Treatment of Sex Offenders in Israeli Prison Settings

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The number of incarcerated sex offenders in the Israeli prison system has steadily increased during the past decade. While treatment of sex offenders is complex, treatment of those in prison seems to be more challenging. This publication presents major considerations and dilemmas, clinical as well as ethics-related, derived from the experience of the psychiatric division in the Israeli prison service in treating sex offenders in this special setting. The psychiatrist treating the incarcerated offender must always maintain a sensitive balance between the needs and wishes of his patient and the potential threat to society stemming from recidivism.

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The number of incarcerated sex offenders in Israeli prisons, which may be related to the total number of sex offenders, has been steadily increasing, from 350 offenders in 1997, to 1300 in 2009.[1] Possible contributors to this remarkable growth include increased public and law enforcement agencies' awareness of the offenses, a rise in the use of disinhibiting substances such as alcohol and sympathomimetic drugs, and increased access to paraphilic pornographic material.

About 60 percent of convicted sex offenders in Israel have committed offenses against children under the age of 13.[1] Approximately one-half of those individuals are diagnosed with pedophilia. These data have to be evaluated with skepticism, mainly due to secondary gain factors, since sex offenders tend to deny or minimize their crimes. Furthermore, the current available body of knowledge lacks a gold standard objective assessment method that can confirm or rule out sexual pathology. For example, phallometric tests have yielded false-negative and false-positive results.[2]

The growing number of sex offenses against children has become a major public concern and during the past 10 years has initiated substantial legislative measures by the Knesset (the Israeli parliament). A law regarding the safeguarding of the community from sex offenders has been operative since 2006. The risk imposed by any sex offender who is discharged to the community is assessed. In the case of moderate to high levels of dangerousness, the state can apply for supervisory measures, with specifications and length that are adjusted according to level of dangerousness and the nature of the offenses.[3] A special unit of the Israeli Prison Service has been assigned to this task.[1] It is hoped that this year a supplement to the law that mandates provision and regulation of sexual treatment programs both in prisons and in civil settings will be approved by the Knesset.

The Treatment of Sex Offenders in the Israeli Prison System

For years, the Israeli prisons service has been providing sex offenders with treatment that is planned and organized in accordance with the current body of scientific and clinical knowledge. Israeli law does not sanction compulsory treatment of sex offenders; therefore, informed consent of the patient must be obtained. Over the past 20 years, our treatment model has shifted dramatically. Group cognitive behavioral therapy has gradually replaced the personal-

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ized psychotherapeutic dynamic approaches, and there is a wider use of additional pharmacological agents.

Upon admission to the prison, each sex offender is clinically assessed for the assignment of a suitable therapy. Some of the prisons have various ongoing sex offender group therapy programs modeled according to a psychoeducational approach for a period of 1.5 years. Sex offenders who pose a greater risk to reoffend are assigned to groups that work according to the principles of relapse prevention. This target population consists of convicted sex offenders, among whom many are assessed as highly dangerous offenders who committed crimes and violated others. Pharmacological interventions are therefore essential for the control of their sexual drives.

Pharmacological as well as non-pharmacological interventions are mainly indicated in the cases of paraphilias (when behavior is based upon deviant sexual fantasies or urges) or uncontrollable sexual drive (hypersexuality). First, the level of dangerousness is assessed according to the prevailing criteria. The patients are also evaluated for underlying medical conditions and concomitant medication use. Subsequently, staff members evaluate the patients for additional co-morbidities and divide them into three main groups: patients without any significant co-morbidity; patients with an Axis I co-morbidity, such as psychotic illness; and patients with a severe personality disorder.

Most sex offenders present additional co-morbidities, the more common being dysthymia or depression.[4] Although not common, some patients may also have major psychiatric disorders. People with schizophrenia or related psychoses may commit sex offenses or show deviant sexual behavior. Their actions may be related to the psychosis content itself or may be caused by disinhibition secondary to the disease process. Some schizophrenic patients have co-existing deviant sexual fantasies. Patients with hypomania may behave in a sexually disinhibited manner, leading to offenses ranging from indecent exposure to indecent assault.[5–7] Sexual offending may also be associated with organic brain damage,[8] substance use disorders,[9,10] and personality disorders.[11]

We tend to exclude antisocial or severe borderline personality disorders from treatment because of problems regarding adherence, litigation, and manipulation. Schizophrenia patients who have co-morbidity of a paraphilic disorder are not excluded from therapy and are treated with a combination of antipsychotic and anti-androgenic medications, with favorable results.

Treatment Strategies and Special Setting Considerations

The specific goal of treatment is to suppress deviant sexual fantasies and urges, thus reducing the risk of further victimization, while maintaining a normophilic sexual drive. This end is seldom achievable with pharmacological agents.

In general we tend to administer anti-androgenic medication in the cases of paraphilias and hypersexuality. In cases of paraphilias not involving contact offenses, we use an array of selective serotonin reuptake inhibitors (SSRIs).[12] These treatments require special attention when given in this unique setting. It is imperative to be very cautious of side effects, since the prisoners do not have immediate free access to the treating physician. Some of the prisoners may be litigious and impose a latent threat to the treating staff. Nonadherence to treatment or false reports of the therapeutic effects are other problems presented by this population.

The prison environment is devoid of pedophilic sexual stimuli. It seems that in the average prisoner, sexual interest as a whole is reduced by the gloomy atmosphere that characterizes prison settings. Since anti-androgenic treatment is not without complications and may involve prominent side effects, such as osteoporosis and renal impairment,[13] it is our opinion that drug treatment during imprisonment is unnecessary and should be considered only when the prisoner is about to be released. One may advocate for initiation of treatment in the early stages of incarceration, arguing that the sooner treatment is started the less tendency there will be for the sex offender to minimize his offenses psychologically and the more apt he will be to assume responsibility for his acts. We believe administering long-term anti-androgenic therapy during incarceration is unjustified in inmates devoid of active deviant sexual interest. This option must be reserved for the inmate who is preoccupied or obsessed by deviant sexual impulses, even within the prison setting.

With inmates who present a distinct clinical picture of recurrent fantasies and/or obsessions, we consider a trial treatment with specific serotonin reuptake inhibitors. This approach has proved

effective, especially in noncontact paraphilias such as exhibitionism, voyeurism, and fetishism.[12]

Treatment of sex offenders involves the fields of psychology, criminology, sociology, law, ethics, psychiatry, anthropology, policing, and even theology. Pharmacological treatment requires the collaboration of a multidisciplinary team including a psychiatrist, an endocrinologist, and a forensic psychologist or a clinical criminologist. Forensic psychiatrists working in prisons are in need of special training in the diagnosis of paraphilias, in understanding the links between mental disorders and sexually abnormal behavior, in the advantages and limitations of psychophysiological methods in assessment and treatment, in the use of medication in addition to psychological methods in the treatment of sex offenders, and in the risk assessment of sex offenders.[14] Good clinical practice also necessitates many lab tests, with well-planned follow-up. These preconditions cannot be fulfilled in many countries because of the lack of training facilities and budgetary factors.

The treatment of sex offenders requires vast knowledge of the availability and underlying biological mechanisms of the existing pharmacologic compounds. In Israel, only the anti-androgenic compound cyproterone acetate is legally authorized by the ministry of health for the treatment of disturbances of sexual drive, while gonadotrophin releasing hormone (GNRH) agonists are authorized for sexual hormone reduction.[15] Risk assessment and treatment of sex offenders are taught in academic courses. Still, when considering pharmacological treatment, apart from a sound theoretical basis, significant clinical experience is crucial.

According to Israeli law, inmates may be entitled to short out-leaves from prison once they have completed a quarter of the prison term.[16] In the case of sex offenders, this privilege requires a preliminary risk assessment.[17] Although administering anti-androgenic therapy generally reduces sexual drive and thus allows out-leaves to be granted, we tend not to apply this policy, to avoid associating therapy with secondary gains. According to cognitive behavioral theories, treatment outcome is more successful when motivated by internal factors, such as guilt and a genuine wish to recover. It is noteworthy that in most sex offenders, the initial motivation for therapy is based on secondary gain factors.[18] We hold that good clinical practice advocates a reliance on such factors to motivate inmates to initiate treatment, but we expect that with a concomitant psychotherapeutic approach, the recruitment of internal factors will be achieved in subsequent phases. Some may regard short leaves as an important ingredient among other psychosocial interventions that enable the reintegration of sex offenders into their natural environment. According to this approach, it is advocated that pharmacological treatment be started much sooner than the time suggested by our current policy.

One of the main obstacles to the administration of medications in a larger group of inmates is that, in contrast to other countries, in Israel the matters of follow-up and supervision are still not officially settled. There are no public treatment facilities, and released prisoners find it hard to finance treatment. Not only that, but supervision mainly relies on a subjective report and the measurement of testosterone levels. It is important for treatment facilities in the community to be available and accessible, preferably with accompanying supervisory measures.

Ethics of Pharmacological Treatment

When considering the ethics of providing pharmacological treatment to sex offenders, some basic questions come to mind. From a utilitarian point of view, one must assess the harm and benefit of such treatments both to the patients themselves and to others (the treating staff, other inmates, their families, and the general public). Pharmacological treatments that alter sexual drive deprive individuals of a basic bodily function. Sexual activity is psychologically related to a sense of vitality, personal identity, and gratification. The dilemma of whether a person should be deprived of a vital bodily function—that is, sexual activity—to reduce his future dangerousness to others is a difficult one. It should be further emphasized that, in our experience, although many of the inmates wish to participate in psychotherapeutic modalities, only a small minority are willing to receive medications that reduce sexual drive. One reason may be their wish to maintain this basic bodily function.

Other reasons for the lack of motivation, as assessed by our team, are denial of the crime or of the underlying sexual pathology and fear of side effects. In cases of a short period of incarceration, it is our impression that inmates are not motivated enough to obtain treatment. When treating sex offenders, pharmacotherapy may be administered on a long-term basis. The medication may have known and un-

known side effects, such as fertility problems.[13] At the same time, information is still lacking regarding the efficacy of such treatment in reducing recidivism.[19,20] The need for more information regarding efficacy led us to conclude that, at this time, antiandrogenic treatment is justified as an intervention for high-risk recidivistic paraphilic offenders. As more information is available, this topic should be discussed further.

Administering pharmacological treatment also involves the ethics of informed consent. According to the informed-consent doctrine, a patient must be competent to make a decision, be fully informed of the potential consequences of his decision, and be allowed to decide without coercion.[21] Can informed consent be achieved by the incarcerated sex offender? Should mental health professionals offer pharmacological treatment in this particular setting? Should they offer a treatment that considers the benefit to society, or are they obligated only to benefit the patient? Should the patient's spouse be a part of the decision-making in this regard?

While some argue that informed consent is unlikely to be achieved in conditions in which the incarcerated sex offender could perceive that refusal to accept therapy might have a negative impact on his release terms (which might imply some form of mental coercion),[22] others claim that denying these prisoners the opportunity of making the decision may deprive the inmate of the opportunity to live safely and freely in the community.[23] The debate is further complicated by the additional and perhaps conflicting ethics of the obligation of the psychiatrist to society.[24] The psychiatrist treating the incarcerated offender must always maintain a sensitive balance between the needs and wishes of his patient and the potential threat to society stemming from recidivism.

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