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Treaters or punishers? The ethical role of mental health clinicians in sex offender programs

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ABSTRACT

Clinicians in sex offender treatment programs are forced to breach traditional mental health ethical principles in order to successfully achieve their outcomes. These breaches include placing the community's interest ahead of those of the offender, restricting confidentiality, and the imposition of involuntary treatment. Unlike breaches in other treatment settings, they are not exceptions to general rules of non-maleficence or beneficence but, rather, must be carried out routinely and universally. Such programs thus take on the characteristics of punishment, rather than treatment, and, unsurprisingly, traditional codes of mental health ethics fail to give any real guidance to clinicians providing them. It is argued that ethical principles justifying and limiting punishment will be of more value in limiting the harms which might be inflicted on offenders participating in these programs while maintaining the integrity of the clinicians working with them.

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The central issue facing mental health clinicians in correctional settings has always been the conflict between the best interests of the offender and the protection of the community. For clinicians, balancing these two imperatives has sometimes been an impossible task. A classic example is that of offenders who tell their treating clinician that they are planning to re-offend. Whether the clinician should then notify the relevant authorities and thus breach an ethical duty to maintain confidentiality is not at all clear. The offenders, having been asked to reveal all by their therapists, may feel they are being punished for attempting to comply with treatment. The plans may not have sinister import at all but may be a bluff — the bravado typically exhibited by many young offenders. The planned re-offending may represent only a minor risk to community safety (e.g., shoplifting). On the other hand, the therapist risks much by breaching confidentiality: betraying the trust of a possibly very fragile client.

The pragmatic and ethical dilemmas in this sort of case are not capable of easy resolution. Although the interests of the offender and of society need not always be at loggerheads, there will continue to be times when a choice needs to be made. In well-run correctional settings (whether prison or community) there may be clear institutional rules to be followed when (as in the above example) confidentiality must be breached, but in many other situations there is little guidance for even the most conscientious mental health provider.

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This article will consider some of the guidelines which have been offered to date. It begins with the important distinction between punishment and treatment and, in particular, between mental health treatment which is offered to offenders to alleviate their suffering (e.g., treatment for mentally ill prisoners) and that which is provided as part of a punishment regime aimed at reducing their danger to the community (e.g., treatment programs for sex offenders and violent offenders). While the distinction is not always clear-cut, it is an important one to make. Treatment *as punishment,* as opposed to treatment offered to those *being punished*, is very often associated with breaches of the ethical codes usually used by mental health practitioners to determine their standards of care. Furthermore, these breaches, rather than being regarded as undesirable or exceptional, are considered necessary for optimal treatment.

Traditional ethical codes, even those applying specifically to mental health practitioners working in correctional settings or with specific offender populations, have offered only vague guidelines for dealing with, or have simply ignored, such breaches. Yet if clinical mental health services are to be used for the purposes of punishment, ethical guidelines still appear to be necessary. It is argued that principles governing the justification for, and the use of, punishment may well be more appropriate in these cases.

1. Treating the punished versus treatment-as-punishment

In the mental health system, although interventions such as involuntary detention in hospital inflict suffering on an individual, mental health clinicians distinguish such interventions from punishment. Punishment involves an authority's intentional infliction of a penalty on an offender who has broken a rule, or has caused someone else to break a rule, whether intentionally or negligently (Honderich, 1989, p. 19). Treatment, on the other hand, must, as far as possible, avoid harming clients (including offenders) and, if possible, be of benefit for them. These principles of non-maleficence and beneficence are primary obligations for health care providers; "intentionally or negligently caused harm is a fundamental moral wrong" (Beauchamp, 1999). When treatment involves the infliction of suffering (e.g., involuntary detention in a psychiatric facility), the benefits for the client must outweigh the harm caused (e.g., the benefit of improved mental health) (Beauchamp, 1999).

Of course, it is not always easy to distinguish treatment from punishment. From the client's point of view, practices such as enforced administration of medication, deprivation of personal possessions, and limiting access to friends or family members may all be seen (and often rightly so) as intentionally and senselessly punitive. Clients have the right to object to these practices if they are indeed punitive and harm-causing procedures that are not consistent with the aims of good health care. A more useful distinction in correctional environments proposed by Glaser (2003) contrasts treatment which is administered to those *already undergoing punishment* (e.g., prisoners receiving interventions for psychiatric disorder) and treatment which is either implicitly or explicitly *a component of a punishment regime* (e.g., sex offender treatment ordered by a court or undertaken by offenders in expectation that they will have a better chance of being granted parole). In the former case, clinicians may infringe ethical principles such as non-maleficence but must recognize that such breaches are unfortunate (if necessary) *exceptions* to ethical rules which would otherwise apply universally. On the other hand, in treatment programs which are a component of an offender's punishment, breaches of health practitioner ethical codes are not only routine features of treatment but are often regarded as being desirable or even necessary for the success of that treatment.

The example of confidentiality with which we began this article provides a useful illustration. Traditional ethical codes for health care professionals generally agree that the maintenance of confidentiality for all issues raised by the client is always a primary concern even in cases where this would result in harm to others (Beauchamp & Childress, 1994). By contrast, guidelines for sex offender treatment programs, since their inception, have stressed that confidentiality must be limited as a universal requirement for successful treatment. An enormously influential early writer in the field declared:

> Limited confidentiality is a necessity if a child sexual abuse treatment team is to function effectively. In this, sexual abuse differs from all other therapeutic programs known to the author.. sexual abuse programs differ from the traditional stance on confidentiality in that individuals are asked to surrender their right to have total confidentiality upon entry to the program and may be denied entry if they do not agree... (Salter, 1988, pp. 89–90).

Best–practice models of sex offender treatment have continued to incorporate mandatory limitations on confidentiality as they spread globally. Across the Atlantic from Salter, English authors have asserted that:

> As our primary duty in this work is the protection of the public, we must act upon the results of any assessment work undertaken. This means that the usual requirements of client confidentiality must take second place to the needs of public protection. (Briggs, Doyle, Gooch, & Kennington, 1998, p. 17).

There have been no changes in this position in the last two decades. As recently as November 2008, national guidelines in the US have unequivocally confirmed that limited confidentiality remains a "key element" specific to sex offender treatment (Center for Sex Offender Management, 2008). The point to highlight is that not only are breaches of confidentiality allowed under such guidelines, they are regarded as necessary for treatment success. They need not be justified nor are they even regarded as exceptions to a general rule.

Some authors have argued that confidentiality can be breached provided that the client is offered the option of informed consent. For example, section 1.07(d) of the Code of Ethics of the National Association of Social Workers (1999) in the US, and section 3.10(c) adopted by the American Psychological Association Ethics Code (2002) both oblige a clinician to warn a client that confidential information may be disclosed, where a threat of harm to others is present and/or where this is required by law (Levenson & D'Amora, 2005). However, such a warning does not resolve this ethical dilemma at all. Firstly, the consent provided by a client will be neither free nor voluntary; there will be nearly always negative consequences (including possible imprisonment) for a refusal to agree to disclosure of confidential details. Secondly, and equally as important, both these codes seem to imply that breaching confidentiality in these circumstances is an exception to a general rule, only to be applied under specific circumstances such as the potential of harm to others. The suggested warning does not state the reality: breaching of confidentiality is a routine, universal, and mandatory requirement for treatment service providers. The client undergoing treatment-as-punishment may well be misled into believing that confidentiality regarding his personal details *generally* is maintained, even when this is not the case.

Values which contravene traditional health practitioner codes of ethics pervade all areas of clinical practice with sex offenders. Clinicians have been exhorted to use involuntary treatment or other coercive measures including prosecution or even imprisonment (ATSA, 2001; Marshall, Anderson, & Fernandez, 1999), deny offenders any choice of therapy or therapist (Salter, 1988), force offenders to adopt sometimes quite arbitrary limitations on their lifestyle such as standards of personal hygiene (Marshall et al., 1999), and require offenders to incriminate themselves by confessing to prior offences which may not have yet come to the attention of the police (Kaden, 1998). If offenders object to these requirements, they possibly face

heavy penalties: expulsion from the program and/or an unfavorable report to a court or parole board.

2. Can we adapt health professional ethical codes to guide treatment-as-punishment?

Attempts have been made to formulate codes of conduct for health professionals which take into account the ethical dilemmas described above. One strategy is the Practice Standards and Guidelines adopted by the US Association for the Treatment of Sexual Abusers (ATSA) (ATSA, 2001, 2004). These endorse a number of practices which seemingly promote an offender's welfare (e.g., provisions for reporting ethical breaches by ATSA members, the use of evidence-based treatment, and the development of treatment plans serving the needs of individual offenders). Even so, it is clear that the interests of the community always trump those of the offender. Indeed, the first of the Guiding Principles of the 2001 version of the Standards and Guidelines stated unequivocally that "community safety takes precedence over other considerations and ultimately is in the best interests of sexual abusers and their families" (ATSA, 2001).

Although this Guiding Principle has now been modified (ATSA, 2004), other principles in the 2004 version of the Guidelines still declare that: "external motivation" (i.e., court-ordered treatment) is necessary to ensure treatment compliance; that criminal investigation, prosecution, and court orders are "important components of effective intervention and management"; and that treatment programs should work "collaboratively" with (amongst others) probation/parole officers and child welfare workers. In other words, the therapist is justified in using force to make an offender complete a program, the therapist co-operates with agencies who may be antithetical to the client's welfare, and the mark of a good therapist is not only his or her skills but also adherence to values which justify the abandonment of beneficence and non-maleficence.

Now it could be argued that many enforced interventions can ultimately be justified as being in the offender's own best interests. For example, court-ordered treatment may be necessary to ensure treatment compliance, but this will ultimately produce benefits for the offender, who will develop, through treatment, the skills to ensure long-term behavior change and, presumably, a more meaningful and productive lifestyle (Levenson & D'Amora, 2005). Certainly there are recent models of offender treatment which explicitly focus on benefiting the offender, for example, the Good Lives Model of offender rehabilitation developed by Tony Ward and his colleagues (e.g., Ward, Mann, & Gannon, 2007). Marshall and his colleagues have found that therapy with sex offenders conducted in a more traditional psychotherapeutic fashion, with the therapist being less confrontational and more warm and empathic, produces better outcomes in terms of both offender satisfaction and treatment compliance (Marshall et al., 2003; Marshall, Marshall, & Serran, 2006).

There is a danger, however, in this paternalistic approach. Paternalism really draws its justification from cases where clients lack the capacity to understand the effects of their condition or their need for care and treatment, for example, those with severe mental illness, substantial brain damage, or significant intellectual disability (Szmukler, 1999). Most sex offenders, however, are well able to give informed consent to treatment; the reason that many of them do not want it is that offending is a pleasurable and productive achievement; it is "associated with positive emotions and explicit and immaculate planning.." (Ward & Sorbello, 2003, p. 12). Thus there seems little justification for forcibly treating those who have decided, misguidedly perhaps but certainly rationally, to follow lifestyles which may be socially unacceptable and even dangerous to others but which are definitely not the product of impaired decision-making abilities.

The Good Lives Model mentioned above aims to overcome the dangers of paternalism by recognizing the human agency of offenders, promoting the respect for their needs and aspirations that should be afforded to all human beings, and providing them with the capabilities to implement a better life plan based on their own goods and values (Ward, Gannon, & Birgden, 2007; Ward & Maruna, 2007). Yet, the problem remains that consideration of an offender's welfare is entirely contingent on the maintenance of community safety. It is gratifying to see that, as Marshall and his colleagues have found, traditional attributes of the "good" psychotherapist promoting "good lives" – empathy, warmth, openness, a non-confrontational style and so on – are all associated with positive changes in treatment and, presumably, with subsequent decreased recidivism (Marshall et al., 2006). But what treatment guidelines would these studies have recommended if the findings had been different? If techniques such as confrontation, humiliation, and torture had produced better outcomes for community safety, then these may well have justifiably formed part of the "treatment" of sex offenders, however distasteful they might be to ethical mental health professionals.

3. Should mental health clinicians abandon sex offender treatment programs?

Using the outcome measures set by community expectations, sex offender treatment programs work. Treatment is associated with significant reductions in both sexual and non-sexual recidivism, as demonstrated convincingly by large meta-analyses (e.g., Hanson et al., 2002; Losel & Schmucker, 2005). This reduction translates into an enormous lessening in the suffering of victims and their families and huge savings in the costs of victim support and the processing of offenders by the criminal justice system. Skilled and well-trained mental health clinicians provide the technology and organization to make effective treatment possible and have an important humanizing effect on the criminal justice system generally. Clinicians can remind police, corrections officers, legal professionals and, of course, offenders themselves that not all offenders are incorrigible, that relationships with them need not always be marred by conflict, and that harsh punishment is not the only, or even the most desirable, solution to criminal behavior (Burt, 1993). But the mere fact that an intervention works and that clinicians contribute significantly to its success does not mean that it is ethically justified. The problem is not that of whether clinicians should remain involved with sex offender treatment but rather that of whether their work can continue to be guided by the codes of ethics traditionally used by mental health practitioners.

One solution might be to abandon any pretence that sex offender treatment programs follow any code of ethics. Individual practitioners in such programs would have to rely on the limited ethical guidance which might be available from the arbitrary application of other, probably irrelevant, codes of ethics or their own personal belief systems. However, any professional group which purports to serve the needs of the community will ultimately need a code of ethics to validate their professional standing. Such codes may serve a number of functions. For example, they educate practitioners about their ethical obligations, they ensure that practitioners comply with those obligations by censuring those who do not or offering incentives to those who do (e.g., professional accreditation, encouraging widespread conformity so that practitioners who do comply are not disadvantaged by doing so), and they provide practitioners with a justification for assuming special privileges (e.g., self-regulation using an ethical code justifies allowing professional groups to determine their own standards of practice and their own fees, often unilaterally) (Bloch & Pargiter, 1999; Lichtenberg, 1996).

From the point of view of the community, however, the most important function of an ethical code is that it is a public commitment by the profession concerned to a particular standard of ethics and rules (Coady, 1996b). The numerous scandals that have repeatedly blackened the reputations of many health professional groups demonstrate a commitment to high ethical standards; they reflect the community's expectations of the profession involved. Nobody

cares much if a real estate agent or a car salesperson has a sexual relationship with a client; people care very much if a psychologist, social worker, or doctor engages in the same activity.

Importantly, the commitment is *public* and the rules are *specific* and consistent with the fundamental principles guiding the conduct of the profession concerned:

> Those enforcing the code… are not there merely to rule out practices, experiments or changes that will actually fail in their intended effects or that are aimed at bad outcomes; they are also there to rule out morally objectionable ways of promoting good ends. (Coady, 1996a, p. 275).

This, of course is the fundamental problem with current codes governing practice in sex offender programs. The programs aspire to "good ends", particularly the reduction of suffering by victims and the community caused by the depredations of their clients. But they do so in ways which are "morally objectionable" in that they are quite inconsistent with the fundamental ethical principles which characterize treatment, that is, non-maleficence and beneficence.

4. The ethics of punishment

One way in which a new code for sex offender treatment might be devised is to begin with an acknowledgement that it is not "treatment" at all. This type of treatment does not have the interests of the offender as its primary focus and allows, indeed sometimes compels, the "therapist" to inflict harms on them. The imposition of these harms is only contingently beneficial for the offender and such benefits will always cease to be provided if the interests of the community or the offender's victims (current, past, or future) are placed at risk. Furthermore, these harms are inflicted in a deliberate planned fashion and are authorized by an appropriately constituted legal body such as a court or parole board. What we are looking at here is, in fact, punishment, as defined above (Honderich, 1989, p. 19).

The nexus between a treatment program and the punishment being meted out to an offender is not as clear as the link (for example) between punishment and imprisonment. Yet this nexus needs to be recognized in order to shift the ethical focus of such programs away from treatment. If our duty as therapists includes the inflicting of harms that are not in the offender's best interests, then our ethical duty now is to justify and minimize them, while acknowledging them as a necessary evil. In particular, we need to face up to the conflict which the infliction of such harms creates with the wider moral rules of society generally:

> What seems to worry most of those whom punishment worries at all is how punishment coheres with morality. Moral rules generally forbid killing, maiming, holding others against their will, taking the property of others without their consent, and causing pain; yet punishment…consists almost entirely of such acts. (Davis, 2009, p. 79)

Clinicians in sex offender programs, therefore, need to understand that they administer a component (often an important component) of a system for punishing offenders. Their participation in that system means that, for the good of society, they will be obliged to carry out activities which are evil, immoral and, under other circumstances, illegal. As clinicians, they cannot help but be aware of the dangers to their clients and, indeed their own integrity, of such interventions.

The rest of this paper will be devoted to sketching out some of the elements of an ethical code which might resolve these dilemmas. Before we do this, we need to note a preliminary observation. The proposed code is definitely not intended to provide guidelines for *all* types of punishment, although it will borrow heavily from theories justifying punishment generally. At a pragmatic level, however, clinicians cannot be considered to be punishment experts (nor, probably, would they want to be). Rather, their expertise has been co-opted to provide very specific interventions covering only a limited part of the spectrum of lawful punishments available to society. It is only to these narrowly-defined forms of punishment that the ethical principles discussed below would apply.

A code of ethics based on the justification of punishment needs to consider a number of questions. In the context of this paper, three appear to be of some significance (although it is freely acknowledged that they may not be the only or even the most important issues to be canvassed). Firstly, is it necessary to disclose to offenders and the community that treatment-as-punishment (and especially, sex offender treatment) is punishment even if this is in fact the case? Secondly, which of the traditional justifications for punishment is most applicable to the specific ethical challenges of treatment-as-punishment (and how)? Thirdly, what are the pitfalls of such a code, particularly with respect to an offender's rights?

5. Is it necessary to reveal that treatment is punishment?

At first glance, whether treatment should be re-labeled as punishment appears to be a trivial issue. Surely, one would argue, it does not matter what you call an intervention; the important consideration is that of whether it works or not. From the client's point of view, undergoing "treatment" may well be a more comforting, satisfying, or meaningful experience than seeing the same clinician in another context, even though their interactions are the same in each case. From the therapist's point of view, the role of punisher will cause considerable disquiet; recall the change in the principles governing the ATSA practice standards after 2001, discussed above. One suspects (and hopes) that ATSA's (2004) apparent de-emphasizing of community protection and the increased focus on an offender's welfare was a recognition that "treatment" usually means that the client's interests are primary. Finally, from the point of view of a criminal justice system administrator, the label of "treatment" (as part of "rehabilitation") provides a useful and seemingly harmless misrepresentation of useful strategies which, because of their effectiveness in reducing crime, now attract a lot of government expenditure. Indeed, in the UK during the 1990s, the systematized development of expensive rehabilitation programs was associated with an abandonment of the premise that treatment in such a program was an offender's right (i.e., serving the interests of the offender) and growing enthusiasm for the justification that such treatment reduced crime (i.e., was in society's interests) (Robinson, 2008).

Yet it is important to tell it like it is. Dressing up punishment as something else is ultimately counter-productive. As already noted, "treatment" ultimately becomes a disguise not only for punishment but for the arbitrary detention of people disliked by those in power, the discrediting of political opponents, and the suppression of dissident voices (Reich, 1999). Those deemed to require treatment have included not only political dissidents in the former USSR (Amnesty International, 1985) but also homosexuals (Szasz, 1971) and those labeled by their family as mentally ill (Scheff & Culver, 1989).

Furthermore, persons representing themselves as mental health clinicians have a role distinct from that of other professionals, and, in fact, distinct from that of other health service providers. That role emphasizes the therapeutic relationship, the vulnerability of clients (in terms of both their possibly diminished capacity to run their lives and the stigma and ostracism to which they are often exposed), and the "moral seriousness" of the goals of therapy which may need to produce radical and long lasting changes in clients' characters (Radden, 2002). There has been a traditional emphasis on the character required of the healer to "inhabit" this role (witness the Hippocratic oath) involving the demonstration of virtues such as trustworthiness, honesty, kindness, compassion, fidelity, humility, respect for confidentiality, veracity, prudence, warmth and sensitivity,

and perseverance. Ethically the therapist is obliged to cultivate them in their role as teacher, mentor, and guide for the client.

Could not, however, the same results be achieved by the therapist learning skills in feigning such traits, for example, adopting a persona displaying such traits (the concept of the "bedside manner" for example)? Radden (2004) thinks not. Ultimately this results in manipulation and deception of the patient/client which the client, because of the nature of the therapeutic relationship and their own vulnerability, has less chance of detecting than in other situations. Furthermore, the therapist's own character is corrupted; they become deceptive, dishonest, and hypocritical and there is a considerable danger that they will start to accept such vices as being acceptable in their role as therapists. It is easy to convince oneself that a positive and empathic therapeutic style and encouragement of the client to follow a more meaningful life are good for the client even when one's true motive for using such techniques is that of fostering community safety.

There is some empirical work which seems to add weight to these concerns. A recent survey of 540 ATSA members, almost half of whom had had 15 years of clinical experience, found that a large majority thought that some violent sex offenders should not be released into the community even after treatment, were concerned about the legal and moral ramifications of such offenders re-offending, and felt that sex offenders should be treated differently from other offenders (Engle, McFalls, & Gallagher, 2007). In other words, sex offenders are a special group who (possibly realistically) inspire pessimism in therapists. Under such circumstances it is tempting for therapists to play-act stereotyped roles with the excuse that anything is justified when attempting to control incorrigible and dangerous offenders. Of course, this has the unfortunate further effect of providing a model for offenders to emulate, thus increasing their repertoire of the cognitive distortions which underlie their behaviors.

Clinicians challenged by such difficult clients must cultivate the virtue of "good faith" (i.e., a congruence between one's behaviors and one's inner thoughts and feelings, the virtue of being "true to yourself"). The French philosopher Comte-Sponville (2003) has described this eloquently as the "philosophical virtue par excellence" because its possessor

> Sets truth above all things, above honor or power, happiness or systems, or even virtue or love. He would rather know that he is evil than pretend he is good; he would rather stare love's absence in the face when it occurs or his own egoism when it prevails (which is almost always) than persuade himself falsely that his is loving or generous. (p. 209)

For clinicians in sex offender programs showing good faith means stating very explicitly to the community, offenders, and themselves that what they are providing is not treatment. It is a form of punishment, admittedly a specialist and circumscribed form of punishment, which they have the technical expertise to administer, but punishment nevertheless. By not clarifying this role they play straight into the hands of the offenders they are "treating", who could quite justifiably accuse their therapists of the same deviousness and denial which those offenders are being urged to abandon Glaser, 2005.

6. What model of punishment provides the best ethical guidelines?

In some ways this is a loaded question. I am not attempting here to provide a *philosophical* justification for the punishment administered by sex offender therapists. As well, there seems to be no need to *empirically* justify this sort of punishment: we know that the interventions used in treatment reduce recidivism and this generally is a desirable thing to do. Rather, we are seeking a theory of punishment which fits the description of what actually happens in sex offender treatment programs and thus (hopefully) will canvas the ethical issues which need to be considered in such programs.

To begin with, we should try to broadly characterize the ethical context of sex offender programs. As we have already seen, their primary goal is the ensuring of community safety through the prevention of re-offending. This should be done, as far as possible, while taking into account the interests of the offender, although some of these interests are routinely ignored or curtailed in order to further the greater need for community protection. Such programs do not aim to deter sex offending generally (although they may assist in promoting public education and non-legal forums to heighten the community's awareness of undetected or potential sex offending activities). Rather, their focus is on specific offenders who already have been found guilty of an offence, although for those offenders undergoing some form of indeterminate detention, the offence may have occurred a very long time ago. The programs themselves have a very circumscribed place in the criminal justice process: they are not required to judge an offender's innocence or guilt, whether they deserve punishment or whether the punishment they receive is fair and proportionate (except to the extent that less serious offending may be associated with a lower risk of re-offending and hence merit less in the way of program interventions). Clinicians do not make any judgments as to the moral wrongness of offenders' actions although they may (and often do) attempt to educate offenders regarding the objective harm they have caused.

These considerations strongly suggest that a consequentialist model of punishment is the best "fit" for what actually happens in sex offender treatment. The consequentialist model is based on the utilitarian ideal that something is ethically justified if it furthers the common good and especially if it provides the greatest happiness or satisfaction to the greatest number in the community (Duff, 1998). The model states that a particular punishment is justified by satisfying three conditions. Firstly it must indeed deter future offending (and, as noted above, there is strong empirical evidence that sex offender programs do just this). Secondly, it does not cause more distress overall in a society than if it were not imposed. Thirdly, no other punishment is available that would deter as effectively but cause less distress (Honderich, 1989). This is the model of "economical deterrence": punishment is ethically justified if it can prevent the occurrence of future crimes while producing the minimum possible amount of distress in an offender.

This does not mean that *other* punishment models cannot be used with sex offenders (and, of course they are). But for the specific purposes of sex offender treatment programs other theories of punishment are not, or are only minimally, applicable. Clinicians in such programs would pay little regard to (for example) retributivist notions of punishment such as obtaining "just deserts" for one's crimes, being morally obliged to punish, criminals having a "right" to be punished and so on (see Honderich, 1989) even though such principles have an important place in other legal dealings with sex offenders. Sex offender programs are only one component of the punishment of offenders, although programs may have a considerable say as to what other punishments are inflicted on them such as recommendations regarding parole. The important point is that such recommendations are made on the basis of consequentialist considerations. For example, a clinician would normally not comment as to whether an offender *deserves* parole (e.g., as a result of his crime or his behavior in prison). However a clinician may have a great deal to say as to whether an offender is a *parole risk*, on the basis of the offender's risk assessment, response to treatment and so on.

7. Applying the consequentialist model

What ethical problems are solved by a consequentialist punishment model that cannot be dealt with by ethical codes traditionally applying to mental health professionals? This preliminary discussion will not be able to cover all the relevant issues and it is important to emphasize from the outset that the consequentialist model has its

weaknesses (as discussed further below). However, there appear to be a few important and obvious dilemmas that the consequentialist model appears to handle more effectively:

Consequentialist models place definite limits on the harm that may be caused to an offender and oblige clinicians to minimize it. Recall that a major difficulty of traditional mental health ethical codes was that they could only justify harms inflicted on offenders, such as restrictions on confidentiality, involuntary treatment of competent adults and so on, as exceptions to general rules of beneficence and non-maleficence; they could not justify the routine and obligatory infliction of such harms required by sex offender programs. Once the rules of beneficence and non-maleficence had been broken there did not appear to be any clear limit as to how much further harm could be justifiably produced. By contrast, the consequentialist punishment model immediately recognizes the (unfortunate) necessity for such harms but then sets a limit on them: they are only justified if the overall level of distress in the community is not increased. Once an offender's punishment has reached the point where the potential distress prevented for future victims is equivalent to the suffering the offender has endured, then punishment must stop. Furthermore, the clinician is obliged to consider every type of intervention which will cause the offender less suffering than this maximum amount but still be as effective in preventing re-offending.

Of course there are enormous difficulties in making an accurate assessment of the amount of future distress which might be saved by an offender not re-offending (although useful estimates have been derived of the economic costs of re-offending in comparison to the costs of sex offender programs). Nevertheless the principle is important: we now have a method for determining how much distress we can justifiably cause to an offender in a treatment program. That, in itself, should inspire research attempts to discover what harm-causing elements of the program are more likely to be effective than others. For example, it may be that full disclosure of past offending behaviors (and hence an increased risk of self-incrimination) results in only a modest increase in treatment effectiveness and hence the focus on it could be reduced (Kaden, 1998).

Therapists should always choose interventions which are consistent with human rights and dignity. Recent work on offenders' rights (see, for example, Connolly & Ward, 2008; Ward, 2007; Ward & Birgden, 2007) stressed the status of offenders as rights-bearers rather than as bearers of risk. It reasons that rights are necessary for all human beings who are capable of acting as agents for themselves, so that they can achieve their preferred goals. It is irrational to arbitrarily deny rights to some but not others because in doing so we are effectively declaring that some people need them to achieve their goals while others do not, an assertion which is patently untrue (Connolly & Ward, 2008). Offenders thus should retain as many of their rights as possible, especially those identified as core objects in such documents as the UN Declaration of Human Rights; these include personal freedom (albeit with necessary restrictions), material subsistence, personal security, elemental equality, and social recognition (Ward & Birgden, 2007).

Consequentialist punishment models justify the importance of offenders' rights in several ways. Firstly, depriving offenders of their rights to the degree which is more than necessary to deter them will create feelings of resentment which may be detrimental to their ability to monitor and control future re-offending behaviors. Secondly, respect for an offenders' rights by clinicians creates useful models which can be applied by offenders when they are seeking, in the future, to avoid the violation of the rights of their victims (Connolly & Ward, 2008). Thirdly, and perhaps most importantly, consequentialist punishment sets a limit on what rights an offender can be deprived of, and to what extent. The principle here is the same as that applying to the prevention generally of harms to offenders which has been set out above: deprivation of rights can only occur to the degree incurring the amount of suffering which would be saved if an offender is effectively deterred from re-offending. Furthermore, as we have noted with harms inflicted on offenders, the clinician is obliged to use any intervention which might result in a lesser deprivation of rights but still deter as effectively.

This rule, paradoxically enough, forbids the use of restrictive treatment settings and modalities which might be otherwise available to the therapist guided by more traditional mental health codes. For example, if treatment is as effective in a community setting as in the prison then the program is obliged to make community-based treatment available. Unfortunately, funding and resources continue to be preferentially directed towards prison-based programs even though there is growing empirical evidence that effective community-based programs for offenders can be implemented, particularly by incorporating features such as motivational interviewing, rigorous external supervision, and appropriate training of correctional staff (Birgden, Owen, & Raymond, 2003). Courts should not impose a prison sentence on offenders whose risk otherwise justifies a community-based disposition, simply because prison is where the treatment programs are. Consequentialist ethics demand a substantial rethinking of the planning and co-ordination of many correctional rehabilitation and treatment programs generally.

Punishment should not be described as "treatment". As explained above, persisting with the pretence that treatment programs for sex offenders are not punishment promotes deviousness in offenders, compromises the integrity of clinicians, and fuels perceptions in the community that offenders are getting a "soft" option. There needs to be more empirical research on the issue but one suspects that less suffering for all concerned would be caused if it was frankly stated that sex offender programs are in no way "treatment", at least in the traditional sense of the term, but are intended to be a specialist form of punishment.

There can be greater flexibility in choice of treatments and outcome measures. Many mental health interventions achieve other goals apart from the welfare of an offender or the protection of society, a fact which is more easily appreciated when adopting a consequentialist approach. Indeed, these goals may not be the sole, or even the main, ways to decrease the overall level of distress caused by sex offending. For example, offenders' obligation to mitigate their victims' distress may be important and is now a major component of restorative justice programs targeting "minor" sex offenders. Offenders' "treatment" includes providing apologies, reparations, and practical support to victims; offenders and victims appear to regard these interactions as both "fair" and personally satisfying (Koss, Bachar, Hopkins, & Carlson, 2004).

8. Problems with consequentialist punishment

Of course no system of ethical principles will provide complete or satisfactory answers to the multiple and complex dilemmas which are inherent parts of practice with sex offenders. Just as with other ethical codes, a code of conduct based on a consequentialist model of punishment carries with it the possibility of causing significant harm to offenders, clinicians, and the community:

Overly harsh punishments and/or victimization of offenders. Some substantial harms inflicted on offenders could be justified by the assessment that the future offences they are likely to commit will cause so much distress that drastic measures are needed to prevent them. That is precisely the reason for the introduction of lengthy or indeterminate prison sentences and civil commitment laws for sex offenders (La Fond & Winick, 2003) and for post-sentence residential supervision orders. In such cases, a more lateral interpretation of consequentialist ethics could be helpful.

Firstly, as with theories of punishment generally, there may be a need for "side-constraints" on consequentialist theories (Duff, 1998). For example, it could be argued that offenders have a right not to be subjected to harsh or indeterminate punishments, whatever the nature of their crime and that this right over-rides consequentialist considerations.

A second argument concerns the usefulness of prolonged detention. Impending release from incarceration is a powerful motivator for offenders to comply with treatment programs; conversely if release is only a distant and remote possibility then offenders' motivations to comply will correspondingly be decreased and they will be more likely to re-offend when they are eventually discharged. The benefits of prolonged incarceration are thus illusory and the additional suffering imposed on offenders cannot be justified.

A third approach stresses the responsibility of the clinician, under consequentialist guidelines, to cease treatment when the additional suffering it entails can no longer be justified. For most sex offenders, treatment consists of an intensive course lasting months, perhaps followed up by fairly infrequent "maintenance" interventions involving contact with a therapist. Therefore, in most cases, the detention of an offender for many years after the intensive component of treatment had ceased would not be justifiable from the point of view of the treatment program, in that there is no more suffering that could be justifiably inflicted (i.e., that could add to the safety of the community). Clinicians are simply not qualified, ethically or practically, to administer other forms of punishment (e.g., prolonged incapacitation of the offender) and they must make it clear that they cannot do so. That point could be emphasized by the refusal of mental health clinicians to continue to accommodate such offenders in mental health facilities.

Consequentialist models may result in perceived inadequate punishment. Certain types of sex offenders (e.g., intrafamilial offenders against children) are less likely to re-offend and hence may receive "soft" dispositions such as deferral of prosecution while attending a treatment program, even though the damage caused to their victims might have been considerable. In a sense, this is a problem for the consequentialist model only because treatment-as-punishment such as a sex offender treatment program is seen to be a preferred option for such offenders rather than (say) imprisonment. (But one consequentialist justification for such dispositions might also be that imprisoning a father and breadwinner will cause more harm overall – particularly to his family – than that arising from participation in a community-based "treatment" program). Nevertheless, for such offenders, the distress associated with participating in such programs will need to be kept to a low level, because the risk of the offender causing future distress to potential victims is not high. If the court regards the offending as deserving a greater level of distress that that which can be legitimately imposed by a treatment program, it may need to look to other forms of punishment.

Traditional principles of sentencing such as proportionality and parity may not always apply. As would be increasingly obvious from the above discussion, consequentialist ethics does not always mandate that more serious offences attract heavier penalties or that offences of equal seriousness receive similar sentences. Of course this is a problem with all theories of punishment but the special problem with consequentialism is that it is based on predictions of risk. The more potential suffering caused by future reoffending, the greater the justification for inflicting harm on the offender now, even though the index offence might be trivial. The converse also holds true. Consequentialist ethics can go part-way to answering this objection by pointing out that in most cases, the seriousness of offences already committed has a fairly robust empirical correlation with the potential seriousness of future offences but, as increasingly sophisticated studies of risk prediction tell us, this is not always the case.

It is difficult to know how to respond to this criticism which remains the major downfall of consequentialism. It certainly rears its head in clinical situations. For example, this author has encountered an offender whose extensive (and serious) sex offending history only came to light when he was serving a community-based order for a relatively minor non-sexual assault. His community corrections officer, appreciative of the high risk of sexual reoffending, ordered him to attend a sex offender treatment program. Did the program have the right to treat him under these conditions? It certainly was not part of the punishment ordered by the court which sentenced him for the assault offence. On the other hand, the same situation would have almost certainly caused similar ethical dilemmas for clinicians following traditional mental health codes.

9. Some conclusions

Ethics is very much about making appropriate decisions in particular contexts. It is no good trying to make decisions about treatment interventions if what you are offering is not treatment at all. It is also hypocritical for professionals to make a public commitment to an ethical code which stresses the primacy of the client when, all along, their true concerns may be anything but the client's welfare. That we punish our clients is an unpalatable fact but we need to be honest about it. We can then adopt an ethical code which is consistent with our practices and which places much firmer and clearer boundaries on some of the unpleasant things that we sometimes force our clients to do. It will no doubt be distressing for our clients that we will always require them to make sacrifices (often considerable) for the good of society. However they can always derive comfort from our ethical duty to minimize their suffering to the least extent necessary and to be never duplicitous or two-faced in our dealings with them.

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References

American Psychological Association (2002). *Ethical principles of psychologists and code of conduct.* Washington, DC: American Psychological Association.

Amnesty International (1985). *Prisoners of Conscience in the USSR.* Sydney: Amnesty International, Australian Section.

Association for the Treatment of Sexual Abusers (2001). *Practice standards and guidelines for the treatment of sexual abusers.* Beaverton, OR: Author.

Association for the Treatment of Sexual Abusers (2004). *Practice standards and guidelines for the evaluation, treatment and management of adult male sexual abusers (2004).* Beaverton, OR: Author.

Beauchamp, T. R. (1999). The philosophical basis of psychiatric ethics. In S. Bloch P. Chodoff & S. A. Green (Eds.), *Psychiatric ethics* (pp. 25—48)., Third edition New York: Oxford University Press.

Beauchamp, T. L., & Childress, J. (1994). *Principles of biomedical ethics*, Fourth edition New York: Oxford University Press.

Birgden, A., Owen, K., & Raymond, B. (2003). Enhancing relapse prevention through the effective management of sex offenders in the community. In T. Ward D. R. Laws & S. M. Hudson (Eds.), *Sexual Deviance: Issues and Controversies* (pp. 317—337). Thousand Oaks, California: Sage.

Bloch, S., & Pargiter, R. (1999). Codes of ethics in psychiatry. In S. Bloch P. Chodoff & S. A. Green (Eds.), *Psychiatric ethics* (pp. 81—103)., Third edition Oxford: Oxford University Press.

Briggs, D., Doyle, P., Gooch, T., & Kennington, R. (1998). *Assessing men who sexually abuse: A practice guide.* London: Jessica Kingsley.

Burt, R. A. (1993). Cruelty, hypocrisy and the rehabilitative ideal in corrections. *International Journal of Law and Psychiatry*, *16*, 359—370.

Center for Sex Offender Management (2008). *The comprehensive approach to sex offender management.* Washington: Center for Effective Public Policy.

Coady, C. A. J. (1996). On regulating ethics. In M. Coady & S. Bloch (Eds.), *Codes of ethics and the professions* (pp. 269—287). Melbourne: University Press.

Coady, M. M. (1996). The moral domain of professionals. In M. Coady & S. Bloch (Eds.), *Codes of ethics and the professions* (pp. 28—52). Melbourne: University Press.

Comte-Sponville, A. (2003). *A short treatise on the great virtues: The uses of philosophy in everyday life.* London: Vintage.

Connolly, M., & Ward, T. (2008). *Morals, Rights and Practice in the Human Services.* London: Jessica Kingsley.

Davis, M. (2009). Punishment Theory's golden half-century: a survey of developments from (about) 1957 to 2007. *Journal of Ethics*, *13*(1), 73—100.

Duff, R. A. (1998). Crime and punishment. In E. Craig (Ed.), *Routledge encyclopedia of philosophy* London: Routledge Retrieved March 24, 2009, from http://www.rep.routledge.com/article/T002SECT2

Engle, M. J., McFalls, J. A., & Gallagher, B. J. (2007). The attitudes of members of the association for the treatment of sexual abusers towards treatment, release and recidivism of violent sex offenders: an exploratory study. *Journal of Offender Rehabilitation*, *44*(4), 17—24.

Glaser, B. (2003). Therapeutic jurisprudence: an ethical paradigm for therapists in sex offender treatment programs. *Western Criminology Review*, *4*(2), 143—154.

Glaser, B. (2005). Commentary: an ethical paradigm for sex offender treatment: a response to Levenson and D'Amora. *Western Criminology Review*, *6*(1), 154—160.
Hanson, R. K., Gordon, A., Harris, A. J. R., Marques, J. K., Murphy, W., Quinsey, V. L., et al. (2002). First report of the collaborative outcome data project on the effectiveness of psychological treatment for sex offenders. *Sexual abuse: A Journal of Research and Treatment*, *14*, 159—194.
Honderich, T. (1989). *Punishment: The supposed justifications.* Cambridge: Polity Press.
Kaden, J. (1998). Therapy for convicted sex offenders: pursuing rehabilitation without incrimination. *Journal of Criminal Law and Criminology*, *89*, 347—368.
Koss, M. P., Bachar, K. P., Hopkins, C. Q., & Carlson, C. (2004). Expanding a community's justice response to sex crimes through advocacy, prosecutorial and public health collaboration. *Journal of Interpersonal Violence*, *19*(12), 1435—1463.
La Fond, J. Q., & Winick, B. J. (2003). Sex offender re-entry courts: a cost-effective proposal for managing sex offender risk in the community. In R. A. Prentky E. S. Janus & M. C. Seto (Eds.), *Sexually coercive behavior: understanding and management* (pp. 300—323). New York: New York Academy of Sciences.
Levenson, J., & D'Amora, D. (2005). An ethical paradigm for sex offender treatment: response to Glaser. *Western Criminology Review*, *6*(1), 145—153.
Lichtenberg, J. (1996). What are codes of ethics for? In M. Coady & S. Bloch (Eds.), *Codes of ethics and the professions* (pp. 13—27). Melbourne: University Press.
Losel, F., & Schmucker, M. (2005). The effectiveness of treatment for sexual offenders: a comprehensive meta-analysis. *Journal of Experimental Criminology, 1*, 117—146.
Marshall, W. L., Anderson, D., & Fernandez, Y. (1999). *Cognitive-behavioral treatment of sexual offenders.* Chichester (UK): John Wiley & Sons.
Marshall, W. L., Marshall, L. E., & Serran, G. A. (2006). Strategies in the treatment of paraphilias: a critical review. *Annual Review of Sex Research*, *17*, 162—182.
Marshall, W. L., Serran, G. A., Fernandez, Y. M., Mulloy, R., Mann, R. E., & Thornton, D. (2003). Therapist characteristics in the treatment of sexual offenders: tentative data on their relationship with indices of behavior change. *Journal of Sexual Aggression*, *9*, 25—30.
National Association of Social Workers (1999). *Code of ethics.*Washington D.C.: Author Available on-line at http://www.socialworkers.org/pubs/code/code.asp
Radden, J. (2002). Notes towards a professional ethics for psychiatry. *Australian and New Zealand Journal of Psychiatry*, *36*, 52—59.
Radden, J. (2004). The debate continues: unique ethics for psychiatry. *Australian and New Zealand Journal of Psychiatry*, *38*, 115—118.
Reich, W. (1999). Psychiatric diagnosis as an ethical problem. In S. Bloch P. Chodoff & S. A. Green (Eds.), *Psychiatric ethics* (pp. 193—224)., Third edition Oxford: University Press.
Robinson, G. (2008). Late-modern rehabilitation: the evolution of a penal strategy. *Punishment and Society*, *10*, 429—439.
Salter, A. (1988). *Treating child sex offenders and victims: A practical guide.* Newbury Park, California: Sage.
Scheff, T. J., & Culver, D. M. (1989). The societal reaction to deviance: ascriptive elements in the psychiatric screening of mental patients in a midwestern state. In D. H. Kelly (Ed.), *Deviant behavior* (pp. 308—323). New York: St Martin's Press.
Szasz, T. S. (1971). *The manufacture of madness.* London: Routledge and Kegan Paul.
Szmukler, G. (1999). Ethics in community psychiatry. In S. Bloch P. Chodoff & S. A. Green (Eds.), *Psychiatric ethics* (pp. 363—382)., Third edition Oxford: University Press.
Ward, T. (2007). On a clear day you can see forever: integrating values and skills in sex offender treatment. *Journal of Sexual Aggression*, *13*(3), 187—201.
Ward, T., & Birgden, A. (2007). Human rights and clinical correctional practice. *Aggression and Violent Behavior*, *12*(6), 628—643.
Ward, T., Gannon, T. E., & Birgden, A. (2007). Human rights and the treatment of sex offenders. *Sexual Abuse: A Journal of Research and Treatment*, *19*(3), 195—216.
Ward, T., Mann, R., & Gannon, T. (2007). The good lives model of offender rehabilitation. *Aggression and Violent Behavior*, *12*, 87—107.
Ward, T., & Maruna, S. (2007). *Rehabilitation: Beyond the risk paradigm.* London: Routledge Taylor and Francis Group.
Ward, T., & Sorbello, L. (2003). Explaining child sexual abuse: integration and elaboration. In T. Ward D. R. Laws & S. M. Hudson (Eds.), *Sexual Abuse: Issues and Controversies* (pp. 3—20). Thousand Oaks (Calif): Sage.