The Ethics of the Use of Androgen Deprivation Therapy (ADT) for Child Sex Offenders

This thesis is submitted to fulfil the requirements for the degree of

Master of Research

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Summary

In August 2013 a New South Wales government Joint Select Committee commenced an inquiry into alternative sentencing options for convicted child sex offenders. One of the options under their consideration is Androgen Deprivation Therapy (ADT), a treatment that consists of administering anti-androgenic medication to decrease the level of testosterone to a pre-pubescent level. This thesis considers the option of offering ADT to offenders with the incentive of earlier release from incarceration, as an alternative to continuation of the full incarceration period. These particular conditions raise ethical questions regarding whether the offender's autonomy can be respected under what I describe as incentivized circumstances. I explore autonomy in the context of incentivizing offers, and examine the concerns of philosophers who debate whether offenders can make autonomous choices under such circumstances. The conclusion of this analysis is that while the choice conditions in which offenders are offered ADT do constrain the extent to which fully voluntary consent can be given to the treatment, nevertheless, offering ADT can be understood to enhance autonomy when offered to offenders with the greatest prospect of benefitting from such treatment. Finally, the thesis makes proposals as to the specific conditions in which ADT should be offered if it is to have the potential of enhancing the autonomy of such offenders.

Candidate's statement

I hereby state and certify that this work has not been submitted for a higher degree to any other university or institution and that I am the sole author of this thesis. All references to the work of others has been indicated and acknowledged.

Signed,

Michelle Qian Yang Lai

Acknowledgements

Entering graduate philosophy from an undergraduate psychology background was never going to be an easy task. There have been many moments of shock and joy, and periods of enlightenment and despair. My entry into philosophy has been bumpy but exciting. I jumped straight into the deep end in early 2013, when I commenced the Master of Research program by reading the works of Aristotle, Kant, and Wittgenstein. Attending the Bioethics Reading Group that is run by the Department of Philosophy's Centre for Agency, Values and Ethics (CAVE) has opened my eyes to the world of applied ethics and enabled me to think more critically about moral dilemmas that are present in health and medicine fields.

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Introduction

Child sex offenders in Australia have been placed under the public spotlight in recent years. Particularly, scrutiny has been placed on how sex offences have been responded to by both institutions and criminal courts. Governments at both the federal and state levels have begun addressing child sex offences of both the past and future. Commissions such as the federal government's Royal Commission into Institutional Responses to Child Sexual Abuse, which is an ongoing enquiry that began in January 2013, have shone lights on child sexual abuse that occurred in institutions such as schools, religious groups, sport clubs, youth groups, and state organisations such as foster care homes (Australian Government, 2013). Particularly, the Commission focuses on how the institutions have responded to claims and acts of abuse, as well as aims to make recommendations for improvement with regards to policy, law, and practices.

On a state level, the attention of the New South Wales government has focused on the sentences given to convicted child sex offenders by the court. The government announced that the community was "sickened" by child sex offences, sentences are out of step with community expectations, and that current sentencing options must be investigated to ensure they remain effective; though the government did not specify exactly what sentences are supposed to be effective at (O'Farrell, 2013). Furthermore, sentencing options such as minimum mandatory sentences and anti-androgenic medication will be considered as alternative sentencing options to the current system (O'Farrell, 2013).

This reaction coincides with the media's reporting of particular cases of child sex offence sentences. For example, a man was sentenced to receive treatment for 2 years at a residential treatment centre for first-time incest offenders called Cedar Cottage and was given a three year good behaviour bond, avoiding incarceration. The response of The Sunday Telegraph and The Daily Telegraph media outlets was to launch a campaign for minimum sentences for child sex offences (The Daily Telegraph, 2013). The Cedar Cottage program was shut down by the then Attorney-General Greg Smith MP, and the non-custodial sentence given to the offender was cited as one of the reasons the program was terminated (O'Farrell, 2013). The community, according to the government, expects offenders to be given custodial sentences (Hall, 2012; O'Farrell, 2013).

The termination of the program was met with disapproval from families of abuse victims, as well as authority figures on sex offender treatment who state that recidivism of offenders

who undergo the program decreases from 12 per cent to 5 per cent, and that it is a more cost-effective alternative to incarceration (Hall, 2012). Some families of abuse victims have also said that the program has also provided support to victims, allowing them to confront their abuser (Hall, 2012). This shows that decisions that are made by the government that concern sex offenders ought to take into account the views of all interested parties, such as the offender, the victim, as well as the community. There is another perspective that the government ought to also take into account: the ethical acceptability of the alternative sentencing options they are considering.

The focus of my thesis will be on whether it is permissible, from an ethical standpoint, for offenders to be offered to anti-androgenic treatments, otherwise known as Androgen Deprivation Therapy (ADT). Particularly, I will examine whether, in a legal context, ADT can be considered autonomy-respecting when it is offered with the incentive of earlier release from incarceration. Autonomy is one of the most commonly appealed to concepts in applied ethics, particularly in discussions of controversial issues pertaining to how we ought to treat each other. It is an important moral consideration that must be taken into account if offering ADT is to be considered morally justified, particularly whether it is compatible with making fully voluntary choices in incentivised contexts. Therefore, the aim of my thesis is to examine whether these practices are defensible in relation to autonomy.

The first chapter of this thesis will outline what ADT entails, as well as the medical effects that are associated with the treatment. I will also highlight how ADT is administered in various international and domestic jurisdictions. I will finally outline the empirical research that has been conducted on how ADT ought to be implemented to be effective in reducing recidivism, as well as the methodological limitations of such research. The second chapter of my thesis will examine the existing literature on autonomy, focusing on procedural and substantive accounts of autonomy as well as raising the key issues that ought to be addressed in an analysis of incentivised ADT. I will also arrive at the two key questions my thesis seeks to address. In the third chapter, I will answer the first question that my thesis focuses on. This concerns whether offering incentivised ADT can be considered autonomy-respecting in relation to the issue of valid consent and whether it is appropriate to make such an offer. I will also consider whether offering incentivised ADT can be considered autonomy-enhancing. In the final chapter, the second question will be addressed where, as a result of my analysis in the previous chapter, I will suggest how ADT ought to be offered to offenders in order for it to be autonomy-respecting.

Chapter One: Androgen Deprivation Therapy (ADT)

On the 11th of August, 2013, the now former premier of New South Wales, Barry O'Farrell MP announced that a parliamentary committee would examine the sentences given to child sex offenders, as well as alternative sentencing options for such offenders (O'Farrell, 2013). The committee that was established is called the Joint Select Committee on Sentencing of Child Sexual Assault Offenders and is comprised of members from both houses of parliament – the Legislative Council and the Legislative Assembly. On the 21st of August 2013, the Committee commenced an inquiry into the current sentencing options for convicted child sex offenders. The Committee is examining whether existing sentencing options are effective (though they did not specify what exactly sentencing options should be effective at), as well as whether alternative sentencing options could improve the public's confidence in the judicial (Parliament of New South Wales, 2013a). As part of the inquiry, the Committee will consider alternative sentencing options such as minimum mandatory sentences and the use of anti-androgenic medication, otherwise known as Androgen Deprivation Therapy (ADT), which the Chair of the committee, Troy Grant, emphasised will be investigated to determine whether it "may produce better outcomes for victims and offenders alike" (Parliament of New South Wales, 2013b).

In the first section of this chapter, I will explore what ADT involves and for which groups of offenders it may be effective in reducing recidivism, as well as the medical side effects associated with ADT. In the second and third sections of this chapter, I will examine the legal treatment of sex offenders and how ADT is utilised and implemented in both domestic and international settings. In the final section, I will examine expert opinion on how ADT should be implemented as well as research on the efficacy of ADT that has been conducted on sex offenders. I will also consider methodological limitations of such studies in my examination to evaluate the strength of the findings of these studies.

The treatment

ADT involves the periodic administration of anti-androgens, these being pharmacological agents such as Medroxyprogesterone acetate, Cyproterone acetate, and Gonadotropin-releasing hormone agonists that inhibit the production of testosterone to the levels seen in pre-pubescent boys (Thibaut et al., 2010). Testosterone plays an important role in a male's sexual interest and sexual arousability (Jordan et al., 2011). Changes to testosterone levels affects their central arousal mechanisms, whereby a reduction is consistently shown to be associated

with a decrease in sexual impulses. This is evident within 3 to 4 weeks of testosterone inhibition (Bancroft, 2005). This reduction in testosterone attenuates the offender's sexual urges and suppresses their sexual thoughts and sex drive; however, these effects are reversible once the medication is ceased.

Studies have suggested that ADT may be particularly effective at reducing recidivism for child sex offenders with a paraphilic disorder (Garcia et al., 2013). A 'paraphilic disorder' denotes "any intense and persistent sexual interest other than sexual interest in genital stimulation or preparatory fondling with phenotypically normal, physically mature, consenting human partners" (pp. 685). In other words, a paraphilia is sexual arousal in response to objects, situations, or non-consenting individuals that is outside the range of usual sexual interests (Beech & Harkins, 2012). The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders 5th Edition (2013) defines a paraphilic *disorder* as "a paraphilia that is currently causing distress or impairment to the individual or a paraphilia whose satisfaction has entailed personal harm, or risk of harm, to others" (pp. 685-686). The most notable type of paraphilic disorder relevant to child sex offenders is pedophilic disorder, where the paraphilia concerned is children; specifically, it is characterised by a targeted preference towards prepubescent children or children aged 13 years or younger (pp. 697).

The intense sexual urges and thoughts may impact on a paraphilic offender's ability to focus or participate in psychological treatment programs such as counselling or psychotherapy that aims to help the offender apply techniques to manage their sexual preoccupation (Marshall et al., 2006, Saleh et al., 2010). Focusing on deviant sexual thoughts can impair the offender's ability to comprehend and acknowledge their problems and thereby decrease their receptivity and response to psychological intervention, particularly if they do not wish the sexual thoughts to cease. Marshall et al. (2006) incorporated ADT into their rehabilitation of paraphilic sex offenders in order to lower their libido and alleviate their feelings of being overwhelmed by sexual urges. In some cases selective serotonin reuptake inhibitors (SSRIs) would also be administered to manage sexual thoughts. Such pharmacological interventions are considered to be part of the total treatment approach for offenders and aid their receptivity and responsiveness to psychological interventions (Marshall et al., 2006).

Medical Effects of ADT

While ADT causes a reduction in testosterone levels which may be helpful in controlling sexual urges in sex offenders, the inhibition of testosterone to prepubescent levels in adult

males is associated with numerous medical side effects that require further medical treatment to address. For example, ADT can cause effects to the health of bones, by decreasing the offender's bone mineral density, thereby increasing their risk of sustaining fractures (Gooren, 2011). Changes can also occur to metabolic function, mood, and sebaceous gland activity of the skin (Giltay & Gooren, 2009). It is also associated with osteoporosis, weight gain, increased visceral adiposity (abdominal fat), impaired glucose tolerance, dyslipidaemia (abnormal amount of lipids in the blood), as well as emotional disturbances. Giltay & Gooren (2009) found that co-morbidly, these conditions may result in an increased risk of fractures and diabetes mellitus (both by 40% to 50%), as well as an increased risk of cardiovascular disease and depression (both by 10% to 20%). This suggests that effective and safe monitoring and management of sex offenders and side effects is required by specialists such as endocrinologists, as well as preventative measures to ensure minimal harm is caused (Harrison, 2007).

Existing international legal treatment of sex offenders

Internationally, ADT is administered in some countries in North America, Europe, and most recently South Korea (Douglas et al., 2013; Koo et al., 2013; Scott & Holmberg, 2003). In the United States eight states (Georgia, Montana, Oregon, Wisconsin, California, Iowa, Florida, and Louisiana) allow the administering of ADT for certain sex offenders (Scott & Holmberg, 2003). ADT is largely discretionally offered to offenders, particularly when they are being considered for parole, as a condition of release, or when their sentence is being reviewed whilst they are already incarcerated. To determine whether an offender is psychologically and medically suitable for the treatment, they must undergo psychiatric or medical assessments, or both (Thibaut, 2010). Furthermore, factors such as the severity of the offence, the age of the victim, and whether the offender is a repeat offender is also considered (Scott & Holmberg, 2002).

ADT programs are typically offered in two different forms, depending on the individual jurisdiction. They can be offered either as *formally optional* or *mandated* as a condition of release (Douglas et al., 2013). ADT is *formally optional* where no link is made between refusal to consent to ADT remaining incarcerated for the remainder of their sentence. Therefore, there will be no impact on whether the offender will continue to be incarcerated if they do not give their consent to be administered ADT. For example, in the situation where an offender is being considered for parole and they are offered formally optional ADT and refuse to give their consent, they will not be kept incarcerated after their date of release or prevented

from being paroled, and will subsequently be released. Thus, ADT is only administered when consent is obtained from the offender. In European countries such as Denmark, England, Sweden, Spain, Germany, Italy, the Czech Republic and Hungary, as well as states in America such as Georgia, Wisconsin, and Montana, the dominant approach is to offer ADT as a formally optional intervention (Aagaard, 2014, Douglas et al., 2013, Harrison, 2007, Scott & Holmberg, 2002). In Denmark, offenders must not only volunteer and give their consent to undergo ADT, but they must also admit their guilt (Aagaard, 2014). This is part of a process whereby the prison and probationary services assess the offender's motivation for undergoing ADT and whether they are medically and psychologically suitable for it. In cases where it is considered appropriate for the offender to undergo ADT, the Danish Legal Medical Council must approve the treatment.

When ADT is *mandatory* as a condition of release, offenders must undergo ADT, otherwise they will not be released; and if they cease the treatment after being released, they will be re-incarcerated. In Florida, under the *Florida Statutes* (1997, 794.0235), offenders who are required to undergo ADT upon release face a choice between ADT and remaining incarcerated (Douglas et al., 2013). Furthermore, if they refuse to comply, it may result in a new conviction of felony of the second degree which entails further punishment. Whether or not an offender is required to undergo ADT depends on whether it is the offender's first or second conviction of sexual battery, as well as the results of the assessment of a court-appointed medical expert. For an offender's first conviction of sexual battery the court has the discretion to include ADT in the offender's sentence. Offenders with a prior conviction of sexual battery who is convicted a second time for the same offense are required to undergo ADT unless the court-appointed medical expert assesses ADT to be medically inappropriate for the offender. In the sentence, the court must also specify the duration that the offender must under ADT, which can last up to the offender's lifetime and must begin at least one week prior to the offender's release. This practice also exists in the American states of California, Iowa, Oregon, Louisiana, as well as in Poland, Belgium, and South Korea (Douglas et al., 2013, Koo et al, 2013, Scott & Holmberg, 2002).

Existing domestic legal treatment of sex offenders

Domestically, the states of Western Australia[1], Victoria[2], and Queensland[3] implement ADT under the same conditions as New South Wales, but in relation to their relevant respective institutions. Therefore, I will focus on the legal measures in place in New South Wales in order to demonstrate how ADT is deployed by the states' legal systems.

Presently within the court system of New South Wales, under the *Crimes (High Risk Offenders) Act 2006 (NSW)*[4], high risk sex offenders may be directed to participate in treatment and rehabilitation programs as a condition of an extended supervision order which is imposed by the Supreme Court of New South Wales. Offenders are considered by the Supreme Court to be high risk if there is a "high degree of probability that the offender poses an unacceptable risk of committing a serious sex offence if he or she is not kept under supervision" (section 5B). Such orders stipulate that an offender must be intensively supervised and monitored according to particular conditions that commence when the offender's custody or current supervision order expires and cannot last longer than 5 years (section 10).

The State of New South Wales can apply to the Supreme Court for an extended supervision order for an offender they consider a high risk in the final six months of the offender's current custody or supervision (section 6). The application must include supporting documentation, including a report prepared by a registered psychologist, psychiatrist, or medical practitioner who assesses the likelihood of the offender committing another serious sex offence (section 6). The Supreme Court determines whether or not to make an order, by considering matters such as the results of psychiatric or psychological examinations of the offender's likelihood to commit further serious sex offences, the willingness of an offender to participate in treatment or rehabilitation programs, and the results of statistical or research evidence regarding whether people with similar characteristics reoffend (section 9).

The order imposes conditions for the offender to comply with. Of importance to this thesis is that one such condition that may be imposed is that the offender must participate in treatment and rehabilitation programs (section 11). Such treatment includes pharmacological

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[1] *Dangerous Sexual Offenders Act 2006 (WA)*
[2] *Serious Sex Offenders Monitoring Act 2005 (VIC)*
[3] *Dangerous Prisoners (Sexual Offenders) Act 2003 (QLD)*
[4] The *Crimes (Serious Sex Offenders) Act 2006 (NSW)* stipulates the exact same conditions as the *Crimes (High Risk Offenders) Act 2006 (NSW). Therefore, I will only refer to sections in the Crimes (High Risk Offenders) Act 2006 (NSW) for reasons of brevity.*

interventions such as antidepressants, antipsychotics, and a further option that is available and sometimes deployed is the option to treat with anti-androgens. Thus, the Court has the capacity to impose conditions that require the offender to take part in treatment programs such as ADT. As part of an extended supervision order, ADT is used to facilitate rehabilitation and reduce the risk of recidivism upon release, rather than to punish offenders. Furthermore, the *Act* does not specify that the offender's consent must be obtained for an order to undergo ADT to be made; however, in practice it is difficult to impose such an order on an offender when health professionals are unable to administer ADT if the offender does not give their consent.

ADT is typically administered outside the direction of the Court and instead under the direction of Corrective Services New South Wales (CSNSW) sex offender program psychologists, who work in both custody settings and the community (New South Wales Government, 2014). They refer offenders to the Justice Health department, which provides health care in the New South Wales criminal justice system. Referrals are made based on whether there is a high risk of the offender reoffending, whether the offender is sexually preoccupied with deviant sexual thoughts, and whether psychological treatment to treat these thoughts has been ineffective. A team of Justice Health clinicians assess the offender's suitability for ADT in a community-based sex offender program site that was established in 2007 for the purpose of the clinical assessment and pharmacological treatment of offenders. ADT is administered only as a supplement to psychological intervention rather than as an alternative, as it only addresses the sex drive and urge component in the offender's management and it is also voluntary.

The practice of requiring high risk sex offenders to undergo ADT under the conditions of an extended supervision order have received little coverage; however in 2012, media reports suggested that in Western Australia, 7 offenders who were deemed high risk sex offenders were released on extended supervision orders on the condition they continued to undergo ADT (Perth Now, 2012). However, in 2013, one of the offenders who was undergoing ADT experienced sufficiently many adverse effects that the supervising authorities deemed the treatment to be too dangerous to continue, and they ordered the offender to cease ADT (Australian Broadcasting Association, 2013). The offender experienced serious side effects such as osteoporosis and cardiac problems. This shows that ADT is indeed being implemented domestically according to legal requirements, and that there are mechanisms in place for the termination of ADT if required.

Expert opinion on the implementation of ADT

There is a general consensus among clinical professionals, such as psychiatrists and psychologists who are involved in the treatment of sex offenders, that a process which is voluntary and where release is not connected with or dependent upon avoiding further incarceration, is the most effective approach to implement ADT (Harrison, 2007; Saleh et al, 2010). They advocate for ADT to be part of a process centred on rehabilitating the offender as part of, or separate to, the sentence, rather than being at the core of punishment. They believe that ADT should not form part of the punishment, but should rather be a means to rehabilitating the offender to ensure recidivism does not occur when they are released.

There is also general consensus in the literature on ADT that it is effective in treating offenders with paraphilic disorders such as exhibitionism and pedophilic disorder (Thibault et al, 2010). In 2010, the World Federation of Societies of Biological Psychiatry (WFSBP), which is an international world authority on biological psychiatry and represents 4500 professionals in the field, published guidelines for the biological treatment of paraphilia (Thibault, et al., 2010). The guidelines were recommended to be followed by clinicians who diagnose and treat patients with paraphilia. They recommend that offenders with a paraphilia should undergo ADT as long as it is part of a comprehensive treatment program that includes psychological interventions such as psychotherapy, as well as behavioural therapy. This is because paraphilias are often associated with other psychiatric co-morbidities, including affective disorders, substance abuse disorders, schizophrenia, personality disorders, depressive disorders, as well as impulse control disorders that must also be addressed as part of rehabilitation (Kafka & Hunnen, 2002; Thibault et al., 2010).

Furthermore, studies have also shown that psychological intervention alone is not as effective in reducing the level of sexual preoccupation suffered by offenders who experience high levels of sexual preoccupation, such as those with paraphilic disorders, compared with offenders who do not have such disorders (Guay, 2009). Particularly, offenders who do not have an ability to distract themselves from their preoccupation may receive reduced benefits from stand-alone psychological interventions (Winder et al., 2014). This is particularly seen in offenders who have a history of failed sex offender treatment where the dominant form of treatment is psychological intervention such as cognitive behavioural therapy (Turner et al, 2013).

Whilst ADT may appear to be effective for paraphiliacs in reducing recidivism, the effectiveness of ADT relies on the adequate monitoring of offenders. This is to ensure that offenders are taking the correct dosage, or are not reversing the effects by taking testosterone supplements, as the desired effects of reducing sexual arousal will not be achieved if they are not taking adequate doses of anti-androgens or are not complying with the prescribed regimen. Furthermore, as mentioned earlier in this chapter, there are many medical effects associated with a reduction in testosterone that may manifest into other illnesses that must be treated or monitored by medical professionals. Thus, any ADT programs must be closely monitored and controlled to ensure compliance as well as to ensure that adverse medical effects are managed appropriately and minimised (Thibault, 2010).

One of the most comprehensive studies of the implementation of ADT for sex offenders as part of a legal setting has been the Depo-provera program in the American state of Oregon (Maletzsky et al., 2006). Under the *House Bill 2500*, selected sex offenders are required to be evaluated prior to their release to determine whether the risk of recidivism would be reduced for the offender if they underwent ADT. Maletzsky et al. (2006) studied 275 offenders who were evaluated for the treatment in the period 2000–2004. Three groups were studied: offenders evaluated as requiring ADT and who underwent it as a condition of their post-release supervision; offenders evaluated as requiring ADT but who did not undergo it; and offenders deemed to not require ADT. All offenders received cognitive behavioural therapy (CBT). The researchers found that offenders who received ADT were less likely to commit new offences or violate conditions of their parole compared to the other two groups. Furthermore, a large majority of new offences – where they did occur - were not of a sexual nature. The researchers believe that this is consistent with the lowering of sex drive that ADT causes. Almost a third of the offenders who were evaluated as requiring ADT but did not receive it committed new offences, 60% of which were sexual offences (Maletzsky et al, 2006).

Methodological issues

It is important to note that studies on the efficacy of treatments for paraphilic child sex offenders to reduce recidivism often have methodological limitations that constrain the strength of their findings (Thibault et al, 2010). Such limitations include methodological biases as well as difficulties with conducting such studies (Beech & Harkins, 2012). For example, small sample sizes may lead to false negative or false positive results. The relatively

low base rate of sexual offence recidivism requires large samples to reveal a statistically significant treatment effect (Bradford et al, 2013). Also, many of the studies do not examine treatment-outcome and recidivism-outcome in the long-term (Bradford et al, 2013). Therefore, until more longitudinal studies are conducted to gauge the long-term effects of ADT, the applicability of the findings ought to be approached with caution.

It is also difficult to replicate the findings of studies or even to compare them due to methodological differences. These include: differences in the duration of treatment until follow-up; type of paraphilias that were studied; varying definitions of recidivism (particularly, what types of offences were constituted as a sexual offence; whether a retrospective or prospective design was used; whether the participants were prisoners in a goal setting or out-patients in a community setting; the level of compliance of the offender; and the statistical analyses used (Rice & Harris, 2011). Furthermore, it is also difficult to compare studies that examine the efficacy of ADT in conjunction with psychological intervention as the therapists who are counselling the offenders may have a significant impact on therapeutic outcomes (Guay, 2009). It is difficult to delineate the effects of ADT from the effects of psychological intervention when both are administered in conjunction with each other. This is difficult in cases where offenders may have comorbid psychiatric conditions that must be managed by psychological intervention (Guay, 2009, Naficy et al., 2013). Furthermore, it is also difficult to delineate the effects of ADT when other pharmacological agents are taken by the offender. For example, Dunsieth et al. (2004) found that a number of sex offenders have comorbid depressive disorder and take antidepressants that may cause a reduction in sex drive as well as a decrease in sexual thoughts as a side effect. Therefore, it is difficult to assess the impact of ADT separate from other forms of treatment the offender is concurrently taking.

For these reasons, the conclusions of the findings of studies examining the efficacy of ADT in reducing recidivism of sex offenders are preliminary and tentative and require more research with robust methodology. However, despite these shortcomings, it is generally accepted that ADT can be and has been successful in reducing recidivism rates of sex offenders, particularly for those with paraphilic disorders, in conjunction with psychological interventions (Saleh et al, 2010; Thibault et al., 2010).

Chapter Two: Autonomy

As the Joint Select Committee on Sentencing of Child Sexual Assault Offenders considers ADT as a sentencing option for child sex offenders, the question is posed of whether the use of ADT is acceptable, particularly whether it is morally acceptable. Autonomy is one of the most commonly appealed to principles in moral philosophy, particularly in applied ethics, where discussions centre on controversial issues relating to how we ought to treat each other in particular circumstances. Autonomy is therefore an important moral consideration that ought to be taken into account if ADT is to be considered to be morally justified; of particular importance is the question of whether the offender's autonomy can be respected whereby they are able to make free and voluntary choices in an incentivised legal context.

The overall goal of this chapter is to arrive at the key questions that my thesis will explore by examining the crucial issues that are related to ADT and autonomy in an incentivising context. The first task of this chapter is to present two distinct accounts of autonomy – procedural and substantive – that have been offered by key theorists such as Harry Frankfurt (1971), Gerald Dworkin (1976, 1988, 1989), John Christman (1991), Susan Wolf (1987, 1990), and Paul Benson (1987, 1991, 1994), and outline the key concepts each account engages with. It is necessary to survey the existing accounts of autonomy in order establish the key issues related to autonomy that ought to be considered.

I will then briefly introduce the particular circumstances that my thesis will consider, particularly the choice conditions under which ADT is offered. This will lead me to the second task of this chapter, which is to present a narrative of what philosophers such as Lene Bomann-Larsen (2013), Jesper Ryberg (2012), John McMillan (2014), Elizabeth Shaw (2014), and Douglas et al., (2013), believe to be important autonomy issues that are raised by ADT. This includes issues focusing on validity of consent, coercion and the intentions of the state, and the enhancement of future and present autonomy. This will allow me to arrive at the key questions for consideration in my thesis, the objective of which is to examine whether ADT can be considered autonomy-respecting, and if so, precisely *how* ADT could be implemented so as to ensure that respect for autonomy is achieved.

Procedural accounts of autonomy

The accounts of autonomy that I will first explore are what have become known as 'procedural' accounts. The first kind of procedural account I will explore is the so-called structural or hierarchical account – the most influential of which is presented by Harry

Frankfurt (1971), and later developed by Gerald Dworkin (1976, 1988, 1989). Such accounts focus solely on the formal relation between beliefs, desires, actions and goals of the individual and on agents' competency when forming them, in order to establish whether they are an autonomous agent. These accounts conceive autonomy as content-neutral. This means that an agent can be deemed to be autonomous in relation to their motivational structure and their resulting actions regardless of the content of their beliefs, desires, values, and attitudes (Dworkin 1989, 12). For such accounts, what matters is the kind of process of critical reflection to which the agent subjects their motivations and actions, and the conditions under which it occurs.

According to Frankfurt's account of autonomy, individuals have a capacity to form first-order values, motives, beliefs, and goals, which he calls first-order desires (1971, 7). For example, an individual may have a first-order desire to smoke; however they also have the knowledge and belief that smoking is associated with harmful health effects, and they have the goal to quit smoking. Individuals who are autonomous have the capacity not just to have first-order desires but to form desires regarding their first-order desires. These are called second-order desires, or "second-order volitions" and are preferences regarding their first-order desires that have been formed in a critical way (1971, 10). As an autonomous agent, they are able to form a second-order volition to desire to refrain from being motivated by their first-order desire to smoke, as they recognise that smoking may cause harmful effects to their health and wish to attain their goal of quitting smoking. This second-order volition could potentially cause them to refuse to identify with their first-order desire to smoke and instead choose to be motivated by a desire to quit smoking. It is this second-order capacity to critically reflect on whether one chooses to identify with particular first-order desires that allows the individual to causally influence and shape the person they want to be and are. This critical reflection includes the acceptance, rejection or modification of their first-order desires in light of their second-order volitions. Therefore, according to this kind of account, if an individual does not have the capacity to reflect upon, question or identify with their first-order desires, then they are not considered to be autonomous.

Developing Frankfurt's account, Gerald Dworkin found that it was necessary to specify that desires must have certain properties (not content) in order for them to be considered desires that are made by an autonomous agent. He labelled such desires to be 'authentic' to the agent. For an individual's desires to be considered authentic, the agent must endorse the desires as

their own through a process of critical reflection and identification that is attributable to no one else (1976, 24-25). The individual must relate to their desires and what motivates their actions as their own. This means that they identify with their desires and integrate them to into their wider values and motivations and also view themselves as the kind of person who wishes to be motivated by these desires. However, having authentic desires alone is not enough for an individual to be considered autonomous (1989, 61). Autonomy also requires second-order volitions to be made under procedural independence (1988, 20). This occurs when the individual's critical or reflective capacities, used when making second-order volitions, are not causally influenced by another and are only attributable to the individual (1988, 18). The notion of procedural independence creates a distinction between, on the one hand, forms of influence or causal history that contribute to the individual making their own decisions (such as education and role models), and, on the other hand, forms of influence that are effectively the decisions of others (such as deception, brainwashing, and manipulation). Influences of the former kind contribute to the individual forming authentic desires, whereas influences of the latter kind do not enable the individual to recognise how they have come to hold the desire, even if they may endorse it. Where an individual forms second-order volitions regarding their first-order desires and they have not been influenced by others in a way that undermines their ability to consider their preferences as being of their own choosing, the individual can be regarded as autonomous.

The second kind of procedural account that I will explore are what can be referred to as 'historical' models of autonomy – of which John Christman's (1991) is the most eminent. Like Dworkin, Christman also develops Frankfurt's account of autonomy by highlighting that the history of how an individual forms volitions determines whether an individual is autonomous. Specifically, the individual must not resist the formation and development of the desire (1991, 11). Individuals must be aware that they are adopting such volitions and also why they are adopting them. According to Christman, this self-awareness will not only allow them to consciously and self-reflectively embrace such volitions, but also afford them the opportunity to resist or change them. Therefore, through a critical process, if an individual cannot recognise that they have adopted such volitions and for what reasons, then they cannot be considered autonomous as they cannot have fully comprehended and sanctioned the volitions they have come to have.

Substantive accounts of autonomy

As discussed earlier, procedural accounts are content-neutral and are only concerned with the process of critical reflection. Subsequent theorists have found inadequacies in procedural accounts. Particularly, proponents of 'substantive' accounts of autonomy, by contrast, do not take critical reflection to be sufficient to distinguish between autonomous and non-autonomous action. Such accounts hold that constraints must be placed on the particular kinds of actions and agents that can be considered autonomous, as well as the particular content of the desires which motivate their action (Wolf 1987, 1990; Benson 1987, 1991, 1994). Thus these accounts determine or place limits on the *content* of autonomous volitions (Formosa 2013, 205).

Individuals are exposed to both positive and negative external influences and socialisation through the course of their life. If they have no ability to identify, through reason, which influences are right or wrong, they cannot be considered autonomous. This can occur in situations where the individual has internalised the values and desires that have been disseminated by negative or oppressive influences, such as oppressive socialisation, that interferes with their capacity to distinguish right from wrong, thereby reducing their ability to be free and responsible (Wolf 1987, 53). An individual may act in a way that accords with their values and desires, but may not be considered fully free, or fully morally responsible, if, for example, their upbringing has prevented their capacity to objectively distinguish and reason right from wrong. Particularly, if an individual has grown up in conditions of oppressive socialisation, such as a racist or sexist environment, and has internalised the views and attitudes perpetuated by such forms of socialisation, and cannot reason that the views and attitudes are wrong, then they cannot be considered substantively autonomous, according to these accounts – even if they are autonomous in the procedural sense.

However, the question of a person's substantive autonomy does not play a role in the issues I am considering in my thesis. Whilst the distinction between procedural and substantive autonomy is important, it does not have significant implications for my thesis. In considering the relevance of substantive accounts for my thesis, such accounts would raise questions regarding how individuals come to commit sex offences, incorporating an examination of the causal history and derivation of the beliefs and desires and whether they came about through negative external influences. As the goal of my thesis is to examine autonomy in relation to whether offenders can presently make autonomous decisions from within the choice conditions they are given, the questions that are raised are ones regarding procedural

autonomy. The concerns that arise focus on whether offenders are placed in a situation that may place external pressure on their ability to deliberate and exercise their choice under coercion or an overly incentivised position. These are aspects of the present autonomy of the offender rather than the causal history of how they came to be an offender. Whilst substantive accounts provide an important conception for autonomy generally, it will not be relevant for the purposes of my thesis to explore how an offender's causal history is pertinent to the determination of whether they have the autonomy to choose or reject ADT. Therefore, I will be focusing on questions of procedural autonomy only.

The choice conditions

The task of this section is to present the choice conditions that will be considered in the evaluation of whether ADT can be deemed autonomy respecting. It is necessary to do this in order to clarify exactly what circumstances and conditions are of key concern for my thesis. By concentrating on particular choice conditions, it will give me a clear focus on the important and relevant issues in relation to ADT and autonomy. To do this, it will be necessary to explain that any evaluation of the extent to which ADT is autonomy respecting will involve a consideration of the circumstances in which ADT is offered. These circumstances have been described in the first chapter of this thesis in the sections outlining the domestic and international legal landscape in which ADT is situated and how it is implemented. Questions of autonomy that arise must take into account the conditions set out by individual jurisdictions.

As described in the first chapter, ADT is typically offered either as formally optional or mandated as a condition of release. Invariably, ADT is administered towards the end of an offender's incarceration before release or immediately after their release. When it is formally optional, the offender is able to choose to either undergo ADT or refuse, without receiving any punitive responses such as increased time in incarceration or a negative effect on their application for parole. Notably, under these conditions, the offender has no incentive to undergo ADT other than their own desire to. Their decision to either forgo or undergo ADT does not determine whether or not they will be released. These choice conditions not only ensure that the offender is able to exercise their choice without repercussion if they choose to refuse it, but it also affords offenders the opportunity to undergo ADT if they wish to.

On the other hand, when ADT is mandated as a condition of release, offenders will not be released unless they undergo ADT. Thus, if they refuse, they will continue to be incarcerated.

In this instance, the offender seems to be offered a fairly strong incentive to undergo ADT: namely, freedom from incarceration. An offender would have an inducement or incentive to undergo ADT (possibility of release); this creates an incentivised context where an offender is given an external motivation to undergo ADT, assuming that they wish to be released. This raises the question of whether offenders can make fully free choices under such incentivising conditions and whether their ability to make free choices is affected by this incentivisation. The focus of my thesis will be on the particular choice conditions in which ADT is not fully optional, particularly the circumstance where the offender must face a choice between ADT and being released earlier or remaining incarcerated. In the next section, I will examine specifically how the choice conditions may affect the offender's ability to make autonomous decisions, particularly what pressures offenders face in their decision-making, and give consideration to whether it could be considered that such conditions may even enhance the autonomy of the offender.

Issues raised by autonomy in relation to ADT

The issue of whether valid consent can be obtained from the offender under the choice conditions highlighted in the previous section is discussed by Bomann-Larsen (2013). She considers such choice conditions to be offered under coercive circumstances whereby the coercive element is the prospect of remaining incarcerated, and choosing ADT is the only way that the agent is likely to be released earlier from incarceration. In such a situation, it is difficult for offenders to freely exercise their choice as there is the presence of a choice-restricting and choice-facilitating influences (2013, 68). However, counterintuitively, Bomann-Larsen does not rule out that valid consent can be obtained under such coerced conditions (2013, 76). She defines valid consent as "consent which is sufficient to take the wronging out of the act" of administering ADT to the offender (2013, 68). Her argument is that if an offender was to give their consent to undergo ADT, whether or not that consent is valid depends on whether it is appropriate to offer ADT in the first place. Bomann-Larsen labels this the 'appropriateness-constraint' (2013, 74). The appropriateness of offering ADT to the offender is determined by whether ADT constitutes a wronging to the offender. For an offer of ADT to be considered inappropriate (and consequently, rendering any consent to be invalid), the offender is treated in a way that fails to recognise that they are their moral equal by exploiting their vulnerability and violating the offender's claim to moral respect (2013, 73). This occurs when the treatment that is offered does not treat or address behaviour that fall within the scope of the behaviour which the offender is convicted of (2013, 74). According to

Bomann-Larsen, offering a treatment that does not directly treat the offender's sexual behaviour is wrongful. Even if the offender was to give his consent to such treatment, his consent is not sufficient to alleviate the wrongfulness of being offered a treatment that will provide them with no relevant benefit.

According to Bomann-Larsen, what an offender is "answerable for to the state determines the scope of behavioural conditions for which the state can appropriately offer convicts treatment" (2013, 74). Therefore, an offender who has committed a sex offence must only be offered treatment that will directly address their sex offending behaviour. To offer a treatment that does not fall within the scope of the behaviour for which they are convicted of amounts to wronging the offender and renders consent invalid (2013, 74). In line with Bomann-Larsen's view, if ADT is to be offered in a way that satisfies the appropriateness-constraint, it must be narrowly aimed at the criminal behaviour for which the offender is answerable to the state and should not overstep the boundaries of what is necessary to treat and rehabilitate the offender's behaviour for which they are convicted (2013, 75). In the next chapter I will consider whether ADT can be considered appropriate to be offered to sex offenders, and hence whether their possible consent to ADT is valid.

Like Bomann-Larsen, Jesper Ryberg (2012) believes that it is possible to obtain valid consent under coerced circumstances such as the conditions described in the previous section. However, in response to Bomann-Larsen's 'appropriateness-constraint', Ryberg does not believe that appropriate offers should be limited to the treatment of the behaviours the offender was convicted of (2012, 237). Particularly, he contends that the treatment offered to criminals should aim to prevent all future crimes, particularly if "a criminal is convicted for crime C_1, but we have strong reasons to believe that he or she will in the near future commit crime C_2" (2012, 238). The state, according to Ryberg, should be concerned with prevention of future crimes as well as treating the current behaviour for which the offender is convicted of and to fail to do so is to fail to treat the criminal as an equal (2012, 238). To elaborate on Bomann-Larsen's view, Ryberg believes that the state or court should be concerned with offering treatments that will decrease the likelihood of future criminal conduct and long-term future incarceration (2012, 238).

Another issue Ryberg argues for is that what makes an offer wrong is not, as Bomann-Larsen argues, that the treatment fails to narrowly target the criminal behaviour of the offender, but that another treatment option exists which was not offered to the offender that would yield

better outcomes (2012, 238). If there is a better approach to preventing the offender from committing crimes in the future, it would be inappropriate not to offer that treatment and instead offer an inferior one that does not maximise the benefits compared to the alternative. Only when the treatment that is offered is the best option for both the present and future benefit of the offender will the treatment be appropriate to be offered to the offender, and hence the consent of the offender to the treatment will be potentially valid. In the next two chapters of this thesis I will consider both Ryberg and Bomann-Larsen's accounts to outline how the appropriateness-constraint can be enacted in order to ensure that offenders can give valid consent to ADT.

In his paper on surgical castration, John McMillan (2014a) considers the notion that any consent to surgical castration under the choice conditions explained in the previous section is coerced, and thus invalid. Whilst surgical castration is a permanent procedure, the concepts McMillan discusses can still yield useful considerations that can be applied to ADT. He firstly points out that surgical castration can be offered with varying levels of coerciveness and there is a difference between making a coercive *offer* to an offender and making a coercive *threat* to an offender (2014a, 586). According to McMillan a 'coercive threat' occurs when the court removes an option by making it undesirable and the other option desirable. The undesirable option is also linked to a particular threat, such as remaining incarcerated. For example, this would occur when the court makes it clear that they will do everything possible to ensure that the offender is not released if they do not agree to undergo surgical castration (2014a, 587). In such a situation the offender is made to feel that the only rationally defensible outcome is to choose ADT. A 'coercive offer', on the other hand, makes an offer to the offender that is independent from a threat, such as the threat of remaining incarcerated. However the offer itself relies upon the undesirability or desirability of one of the options to pressure the offender to choose the other option (2014a, 587). For example, this would occur when the possibility of remaining incarcerated is mentioned to the offender through non-threatening means, when they are offered surgical castration and earlier release from incarceration as an alternative.

McMillan believes that even though there are fundamental differences between coercive offers and coercive threats, any offer of castration must not entail any coercion, regardless of whether it is via a coercive offer or threat. There is a third form of offer that is made to the offender and the link to earlier release is not intended by the state to be a reason for the offender to be castrated. In such a case, according to McMillan, offering ADT to the offender

would be considered morally acceptable. However, due to the permanent nature of surgical castration, it is still morally unacceptable to coerce offenders to choose surgical castration, be it by means of a threat or offer as the procedure entails irreversible consequences (2014a, 587). It is the coercive intent, according to McMillan, that should be the focus of moral evaluation when judging castration offers, not whether it is coercive threat or coercive offer (2014b, 596). Whilst McMillan does not provide an explanation for why coercive intent should be the focus of moral evaluation, I believe he makes a strong point and I will offer support for his view. This is because regardless of whether the state's offer is in the form of a threat or offer, the state's intention is what guides its actions and the extent of the coercive intent of the state reflects the moral acceptability of the form of offer made to the offender. Therefore, we can evaluate the moral acceptability of the state's actions only through evaluating their intentions.

An offer from the state, according to McMillan, will only be morally acceptable if it does not intend to link castration with earlier release in a way that induces the offender to choose castration (2014a, 587). Therefore, there must be no coercive intent, and the offender must form an informed, competent, and rational choice regarding castration and the implications for his ability to manage his life and be integrated into society without the state associating castration with earlier release in order to intentionally induce him to choose castration (2014a, 587). Whilst McMillan has rejected the moral acceptability of offering surgical castration in exchange for earlier release on the grounds that it is an irreversible procedure, it is reasonable to say that ADT should certainly not be considered morally unacceptable on such grounds at present as it has a reversible and temporary effect.

In the next chapter I will consider whether the choice conditions mentioned in the previous section are guided by coercive intent with the intention of inducing the offender to choose ADT. The issue which arises that is related to autonomy is that if the state intends for the offender to choose ADT and makes it clear to the offender that a refusal of ADT will result in them remaining incarcerated, then the environment in which the decision is made arguably places external pressure on the offender's decision making process, and the consequent decision they make. A consideration of what are the state's intentions when it offers ADT will enable the determination of whether the state is coercing the offender and hence, the moral acceptability of such a course of action.

Elizabeth Shaw (2014) claims that while the state may be entitled to compel offenders to "endure some kind of interference with their liberty" if the aim is to protect society, the state is not entitled to induce offenders to choose one particular form of interference over another when offering the two forms of interference (2014, 595). For example, it is not acceptable, according to Shaw, for the state that wants an offender to undergo ADT, to induce the offender to accept ADT over remaining incarcerated. Instead, according to Shaw, the state must allow offenders to decide for themselves which option to choose as well as remain disinterested regarding both options (2014, 595). This is because the state, according to Shaw, is not entitled to or concerned with desiring or intending the offender to choose ADT over remaining incarcerated or vice versa. The only thing that the state should be concerned with is that if the offender does choose ADT, he does so on morally relevant grounds, such as the informed belief that ADT will aid their rehabilitation (2014, 595).

I find Shaw's argument to be slightly confusing. Inducing the offender to choose one option over another does not bare much difference to compelling the offender to have their liberty interfered with (presuming that the form of interference aims to protect society). Shaw argues that the state is entitled to compel an offender to have their liberty interfered with in order to protect society, yet the state is not entitled to induce an offender to choose a particular option over another. It is reasonable to say that the state would want the offender to choose an option which would result in the protection of society. In both instances, the state is acting in a way where the offender's voluntariness is compromised and the choice-making environment is such that the offender cannot but be influenced by the state. It seems puzzling that Shaw finds both instances to be different and that one is acceptable, and the other not, when they are guided by the same principles – to influence the offender to choose a particular option.

In my view, the remainder of Shaw's argument, where she claims that the state is not entitled to desire or intend the offender choose a particular choice over another, is in the same vein as McMillan's argument; that what should be of primary concern for the moral evaluation of offers of ADT should be what the state's intentions are. I am certainly not advocating that that the manner of the state's offer – be it via compelling, inducing, coercively offering, or coercively threatening the offender - should not be considered in the evaluation of the moral acceptability of ADT offers. I am stating that the state's intentions reveal the extent to which the state wishes to interfere with the autonomy of the offender and influence their decision.

The final issue I will raise concerning the autonomy of the offender is presented by Douglas et al. (2013) who believe that offering ADT and earlier release from incarceration as an alternative to remaining incarcerated should not be considered to be coercive or to render the offender's consent invalid. Instead, they argue, even if it was not possible for valid consent to be obtained, offering ADT as an alternative to incarceration respects the present autonomy and can even enhance the future autonomy of the offender. Douglas et al. argue that it may not be necessary for valid consent to always be obtained for medical intervention that increases the autonomy of the offender (2013, 398). If the sexual desires an offender experienced were impediments to their autonomy, ADT will increase their autonomy as long as it removes that desire. Withholding ADT as an option for the offender on the grounds that they cannot give valid consent would arguably restrict their autonomy (2013, 399). The desires that lead offenders to commit sex offences can be seen to be autonomy-restricting impediments that can be alleviated if ADT was offered to them, and to thereby enhance their future autonomy and allow them to not only be released earlier, but to also pursue their life without being impeded by inappropriate sexual desires.

I do not question Douglas et al.'s argument that ADT may provide relief for individual offenders who are preoccupied by inappropriate sexual thoughts to the point that their wellbeing and the wellbeing of others is impeded or threatened. If administered in accordance with best clinical practice, ADT can enhance the autonomy of such offenders. However, I believe what must be questioned further is their argument that ADT should still be offered to offenders even if valid consent cannot be obtained. If the offender cannot give valid consent, then it is difficult to see how the autonomy of the offender can be promoted by offering ADT – particularly their present autonomy. However, Douglas et al., have a response to this doubt.

According to Douglas et al., what is also important for the state is that offering the choice conditions of ADT and earlier release or remaining incarcerated, does not reduce the present autonomy of the offender (2013, 400). This also means that the present autonomy of the offender cannot be decreased even if it results in an enhancement in the future autonomy of the offender, unless the gain in future autonomy grossly outweighs the present decrease in autonomy. Inappropriate sexual desires can be considered to be serious impediments for some sex offenders, particularly their autonomy, such as their ability to think freely from intrusive sexual thoughts. This can occur when the offenders are unable to think about anything but sex because of intrusive sexual desires that are invasive to the point that it is arguable that constraining the present autonomy of such offenders to alleviate the desires in the future is

justifiable (2013, 400). Therefore, what must be shown is that offering ADT would result in the enhancement of future autonomy that completely outweighs the decrease in present autonomy, such as failing to obtain valid consent from the offender. This will be dealt with in the next chapter.

Douglas et al. also make the point that offering ADT need not constitute a decrease in the offender's autonomy. By offering the offender an extra alternative beyond simply incarceration, particularly one which may benefit the offender, the extra choice will render them more autonomous as they are given an opportunity for rehabilitation. Even though they are still constrained by such choice conditions, they are less constrained than if they had not been offered the alternative of ADT and earlier release from incarceration because there is now an expansion of the number of alternatives open to the offender. However, Douglas et al., has not considered the incentivising circumstances that are created when ADT is offered with early release. Even if offering ADT does create an opportunity for the offender to be released and rehabilitated, the circumstances under which they have made their decision is one where the decrease in present autonomy could possibly outweigh the advancement in autonomy when more options are available to the offender.

Douglas et al. are not, however, arguing that offering ADT and earlier release as an alternative to an offender will *always* enhance the future autonomy of the offender, or respect their present autonomy. None of this will occur if the offender's desire to undergo ADT is motivated by desires such as a desires to avoid continuing their incarceration, or an irrational desire such as an irrational fear of incarceration (2013, 401). Furthermore, alleviating the inappropriate desires of an offender may still fail to increase their autonomy. This may be the case for offenders who do not experience any inappropriate sexual desires (for example, an opportunistic sex offender, rather than a paraphilic sex offender), or who refuses to admit the wrongfulness of their actions. ADT would provide little rehabilitation for such offenders and therefore offering ADT would do little to enhance their autonomy from inappropriate sexual desires.

Overall, the issues that I have discussed in this section that are related to autonomy include whether the offender can give valid consent when faced with the choice conditions of ADT with earlier release or remaining incarcerated; whether some offers that involve coercion can be considered morally acceptable based on the intentions of the state and what kind of offers the state is entitled to make; and the enhancement of the present and future autonomy of the

offender. Now that I have considered many of the issues related to autonomy that are raised by various philosophers in response to ADT, this will allow me, in the next chapter of my thesis, to consider and respond to objections in order to answer the first question my thesis seeks to answer. I will then be able to determine the specific conditions under which ADT might ideally be offered in such a way as to respect the autonomy of the offender. Therefore, the two key questions I seek to answer in the next two chapters of my thesis are the following:

(1) In a context in which offenders are offered the choice between ADT and earlier release or remaining incarcerated (in other words, if they are released earlier in exchange for undergoing ADT), are offenders able to make autonomous decisions under such choice conditions?
(2) Ideally, under what conditions should ADT be offered in order to respect the autonomy of the offender?

Chapter Three: Can incentivised ADT be considered autonomy-respecting?

In this chapter, in order to determine whether offering ADT and earlier release from incarceration in contrast as an alternative to remaining incarcerated can possibly respect the autonomy of the offender, I will address the issue of whether valid consent can be obtained from the offender. I will firstly discuss the offering of ADT under an incentivised context and whether such choice conditions allow for valid consent to be obtained from the offender. To do this, I will refer to Tom Beauchamp's (2010) three requirements for valid consent and consequently, autonomous action; intentionality, understanding, and voluntariness. I will then evaluate whether it is appropriate to offer ADT under such incentivising choice conditions, as well as whether it satisfies four particular conditions as set out by Farah Focquaert (2014): (1) the status quo (remaining incarcerated) is not cruel, inhuman, degrading or wrong, (2) the treatment (ADT) is also not cruel, inhuman, degrading or wrong, (3) the treatment serves the best interests of the offender, and (4) the offender gives his informed consent. Finally, I will also consider whether offering incentivised ADT can in fact enhance the autonomy of the offender by referring to the views of the philosophers I discussed in the final section of the previous chapter, as well as the work of Arthur Caplan (2006),

Before I begin, I would like to point out that many of the philosophers in the final section of the previous chapter have used the term 'coercion' or 'coercive' in their discussions when referring to the choice conditions. Apart from the examination of coercive offers and coercive threats by McMillan (2014a), whereby he denounces any form of coercion as morally unacceptable, there has been little discussion on whether offering ADT with earlier release from incarceration in contrast to remaining incarcerated actually amounts to coercion. It is therefore worth mentioning that coercion occurs when one party "intentionally uses a credible and severe threat of harm or force to control another" (Beauchamp 2010, 69). This, in my view, carries a particular meaning that requires attention and debate as it is questionable whether the state is intentionally threatening the offender with continued incarceration in order to control them and the choice they make. Whilst I will consider the notion of coercion in the next section, as well as the state's intentions in my overall discussion of whether ADT can be autonomy-respecting, it is not the central focus of my thesis to examine whether the state is coercing the offender in the sense that Beauchamp describes. I will instead to use the term 'incentivisation' to describe the state's action whereby they are providing an incentive

for the offender to choose ADT. The prospect of earlier release is an incentive to choose ADT when it is offered in contrast to remaining incarcerated.

Valid consent: Intentionality, understanding, voluntariness

The first autonomy-related issue I will investigate is whether valid consent can be obtained from offenders when they are presented with the choices of ADT and earlier release or remaining incarcerated. In order to determine this, I will refer to three conditions that Tom Beauchamp (2010) posits are central to valid consent and consequently, autonomous action; intentionality, understanding, and voluntariness (2010, 57). By meeting all three requirements, there is a case to support the validity of consent given by offenders who are offered incentivised ADT.

(1) Intentionality: intentional actions require that the offender wills an action in accordance with a plan for the execution of the action (2010, 66). Intentional actions include any action and any effect specifically willed in accordance with a plan, including merely tolerated effects (2010, 67). Therefore, if the offender intends to choose ADT, the offender must plan to undergo ADT, including the effect of such a choice; being released earlier from incarceration. Accordingly, if the offender wishes to be released and his plan of action is to undergo ADT in order to see his wish eventuate, then he would possess intentionality.

(2) Understanding: the offender must have an appropriate understanding of their choice; including possessing the relevant information and have formed relevant beliefs about the nature and consequences of their actions or choice (2010, 68). Their understanding need not be complete, yet they must understand the *material* facts regarding each choice, such as the possible risks to their health if they were to choose to undergo ADT (2010, 68).

(3) Voluntariness: the individual is free from the control of external sources or their own internal states that deprive them of self-directedness (2010, 69). One principal category of external influence is that of coercion. This occurs when one party "intentionally uses a credible and severe threat of harm or force to control another" (2010, 69). When the threat disrupts an individual's self-directed course of action in a way that renders their action involuntary, they are then considered coerced (2010, 69-70). In the context of my thesis, the threat of remaining incarcerated and

> serving the full sentence can be influential on an offender's decision. If the offender does not choose ADT, then they will remain imprisoned to the end of their sentence until they agree to undergo ADT. According to Beauchamp's definition, what is required for coercion to occur is that firstly, the state intends to use the threat of continued incarceration to control the offender, and secondly, as a result of this, the offender is deprived of self-directedness resulting in them making an involuntary choice. Their actions are directed by the state's intentionally-made threat.

I will now address the first condition of intentionality. A concern for my thesis is whether the intentionality of the offender is preserved when the offender does not wish to undergo ADT, yet they wish to be released earlier from incarceration. If their plan is to be released earlier, ADT can be considered to be a tolerated effect of the offender's plan for earlier release. As stated by Beauchamp (2010), intentional actions include any action and effect, including tolerated effects. An offender may decide that there is no way to be released earlier without undergoing ADT. If he finds the alternative (remaining incarcerated) to be undesirable, and chooses to be released earlier, by doing so he intentionally chooses to tolerate the effects of this action, which includes undergoing ADT. Thus, this intentional act of consent to ADT is no less the offender's own act than his choice to be released. An offender who chooses to undergo ADT even though he does not wish to, yet does so as it is in accordance with his plan to be released from incarceration, is making an intentional choice. The requirement of intentionality can therefore be considered to be achievable under the choice conditions that my thesis focuses on.

With regards to the issue of understanding, if the state does not provide the offender with enough information to allow the offender to come to an adequate understanding as to what each choice entails and the relevant consequences and risks, then this would impede the offender's ability to meet the understanding requirement. It is the onus of the state to ensure that the offender has acquired an adequate understanding, and provided that this is satisfied, the condition of understanding can be met.

The issue of voluntariness, particularly whether offenders are coerced when making their choice, has received attention from McMillan (2014a, 2014b) and Shaw (2014), who argue that coercive intent is morally unacceptable and renders any consent invalid. If the state intentionally offers ADT in a way that coerces the offender to choose ADT – such as directly

linking the rejection of ADT to no prospect of earlier release – then arguably, this places pressure on the offender to agree to undergo ADT as they face remaining incarcerated. The choice they are making is affected by the threat which "disrupts and reorders a person's self-directed course of action" (Beauchamp 2010, 69). The issue of interest for my thesis is that if the state has intentionally used the prospect of remaining incarcerated as a threat to the offender in order to pressure them to choose ADT over incarceration, then this would amount to coercion and would arguably undermine the validity of consent. This is because the link between rejection of ADT and remaining incarcerated is made in such a way as to serve as a "credible and severe threat of harm or force to control" the offender in a way which exerts control over the offender's "self-directedness" when making their choice, then this would amount to coercion (Beauchamp 2010, 69).

When the offender is coerced, it is difficult for the offender to acknowledge his choice as a course of action that he himself has directed as he is effectively directed by the state which has used the threat of continued incarceration to ensure that the offender chooses ADT. This renders their choice one that is not fully voluntary. When the conditions the state has offered to the offender induces them to choose ADT in a way which is not entirely voluntary, the offender is no longer making a choice that is directed by their own wants and desires. Instead, the threat of remaining incarcerated drives the decision the offender will make; this threat is attributable to an external source – the state. If the offer of ADT is made coercively the offender's choice would reflects little self-directedness as it is directed by the threats of the state and would not adequately meet the third condition for valid consent - voluntariness.

Now we must turn our attention to whether incentivisation allows the offender to make a self-directed choice. I believe that offering earlier release as an incentive to choose ADT, would not involve any threat or coerciveness. Instead, the offender would be given an attractive inducement to choose ADT. The issue of concern is whether this inducement compels the offender to choose an offer that they may not have otherwise chosen. The element of self-directedness is at the core of this concern. If an offender wishes to be released earlier and they have no desire to undergo ADT, the offer of early release attached to ADT would make the offer more attractive and provide an inducement to choose ADT – a choice they would otherwise not have chosen if there was no incentive of earlier release. The lack of self-directedness occurs when the offender who does not wish to undergo ADT is enticed by an external source (the state) to choose it regardless of their wish to avoid it. The condition of voluntariness requires that offenders are free of external or internal sources that deprive them

of self-directedness when making their choice. The incentive can be considered to be an external source that influences the choice of the offender in a way that the offender cannot be fully voluntary.

Whilst the offender's choice is not fully voluntary, the level of influence from incentives is lesser than that of coercion. Voluntariness should be understood as a matter of degree; the influence of the state can be to a greater or lesser extent (Beauchamp 2010, 71). The voluntariness of the offender would be greater (though not fully voluntary) in an incentivised situation than in a coerced one. This is because the state is providing an incentive for the offender to choose ADT with the absence of the intention to threaten or control the offender in a way which deprives them of a self-directed choice. Furthermore, the absence of any incentive to choose ADT would allow for even greater voluntariness as there is no incentive to choose ADT provided by an external source other than its own merits as perceived by the offender. Therefore, it can be understood that consent given under incentivised circumstances is not fully voluntary, even though it allows for more voluntariness than under coercive circumstances. Consequently, under incentivised conditions, offenders cannot give valid consent as they cannot fully meet the voluntariness condition. This does not mean that the offender's choice is involuntary under such conditions; it does not deprive the offender of self-directedness, but it constrains the offender's self-directedness.

Appropriate ADT offers

Another perspective on whether valid consent can be obtained from offenders relates to the appropriateness of offering ADT to offenders. I will firstly consider whether ADT suitably targets the criminal behaviour the offender is guilty of. Consent is rendered valid when what is offered is itself deemed 'appropriate' (Bomann-Larsen, 2013). What makes ADT an appropriate treatment to be offered is if it targets the criminal behaviour for which the offender is convicted of and provides direct benefit by rehabilitating the particular behaviour. An offender who is offered an inappropriate treatment is placed in a position whereby they must choose between remaining incarcerated and an alternative that provides no direct rehabilitative benefit to their inappropriate sexual behaviour. In such a case, the treatment poses a serious risk to their health particularly as they can derive no benefit and, as highlighted in the first chapter, ADT is a pharmacological agent that lowers the testosterone of the offender, which is associated with various serious medical side effects. This would only wrong the offender in a harmful way which there is little justification for.

This suggests that it is vital offenders are considered individually for their suitability to undergo ADT before offers of ADT are given. This ensures that only offenders who would benefit from ADT are being offered it. Ryberg (2012) differs with Bomann-Larsen's point that any treatment offer should be targeted specifically at the criminal behaviour. He advocates that treatments that are offered to the offender should aim to treat all behaviours which may increase the possibility of future criminal conduct, rather than simply the behaviour they were convicted of. I believe that this is a moot point and is not a concern of my thesis. As long as ADT is offered to a particular offender who can derive real benefits from it, then it is can be considered appropriate to offer it to them.

Bomann-Larsen and Ryberg's conclusions are in direct conflict with the conclusions I have drawn earlier in my consideration of Tom Beauchamp's (2010) three conditions for valid consent. I disagree with Bomann-Larsen and Ryberg's claim that as long as ADT is deemed appropriate to offer to offenders, then valid consent can be obtained. Whilst their arguments provide worthy contributions to the debate on the appropriateness of ADT, I believe that their conclusion linking the appropriateness of offering ADT to offenders to obtaining valid consent cannot be substantiated. Valid consent should be evaluated on the grounds of what qualities the offender is capable of exhibiting when making their decision as a result of the state's actions. Appropriateness alone cannot account for the ability of the offender to provide valid consent. I therefore support their claim that ADT can be considered appropriate to offer to offenders on the ground that it will aid their rehabilitation. However, I do not support their claim that offenders can give valid consent if offering ADT is deemed appropriate.

I will now examine the view of Focquaert (2014) who discusses the offering of mandatory neuro-technological treatment as a condition of probation, parole, or (earlier) prison release. Even though her discussion concerns neurotechnological treatment, the essence of her argument is still relevant to ADT. According to Focquaert, provided that the treatment does not entail severe to moderate side effects for the offender, and it effectively reduces recidivism, then it can be convincingly argued that valid consent can be obtained, and that it is ethically permissible, to offer such treatments provided that four conditions are met: (1) the status quo (remaining incarcerated) is not cruel, inhuman, degrading or wrong, (2) ADT is also not cruel, inhuman, degrading or wrong, (3) ADT serves the best interests of the offender, and (4) the offender gives his consent to ADT (2014, 70).

The first condition concerns whether the status quo, or the offer that ADT is being contrasted with, is itself not an offer that is cruel, inhuman, degrading or wrong whereby the only "rationally defensible" and irresistible option is the alternative (2014, 66). This condition particularly concerns coercion. If the alternative to ADT is one that violates the offender in a cruel or demeaning way, then any consent to ADT the offender is to give is undermined by the coerciveness of the status quo. However, I would argue that it is reasonable to say that remaining incarcerated until the end of the period of imprisonment as dictated by the sentence given by the state is arguably not cruel or wrong – certainly not in the sense that it places coercive strain on the offender's choice to the extent that they have no choice but to choose ADT as remaining incarcerated would be the course of events that would have taken place if ADT was not offered.

The second condition demands that ADT must not be cruel, demeaning or wrong. ADT may potentially involve life-long administration in order to ensure that inappropriate sexual desires do not manifest into inappropriate sexual behaviour in the remaining lifetime of the offender. As discussed in the first chapter, it is associated with various medical adverse effects that themselves require care and management from professionals. As I highlighted early in this section, as long as ADT is offered to individual offenders who will actually benefit from such treatments and the side effects are managed appropriately, then it can be considered appropriate to offer ADT to those offenders provided that the other three conditions set out by Focquaert (2014) are also met. Therefore, ADT should not be considered cruel, demeaning or wrong if it is offered to suitable offenders.

The third condition stresses that ADT must be in the best interest of the offender. I believe that offering ADT would not be in the best interests of the offender and constitutes wronging them if there is no prospect of the offender deriving any benefit from ADT. In such a case the offender would be placed at risk of unnecessary harm. Therefore, whether or not ADT is in the best interest of the offender depends on whether they are a suitable candidate that will respond to such treatment in order to reduce recidivism.

The fourth condition which specifies that the offender must give his informed consent has already been dealt with in the previous section. To reiterate, the offender cannot give fully voluntary consent to ADT as he cannot make a fully voluntary choice under incentivised conditions. Therefore, incentivised ADT cannot respect the autonomy of the offender until circumstances are rectified to ensure that offenders can make a fully voluntary choice.

Autonomy enhancement

The final consideration in my analysis focuses on whether offering ADT and earlier release as an alternative to remaining incarcerated can in fact enhance an offender's autonomy. Douglas et al. (2013) believe that offering incentivised ADT is justified as long as the offender's present autonomy is not decreased. The exception to this is that if offering incentivised ADT can be shown to that the enhancement to the future autonomy of the offender grossly outweighs the decrease in present autonomy, then it is acceptable for the offender's present autonomy to be temporarily reduced in order to achieve this. As discussed earlier in this chapter, offering incentivised ADT decreases the present autonomy of the offender in a way that the offender cannot make a fully voluntary choice However, even though their present autonomy is undermined when they are offered ADT under incentivised conditions, if they do not wish to undergo it, they can still choose to return to the situation they would have been in had it not been for the offer of ADT. Furthermore, if it can be shown that the future autonomy of the offender can be enhanced to an extent greater than the loss in present autonomy, then offering ADT to the offender is permissible, according to Douglas et al. (2013). The added alternative of ADT, particularly to an offender who can benefit from it, can in fact enhance their future autonomy as they would have the opportunity to rehabilitate so that in the future they can act more free of their sexually inappropriate behaviours, rather than be distressed by them.

Even though Arthur Caplan's (2006) work focuses on offenders with addictions, the essence of his argument is still applicable in the context of my thesis and can apply to the case of ADT to generate an analogous conclusion. He claims that offering a treatment to an individual who would derive a real benefit from such interventions is autonomy-enhancing; this would include offenders with addictions or those who have inappropriate sexual desires and thoughts preoccupying them to a debilitating level. People who are in the grip of these sensations and behaviour, according to Caplan, do not have the full capacity to be autonomous because they are literally internally coerced by them (2006, 118). They are fighting internal coercion where the offender is driven by irresistible and overwhelming cravings and thoughts which determine their behaviour (2006, 119). Therefore, it can be justified to offer a treatment that will treat and lessen the hold the inappropriate sexual thoughts and desires have over the offender.

I find the arguments of Douglas et al. (2013) and Caplan (2006) to be convincing on the proviso that ADT will in fact enhance the future autonomy of the offender. Intrusive sexual

thoughts and desires can be debilitating and inhibit the present autonomy of the offender. It may be necessary to offer incentivised ADT that will lessen their present autonomy to ensure that their future autonomy is maintained and they are free of these sexual thoughts and desires. It can be compellingly argued that allowing the offender's present autonomy to be undermined by intrusive inappropriate thoughts and desires is depriving them of an opportunity to be treated or rehabilitated and can only ensure that neither of their present and future autonomy is enhanced. Condemning offenders to no opportunity to be treated is surely autonomy undermining. However, even offering incentivised ADT is not ideal as it temporarily undermines the offender's present autonomy in order to gain greater future autonomy – assuming that it is offered to an offender who can actually benefit from ADT. In the next chapter I will outline what I believe are the ideal conditions under which ADT should be offered to have the greatest potential of enhancing the autonomy of the offender.

The purpose of this chapter was to answer the following question:

(1) In a context in which offenders are offered the choice between ADT and earlier release or remaining incarcerated (in other words, if they are released earlier in exchange for undergoing ADT), are offenders able to make autonomous decisions under such choice conditions?

What can be surmised from the discussion in this chapter is that offenders are not able to make autonomous decisions when offered incentivised ADT as an alternative to remaining incarcerated as the offender cannot give fully voluntary consent. Therefore, any consent given cannot be valid in such a situation. However, offering ADT to offenders who would actually benefit from such a treatment can promote their future autonomy. Even though offering incentivised ADT lessens the present autonomy of the offender, the enhancement to future autonomy can compensate for the loss in present autonomy as the offender would no longer be plagued by intrusive sexual thoughts and desires and the risk of recidivism would be lowered. However, it must be shown that the enhancement of future autonomy must vastly outweigh the decrease in present autonomy.

Chapter Four: Autonomy-respecting ADT

As concluded in the previous chapter, offering ADT to offenders with the incentive of earlier release from incarceration as an alternative to continuing the period of incarceration cannot be considered autonomy-respecting as the offender cannot give fully valid consent to ADT because their choice is not fully voluntary. By considering the issues highlighted in the previous chapter, this chapter will propose specific conditions that will address the concerns that have been raised in the preceding chapter in order to demonstrate how ADT ought to be offered to have the potential to respect and even enhance the autonomy of offenders. There are two particular issues that must be addressed in order to achieve this: offering ADT will be autonomy-respecting if offenders are not incentivised to choose it in order to give fully voluntary consent, and ADT must be targeted at specific cohorts of offenders who can derive real benefits from it. By addressing these two issues I will be able to respond to the second question my thesis seeks to answer:

(2) Ideally, under what conditions should ADT be offered in order to respect the autonomy of the offender?

Condition 1: Fully voluntary consent

The extent of the voluntariness of an offender is inextricably linked to the state's intentions which dictates how ADT is to be offered to the offender and under what conditions. If the state intends for the offender to choose ADT, then how they offer ADT will invariably reflect this intention. They may do it through coercion by threatening the offender with the prospect of no earlier release if they do not choose ADT. In such a case the voluntariness of an offender is minimal. If the state intends to provide an incentive for the offender to choose ADT by offering to release the offender earlier if they choose ADT, the absence of the threat of harm or control, permits greater voluntariness than that allowed by coercion. In both circumstances, as discussed in the previous chapter, the offender cannot make a fully voluntary choice as they lack the self-directedness required to make a choice free from the influence of the state. The threat of remaining incarcerated (in the case of coercion) or the prospect of release (in the case of incentivisation) influences the offender to the extent that their choice is constrained and under pressure from these external influences. I believe that in order for offenders to make fully voluntary choice, and hence, give valid consent, there must be no incentive attached to ADT and no coercive threat attached to refusing ADT.

Like Shaw (2014), whose view I discussed in the second chapter, I believe that the state should not concern itself with ensuring or intending an offender choose one particular offer over another. In other words, the state should be disinterested with regard to which offer they wish the offender to choose. Only under such circumstances can offenders make a fully voluntary choice free from incentives or threats, and rely upon their own self-directedness. The state should not be concerned with what they believe will be the best choice for the offender to choose. Certainly the state should be concerned with ensuring that the offender is provided the choice of ADT if the offender is a potential candidate who could benefit from ADT. The state's concerns should not continue beyond the point of offering options to the offender that are free of incentives and coercion.

I believe that it is important that offenders are able to endorse their choice from a moral perspective, rather than one which is driven by fear of remaining incarcerated, or a wish to be released earlier. Offers made to the offender that are attached to conditions that allow for motives that have little moral value for the offender, will invariably leave the offender with little moral self-worth. In such a case, the state has exerted itself on the offender in a way where he cannot place any moral value on his own choice. By allowing the offender to make his own choice free of external sources that deprive him of self-directedness, he will be able to choose an option on morally relevant grounds that he can advocate as his own self-directed choice. Therefore, to ensure that the condition of voluntariness is met, there must be no incentive or coercion involved when ADT is offered. Only under such circumstances can offenders give valid consent.

Condition 2: Targeted ADT

In accordance with the appropriateness-constraint outlined by Bomann-Larsen (2013), ADT should only be offered to offenders if it will rehabilitate their inappropriate sexual desires and behaviours. It is therefore reasonable to say that if ADT is to be offered to offenders, it must be in accordance with sound empirical research evidence. This will ensure that all benefits of ADT are maximised, and any harms are minimised. This is particularly important as the treatment in question is invasive and alters the testosterone levels to that of prepubescent levels. This is associated with various medical health effects as outlined in the first chapter of this thesis (Giltay & Gooren, 2009; Saylor & Smith, 2013). It is therefore paramount that ADT should only be offered to offenders who would be receptive to ADT and have the potential to derive benefits that would result in lower recidivism. The benefits and risks of ADT as it applies to each individual offender must be assessed before ADT is offered (Turner

et al., 2013). If the offender is to take on the risk of adverse health effects, the benefits gained from undergoing ADT must outweigh the harm that is associated with ADT. In order to maximise the benefits of ADT, any side effects and complications must be managed by multidisciplinary teams that includes psychotherapists, specialists in sexual medicine, and endocrinologists (Turner et al, 2013; Garcia et al, 2013).

As highlighted in the first chapter, research suggests that the most ideal candidate for ADT, particularly at reducing recidivism, are offenders with a paraphilic disorder (Garcia et al, 2013). This disorder is characterised by intense sexual urges and thoughts towards a target that that causes distress to the offender, or harm to their target if these urges were acted upon (American Psychiatric Association, 2013). The reduction in testosterone attenuates their sexual thoughts, desires, and urges. This allows the offender to be more receptive to psychological interventions as they would be less distracted by inappropriate thoughts and desires. The recommended treatment of offenders with paraphilic disorders is to implement ADT in conjunction with psychological interventions such as cognitive behavioural therapy or psychotherapy (Bradford et al., 2013; Kaplan & Krueger, 2012).

However, much of the empirical research on the treatment of individuals with paraphilic disorders suffer from methodological limitations. For example, many of the studies conducted on offenders with a paraphilic disorder are run for a short duration of time. Little research has been conducted on the long-term implementation of ADT. Therefore, in order to ensure that paraphilic offenders are benefiting from ADT, particularly if they are undergoing it for an extended period of time, more research is required to ensure that ADT is effective at reducing recidivism in the long-term, not just in the short-term. Also, more longitudinal studies are required in order to examine the long-term effects of undergoing ADT as well as the best long-term management and implementation practices.

To conclude, for ADT to be offered in a way that respects the autonomy of the offender, two conditions must be satisfied:

(1) ADT cannot be offered with any incentive: this will ensure that offenders can give fully voluntary, valid consent.
(2) ADT must only be offered to offenders who can derive direct benefit and rehabilitation from it in a way that will reduce recidivism. An ideal candidate would be offenders with a paraphilic disorder, such as a pedophilic disorder. However, this condition is tentative as the methodological limitation in studies on individual with

paraphilic disorders prevent strong links to be drawn between ADT and decreased recidivism in offenders with a paraphilic disorder.

Conclusion

The ethical analysis I have done in this thesis has shown that, from an autonomy-perspective, incentivised ADT cannot be autonomy-respecting as it does not enable the offender to make a fully voluntary choice, and hence, give fully voluntary consent. Yet it can be an appropriate treatment to offer to offenders, provided that it will rehabilitate the offender's inappropriate behaviour. However, even if it is appropriate to offer an offender ADT, it does not mean that valid consent can be obtained under such circumstances. If it is to be offered in an autonomy-respecting way, the state must not attach an incentive to the offer of ADT. Furthermore, ADT should only be offered to offenders who would benefit from it, particularly if it can enhance the offender's response to conventional treatments such as psychotherapy. The benefits of undergoing ADT must outweigh the harms that are associated with ADT. This is because ADT entails a real risk of medical effects that requires monitoring and treatment. The ideal candidate to be offered ADT would be offenders with a paraphilic disorder, such as a pedophilic disorder. The intense sexual urges they experience could be alleviated by ADT, and this would enable them to be more receptive to conventional rehabilitation methods.

The goal of my thesis has been to critically examine, from an ethical viewpoint, the permissibility of offering incentivised ADT to child sex offenders and to come to a conclusion with regards to whether it can be autonomy-respecting. Particularly, I have explored how such an offer can impact on the autonomy of the offender in terms of valid consent, appropriateness, as well as the enhancement of their future autonomy. This thesis, by no means, has been a thorough investigation of all the philosophical questions that are raised by incentivised ADT. I hope that I have provided a rational and critical voice to this issue which is often fraught in heightened emotions and strong opinions in the public sphere.

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