

Legal and Ethical issues when using Antiandrogenic Pharmacotherapy with Sex Offenders

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Abstract

The treatment of sex offenders and more specifically the treatment of high-risk sex offenders is a subject of great importance for practitioners, professionals, policymakers and the public at large. Whilst treatment is thought to largely centre upon cognitive-behavioural methods and other psychotherapy techniques, in more recent years the use of pharmacotherapy has also begun to gain ground. Current debate often centres upon how effective such treatment is; with both supporters and opponents of its use existing. This article, however, does not specifically look at whether pharmacotherapy as a method of treatment with sex offenders actually works, but rather looks at the legal and ethical issues surrounding its use. In particular it considers issues such as whether the treatment should be voluntary or mandatory; whether it should indeed even be classified as treatment or should instead be seen as punishment and finally whether it should be used with convicted offenders or made freely available to all.

Key words: Antiandrogen, pharmacologic castration, sexual offenders, ethical issues

Introduction

The treatment of sex offenders and more specifically the treatment of high-risk sex offenders is a subject of great importance for practitioners, professionals, policymakers and the public at large. Whilst treatment is thought to largely centre upon cognitive-behavioural methods and other psychotherapy techniques, in more recent years the use of antiandrogenic pharmacotherapy has also begun to gain ground. Put simply, this kind of pharmacotherapy is the use of medication to lower testosterone levels which leads to a decrease of deviant and non-deviant sexual urges. Rather than using the irreversible and arguably barbaric option of surgical castration; antiandrogenic pharmacotherapy achieves the same results, but through less invasive and permanent means. It is often known under its more emotive title of 'chemical castration' and this is how, in particular, the media have categorised the treatment; perhaps choosing to exploit the term 'castration', to sum up images of pain and consequently punishment. It is argued here, however, that this is an inappropriate and inaccurate description, as the original Latin definition of castration means to cut and thus suggests permanence. Antiandrogenic medication, however, does not require surgical intervention and its effects are capable of being reversed, often through the simple withdrawal of the drugs involved. Throughout this article therefore, the term antiandrogenic medication or pharmacotherapy will be used rather than that of 'chemical castration'; although it is accepted that all refer to the same method of treatment.

The treatment of sex offenders with pharmaceuticals has been in practice since the 1940s, although through time the drugs involved and the quantities of such drugs have changed. Current debate often centres upon how effective such treatment is in terms of reducing relapse rates; with both

supporters and opponents of its use existing. This article, however, does not specifically look at whether pharmacotherapy as a method of treatment with sex offenders actually works, but rather looks at the legal and ethical issues surrounding its use. In particular it considers issues such as whether the treatment should be voluntary or mandatory; whether it should indeed even be classified as treatment or should instead be seen as punishment and finally whether it should be used with convicted offenders or made freely available to all.

Voluntary or mandatory

Perhaps the most controversial matter relating to the use of pharmacotherapy with sex offenders is whether it should be given on a voluntary or mandatory basis and indeed around the globe practices differ on this basis. The US states of California, Florida and Montana, for example, use Medroxyprogesterone Acetate (MPA) on a mandatory basis; often tying it in with prison/parole release. California was the first US state to enact legislation to 'treat' offenders in this way and since January 1997, pharmacotherapy is employed as a condition of parole release and is mandatory for all repeat sexual offenders where the victim is 12 years or under. Offenders start taking the drugs one week prior to release and will be required to continue taking such medication for the length of their license period. The courts also have the discretion to require that the condition additionally be applied to first time offenders; if it thinks that it is appropriate and expedient to do so (Connelly and Williamson, 2000). If offenders refuse to take the medication, or if for health reasons they are unable to be placed on such a programme, they have the option of being surgically castrated (Carpenter, 1998). Their only other option is life imprisonment. Similarly, in Montana, mandatory pharmacotherapy has been in place since October 1997 and applies to those who have either been convicted of rape or incest for the second time, or where, although it is the offender's first sexual crime, the crime was particularly heinous. Treatment will begin one week prior to release, and will continue until the Montana Department of Corrections deems that it is no longer required (Harrison, 2007). Florida, likewise, has mandatory provisions in place where the offence is one of sexual battery and a previous sexual conviction exists. When faced with this situation, the court is obliged to order a sentence of MPA, as long as the offender is perceived to be medically suitable (Spalding, 1998). It is also worth noting that in many US states, pharmacotherapy is offered as a stand alone solution and not in adjunct with other psychotherapy programmes.

Whilst there may be some positive aspects of mandatory treatment, with the obvious being the fact, that if such treatment works, then it is better to have offenders treated and deviant behaviour controlled through medication than not; there are still problems with maintaining compliance, especially when the treatment is in pill form and administered by the offender. Even where the drugs are administered through injections given by health care professionals; it is still possible to obtain testosterone on the black market, so it cannot be presumed that even where the giving of medication is controlled that its effects will not be compromised. There are also ethical considerations to take into account as prison is effectively being exchanged for medication which can cause serious side effects. The potential side effects which have been equated with MPA, for example, include: weight gain, hot and cold flushes, headaches, nausea, lethargy, nightmares, leg cramps, gallstones, depression including suicidal thoughts, insomnia, difficulties in breathing and fluid retention (Harrison, 2007). More serious effects include thrombophlebitis (blood clots in superficial veins), pulmonary embolism (blockages in the pulmonary arteries) (Bradford, 1983), hyperglycemia, hypertension, shrinkage of the prostate vessels, diabetes (Spalding, 1998) and gynaecomastia (Craissati, 2004), or osteoporosis (Grasswick, 2003). In reality the long term effects are simply unknown.

Conversely, most European Countries, which use pharmacotherapy with sex offenders, do so on a voluntary basis. England and Wales, for example, has had official protocols in place to allow for the

treatment of sex offenders with medication since December 2007 (Home Office, 2007). Medication is offered on a voluntary basis, through referral from either prison or probation personnel. This means that it is currently only available to those who have been convicted of sexual offences and are within the criminal justice system. This point will be discussed in more detail below. Offenders are deemed to be appropriate for referral where either "specific mental health issues are identified that relate directly to assessment or treatment (for instance, where mental illness is thought to contribute to the risk of reoffending) , or where there is evidence of hyper-arousal, intrusive sexual fantasies or urges, sexual urges which are difficult to control and/or sexual sadism (NOMS, 2007: 3). Depending on the needs of the offender Selective Serotonin Re-uptake Inhibitors (SSRIs) (which do not decrease androgen levels), Cyproterone Acetate (CPA) or Luteinizing-Hormone Releasing Hormone (LHRH) agonists will be used. France also offers antiandrogenic pharmacotherapy on a consensual basis; although the French Justice Minister, Dominic Perben, has said that if the treatment works then it might be something which sex offenders will be forced to undergo in the future (<http://news.bbc.co.uk/1/hi/world/europe/4170963.stm> last accessed 6 October 2008). Voluntary use of pharmacotherapy is also used in Canada, Germany and Austria (Koller, 2008, Birklbauer & Eher, 2008).

Whilst it is easy to assume that if treatment is offered on a voluntary and consensual basis that there are no ethical problems involved, this is too simplistic a view to take; as there are still concerns over the issue of the offender's consent. This includes whether that consent is valid and whether the offender truly understands what he is consenting to, including all of the possible side effects involved. It is suggested by Meyer and Cole (1997) that before pharmacotherapy is started, even if voluntary consent has been given, the offender should be assessed by at least two mental health professionals. This would help to ensure that the offender is not being motivated by self hate and a desire to self punish; to check that there are no mental disorders and to check that the offender understands all of the risks involved. An impartial third party should then be selected to certify that the offender's consent is valid and freely given and finally, if relevant, the offender's wife/partner should be told of the risks and consequences of the drugs involved. Bearing in mind that the long term effects of the drugs are simply unknown, it can also be argued that no offender can ever truly give informed consent, because he just does not know what risks he is consenting to.

There is also the problem of ensuring that the offender is not just simply consenting to the lesser evil, in the sense that prison is considered to be worse than undertaking a course of medication; even if that medication can cause serious side effects. Whilst some may say that, such a choice is for the offender to make; is it ethically acceptable that we are placing people in this position? Even when treatment is offered on a voluntary basis, as it is in England and Wales, and where it is not supposedly linked to prison/parole release; there is still the fear that an offender will consent because he thinks, or he is encouraged to think, that participation in such a programme will be viewed positively by the parole board and/or other release/supervisory authorities. So rather than being motivated to participate because he wants to rid himself of his deviant thoughts, fantasies and resulting behaviour, he is agreeing to involvement because of the effect which it may have on his eventual release from custody.

When deciding whether such treatment should be voluntary or mandatory, perhaps one guiding principle is evidence concerning compliance rates with voluntary versus involuntary groups of offenders. One study (Maletzky, 1980), compared court-referred and self-referred paedophiles and exhibitionists, evaluating which group were more likely to succeed in terms of recidivism. Treatment compliance rates were thus measured through a combination of penile plethysmography, self-reported behaviours and observers' reports. Perhaps surprisingly, little difference was found between the two groups, even though logic may tell us that those who wanted to be there were more likely to engage in the programme than those who had to be there. Whilst there was

marginally better compliance from self-referred offenders, this was not significantly different and whilst those who had been court-referred had better attendance, again this was not considerably so. This might suggest then that it does not really matter whether we allow offenders to choose to attend or whether we compel it; although there may be ethical differences when talking about a course of medical treatment rather than a psychotherapeutic treatment programme.

Treatment or Punishment

Antiandrogenic pharmacotherapy is generally referred to as a method of treatment, and indeed this is how this article has referred to it up until this point. This section, however, assesses whether this is the correct use of the terminology 'treatment', asking whether the use of medication with sex offenders should be classified and used as part of a treatment package or instead, as a method of punishment. Whether we view pharmacotherapy as treatment or punishment may be inextricably linked with whether it is voluntary or mandatory; with voluntary participation arguably seen as treatment and mandatory as punishment.

Although referring to the more invasive option of castration through surgical means, Baker (1984) argues the importance of distinguishing between prevention of criminal offending and prevention from all sexual activity, including that which is legally permissible. He states, therefore, that the key question for practitioners to ask is whether the treatment exceeds the cure. As surgical castration prevents all sexual activity he claims that it can only be classified as punishment and never treatment. Pharmacotherapy, however, is slightly different. Whilst there are case studies where men have been unable to achieve erections or ejaculate; this is not the situation for all. Many offenders undertaking medication have still been able to perform sexually and thus able to engage in age appropriate sexual relationships. Applying Baker's question of whether the treatment exceeds the cure then; for these latter group of men it can be argued that the treatment does not exceed the cure and thus that the use of medication here could be presented as a treatment option. The same, however could not be said for the former group and here it might have to be accepted that pharmacotherapy in these circumstances can only be viewed as punishment.

Another issue, due to the prevalence and intensity of the negative side effects is whether participation in a pharmacotherapy programme can ever be described as treatment, even if participation is supposedly consensual and/or voluntary. The myriad of negative side effects for MPA have been noted above and even though this drug is not commonly used in Europe and Canada there are still plentiful risks when using CPA or LHRH agonists. Side effects associated with CPA include: fatigue, hypersomnia (sleepiness), lethargy, depression, a decrease in body hair, an increase in scalp hair and weight gain (Bradford and Pawlak, 1993). Other effects include liver damage, bone mineral loss, nausea, indigestion, skin rashes, galactorrhoea (abnormal production of breast milk), shortness of breath and decreased production of oil from sebaceous glands in the skin (www.netdoctor.co.uk/medicines/100000131.html, last accessed 14 October 2008). Whilst for LHRH agonists, there are concerns about its potential to cause weight gain, depression, pain at the injection site (Briken *et al.*, 2001), mild to moderate bone demineralisation, nausea, depression, mild gynaecomastia (Krueger and Kaplan, 2001) and osteoporosis (Grasswick and Bradford, 2002). With such numerous concerns, it is difficult to see how exposure to such risks can be seen as anything else apart from punishment.

Despite this view, it may actually be more politic for practitioners, policymakers and professionals within the criminal justice system to classify the use of androgen suppressing pharmacotherapy with sex offenders as treatment, rather than as punishment. This is because, as argued by Christie (1982), it is easier to justify pain (and by this it is meant pain suffered by the onset of any of these numerous negative side effects) when it is classified as a method of treatment rather than as a form

of punishment; as even if pain is involved in the cure, it is not intended as pain. As Christie declares, the published aim is rather to help the patient and so through this labelling it makes the use of pharmacotherapy more ethical and thus more widely acceptable.

Such a classification, however, may not suit those who actually want the offender to be punished and through that punishment, suffer, and subsequently does not fit in with 'populist punitiveness' (Bottoms, 1977) and longer than commensurate sentencing; policies which are often used and referred to when the sentencing and management of sex offenders is spoken about. As argued by Icenogle,

"The emotional reaction engendered by criminal sexual behaviour makes it unlikely that society will accept treatment as a sentencing option unless it is clearly viewed as punishment (Icenogle, 1994: 280).

Despite this public reaction to sex offenders and how they are dealt with by the criminal justice system it is worth noting that whilst more punitive measures are demanded when the offender is a stranger to the victim and fits in with the 'stranger danger' notion of offenders; this is not the case when the perpetrator is either a family member or known to the family. Here the desire is often that the offender is conversely treated and helped through rehabilitation so that the family unit can be repaired and once more exist (although it is accepted that in reality this is often not possible). Bearing in mind that the vast majority of offenders are known to their victims (Howitt, 1995; Briere & Elliott, 2003) this need for punishment may not be as accurate as it is often assumed.

There is an obvious danger, however, with labelling pharmacotherapy as treatment, as it might suggest that paedophilia is something which can be treated and cured. As Meyer and Cole (1997) argue, whilst the use of medication with sex offenders can arguably help in treatment, it could also be used to give offenders a 'medical problem' excuse. Whilst they acknowledge that the endocrine system, which the testes are a part of, does affect the quality and intensity of sexual arousal, they also contend that it is the brain which is the offending organ and not the penis. Conversely, Bradford and Pawlak (1993), argue that sex drive is a basic biological factor and is controlled by our biological regulatory systems rather than our sense of right or wrong or willpower. Taking this argument further, if paedophilia and paedophilic behaviour is a medical issue then, some might argue, that we as a society, should not punish those people who offend in this way; as they simply cannot help themselves. This is a view held by Fitzgerald (1990),

"Individuals, whose actions are the result of persistent physiological or psychological conditions which makes them incapable of controlling their behaviour, should receive treatment, not punishment, for their conditions (Fitzgerald, 1990: 55).

Despite the fact that some cultures legally practice paedophilic activities (Green, 2002); this is not an argument which is ever going to carry much weight in the western world. So in this sense, unless pharmacotherapy was used in adjunct with other sentencing options; it is unlikely to be accepted as a censure for sex offending on its own if it was labelled and seen merely as a form of treatment.

Notwithstanding this argument, whilst the different medications used on sex offenders can, for some, decrease strength of deviant sexual interests and desires; it is unlikely to actually cure or change the course of them (Bowden, 1991; Schober, Kuhn, Kovacs, Earle, Byrne, & Fries, 2005).

Gys and Gooren (1996) similarly state that although hormonal treatments can reduce deviant desires and arousals, they cannot alter the direction of them. If this is accepted, it would be wrong to thus classify pharmacotherapy as a treatment method, as even though it may help with lessening the 'problem' it cannot offer an actual cure. It is, therefore, argued that the use of pharmacotherapy should not be labelled as exclusively treatment, nor should it be classified as solely punishment but instead seen as a risk management strategy and should thus be brought into play after punishment has been served and alongside and in conjunction with other treatment techniques.

Availability

Availability of pharmacotherapy would appear to differ around the world. Some countries such as the US and England and Wales only seem to offer such treatment when the offender is being dealt with within the criminal justice system and is thus a convicted offender. Others, however, have structures and protocols in place to include those people who are being treated within mental health settings. Whilst the latter would appear to be the better and more appropriate way of administering and controlling the use of such drugs; this section looks at whether the former is first ethical and second legal. Should pharmacotherapy be available to all those who need or request it or only available to those who have been convicted of a sexual and usually paedophilic offence?

Sharing the view of the author, Money (1979) argues that medical treatment of this type should be available for all; irrelevant of whether that person has offended and without fear of recrimination from the police or other criminal justice agencies. Whilst it is accepted that pharmacotherapy cannot actually cure paedophilic tendencies; if it can be used to prevent offending, then someone who has sexually deviant thoughts and urges and is prepared to undertake the programme, should be given the chance to participate in it. If the situation in England and Wales and other countries, remains whereby you need to have been convicted of an offence (and also fall within the referral guidelines) before such medication is at your disposal, there may come a time where an offender tells a judge that one of the reasons he offended was so that he could be admitted onto a pharmacological programme. When the research literature suggests that many offenders offend several times before they are actually caught and/or convicted (Howitt, 1995; Abel *et al.*, 1987); limiting medication in this way would not appear to be sensible.

Another reason for allowing the use of pharmacotherapy for all who desire it is based on the comments of those who have undertaken such programmes. One example is Wayne, a newsagent in a mid-western town in the US, who pleaded guilty to two charges of child molestation. After having spent three months in a treatment programme using pharmacotherapy he revealed,

"I realised I could walk down the street, see boys I found sexually attractive, and not be possessed by thoughts about having sex with them . . . It took that edge off
(Russell, 1997: 431)

In England, Robert Oliver, a convicted paedophile, advocated the use of pharmacotherapy for those sex offenders who wished to undertake the treatment. In comments to his sentencing judge following a repeat sexual offence he contended,

"No amount of sentence can stop the way I feel at the moment, the only way the streets will ever be safe is to put me on a course of injections where I can be controlled and I can be switched off (World in Action, 1997).

Furthermore, another offender in California, subject to weekly injections of MPA described how the drugs had,

"Just changed a lot of things . . . I'm not focused on sexuality. I don't have that major sex urge within me all the time. I can sit down and concentrate on different things, where I couldn't really concentrate on things before. I have a little more hope that I am not going to get into more trouble, so I am more involved in things (World in Action, 1997).

Such comments would therefore suggest that ethically we should ensure that if medication to reduce sexually deviant behaviour does work; then it should be made available to all who want and desire it. Whether a country can be legally compelled to follow this is, however, perhaps different.

Whilst there do not appear to be any relevant UK or European cases on this matter, with most involving issues of consent (*Freeman v Home Office* No 2 [1984] QB 524) rather than the availability and right to receive treatment, such concerns have arisen in the US. In *Paoli v Galley* (US District Court, District of Maryland, Civil No. K-74-476, May 1975), the Department of Corrections in Maryland were told that they could not refuse to give MPA to an inmate who first, had requested the treatment and importantly, second, was deemed medically appropriate to receive it. Similarly in *McDonald v Warden State Prison* ((Connecticut): No. 32654, Judicial District of Hartford New Britain at Hartford, 1983, Case Withdrawn), the Department of Corrections in Connecticut backed down in its refusal to supply an inmate with MPA, when it had no evidence to support why they were denying his request. Furthermore, the Ninth Circuit Court in *Ohlinger v Watson* 652 F.2d 775 (9th Cir. 1980) held that if an offender had been admitted to imprisonment for an indeterminate sentence then constitutionally he was entitled to the best opportunity for rehabilitation, regardless of cost, staff availability or facilities. The court found that as MPA provided the most effective form of treatment he was entitled to be offered it.

Whether the courts in England and Wales or indeed in Europe would reach similar conclusions is unclear, but as Berlin (1989) has argued, withholding treatment from those people who have been fully informed of the side effects and have freely chosen to participate may be as much in breach of their human rights as forcing their participation. Likewise, if the offender is being kept under an indeterminate sentence, where it is necessary to show evidence of risk reduction before the Parole Board will consider release, then the provision of such treatment could be argued to legitimise his confinement. Although, as mentioned above, there are ethical issues when connecting the use of pharmacotherapy and parole release decisions. Despite this real concern, it is nevertheless argued here that pharmacotherapy "should be available to all who need it (Berlin, 1989: 238).

Other ethical concerns

Other ethical concerns involving the use of medication with sex offenders include the use of 'off label' drugs; the need for more rigorous testing using double-blind randomised trials and the need for full medical tests prior to, during and after treatment. The concern regarding the use of 'off label' drugs is one which has been expressed by academics and practitioners for some years (Berner and Briken, 2008). The term 'off label' refers to the situation whereby drugs are being used for a purpose other than that which the drug is licensed for. An example can be seen with the use of the SSRI, Sertraline. Whilst the drug has been approved of and licensed for the treatment of depression, and although not lowering androgen levels, it is also being used by countries across the globe to treat

sex offenders; as an additional effect of the drug is to reduce sexual functioning, sexual desires and associated sexual performance behaviours (Kafka, 1997). Whilst the use of 'off label' drugs is legal, and can be justified on the basis that it would be too expensive and time consuming to have every drug officially tested and approved of for every single disease and/or medical condition, there are still adjacent ethical concerns. It can be argued that it is wrong to use people to test drugs on, especially if the administration of such drugs is mandatory, and is occurring within the criminal justice system. If a drug has not been approved of for the condition which it is being used for, there is no way of knowing what side effects will occur and how serious these side effects could be for that person involved. Many would disapprove of the use of offenders in mandatory drug testing trials, but in reality is this really any different. Whilst it is accepted that the use of drugs for off label purposes has saved lives, especially in cases of cancer and AIDS

(<http://www.healthatoz.com/healthatoz/Atoz/common/standard/transform.jsp?requestURI=/healthatoz/Atoz>

last accessed 14 October 2008); the patients in these circumstances were given free choice as to whether they should participate or not. This is arguably not the same for sex offenders however; either because participation is mandatory or even though consent might have been sought and given, it may be marred by a desire to impress and show willing to the relevant authorities.

Whilst this article has not been about the effectiveness of using medication to treat sex offenders it is still worth noting that one of the ethical issues surrounding the use of pharmacotherapy is whether the drugs used are effective, especially considering the negative side effects which offenders are potentially being subjected to. Most academics and practitioners in the area accept that whilst there are a number of studies which show that certain medications have been successful with patients, most are single-case studies or involve small groups. Most practitioners therefore believe that more testing is needed including the use of double-blind randomised trials (Beech and Mitchell, 2005; Maletzky and Field, 2003; Grubin, 2007). Whilst this would provide the best methodology for effective testing; as you would truly be able to see whether lack of recidivism was due to the use of medication or to some other reason, there are ethical considerations to take into account as well. If a double-blind randomised trial was to take place then you would need offenders of similar risk levels and similar patterns of offending. Offenders would be randomly placed into treatment and control groups; meaning that only half would actually be treated. When presumably we are talking about offenders who find it difficult to control their deviant thoughts and resulting behaviour; as a society it is unlikely that we would feel happy or safe knowing that only half of these high-risk and highly-deviant offenders were being treated. To allow for full testing, you would need to release all into the community (although of course other risk management and risk treatment techniques would be in place as well) and again this is unlikely to be approved of by the public. Additionally if we look at this from the viewpoint of the offender; is it fair that one offender is freed from deviant fantasies and is given the opportunity to lead a 'normal' life, when another is not? The researchers are therefore in a very unenviable position.

Finally all practitioners, policymakers and personnel from criminal justice agencies need to ensure that if pharmacotherapy is used that there are adequate protocols in place to protect the health of the offender. It is thus important that prior to treatment commencing the offender is fully screened for a variety of conditions to ensure that the drugs or the combination of drugs is suitable. Even if the offender is considered suitable for the treatment at commencement, it is still important that his health is regularly checked. For example when using LHRH agonists, Briken *et al.* (2003) recommend that each person should be tested at the beginning of the programme, and every six months, for testosterone levels, kidney function, cardiovascular status, complete blood count and monitored using electrocardiograms. It is also important, due to the risks of osteoporosis, that baseline bone density is monitored on an annual basis. Whilst such tests are an essential part of the programme, it is necessary to consider the additional costs which such checks will bring. Therefore, policymakers need to be informed about the true extent of the use of pharmacotherapy and made to

realise that the cost of the drugs is the mere tip of the iceberg.

Conclusion

The use of antiandrogen pharmacotherapy is potentially an opportunity for practitioners and criminal justice professionals to make a real difference in the lives of motivated sexual offenders who truly desire to control their deviant behaviour. Whilst concerns over its effectiveness have been acknowledged by practitioners and academics, it is also important to bear in mind a myriad of ethical concerns surrounding its use. It is argued here that if a jurisdiction decides to include pharmacotherapy in its sex offender strategy, then it should only do so on a voluntary basis. Offenders should be assessed properly to ensure that their consent is free, informed and given without pressure or belief that it will affect prison/parole release. It should form part of a risk management approach and be used in conjunction with psychotherapy and other risk reduction techniques. It is preferable that the drugs used are licensed for the purpose of treating sex offenders and that they are made available to all who desire them; even if they are not within the criminal justice system. Finally and importantly it is necessary to administer full medical checks, prior to, during and after treatment, immaterial of the costs involved. The use of pharmacotherapy with sex offenders may help give offenders a real chance to live a more 'normal' life and through this could greatly enhance public protection; but it must be administered in a responsible and ethical manner. If we expect offenders to show respect and dignity to others, then we must treat them with that same respect and dignity.

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