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Justifications and Rationalizations for the Civil Commitment of Sex Offenders

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In response to rising community concern about the release of convicted child sex offenders, most states of Australia have enacted legislation to use civil commitment proceedings to extend detention and supervision after the expiry of the original sentences. This article considers the arguments for and against this form of legislation.

The arguments in favour of the civil commitment of sex offenders are for further treatment so as to decrease the likelihood of child sex assaults once the offender is released, in order to prevent child sex offences during the period of extended detention, and because previous sentences are seen to be inadequate according to current community standards. We then consider the arguments against preventative detention, which include abandoning the presumption of innocence with regard to future offences and the high probability of detaining some offenders who will not reoffend because of the unreliability of risk assessment.

We express our concerns about laws that overthrow longstanding legal principles and pass much of the responsibility for decisions regarding commitment from courts to psychiatrists. Despite the unsatisfactory nature of these laws and the cumbersome procedure required to administer them, the political reality is that these laws are unlikely to ever be repealed. Hence we also consider how the laws should be applied.

Key words: sex offender; paedophile; treatment; recidivism; preventative detention.

Introduction

Laws to detain and control sex offenders after their sentences have expired have been passed or are being considered in most states of Australia. These acts include the sexual offender civil commitment schemes (''the schemes'') of Queensland,[1] New South Wales,[2] and Western Australia,[3] under which offenders who have completed sentences for serious sex offences, including offences against children, can be detained in prison on the grounds that they are considered be at risk of committing further sex offences. The Victorian scheme[4] provides for outpatient civil commitment after the expiry of some sentences for child sex offences, but the condition that the person reside in a designated facility can amount to a form of detention. While the schemes include all sex offenders, the main reason for the laws

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has been the public outcry against a small group of offenders who have committed repeated offences against children.

The terms child "sex offender" and "paedophile" require some clarification as they have been used synonymously in public debate. Definitions of child sex assault have changed over time and between jurisdictions, but generally include any sexual activity between a minor and an adult. A grey area may exist in some cases of consensual relationships between post-pubescent children and young people.

Sexual contact with children is a behaviour that is also an offence in the penal codes of most countries. It is not a psychiatric disorder in itself. A proportion of those who commit sexual offences against children may meet the criteria for the psychiatric diagnosis of paedophilia, but paedophilic interest does not inevitably result in child sex offences, as many paedophiles are acutely aware of the legal consequences of any sexual contact and may also consider the effect on the child. Moreover, many child sexual offences are committed by people who do not meet the criteria for a diagnosis of paedophilia[5] as their account of their sexual interests and the pattern of their sexual activity may include adults as well as children. In these offenders, the pattern of substance abuse or severe mental illness may better explain their behaviour.

The definition of paedophilia in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)[6] involves "recurrent, intense sexually arousing fantasies, sexual urges or behaviours involving sexual activity with a prepubescent child or children" whether the person has either "acted on these sexual urges, or the sexual urges or fantasies cause marked distress or interpersonal difficulty".[7] It is important to note that sexual activity involving children is not required for the diagnosis of paedophilia, and those who can be diagnosed with paedophilia and those who commit child sex assault are separate but overlapping groups.

Not everyone agrees with the classification of paedophilia among the psychiatric disorders. Members of the general public may regard this behaviour as "sick" but would generally not consider it to be the manifestation of a mental illness, and the law does not regard the presence of paedophilia as grounds for mitigation at the time of sentencing. People rarely present to psychiatrists complaining of an attraction to children and many paedophiles experience no particular distress or interpersonal difficulty.[8] Patients sometimes present with the fear that they may be a paedophile, but most of these patients turn out to have anxiety disorders or severe depression with obsessional doubt and have never been attracted to children.

It is widely accepted among mental health professionals with experience in assessing sex offenders that there is a distinct class of individuals who have a persistent sexual preoccupation with children and have a range of common emotional responses and behaviours that include an increased risk of committing child sexual assault. However, little is known about the aetiology and clinical course of paedophilia; even the nosological validity and usefulness of the term "paedophilia" remains open to serious question.[9]

The lack of scientific understanding of paedophilia becomes relevant if the currently accepted view of the characteristics of paedophiles is to form the basis of legal interventions based upon perceived risk. This article examines the arguments for and against preventative detention as a means for controlling child sex offending.

Preventative Detention for Treatment

The first argument in favour of preventative detention of child sex offenders is that it could allow for treatment to reduce the risk of further offences. If treatment for sex

offenders did lower the risk of future offending, this argument would be very persuasive as most of the offenders brought before the courts in New South Wales and Queensland have refused to participate in prison-based treatment programmes. However, despite published outcome studies describing as many as 20,000 offenders who have completed custody-based group therapy treatment programmes worldwide, there is very little evidence that psychological treatments in custody reduces the risk of sexual recidivism.[10]

The failure of custody-based programmes to show a significant effect on recidivism may be in part because treatment have not been specific to the individual offender's needs. For example, if the basis of the sexual behaviour towards children is in response to symptoms of a psychotic illness, a treatment programme that involves disclosure, victim empathy, identifying triggers for offending and other components of a relapse-prevention model may not be appropriate. In this case, consistent treatment with antipsychotic medication under mental health legislation may be a more appropriate framework for the protection of the public. Similarly, sex offenders with substance abuse disorders or intellectual disabilities may require different management from child sex offenders of high or normal intelligence who were not affected by alcohol or other drugs at the time of their offending.

Until recently, participation in most sex offender treatment programmes has been on a voluntary basis. Most studies of the outcome of psychological therapies are based on samples of patients who have consented to participation. The preferred model of "relapse prevention" using group therapy is drawn from treatment of substance addiction. This has meant that the intensive programmes have only been open to offenders who admit their offences. The prognosis of those who have entered treatment programmes in order to get released is likely to be worse.

All states with civil commitment schemes have intensive custody-based sex offender treatment programs, such as the Custody Based Intensive Treatment [CUBIT] programme in New South Wales.[11] Unfortunately, none of these programmes have been able to demonstrate that participants have a lower rate of subsequent reoffending. The only published review of efficacy, from the West Australian programme concluded that "examination of the treated and untreated recidivism rates reveals there is no significant effect of treatment".[12] The rearrest rate for a sexual offence after seven years was 7% for the untreated group and 14% for the treated group. As in other published studies, the community-based programmes in Western Australia were marginally more successful than the custody-based programmes in reducing recidivism and the recidivism rates of those who denied committing an offence (and were hence ineligible for the intensive custody-based programme) was not significantly different to those who admitted their offences.

The Cochrane Review of outcomes of psychological treatments for sex offences found that psychological treatments were not only ineffective, but that some interventions may even increase the likelihood of recidivism in the long term.[13] Perhaps the ineffectiveness of psychological treatments in changing primary sexual interest is not surprising when one considers the failure of the historical attempts to treat homosexuality.

The oldest treatment for sex offending is surgical castration. Treatment with libido-lowering medication is still sometimes referred to as "chemical castration", even though the effects are largely reversible. There are now a number of medications that are available as tablets or by injection, including medroxyprogesterone acetate, cyproterone acetate, leuprolide, or luteinising hormone-releasing hormone agonists – such as leuprorelin, triptorelin,

goserelin. All these medications have the effect of lowering circulating testosterone, which inhibits sexual arousal through the reduction in the activation of androgen receptors in the brain, and may also reduce erectile function. Sexual drive is lowered irrespective of the presence of deviant sexual interest.

Although there have been few controlled trials of treatment with anti-libidinal medication, there is little doubt about its effectiveness in reducing sexual drive.[14] In the studies that have been performed there are few reports of treatment failure, and in one important study of repeat child sex offenders treated with anti-libidinal medication the recidivism rate was in the range of 3% to 10%, significantly lower than any other treatment modality.[15]

The two main drawbacks of anti-libidinal treatment are the side effects of the medication, including weight gain, feminization, reduced bone density, the risk of blood clots,[16] and the return of libido to normal after the treatment has stopped.

While we argue that preventative detention cannot be justified on the basis of the need for psychological treatment, the provision of anti-libidinal medication is not a rational reason for further detention as the medical risks outweigh the benefits if there are no potential victims. In contrast, it is not difficult to conceive of situations in which the compulsory use of anti-libidinal medication after release can be justified, despite the side-effects, on the basis that it would reduce the risk of reoffending.

Until custody-based treatment programmes are shown to be effective we can only conclude that the need to provide treat ment to reduce the risk of recidivism is a poor justification for preventative detention.

Preventative Detention to Protect the Community

A high degree of certainty that a child sex offence would occur were it not for continued detention is needed to justify incarceration beyond the original sentence. In addition, an argument would have to be made that the consequences for the victim would be so serious that preventative detention is justified.

In fact, the recidivism rate for those convicted of sexual offences is lower than for most other classes of offender. For example, 47% of prisoners released from prisons in New South Wales will return within two years, whereas the overall rate of re-incarceration for those convicted of sex offences is about 7%.[17] In addition, reconviction rates for sexual offences may be declining in Western countries.[18] The high risk sex offender group identified by the actuarial instrument had a recidivism rate for any offence of only 36% after five years and 52% after 15 years.[19] There is no method that has been shown to predict which members of the high risk group will actually go on to offend.

The other argument for preventative detention of those convicted of child sex offences is that child sex crimes are so damaging to the victim that the detention of high-risk offenders can be justified in order to prevent any crime. This argument is supported by a large body of scientific evidence that sexual offences against children have permanent detrimental effects, which do not exist for crimes such as robbery, fraud, and even crimes of violence against adults.

Assuming that sex crimes against children are so harmful that it is in the community interest to prevent the release of some offenders, how then do we choose who to detain and for how long. In some rare instances of the high functioning but extra-familial child sex offender with undoubted paedophilic urges, a string of prior offences and impenetrable rationalizations to justify their behaviour, the prediction of further assault may not be difficult. In these instances it is easy to argue that the public requires some

protective measures. As detention itself does not reduce risk, the period of detention should be for the duration of the risk. Thus when preventative detention is used, it should be for a long period of time or not at all. However, preventative detention of many years duration should not be in an environment that has an element of punishment in addition to the deprivation of liberty, and a different kind of institution may have to be developed for these offenders.

In the remaining cases the offending behaviour may be associated with psychological and social factors, including substance abuse, poor social skills, mental illness, intellectual disability, or brain damage. In these cases the science of risk prediction could be of assistance in devising a plan to mitigate risk, despite the high error rate.[20]

Scales for the prediction of further sexual offending are particularly hard to establish because of the low base rates of the outcome being measured and dependence on reconviction to measure outcome, which substantially underestimates offending behaviour.[21] A combination of detailed actuarial and clinical approaches may produce more accurate results,[22] but the fact remains that all current forms of assessment, whether based on actuarial or clinical findings, will have high rates of false positives and no assessment method can predict the offender's future circumstances in any detail. Based on the published results of the scales themselves, the false positive rate may be as high as two out of every three offenders who are assessed for their level of dangerousness.[23] A false positive rate is of significance when the consequence is ongoing civil commitment predicated on presumed risk. The false negative rate also means that schemes of preventative detention will be less effective in reducing further child sex offences than some legislators may have been led to believe.

Despite the inability of psychiatrists and other behavioural scientists to predict accurately who will reoffend, the Australian civil commitment schemes all include the requirement for psychiatric risk assessment.

Australian judges have commented on the inherent difficulties in predicting the risk of reoffending. In *Fardon*, Kirby J said that 'experts in law, psychology and criminology have long recognized the unreliability of predictions of criminal dangerousness'.[24] His Honour observed that in expert evidence, psychiatrists notoriously over-predict and that predictions of dangerousness have been shown to have only a success rate of between 33% and 50% as suggested.[25] The Australian Law Reform Commission in its discussion paper, *Sentencing of Federal Offenders*, also noted the widespread view that predictions of future criminality are inherently unreliable and more often than not result in erroneous predictions that an offender is likely to reoffend.[26] Moreover, judges and juries can misconstrue risk assessments that are put in figures and place greater reliance on their accuracy than is warranted.[27]

Preventative Detention to Increase the Sentence to Meet Current Standards

The true justification for many of these laws appears to be the perception that the original sentences of many child sex offenders are inadequate by today's standards. Child sexual assault has been viewed as an increasingly serious offence attracting longer sentences in many jurisdictions. Hence some prisoners' sentences are expiring at a time when those convicted of similar offences are receiving longer sentences. This leaves governments open to attack in the media should an offence occur after the expiry of a sentence considered to have been too short to adequately protect the community. Clearly, this is a poor

argument for preventative detention, but does suggest that the perceived need for additional detention may decline as repeat child sex offenders are given longer sentences.

Psychiatric Opinion May be a Rationalization Rather than a Justification for Civil Commitment of Sex Offenders

The principal argument against preventative detention is that it is an infringement on liberty that can not be justified on scientific grounds and may only be justified to manage risk in exceptional cases.

Preventative detention contravenes the longstanding legal principle of the presumption of innocence in the criminal law. Supporters of the civil commitment of sex offenders may point to other protective legislation such as mental health and public health legislation, both of which have provisions for detention on the basis of risk. However, in contrast to the non-consensual treatment of psychosis, paedophilia and most of the other disorders associated with child sexual offences do not rob the offender of a capacity to make decisions about treatment and there is little evidence that child sex offenders respond to treatment. Moreover, detention under mental health legislation is generally for a short period.

Another difference between mental health legislation and schemes to detain sex offenders is in the direction of inquiry between the law and medicine. Under mental health legislation, doctors apply to administer treatment they know has a high probability of working. A legal inquiry is held as to whether detention is justified in the interests of the patient and others.

In the schemes for the civil commitment of sex offenders, in order to provide a rationalization for further detention the law conducts an inquiry of doctors about the level of risk. For example, in Queensland, if the Supreme Court receives an application by Corrective Services employees about a prisoner about to be released after the completion of their sentence it then requests the opinion of two psychiatrists regarding the level of risk. This passes the burden of responsibility for incarceration from the judicial to the medical domain. Two obvious problems with this scheme are that there is no evidence that any medical prediction of future harm approaches the standards of proof required by criminal law and it asks psychiatrists to adopt a judicial role for which they are untrained.

Preventative Detention May Conceal Government Inaction in Reducing Child Sex Abuse

Preventative detention laws allow governments to spread the false impression they are taking action against child sex abuse, without necessarily doing very much more to reduce the overall incidence of abuse. It is known that a significant proportion of girls and a smaller proportion of boys are subject to unwanted sexual advances by adults during childhood and adolescence. Although the proportion of adults who sexually assault children is unknown, it is likely to be correspondingly high and can never be addressed by the preventative detention of a small number of convicted child sex offenders. The extent of child sex abuse and the psychological harm arising from the problem indicates the need for a public health approach to the protection of children.

In New South Wales the first public awareness campaign with the specific aim of alerting the population to the realities of child abuse did not appear until very recently. Public awareness campaigns have aimed at challenging the rationalizations of domestic violence perpetrators, but there has never been a campaign directed at potential child sex offenders, nor has there ever been a publicly funded service for people who believe that they may be at risk of committing a sexual offence

involving a child. While education programmes and services are not incompatible with preventative detention, they should be given a greater priority. Even if such programmes have limited efficacy, they are likely to prevent more instances of child sexual assault because they influence the behaviour of a much larger number of people.

What a Rational Civil Commitment Scheme Might Look Like

A rational civil commitment scheme would only include repeat offenders, especially those who have reoffended while on parole or who have failed despite what appeared to be optimal post-release plans. The scheme would apply particularly to those offenders who combine deviant sexual interest and compulsive offending.

The identification of eligible offenders should come from a comprehensive register of sex offender data that includes profiles of imprisoned sex offenders. A protocol for comprehensive assessment should be developed in an attempt to apply fair guidelines for the application of orders. A more sophisticated assessment than simply the Static-99 score would also need to be considered and reviewed by experts who are independent of the criminal justice system. The possibility of a continued supervision order could be raised at the time of sentencing.

The requirement for intensive custody-based psychological treatments should be abandoned as it has not been shown to work. Custody-based counselling should be in the form of intensive educational programmes that would also be open to those who deny their offences. There should be an emphasis on the assessment and treatment of other psychiatric disorders and psychosocial deficits that may contribute to sex offending.

Because of the inherent unfairness of the orders themselves, the presumption should be for conditional release. Conditions could include specific counselling and adherence to libido-lowering medication, as well as the usual restrictions and monitoring associated with release on parole. Failure to adhere to any condition would result in revocation of release.

Because the control orders often include residential requirements, the state should provide suitable accommodation that also facilitates appropriate supervision and support. Those subject to long-term detention orders should be housed in a purpose-built secure hostel-type setting not subject to the prison regulations that add to the punishment arising from the deprivation of liberty.

Conclusion

Preventative detention cannot be justified on the grounds of a need for treatment because there is no compelling evidence that psychological therapies reduce recidivism rates, and because effective medical treatments are not required in the prison setting and are ineffective if discontinued after release.

Preventative detention may be justified if it can be established with certainty that such detention will prevent further sexual offences against children. This would only apply to rare instances of people with long histories of recidivism. In these cases, if detention is justified, detention should continue until the risk abates, or until an appropriate level of control can be maintained in a community setting.

The real reason for the enactment of preventative detention may be the lag time between the release of previously convicted persons and longer sentences now given for similar offences. If as a society we have come to view child sex assault as a more serious crime for which longer sentences should be imposed, then the need for preventative detention will probably decline as sentences become longer.

The rush to set up preventative detention appears to satisfy the need for governments to be seen to take action against child sex offenders. However, the resources and administrative energy that has been expended in setting up preventative detention regimes has taken attention away from the glaring need for a public health approach to reduce the sexual abuse of children.

Notes

1. Dangerous Prisoners (Sexual Offenders) Act 2003 (Qld).
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