

# Does it work?

Schmucker & Losel (2005, 2015, 2017)

# Triptorelin (Rosler & Witztum, 1998)

n = 30

"hypersexual": masturbate 32/week
fantasise 48/week
behaviour 5/month
failed on other Rx

dropout = 6 (20%)
{3 from side effects}

# Triptorelin (Rosler & Witztum, 1998)

**RESULTS**

follow-up to 3 1/2 years

masturbation = 0-1 per week
deviant fantasies = 0
behaviours = 0
reoffences = 0 *{except for 2 side effect drop outs}*

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testosterone reduction: 95%
LH reduction: 90%
bone mineral density: 40-50%

# depo-Provera (Oregon)
## (Maletzky, Tolan & McFarland, 2006)

| | Provera<br>n=79 | No Provera<br>n=55 | Not recom.<br>n=141 |
|---|---|---|---|
| sex recidivism | 0 | 10 (18%) | 21 (15%) |
| sex breech | 1 | 12 (22%) | 6 (4%) |
| in prison | 0 | 11 (20%) | 19 (13%) |
| ‘doing well’ | 70 (89%) | 24 (44%) | 89 (63%) |

# Schober (www.clinicaltrials.gov)

N=5
CBT for 2 years; luprolide year one, saline year two

## Results

- decrease but no difference in ppg, Abel Screen
- all reported decreased in fantasies, urges and masturbation
- polygraph: at baseline and placebo, deceptive

# SSRIs: the studies

decrease in strength and frequency of fantasies

decrease in sexual urges

decrease in masturbation

decrease in behaviours

decrease in “unconventional” arousal?

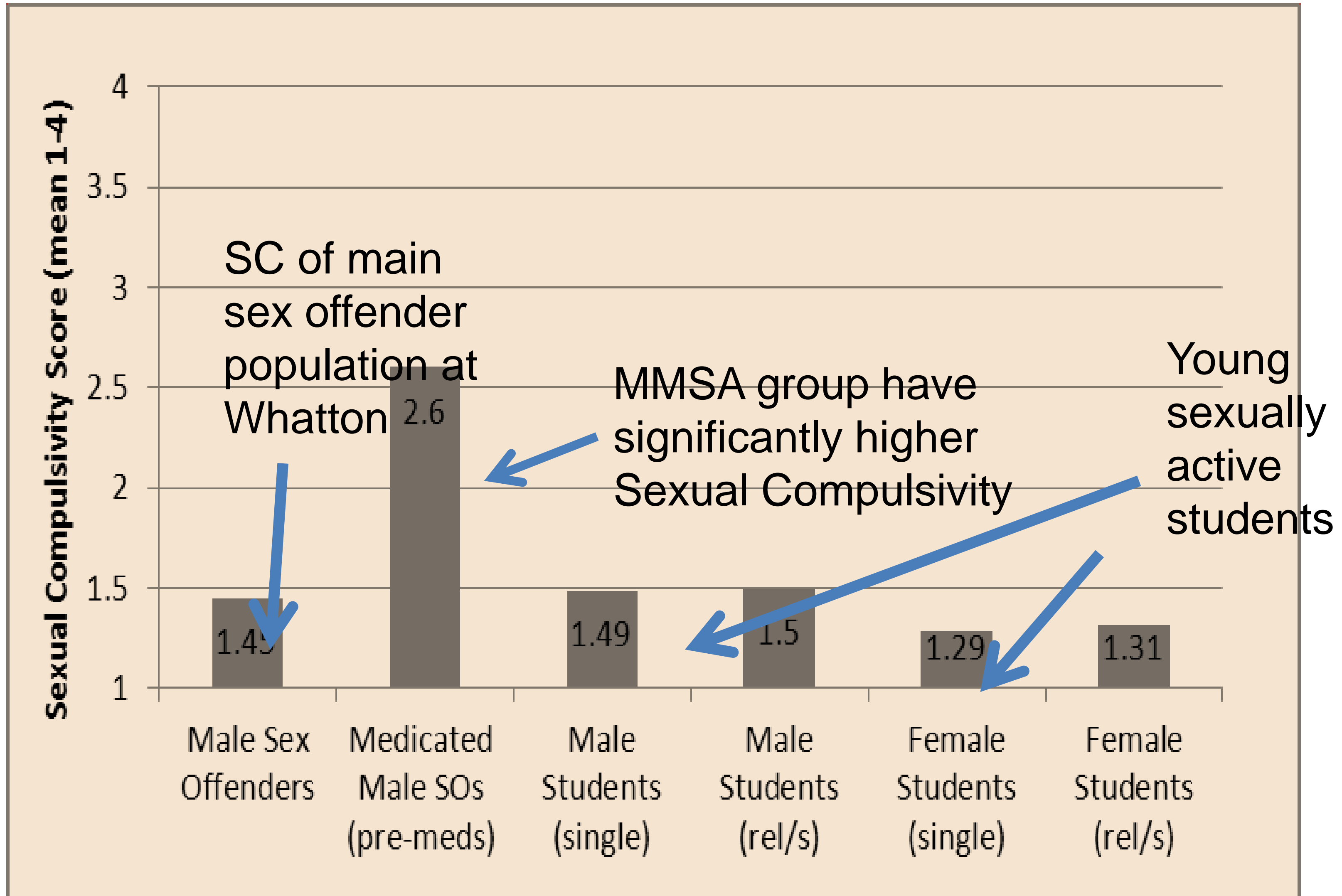
delay in ejaculation

# SSRIs: the studies

BUT

- lack of controls

# Sexual Compulsivity

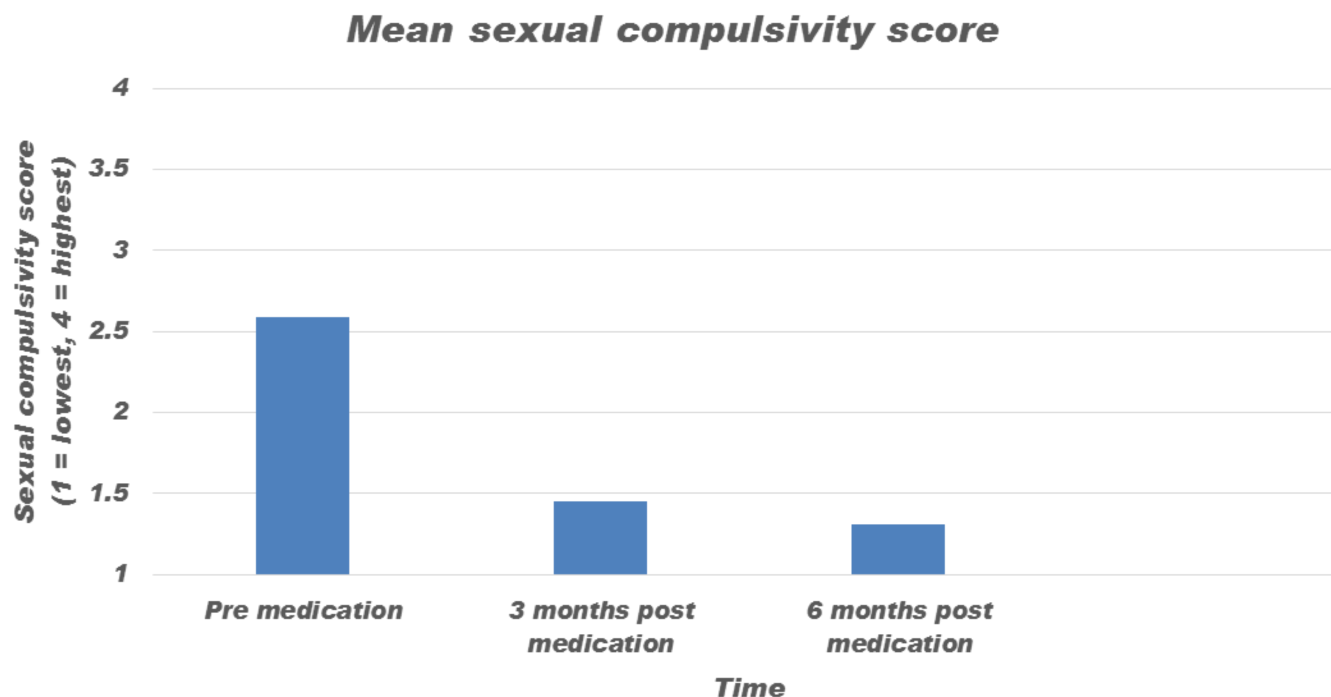



Belinda Winder & colleagues

SOCAMRU
Sexual Offences, Crime and Misconduct Research Unit

# Evidence base in prison – HMP Whatton

**Mean Sexual Compulsivity Scores for participants taking medication to reduce sexual preoccupation**

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# Plan

- community follow-up
- recidivism

# What are the long term effects of anti-androgens

# Anti-androgen side effects

- menopausal symptoms
  (hot flushes, depression, weight gain, cvs)
- gynaecomastia
- carbohydrate metabolism, other endocrine
- cardiovascular
- osteoporosis

# Plan

- retrospective and prospective data collection

# Does preference change?

# What is paraphilia?

# Paraphilia

DSM: fantasies, urges or behaviours that are:

- recurrent, intense
- involve anomalous activity or target
- clinically significant distress or impairment of function (makes it a disorder)

ICD: most important source of sexual stimulation are atypical:

*non-human, suffering, humiliation, children, lack of consent*

# DSM & ICD

- no coherent concept
- confusion between legal, moral, pathological

"The DSM is no more than a distillate of the prejudices prejudices and power plays of a group of aging American academics . . ."

(Pathe & Mullen)

# Models of paraphilias as medical conditions

- OCD spectrum
- addictive spectrum
- impulse control
- mood disorder and regulation
- personality disorder (ASPD)
- hypersexuality

or a variant of normal sexuality
(i.e., what is normal?)