MEDICAL TREATMENT OF SEXUAL OFFENDERS
Protocol and guidance for the referral, assessment and treatment of sexual offenders managed by criminal justice social work and the prison service in Scotland

Introduction
The main interventions for sexual offenders are psychological in nature. Research has established that for some sexual offenders medical intervention can be a successful additional approach to reducing the risk of further offending. Whilst psychological interventions will remain the preferred method of treatment for most sex offenders, in certain cases this could usefully be supplemented by medical treatment. This is particularly the case where individuals experience high levels of sexual arousal, or sexual rumination, which makes psychological treatments difficult. Medical intervention can also be useful in some cases where offenders continue to have intrusive deviant sexual fantasies or strong sexual urges that have not been effectively modified by psychological treatment. It should be noted that medical treatments are not intended to be the sole form of treatment for sexual offenders, and should only be used as part of a wider plan involving sex offender treatment programmes and other management options as appropriate. Further, it should be noted that medical treatments are only available on a voluntary basis, and that offenders cannot be compelled to comply with them.

A network of psychiatrists is being established across Scotland who will provide assessments where appropriate. The network will provide a straightforward route whereby appropriate staff from criminal justice social work or prisons can refer offenders for psychiatric assessment and prescription of medication if appropriate. It should be noted that this service covers only psychiatric assessment in circumstances described above. It does not provide a route whereby other psychiatric assessments can be obtained, for example for court hearings or for general risk assessment. Offenders requiring such assessments should be referred via local arrangements as at present.

The mental health assessment is available to male offenders.

One of two types of medication will be considered:

1. **SSRIs (selective serotonin reuptake inhibitors):**
   These drugs are commonly prescribed for depression, anxiety, and obsessive compulsive disorder. They have a relatively mild side effect profile. They act by increasing the concentration of serotonin, a neurotransmitter (or chemical messenger) found in the brain that is related to mood, impulsivity, appetitive behaviours such as eating and sleeping, and sexual activity (amongst other things). Serotonin systems are known to interact with testosterone in the brain in the regulation of sexual behaviour. SSRIs appear to be most effective where there is:
   - Sexual preoccupation
   - A compulsive aspect to offending
   - Offending associated with depressed or anxious mood state
   - Impulsive offending

   Although sex drive may be decreased by SSRIs, this is not a predictable effect. Instead, the aim is to reduce the *intensity* of sexual fantasies and sexual urges, enabling the offender to control them better, for example by using skills learned in the context of psychological treatment.
2. Antilibidinal medication:
These drugs reduce testosterone levels to those found in pre-pubescent boys, thereby decreasing sexual interest and arousal. Although offenders can still be sexually aroused by relevant stimuli, they are generally less interested in sex, and there is a great reduction in spontaneous sexual behaviour. Response is not instantaneous, and it may take a number of months before effects are maximal.

Antilibidinal medication is associated with a range of side effects, including the risk of liver damage, breast growth, hot flushes, depression and a decrease in bone density.

The most commonly used antilibidinal is cyproterone acetate (Androcur), which is taken orally. Long-acting drugs such as leuprolide acetate, goserelin, or triptorelin can be given by injection, and may be effective in cases where cyproterone has failed to suppress sex drive adequately, although they are substantially more expensive.

It is important to note, as indicated above, that none of these drugs on their own can ensure that a re-offence will not occur, and they should be used only in the context of an overall risk management plan.

As this is voluntary treatment, mental health legislation will not be used to compel individuals to take treatment.
Criteria for referral by criminal justice social work or prison treatment programme managers

1. **Appears to have sexual problems which may benefit from medication.** Any of the following:
   
   a. Sexual pre-occupation  
   b. Hyper sexual arousal  
   c. Deviant sexual fantasy which has not responded to psychological interventions and/or has been subjectively difficult to control  
   d. Sex as way of coping with low mood or anxiety

A score of 2 on any of the three sexual self-regulation items (sexual pre-occupation/sex drive, sex as coping, deviant sexual interests) of the Stable 2007 may give an indication of individuals who have problems in these areas who may benefit from medication. Similarly if using the Structured Assessment of Risk and Needs (SARN) the relevant domain is the Sexual Interests Domain (sexual pre-occupation, sexual preference for children, sexualised violence, other offence-related sexual interest). It should be noted that there needs to be evidence of ongoing difficulties in one or more of these areas rather than just a history of such problems.

2. **Is willing to consider taking medication on a voluntary basis.** Referrals of individuals who do not wish to take medication are not appropriate. Medication will only be prescribed on a voluntary basis with the informed consent of the individual. Individuals who are uncertain or ambivalent can be assessed. Part of the assessment will inform them about the treatment and inform the individuals of the potential pros and cons of treatment.

3. **It is an appropriate time to consider commencing treatment.** In most cases medication should be considered where plans are being made to manage individuals in the community. A period of time to assess the individual and to assess the response to treatment will be required, so for individuals in prison 6-9 months prior to release. This timescale is not hard and fast. Even where an individual is not close to release an assessment may be appropriate to determine if medication may be appropriate and when it should be started. This may, for example, be relevant with some offenders serving indeterminate sentences. For offenders who are already in the community referral can be made at any time. If an offender is undergoing group work then medication may be considered as an adjunct or when psychological treatment alone does not appear to have been effective.

Where it is difficult for individuals to engage in psychological treatment due to sexual pre-occupation, high sexual arousal or deviant fantasies, then medication may be considered to help get these individuals into psychological treatment, either in the community or in prison.

Where individuals are displaying concerning sexual behaviour in prison and they appear to meet the criteria then treatment may be considered even though release to the community is not yet imminent or under consideration.

4. **Referrals should be made using the referral form** (see later) and certain documents should accompany the referral (see later).
Psychiatric Assessment

Initial Clinical Assessment
The psychiatric assessment will involve interviewing the subject, reviewing records and reports, and discussing the case with others involved in managing the case.

The aim of the assessment is to:
- Determine whether the individual has a sexual problem which makes medical treatment appropriate, and if so to determine which medication would be most appropriate
- Determine the understanding the individual has of the role of the sexual problem in their offending behaviour and risk of future offending
- Determine whether it is an appropriate time to initiate such treatment
- Ascertaining that the person is agreeable to take treatment voluntarily
- Ascertaining medical and/or psychiatric issues which may effect any decision to prescribe
- Have a baseline assessment of sexual functioning against which to ascertain future functioning
- Have a baseline assessment of physical health parameters against which to monitor individuals who are given treatment

Choice of medication
The choice of medication should be determined primarily by the clinical phenomena in the case.

SSRIs should be considered first if there is sexual preoccupation (intrusive sexual thoughts or fantasies) without hypersexual arousal; sexual fantasies, arousal or behaviour has an obsessive-compulsive element or is associated with low mood or anxiety

Anti-libidinals should be considered first where there is hypersexual arousal or where deviant fantasies or arousal are associated with behaviour which is subjectively difficult to control. In most cases cyproterone acetate should be used first before considering a GnRH agonist, but where compliance may be an issue or where there is agreement that removal of sexual fantasies and libido is the aim, then a GnRH agonist may be used first.

If the choice of medication is unclear, then given the milder side-effect profile, a trial of a SSRI may be warranted before a trial of an anti-libidinal.

Prescribing
Existing protocols, from North America and Europe, are over-dependent on risk as opposed to clinical indications. Although risk needs to be taken into account, the starting point should be clinical presentation.

1. Where mood state, sexual preoccupation, sexual rumination, or compulsive behaviour appears to be the main problem, start with SSRI:
   i. fluoxetine 20mg, increasing after 4 weeks to 40mg, and then after another 4 weeks to 60mg, depending on response
   OR
   ii. sertraline 50mg, increasing to 100mg and 150mg at 4 week intervals depending on response
   iii. If initial SSRI ineffective, consider change to alternative SSRI, then cyproterone acetate 100mg a day
2. Where subjective sexual drive is exceptionally strong, or where fantasies/urges are associated with particularly high risk behaviours, start with anti-libidinal medication:

- where compliance is not a major issue (bearing in mind that the medication is being taken voluntarily in all instances)
  i. cyproterone acetate 100mg, increased to 150mg after 8 weeks if little or partial effect, and then to 200mg after a further 8 weeks
  ii. if cyproterone ineffective, or side effects intolerable, switch to GnRH agonist

- where compliance may be an issue (because offender may miss doses, or motivation is variable)
  i. start with depot cyproterone or a GnRH agonist (triptorelin, goserelin, or leuprolrelin) on a 4 week schedule, titrating according to response

Follow-up
Follow-up review aims to:
- Assess sexual functioning
- Ascertain the impact of medication on the sexual problem
- Check for side-effects
- Decide whether medication dose or preparation needs to be changed

Follow-up should be at least monthly until the person is established on treatment at the right dose. Frequency of follow-up when an individual is on a maintenance dose should be 2 to 3 monthly, with more frequent reviews if doses are being adjusted.

Medical Examination and Investigations

<table>
<thead>
<tr>
<th>X - GnRH Agonists</th>
<th>Y - Cyproterone Acetate</th>
<th>ICI - if clinically indicated</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Initial Visit</strong></td>
<td><strong>4 Months</strong></td>
<td><strong>8 Months</strong></td>
</tr>
<tr>
<td>Structured History about Metabolic Disorder</td>
<td>XY</td>
<td>XY</td>
</tr>
<tr>
<td>Weight</td>
<td>XY</td>
<td>XY</td>
</tr>
<tr>
<td>BMI / Waist Circumference</td>
<td>XY</td>
<td>XY</td>
</tr>
<tr>
<td>Pulse &amp; Blood Pressure</td>
<td>XY</td>
<td>XY</td>
</tr>
<tr>
<td>Evidence of Gynaecomastia</td>
<td>XY</td>
<td>XY</td>
</tr>
<tr>
<td>Testosterone</td>
<td>XY</td>
<td>XY</td>
</tr>
<tr>
<td>LFT</td>
<td>XY</td>
<td>XY</td>
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<tr>
<td>FBC</td>
<td>XY</td>
<td>XY</td>
</tr>
<tr>
<td>U&amp;E / RFT</td>
<td>XY</td>
<td>XY</td>
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<tr>
<td>Glucose</td>
<td>XY</td>
<td>XY</td>
</tr>
<tr>
<td>TFT</td>
<td>XY</td>
<td>XY</td>
</tr>
<tr>
<td>Lipids (not fasting)</td>
<td>XY</td>
<td>XY</td>
</tr>
<tr>
<td>Cortisol</td>
<td>ICI</td>
<td>ICI</td>
</tr>
<tr>
<td>ECG</td>
<td>ICI</td>
<td>ICI</td>
</tr>
<tr>
<td>Specialised Bone Density Scan</td>
<td>X ICI for Y</td>
<td><strong>X ICI for Y</strong></td>
</tr>
</tbody>
</table>

* After one year, investigations are carried out annually unless otherwise indicated
** Typically every 3 years, but may be more frequent in older patients
Referral and treatment process

1. Potential referral should be discussed with the Sex Offender Treatment Programme manager (for prisoners) or the Criminal Justice Sex Offender Programme Manager (for individuals in the community). The case may be further discussed with the local psychiatrist or Dr Raj Darjee.

2. If deemed appropriate a referral should either:
   a. Be made centrally to Dr Raj Darjee who will screen the referral and pass it on to an appropriate local psychiatrist.

   OR

   b. Be made to the local psychiatrist with a copy to Dr Raj Darjee

   The referral should be made by the Sex Offender Treatment Programme Manager in the community or prison.

3. An assessment will be undertaken in prison or the community by an appropriate local psychiatrist who will feed back to the referrer with a copy to Dr Raj Darjee.

4. Physical investigations and examination will be carried out by the psychiatrist or the psychiatrist may arrange for these to be undertaken by a prison medical officer or GP.

5. Any medication will be prescribed by the assessing psychiatrist, in liaison with the prison medical officer or GP. When offenders are established on medication prescription may be taken over by the prison medical officer or GP, but ongoing psychiatric review will be necessary.

6. The individual should be seen by a psychiatrist or, other health care professional, monthly initially while establishing the person on treatment. After 6 months this may decrease to every two months, then after a year to 3 monthly. Following reviews psychiatrists will continue to feedback information to referrers.

7. If medication doses are changed, medication is stopped or changed to a different type, then the implications of this will be discussed with the individual and with the referrer/relevant agencies involved in managing the case.

8. Psychiatrists will always send copies of correspondence to prison medical officers or GPs.

9. The aim of this protocol and process is to facilitate access to psychiatric assessment for appropriate cases. However the responsibility for accepting and undertaking assessments remains with local mental health services.

Monitoring, evaluation and audit

10. As this is a new development data on referrals, their treatment and their progress will be collected centrally by the forensic network. Copies of initial referral requests, assessment letters and review letters will be sent centrally to the forensic network so that appropriate data can be collected and monitored.

11. An annual report on this work will be submitted to the forensic network board by Dr Raj Darjee.
# APPENDIX 1

## SEXUAL BEHAVIOUR REVIEW FORM

<table>
<thead>
<tr>
<th>Sexual behaviours during the week prior to this review</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>name of patient</strong></td>
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<td>---------------------</td>
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<tr>
<td>________________</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>medication</th>
<th><strong>dose</strong></th>
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<tbody>
<tr>
<td>________________</td>
<td>____________</td>
</tr>
</tbody>
</table>

- Number of days masturbated leading to orgasm | ________
- Number of days masturbated *not* leading to orgasm | ________
- Number of days engaged in sexual behaviour with partner leading to orgasm | ________
- Number of days engaging in sexual behaviour with partner *not* leading to orgasm | ________
- Number of days engaged in any type of sexual behaviour on more than one occasion | ________
- Maximum number of times engaged in sexual activity in any one day | ________
Strength of sexual urges or fantasies

Amount of time spent thinking about sex

ability to distract from sexual thoughts

Side effects reported:
APPENDIX 2
REFERRAL FORM

REFERRAL FOR CONSIDERATION OF MEDICAL TREATMENT FOR SEXUAL OFFENDING

<table>
<thead>
<tr>
<th>Offender details</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Name</td>
<td></td>
</tr>
<tr>
<td>Date of Birth</td>
<td></td>
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<tr>
<td>Current location / address</td>
<td></td>
</tr>
<tr>
<td>GP</td>
<td></td>
</tr>
<tr>
<td>Professionals and services currently involved in case with contact details</td>
<td></td>
</tr>
<tr>
<td>MAPPA level (if applicable)</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Offending history</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Current conviction and date</td>
<td></td>
</tr>
<tr>
<td>Current sentence and expiry date or release date</td>
<td></td>
</tr>
<tr>
<td>Brief description of current offence</td>
<td></td>
</tr>
<tr>
<td>Previous convictions (sexual and non-sexual) and sentences. Please give brief descriptions of previous sexual offences.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Psychological and medical treatment</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment received so far (e.g. group work for sexual offending)</td>
<td></td>
</tr>
<tr>
<td>Previous or current mental health treatment</td>
<td></td>
</tr>
<tr>
<td>Known medical conditions</td>
<td></td>
</tr>
<tr>
<td>Current medication</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Does the person meet criteria for referral?</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief description of why medication may be appropriate</td>
<td></td>
</tr>
<tr>
<td>Is the offender agreeable to consider medication?</td>
<td></td>
</tr>
<tr>
<td>Does the offender appear to have one of the following sexual problems?</td>
<td></td>
</tr>
<tr>
<td>• Sexual pre-occupation</td>
<td></td>
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<tr>
<td>• Hyper sexual arousal</td>
<td></td>
</tr>
<tr>
<td>• Deviant sexual fantasy which has not responded to psychological interventions and/or has been subjectively difficult to control</td>
<td></td>
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<tr>
<td>• Sex as way of coping with low mood or anxiety</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Is it an appropriate time to consider medical treatment?</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• In community or coming up for release from prison in next 6-9 months?</td>
<td></td>
</tr>
<tr>
<td>• Appears to need treatment to facilitate involvement in psychological treatment</td>
<td></td>
</tr>
<tr>
<td>• Current concerning sexual behaviour in prison or community</td>
<td></td>
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<tr>
<td>Documents attached (Please tick)</td>
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<td>---------------------------------------------------------------------</td>
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<tr>
<td>Social enquiry report</td>
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<tr>
<td>Other pre-sentence reports</td>
<td></td>
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<tr>
<td>Sex offender treatment reports</td>
<td></td>
</tr>
<tr>
<td>Risk assessment (e.g. Stable and Acute / RM2000 / RA4 / SARN)</td>
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<tr>
<td>Other psychology reports</td>
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<tr>
<td>Pre-release reports (e.g. reports for parole board)</td>
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<tr>
<td>Psychiatric reports</td>
<td></td>
</tr>
<tr>
<td>Other (e.g. other documents with details of background history, offending history, psychiatric or medical history, or response to treatment and management attempts)</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Referred by</th>
<th></th>
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<tbody>
<tr>
<td>Name</td>
<td></td>
</tr>
<tr>
<td>Designation</td>
<td></td>
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<tr>
<td>Organisation</td>
<td></td>
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<tr>
<td>Date</td>
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<tr>
<td>Signature</td>
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APPENDIX 3
DETAILED INFORMATION ON MEDICATIONS

SSRIs: Fluoxetine and Sertraline

Indications
Licensed for depression, obsessive-compulsive disorder. Not licensed for sexual disorders, but indicated for sexual preoccupation (intrusive sexual thoughts or fantasies) without hypersexual arousal; sexual fantasies, arousal or behaviour has an obsessive-compulsive element or is associated with low mood or anxiety.

Mode of action
Selectively inhibit the re-uptake of serotonin (also known as 5-hydroxytryptamine or 5-HT) from synapses, thus potentiating serotonergic transmission.

Cautions
- Epilepsy
- Cardiac disease
- Diabetes mellitus
- Closed angle glaucoma
- History of mania
- History of bleeding disorders or if on drugs that increase risk of bleeding
- Hepatic impairment
- Renal impairment

Side-effects
- Gastro-intestinal symptoms:
  - Nausea
  - Vomiting
  - Dyspepsia
  - Abdominal pain
  - Diarrhoea
  - Constipation
  - Anorexia with weight loss (increased appetite and weight gain also reported)
- Hypersensitivity reactions:
  - including rash, urticaria, angioedema, anaphylaxis, arthralgia, myalgia, photosensitivity
- Other side-effects:
  - Dry mouth
  - Nervousness
  - Anxiety
  - Headache
  - Insomnia
  - Tremor
  - Dizziness
  - Asthenia
  - Hallucinations
  - Drowsiness
  - Convulsions
  - Galctorrhea
  - Sexual dysfunction
  - Urinary retention
  - Sweating
  - Hypomania / mania
  - Movement disorders and dyskinesias
  - Visual disturbances
- Hyponatraemia
- Bleeding disorders, including ecchymoses and purpura
- Suicidal behaviour

**Prescribing**

Only SSRIs that have been reported on in the literature are fluoxetine, fluvoxamine and sertraline. Although other SSRIs may have similar effects, prescription for sexual problems linked to sexual offending should, for now, be limited to these agents.
Anti-libidinals: Cyproterone Acetate

Indications
Licensed for use in severe hypersexuality and sexual deviation in males.

Indications in sexual offenders:
- Hypersexual arousal
- Deviant fantasies or arousal are associated with behaviour which is subjectively difficult to control

Mode of action
Primarily blocks testosterone receptors, but also reduces GnRH secretion by the hypothalamus and LH secretion by the pituitary.

Contraindications
- Hepatic disease
- Severe diabetes (with vascular changes)
- Sickle-cell anaemia (disease rather than trait)
- Malignant or wasting disease (transient catabolic effect)
- Severe depression
- History of thrombosis / embolism
- Youths under eighteen (may arrest bone maturation and testicular development)
- Metabolic bone disease

Side-Effects
More Common
- Fatigue & lassitude
- Breathlessness
- Weight change
- Reduced sebum production
- Changes in hair pattern
- Gynaecomastia (rarely lead to galactorrhoea & benign breast nodules)
- Inhibition of spermatogenesis (reversible infertility – not to be relied upon for birth control)

Rarely
- Hypersensitivity reactions
- Rash
- Osteoporosis (increased risk with higher dose and longer duration of treatment)
- Hepatotoxicity
Anti-libidinals: Gonadotrophin Releasing Hormone Agonists (GnRH agonists)

Indications
Not licensed for treatment of hypersexuality, sexual deviation or sexual offending yet.

Indications in sexual offenders:
- Hypersexual arousal
- Deviant fantasies or arousal are associated with behaviour which is subjectively difficult to control

Usually second-line after trial of cyproterone acetate, but may be first-line where potential for problems with compliance.

Mode of action
Over stimulate the pituitary, resulting in depletion of LH and consequently a marked reduction in testosterone synthesis. Appear to have a more potent effect on testosterone levels and greater effect on sexual activity and arousal than cyproterone acetate. This may be due to effect on GNRH neurons that project to brain areas beyond the pituitary, particularly the amygdala.

Cautions
- Contraindicated in youths under eighteen (may arrest bone maturation and testicular development) (no clinical trials in under eighteens, not recommended)
- Transient increase in testosterone levels and associated risks
- Metabolic bone disease as decrease in bone density can occur
- Injection site should be rotated
- Hepatic disease (leuprorelin)
- Severe diabetes (with vascular changes)(leuprorelin)
- History of psychiatric disorder
  - (leuprorelin=worsening of depression)
  - (goserelin=mood changes)
  - (emergence psychiatric disorder=triptorelin)
  - (emotional lability=naferelin)
- History of thrombo-embolic disorders (leuprorelin= pulmonary embolism)

Side-effects
More Common
- Orchidectomy-like side effects of hot flushes & sweating
- Gynaecomastia
- Osteoporosis

Less Common
- Hypersensitivity reactions (rashes, pruritis, asthma, & rarely anaphylaxis)
- Injection site reactions (see Cautions – above)
- Headache (rarely migrane)
- Visual disturbance or dizziness
- Arthralgia & possibly myalgia
- Hair loss
- Peripheral oedema
- GI disturbance
- Weight changes
- Sleep disorders
- Mood changes
- Paraesthesia
- Hypertension / Hypotension
- Increased dysuria
- Fatigue & muscle weakness (Leuprorelin Acetate)
• Palpitations (Leuprolrelin Acetate)
• Alteration of glucose tolerance and blood lipids (Leuprolrelin Acetate)
• Jaundice (Leuprolrelin Acetate)
• Thrombocytopenia and Leucopenia (Leuprolrelin Acetate)
• Dry mouth (Triptorelin)
• Pulmonary embolism (Leuprolrelin)
### Prescribing information for anti-libidinals

<table>
<thead>
<tr>
<th>DRUG</th>
<th>LICENCED FOR</th>
<th>TYPICAL DOSAGE</th>
<th>FORMULATION</th>
<th>COST</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TRIPTORELIN</strong></td>
<td>Advanced Prostrate Cancer</td>
<td>Decapeptyl SR – 3mg every 4 weeks.</td>
<td>IM Injection</td>
<td>Decapeptyl SR (powder for suspension) 15mg vial (with diluent) = £207.00</td>
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<tr>
<td></td>
<td></td>
<td>Gonapeptyl depot – 3.75mg every 4 weeks</td>
<td>S/C or deep IM injection</td>
<td>Gonapeptyl depot 3.75mg pre-filled syringe = £85.00</td>
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<tr>
<td><strong>GOSERELIN</strong></td>
<td>Prostrate Cancer, Advanced Breast Cancer</td>
<td>Zoladex – Goserelin 3.6mg in Safesystem syringe applicator every 28 days</td>
<td>S/C Implant</td>
<td>Zoladex – Goserelin 3.6mg in Safesystem syringe applicator = £84.14</td>
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<tr>
<td></td>
<td></td>
<td>Zoladex LA – Goserelin 10.8mg in Safesystem syringe applicator every 12 weeks</td>
<td>S/C Implant</td>
<td>Zoladex LA – Goserelin 10.8mg in Safesystem syringe applicator = £267.48</td>
</tr>
<tr>
<td><strong>LEUPRORELIN ACETATE</strong></td>
<td>Advanced Prostrate Cancer</td>
<td>Prostap SR – 3.75mg every 4 weeks</td>
<td>S/C or deep IM injection</td>
<td>3.75mg vial with 1ml vehicle-filled syringe = £125.40</td>
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<tr>
<td></td>
<td></td>
<td>Prostap 3 – 11.25mg every 3 months</td>
<td>S/C Injection</td>
<td>11.25mg vial with 2ml vehicle-filled syringe = £376.20</td>
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<tr>
<td><strong>CYPROTERONE ACETATE</strong></td>
<td>Prostate Cancer</td>
<td>50mg BD after food</td>
<td>Tablets</td>
<td>Non-propriety 56 x 50mg tablets = £31.54</td>
</tr>
<tr>
<td></td>
<td>Severe male Hypersexuality</td>
<td></td>
<td></td>
<td>Androcur 56 x 50mg tablets = £25.89</td>
</tr>
<tr>
<td></td>
<td>Male sexual deviation</td>
<td>Depot available on named patient basis</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX 4
DYNAMIC RISK ASSESSMENT TOOLS

An overview of dynamic risk domains of relevance to medical treatment

Stable dynamic risk factors are factors of importance to risk of sexual violence that tend to be relatively long-standing (i.e. stable) but may change over-time, perhaps through treatment. Such factors of relevance to sexual offending include deviant sexual interests, pro-offending attitudes, problems in emotional functioning, attachment and relationship difficulties, and problems with self-regulation. The stable dynamic risk factors of potential relevance to treatment with medication are:

- Deviant sexual interests
- Sexual pre-occupation
- Using sex to cope with negative emotions

There are risk assessment tools which have been developed to assess such factors. The two most commonly used are the Structured Assessment of Risk and Needs (SARN) and the Stable and Acute 2007 (SA07).

SARN
The SARN has been used in SPS to assess sex offenders in treatment programmes. There are four domains:

- Sexual interests
- Distorted attitudes
- Socio-affective functioning
- Self-management problems

Within the sexual interests domain are four forms of dysfunction:

- Sexual pre-occupation (obsessed with sex)
- Preferring sex to include violence or force
- Sexual preference for children
- Other offence related sexual interests

The SARN is rated in the basis of the individual’s offending history and so, if using a SARN assessment in considering referral, consideration will need to be given to whether any sexual problem is ongoing.

SA07
The SA07 is the assessment tool which is used by criminal justice agencies in Scotland (police, criminal justice social work and SPS) to assess Stable and Acute Dynamic risk factors in sex offenders. The Stable assessment should be completed once a year and covers a twelve month time frame of functioning. The Acute assessment should be completed at each contact and covers current functioning since last seen. Acute factors may change day to day.

The Stable part of the assessment covers the following factors:

1. Significant social influences
2. Intimacy deficits
   - Capacity for relationship stability
   - Emotional identification with children
   - Hostility toward women
   - General social rejection/Loneliness
   - Lack of concern for others
3. General self-regulation
   - Impulsive acts
   - Poor cognitive problem solving skills
   - Negative emotionality/Hostility
4. Sexual self-regulation
   - Sexual pre-occupation
- Sex as coping
- Deviant sexual interests
5. Co-operation with supervision

The three areas covered by sexual self-regulation are relevant to potential treatment with medication. Each item is scored 0, 1 or 2, so to be potentially suitable for medication an offender should score 2 on at least one of these three areas.
APPENDIX 5
INFORMATION SHEET & CONSENT FORM

INFORMATION SHEET: MEDICAL TREATMENTS FOR PEOPLE WHO HAVE COMMITTED SEXUAL OFFENCES

Psychological therapy like that given in Sex Offender Treatment Programmes is the main type of treatment for men who have committed sex offences. For some individuals, however, medication can provide further benefit. This is something you will be able to discuss with your supervising officer or Sex Offender Treatment Programme treatment manager. If you then think that medication might be right for you, a doctor will need to see you. The doctor will be able to give you much more information about what is involved. The purpose of this information sheet is to tell you about the two types of drugs that are most often used. These are known as Selective Serotonin Reuptake Inhibitors (SSRIs) and Anti-libidinal medication

**SSRIs**

You may have heard of the drug Prozac. This is the brand name for ‘fluoxetine’, which is one of a number of SSRIs. We commonly use SSRIs to treat depression, but they can also treat anxiety, being unable to stop thinking about things (obsessive thinking), feelings of having to do things you might not want to (compulsions), and doing things without really thinking them through (impulsivity). These drugs can be helpful when factors such as these are linked to offending.

SSRIs might be helpful if you have frequent sexual fantasies (particularly when you find it hard to distract yourself from these fantasies), if your sexual urges are hard to control, or if you have thoughts of offending when you feel depressed. In these situations, SSRIs should reduce the intensity of sexual fantasies and sexual urges. Then you can control your fantasies better, for example by using the skills you have learned in your treatment programme. Men who take SSRIs are still capable of having sex as normal.

SSRIs can cause a number of side effects, but these are usually mild, and often go away after the early stages of treatment. Examples are feeling sick, changes in how often you need to go to the toilet, poor appetite, restlessness, and headache. Your doctor will be able to discuss possible side effects with you in more detail.

**Anti-libidinal medication**

These drugs reduce levels of the male hormone testosterone. This has the effect of decreasing sexual interest and arousal. Although you can still have sex, it is much more difficult. It is possible, however, to adjust the dose to a level where you can have sex with a partner.

Doctors may recommend anti-libidinal medication for people who have such a high sex drive that they can’t focus very well in their treatment programme, or if their sex drive affects their normal day to day functioning. The aim is to ‘turn down the volume’ of sexual arousal.

The most common anti-libidinal medication is cyproterone acetate (also known as Androcur), which you take as a tablet. Other examples are leuprorelin acetate, triptorelin, and goserelin, all of which are given by long acting injection. Although very effective at reducing sex drive, these drugs can cause a wide range of side effects, such as hot flushes, breast growth, and a decrease in bone mass. Again, your doctor will be able to discuss all possible side effects with you in more detail.

Whenever medication is used, it is important to remember that the drug on its own will not ensure that reoffending will not take place. Your medication is just one part of your overall relapse prevention plan.
CONSENT FORM FOR ANTI-LIBIDINAL MEDICATION

I have read the information sheet regarding the use of medication to help manage my sexual behaviour. I have discussed the information sheet with ________________, and I have had an opportunity to ask questions about it.

I am aware of the possible side effects that can be caused by ________________. I know that I will be required to have regular blood tests and perhaps other investigations to monitor them.

I understand that these drugs can reduce sperm production, but that a baseline measure of my sperm count will not be carried out.

I have been told that it may be necessary to disclose information regarding my sexual risk and my response to treatment to appropriate people. I give my permission for this, although I have been informed that in most cases any information disclosed will be discussed with me first.

NAME  _____________________________
SIGNATURE _____________________________
DATE  _____________________________

I confirm that I have discussed the above with ________________

NAME  _____________________________
SIGNATURE _____________________________
DATE  _____________________________
APPENDIX 6
CONTACTS

If you have any general queries about this protocol and guidance please contact Dr Raj Darjee or Sharon Bruce.

If you would like to discuss a case and are unsure if referral would be appropriate, then please contact Dr Raj Darjee or Sharon Bruce.

If you would like to refer a case then please discuss the case with a local psychiatrist from the list below or with Dr Raj Darjee. When making a referral please send the referral form with relevant documents and reports. These should either be sent to Dr Raj Darjee who will then contact the local psychiatrist, or to the local psychiatrist with a copy to Dr Raj Darjee.

Forensic Network
Dr Raj Darjee
Consultant Forensic Psychiatrist, NHS Lothian
Lead Clinician for MAPPA and Sexual Offending, NHS Scotland Forensic Network
The Orchard Clinic, Royal Edinburgh Hospital, Morningside Terrace, Edinburgh EH10 5HF
0131 537 5866
rajan.darjee@nhs.net

Sharon Bruce
Forensic Network Administrator
The State Hospital, Carstairs, Lanark ML11 8RP
01555 842018
Sharon.Bruce@tsh.scot.nhs.uk

Psychiatrists – community
The following psychiatrists may be contacted about assessing cases in the community

Grampian
Blair Unit, Royal Cornhill Hospital, Cornhill Road, Aberdeen, AB25 2ZH
Dr Margaret Bremner – 01224 557 931, m.bremner@nhs.net
Dr Pauline Larmour – 01224 557 030, paulinelarmour@nhs.net
Dr John Boyd – 01224 557 227, john.boyd@nhs.net

Highland
New Craigs Hospital, Leachkin Road, Inverness, IV3 8NP
Dr Alistair Hay – 01463 253 614, alistair.hay@nhs.net

Tayside
Murray Royal Hospital, Muirhead Road, Perth, PH2 7BH
Dr Tom White – 01738 562 262, tomwhite@nhs.net

Fife
Stratheden Hospital, Cupar, Fife, KY15 5RR
Dr Bill Dickson – 01334 696 737, bill.dickson@nhs.net

Lothian & Borders
The Orchard Clinic, Royal Edinburgh Hospital, Morningside Terrace, Edinburgh, EH10 5HF
Dr Raj Darjee – 0131 537 5866, rajan.darjee@nhslothian.scot.nhs.uk
**Forth Valley**
NHS Forth Valley, Unit 4, Gateway Business Park, Beancross Road, Grangemouth, FK3 8WK
Dr Rhona Morrison – 01324 667 722, rhona.morrison@nhs.net

**Lanarkshire**
Hartwoodhill Hospital, Shotts
Dr Willie Black – 01501 824 651, William.Black@lanarkshire.scot.nhs.uk

**Glasgow**
Douglas Inch Centre, Woodside Terrace, Glasgow, G3 7UY
Dr Melanie Baker – 0141 211 6462, melanie.baker@ggc.scot.nhs.uk
Dr Louise Ramsay – 0141 211 8000, louise.ramsay@ggc.scot.nhs.uk

**Ayrshire**
Upper Rec hall, Ailsa Hospital, Dalmellington Road, Ayr
Dr Dawn Carson – 01292 513 982, dawn.carson@aapct.scot.nhs.uk

**Dumfries and Galloway**
Crichton Royal Hospital, Bankend Road, Dumfries, DG1 4TG
Dr David Hall – 01387 244 114, dhall2@nhs.net

**Psychiatrists – prison**
The following psychiatrists are available to assess cases in the prisons that undertake work with sex offenders:

**HMP Peterhead**
Dr Margaret Bremner (as above)
Dr Pauline Larmour (as above)
Dr John Boyd (as above)

**HMP Edinburgh**
Dr Raj Darjee (as above)

**HMP Barlinnie**
Dr Melanie Baker (as above)
Dr Louise Ramsay (as above)

**HMYOI Polmont**
The State Hospital, Carstairs, ML11 8RP
Dr Natasha Billcliff – 01555 842035, Natasha.billcliff@tsh.scot.nhs.uk

**HMP Dumfries**
Dr David Hall (as above)

If cases arise in other prisons then the relevant visiting psychiatrist may be contacted and he/she may wish to consult with Dr Darjee about the case.

**Community sex offender treatment programme managers**
Any community referral should be made by, or after consultation with, the local sex offender treatment programme manager.

**Ayrshire/ Dumfries and Galloway**
Ray Jones, ray.jones@east-ayrshire.gov.uk
Dumbarton
Lorna Wilson, lorna.wilson@renfrewshire.gov.uk

Fife/Forth Valley
Jim McCormick, jim.mccormick@falkirk.gov.uk
Richard Munton, richard.munton@fife.gov.uk
Suzanne Ross, suzanne.ross@fife.gov.uk
Angela Simpson, angela.simpson@fife.gov.uk

Glasgow
Angelene Brown, angelene.brown@sw.glasgow.gov.uk

Grampian
Corrine Innes, corinne.innes@aberdeenshire.gov.uk

Highland
To be confirmed.

Lanarkshire
Robert Dempsey, robert.dempsey@southlanarkshire.gov.uk
Cathy Miller, MillerCa@northlan.gov.uk

Lothian and Borders
Susan Forsyth, susan.forsyth@edinburgh.gov.uk
Stewart Stobie, stewart.stobie@edinburgh.gov.uk
Janie Watson, janie.watson@edinburgh.gov.uk

Tayside
To be confirmed.

Prisons
Any prison referral should be made by, or after consultation with, the local sex offender treatment programme manager.

HMP Barlinnie
Lee Avenue, Riddrie, Glasgow, G33 2QX
Phil Kennedy – 0141 770 2018, phil.kennedy@sps.pnn.gov.uk

HMP Edinburgh
33 Stenhouse Road, Edinburgh, EH11 3LN
Sarah Angus – 0131 444 3188, sarah.angus@sps.pnn.gov.uk

HMP Peterhead
Peterhead, Aberdeenshire, AB42 2YY
Allyson Campbell - 01779 485 041, allyson.campbell@sps.pnn.gov.uk
Fiona Barbour – 01779 485 056, fiona.barbour@sps.pnn.gov.uk
Pamela MacDougall – 01779 485 083, pamela.macdougall@sps.pnn.gov.uk

HMYOI Polmont
Falkirk, FK2 0AB
Wendy Gibson – 01324 722 215, wendy.gibson@sps.pnn.gov.uk

SPS Head Quarters
Calton House, 5 Redheughs Rigg, Edinburgh, EH12 9HW
Carole Murphy – 0131 244 6991, carole.murphy@sps.pnn.gov.uk
APPENDIX 7

EVIDENCE BASE

Evidence base

Below are listed some references on the effectiveness of pharmacological treatments for sex offenders. Although there is a dearth of randomised controlled trials, the conclusions of international experts in the field, based on the evidence that is available, is that the evidence for the use of SSRIs (Adi et al. 2002) and anti-libidinal medication (Briken and Berner 2003) is supportive and positive, although not necessarily robust, and that the use of such medications is justified and should be considered in the treatment of sexual offenders. A recent meta-analysis (Lösel and Schmucker 2005) concluded that the effect size for medication in reducing re-offending was large and greater than for cognitive-behavioural therapy, although it should be noted that medication was rarely used in isolation from psychological interventions. These medications are used in a number of developed countries, including Canada, USA, Germany and England, as an adjunct to psychosocial interventions.

References


comprehensive meta-analysis. Journal of Experimental Criminology, 1, 1-29.


