Anti-libidinal medication use in People with Intellectual Disability: Is it in the Person’s Best Interests?

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Background challenges

- Seen as a panacea by Disability Services
- Prescribed by GPs not for offenders
- Ethical issues for anyone prescribed anti androgen medications
- Compounded by the person with an Intellectual Disability ability to consent
- Level of Risk v side effects of medication
- Often not accompanied by other psychotherapeutic treatment
- Although guidelines exist they are rarely used
Role of the Senior Practitioner-Disability (Victoria)

- **Protects:**
  - The rights of people with a disability
  - Especially those with restrictive interventions and compulsory treatment (section 23(2)(a))

- **Ensures:**
  - That appropriate standards in relation to restrictive interventions and compulsory treatment are complied with (section 23(2)(a))

- **Develops:**
  - Guidelines and standards (section 24(1)(a))
  - Links with professional bodies and academic institutions (section 24(1)(f))

- **Provides:**
  - Education and information to DSPs (section 24(1)(b))
  - Information about rights (section 24(1)(c))
  - Advice to improve practice (section 24(1)(d))
  - Direction in relation to restrictive interventions and compulsory treatment (section 24(1)(e))

- **Evaluates and Monitors:**
  - The use of restrictive interventions (section 24(1)(h))

Males reported on RIDS 2008-2012

<table>
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<th>Year</th>
<th>Cyproterone Acetate</th>
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<tr>
<td>2011-2012</td>
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Prescribing of Depo Provera

The Delphi process

- OPP identified a group of 24 experts across Australian states (VIC, QLD, NSW, TAS) and in New Zealand
- These included practitioners, prescribers, policy makers
- All had voiced an interest in discussions on the topic area and were known for their work in the area
- Invited to participate in consultation by email
- Asked to complete and return within 4 weeks
- Three follow-up opportunities to respond
- Aggregate, compare and contrast responses
- Draft Briefing Paper for further comments and suggestions
Two possible guidelines


The task

- Provide some brief details on:
  - legal framework for prescribing anti-libidinals,
  - how capacity and consent are assessed
  - prescribing policies/protocols and adjunct therapies

- Review of WFSBP guidelines
  - how suitable would they be in their jurisdictions, what modifications are/would be required?

- Provide case examples (e.g., lacking capacity to consent; person under care of MHA; person < 16 yrs whose parents object; challenges with therapies)
Consideration of social and human rights issues

- Generally tokenistic in the literature
- Tendency to allude to there being broader ‘ethical’ issues with prescription/use but not transparent on details
- Community demand response due to nature of client group – trump individual human rights to protect community?
- Question general importance in light of nature of offending/inappropriate behaviour/fantasies, risk

Case example 1

Vision impaired middle aged male, in 1995 allegedly inappropriately sexually touched and masturbated in front of his 6 year old female relative with no charges or follow-up

Note - limited success with psychotherapeutic approaches due to rigidity/concrete thinking + paraphilic sense of entitlement

Length of treatment 8 years to date of antilibidinal medication, no baseline medical, private psychiatrist written and informed client will be have to be on antilibidinal medication for rest of his life

Consider protective factors in risk assessment? Additional SSRI and self-reports significant difficulties masturbating and associated MH
Case example 2

A male with established mild ID
Under MHA burglary conviction, high level of sexual motivation
Hx sexual homicide, long hx sexual behaviour & fantasies
Assessment – significant historical risk and increasing, persistent libido and fantasies = second opinion sought
Patient consented to antilibidinal medications no exploration of capacity beyond noting some insight and understanding purpose of antilibidinal medications
Outcome – 3 months later…

Issues…

- Use of ALM as a substitute for/in lieu of behavioural and other psychological treatments
- Concern that broader application may lead to reduction in attempts to robustly attempt/trial psychological approaches (i.e., all too quickly resort to antilibidinal medications as a 'band aid'/quick fix solution
- Persuading patients to continue taking because of how it would be viewed more favourable
Seeking informed consent?

- Despite some services having prescribing practices, the informed consent process remains unsuitably vague.
- Commonly verbally driven, lack of standard, consistent information being provided.
- Raises challenges around nature of prescriber (esp. if outside forensic specialist role).
- Even current WFSBP Guidelines note psychiatrist can decide if patient consent not forthcoming.

Plain Language Consent Form

The therapeutic intention of this medication is to decrease abnormal sexual and aggressive fantasies and urges, while attempting to not affect normal, healthy sexual drive. The medication takes several days or weeks to begin to work and the former type and strength of sex drive returns within a few days or weeks of stopping treatment.
Indications for hormone treatment

- Compulsive fantasies with a proven inability to control sexual arousal
- Predatory, violent sexual behaviours
- Sexual violence under institutional conditions
- Previous (non-pharmacological) treatment failures
- Patient under considerable mental stress because of their uncontrollable drive
- Patients who are less capable of utilising cognitive therapies (e.g. in some cases of ID, major mental illness, ABI)

Balancing the risks...

General consensus that if the risks of withholding hormone treatment outweigh the risk of exacerbating the co-morbid illness, consideration should be given to obtaining the relevant specialist opinion and proceeding with hormones in conjunction with continued specialist treatment and monitoring.
Incorporating the WFSBP guidelines

- Requires an addendum (in the ‘Australasian Context’)
- Careful consideration of specific language/emphasis required
- Underlying need to ensure consistency, therefore very specific terminology consistent with legislation (i.e. predicated around reducing or managing risk)
- Need more specifics re timing and frequency of reviews for:
  - sexual fantasies/function,
  - physical contradictions (e.g. bone density), and
  - reaffirming consent

Addressing the perennial issue of consent

- Simplified approaches which reinforce the day-to-day treatment concepts proving to be effective (Lambrick & Glaser, 2004)
- BUT needs to be particularly thorough and transparent process
- Use of combined picture and word formats in a narrative format
- Written information equivalent ‘understandability’ to a Flesch-Kincaid Readability score of a Grade 3-4 US student
- Simplified language, use of oral checklist and score sheet, e.g., “If you do not want to answer a question what do you say?”
- Reaffirm consent at each and every review meeting
Recommendations arising

- ALM should only be considered for a small population of sexual offenders
- Risk should be assessed by trained clinicians
- Treatment should be through a specialist forensic psychiatrist
- There should be regular follow up and review of treatment response
- ALM should be part of a multifaceted support plan
- Informed consent is paramount
- Medical monitoring should be carried out regularly
- Calcium supplements should be given routinely

Where to from here?

- Publish results of study
- Continue discussions
- Adoption of guidelines
- Influence policy
- Continued research in this area
References


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