

**THE PERMISSIBILITY OF PHARMACOTHERAPY FOR
PAEDOPHILIC SEX OFFENDERS IN THE LIGHT OF THE RIGHTS
PROTECTED UNDER
THE EUROPEAN CONVENTION ON HUMAN RIGHTS**

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ABSTRACT

The use of pharmacotherapy for paedophilic sex offenders (PSOs) has been debated amongst the public, policy makers and scholars regarding the benefits that it brings. Still, controversy remains because pharmacotherapy causes impairment of physical and mental integrity, serious side-effects, ethical and legal dilemmas, and human rights challenges. This thesis investigates a reasonable way of addressing the concerns over pharmacotherapy for PSOs. There is scope for the law to pursue an approach of depriving sex offenders of their liberty to engage in a sexual relationship with the imposition of pharmacotherapy (Deprivation of Sexual Liberty, DoSL) as a means of addressing their sexual criminal behaviour and in the interests of protecting society.

I argue that paedophilia has significant effects on individuals' capacity to critically reflect on first-order-desires which signifies a conflict between first-order-desires and second-order-desires or higher-order-desires. This conflict compromises the capacity of those offenders to make autonomous decisions in terms of being subject to pharmacotherapy. Employing the European Convention on Human Rights as a framework, the use of pharmacotherapy engages or interferes with protected rights. Human rights issues concerning the use of pharmacotherapy for PSOs can be addressed using conformity with the standards established by the Strasbourg Court under Article 3 or being subject to justifiable limitations under Articles 8 and 12. By applying this human-rights-based assessment to DoSL, I also argue that this alternative approach to the problem of PSOs is in accordance with the Convention.

The originality of this thesis, therefore, lies in three main arguments: (i) pharmacotherapy can be used as an involuntary treatment for PSOs; (ii) it can be adopted by the criminal justice systems as an appropriate and justified punishment for those offenders; and (iii) Deprivation of Sexual Liberty can be considered as an alternative approach to resolve the problem of paedophilic sexual crimes.

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List of Abbreviations

CBT	Cognitive Behavioural Therapy
CJA	UK Criminal Justice Act 2003
CPA	Cyproterone Acetate
CPT	European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment
DoL/DoSL	Deprivation of Liberty/Deprivation of Sexual Liberty
DSM	Diagnostic and Statistical Manual of Mental Disorders
ECHR/European Convention	European Convention on Human Rights
ECtHR/Strasbourg Court	European Court of Human Rights
MCA	UK Mental Capacity Act 2005
MHA	UK Mental Health Act 1983
PACE	Parliamentary Assembly of the Council of Europe
PSO(s)	Paedophilic Sex Offender(s)
SOA	Sexual Offence Act 2003
USA/US	United States of America
UK	United Kingdom
Lanzarote Convention	Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse

CHAPTER ONE

INTRODUCTION

A. Background to Study

Child sexual abuse has been of great concern for societies, policy makers and clinicians and has been described as ‘a public health problem of staggering proportions’.¹ In the USA, there was a common belief that given the seriousness and repetition of sex offences against children, effective public policies had to be enacted and implemented. To address this issue, several states passed some form of extraordinary and unique legislations as a method of controlling sex offenders with child victims and preventing reoffending.² Many of these laws were named after high-profile victims in the case that launched the legislative effort, including the Jacob Wetterling Act, Megan’s Law and the Adam Walsh Act, with the aim of attracting a great deal of attention and gaining public support for addressing sexual crimes against children.³ The array of measures for such crimes has varied from inhibition of living within specified areas, using certain goods/services, performing particular jobs and travelling to other states, to indefinite hospitalisation and medical interventions.⁴ Dugan specifies that these regulations have two main purposes: (1) permitting people to protect themselves from violent sex offenders, and (2) preventing or at least decreasing recidivism.⁵ However, these overbroad policies adopted by the USA legislatures as preventive measures have been

¹ John McDonald and Wilson Bradford, ‘The Treatment of Sexual Deviation Using Pharmacological Approach’ (2000) 37 *Journal of Sex Research* 248, 248.

² See John Q La Fond, *Preventing Sexual Violence: How Society Should Cope with Sex Offenders* (Washington, DC: American Psychological Association 2005).

³ See Richard G Wright, ‘Sex Offender Post-Incarceration Sanctions: Are There Any Limits?’ (2008) 34 *New England Journal on Criminal and Civil Confinement* 17.

⁴ A wide range of sex offender laws have been passed in the USA including registration requirements, community notification, civil commitment, residency restrictions, loitering laws, Global Positioning System monitoring, specially marked driver’s licences and surgical and chemical castrations. See Corey Rayburn Yung, ‘Sex Offender Exceptionalism and Preventative Detention’ (2011) 101 *Journal of Criminal Law and Criminology* 969.

⁵ Meghann J Dugan, ‘Megan’s Law or Sarah’s Law? A Comparative Analysis of Public Notification Statutes in the United States and England’ (2001) 23 *Loyola of Los Angeles International and Comparative Law Review* 617, 618.

criticised in that they were enacted without giving a second thought to their consequences.⁶ It has been argued that sex offender law reforms have generally been made ‘at the behest of a fearful public’⁷ and with the impact of ‘agitated activity of the community’⁸. Thus, they have raised serious concerns about the content and rationality in terms of addressing the needs and interests of society, victims and offenders in an effective way.⁹ Especially, given that there is such a wide variety of sex offenders and some of them are to a certain degree impulsive in nature, the effectiveness of some of these policies has been questioned on the ground that they are inadequate, to a greater or lesser extent.¹⁰ They have received several objections that recidivism rates have remained high or relatively constant because offenders’ responsiveness to particular incentives has been low.¹¹ Hanson and others observe that for groups of sex offenders, such as paedophiles, treatment is directly related to the recidivism rates and thus, the recidivism rate for treated sex offenders is lower than untreated offenders.¹² Considering the importance of treatment for sex offenders with paedophilic motivations, in the USA, some of the adopted policies have been criticised that they should have included more specific provisions particularly related to the treatment of

⁶ See Wayne A Logan, ‘The Adam Walsh Act and the Failed Promise of Administrative Federalism’ (2010) 78 *George Washington Law Review* 993; Brittany Enniss, ‘Quickly Assuaging Public Fear: How the Well-Intended Adam Walsh Act Led to Unintended Consequences’ [2008] *Utah Law Review* 697.

⁷ Yung (n 4) 989.

⁸ Edwin H Sutherland, ‘The Diffusion of Sexual Psychopath Laws’ (1950) 56 *American Journal of Sociology* 142, 144.

⁹ Studies question the effectiveness of sex offender laws, see James J Prescott and Jonah E Rockoff, ‘Do Sex Offender Registration and Notification Laws Affect Criminal Behaviour’ (2011) 54 *The Journal of Law and Economics* 161; Amanda Y Agan, ‘Sex Offender Registries: Fear without Function?’ (2011) 54 *The Journal of Law and Economics* 207.

¹⁰ See La Fond (n 2).

¹¹ See Richard Tewksbury, Wesley G Jennings and Kristen Zgoba, ‘Final Report on Sex Offenders: Recidivism and Collateral Consequences’ (US Department of Justice, March 2012) <<https://www.ncjrs.gov/pdffiles1/nij/grants/238060.pdf>> accessed 29 September 2014; Cynthia Calkins Mercado and others, ‘Sex Offender Management, Treatment, and Civil Commitment: An Evidence Based Analysis Aimed at Reducing Sexual Violence’ (US Department of Justice, September 2013) <<https://www.ncjrs.gov/pdffiles1/nij/grants/243551.pdf>> accessed 29 September 2014.

¹² Karl R Hanson and others, *Meta-Analysis of the Effectiveness of Treatment for Sexual Offenders: Risk, Need, and Responsivity 2009-01* (Ottawa: Public Safety Canada 2009).

such offenders in order to meet the expectations for the prevention of their future criminal behaviour and the treatment of their condition.¹³

Despite the critics, the idea of protecting society from dangerous offenders and the impact of media attention and public reaction have also launched several discussions in many European countries concerning the adoption of these extraordinary sex offender policies and the possibility of implementing them in their national laws and criminal justice practices.¹⁴ However, these measures have begun to find their way into European jurisprudence with slight differences due to the concerns over their compatibility with the European Convention on Human Rights (ECHR),¹⁵ which also provided insight for this research project. As is generally accepted in the literature, the rights protected under the Convention impose a duty on the Member States to take necessary and proportionate measures and the approaches adopted by the European Court of Human Rights (ECtHR) preserves a pivotal role for the states in determining the necessity and proportionality of the measure in question. Also, the Convention and the Court's case-law can provide an opportunity to erect a legal and ethical scaffold within reasonable boundaries in terms of setting standards for the use of this particular measure. In this respect, assessing the compatibility of a particular measure with the Convention and the Court's case-law can address the concerns whether this policy is permissible and applicable within the Member States and/or what

¹³ See Tony Ward and Claire A Stewart, 'The Treatment of Sex offenders: Risk Management and Good Lives' (2003) 34 *Professional Psychology: Research and Practice* 353; Robert J McGrath and others, 'Outcome of a Treatment Program for Adult Sex Offenders: From Prison to Community' (2003) 18 *Journal of Interpersonal Violence* 3; Dennis M Doren and Pamela M Yates, 'Effectiveness of Sex Offender Treatment for Psychopathic Sexual Offenders' (2008) 52 *International Journal of offender Therapy and Comparative Criminology* 234.

¹⁴ Charlotte Bailey, 'Poland to Enforce Chemical Castration of Paedophiles' *The Telegraph* (London, 26 September 2008) <<http://www.telegraph.co.uk/news/worldnews/europe/poland/3084770/Poland-to-enforce-chemical-castration-of-paedophiles.html>> accessed 17 September 2014; Angelique Chrisafis, 'Killing Puts "Castration" on French Agenda' *The Guardian* (Paris, 2 October 2009) <<http://www.guardian.co.uk/world/2009/oct/02/france-considers-legalising-chemical-castration>> accessed 17 September 2014.

¹⁵ See Kate Hynes, 'The Cost of Fear: An Analysis of Sex Offender Registration, Community Notification, and Civil Commitment Laws in the United States and the United Kingdom' (2013) 2 *Penn State Journal of Law and International Affairs* 351.

standards/requirements should be set for its administration to be in accordance with the rights and freedoms guaranteed under the Convention.

It is worth noting that this research was initially designed to critically evaluate the sex offender laws in the USA with a special emphasis on chemical castration and to discuss to what extent it could be practiced in European countries. At the outset, the principle issue at stake was to give a general explanation of federal sex offender laws in the USA on the grounds of understanding the purposes and background of these policies and measures, especially, chemical castration. The reason for this way of positioning was that chemical castration has started to be used for sex offenders with child victims and been a controversial subject in the USA since the early 1990s. Over the course of my studies, I came to realise that the cultural, doctrinal and jurisprudential differences between the USA and Europe could lead to methodological difficulties as these two systems attitudes to human rights and criminal justice policies vary considerably. For this reason, this research project is slightly different than what it was planned to be: an analysis and discussion of chemical castration with a more theoretical and critical approach. However, one of the main questions remains the same as it was at the beginning of this research project which is whether chemical castration is consistent with the European Convention or not.

Here, it should be remarked that there is another term used for chemical castration called *pharmacotherapy*. As Harrison puts it, both terms refer to the same form of treatment, however, chemical castration is more emotive and sensational than pharmacotherapy and might be perceived in a general sense as surgical intervention.¹⁶ For this reason, although chemical castration is a more widely used and known phrase in the literature, in order to avoid any misperception and conceptual confusion, throughout

¹⁶ Karen Harrison, 'Legal and Ethical Issues When Using Antiandrogenic Pharmacotherapy with Sex Offenders' (2008) 3(2) Sexual Offender Treatment <http://www.sexual-offender-treatment.org/2-2008_01.html> accessed 27 November 2014.

this research project, my preference will be to use ‘pharmacotherapy’ rather than ‘chemical castration’. In this respect, the principal topic of discussion in this thesis will focus on the examination of what is known –and not known- about the use of pharmacotherapy for sex offenders with paedophilic motivations (with child victims) and its applicability with reference to the Convention.

B. Aims, Objectives and Research Questions

This research is not designed to go into excessive detail of all types of sex offenders, but rather it will focus on paedophiles, and discuss in more detail that pharmacotherapy is mainly useful and effective for paedophilic sex offenders (PSOs).¹⁷ For instance, it is argued that this medical intervention does not work on rapists who sexually attack adults because, for those offenders, the problem is about being sexually dominant over the victim, not about their mental health condition or the ability to control their paedophilic motivations.¹⁸ For this reason, from amongst the measures in dealing with PSOs, the focus of this thesis will be specifically on the use of pharmacotherapy.

Regarding the issue of paedophilia, though it has been studied from different research perspectives, it still remains to be a significant matter and challenging problem that requires further research. The definition of paedophilia varies from time period to time period and state to state due to the cultural issues about sexual maturity. Also, there is an ambiguity in the understanding of it, its causes, behaviour and treatments.¹⁹ Given the normative and descriptive ambiguity and inconsistency surrounding paedophilia, in order to provide clarity and coherence, this thesis will be in line with the definition made in the *Diagnostic and Statistical Manual of Mental Disorders Fifth Edition*

¹⁷ Karen Harrison, ‘The High-Risk Sex Offender Strategy in England and Wales: Is Chemical Castration as Option?’ (2007) 46 *The Howard Journal of Criminal Justice* 16, 26.

¹⁸ Aisha K Gill and Karen Harrison, ‘Sentencing Sex Offenders in India: Retributive Justice versus Sex-Offender Treatment Programmes and Restorative Justice Approaches’ (2013) 8 *International Journal of Criminal Justice Sciences* 166, 171.

¹⁹ See David Wilson and Jon Silverman, *Innocence Betrayed: Paedophilia, the Media and Society* (Wiley Publishing 2002).

(DSM-V) of the American Psychiatric Association (APA). Paedophilia is classified as paraphilia and defined in the DSM-V as having several symptoms over a period of minimum 6 months, including

recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving sexual activity with a prepubescent child or children (generally age 13 years or younger). [...] The individual is at least age 16 years and at least 5 years older than the child or children [who is at the age of 13 or younger].²⁰

In general, from a clinical perspective, paedophilia is seen as atypical sexual interest which is not *ipso facto* mental disorder.²¹ However, it is important to note that in DSM-V, there is a distinction between paedophilia and paedophilic disorder and, according to DSM-V, paedophilic disorder

is a [paedophilia] that is causing distress or impairment to the individual or a [paedophile] whose satisfaction has entailed personal harm, or risk of harm, to others. A [paedophilia] is a necessary but not sufficient condition for having a [paedophilic] disorder, and a [paedophilia] by itself does not automatically justify or require clinical intervention.²²

²⁰ *Diagnostic and Statistical Manual of Mental Disorders, DSM-5* (5th edn, American Psychiatric Association 2013) 697. It is worth noting that there is another technical term, hebephilia, which is an attraction to postpubescent adolescents who are still below the legal age of consent in some jurisdictions (which admittedly varies tremendously across states). However, hebephilia currently is not considered as mental disorder in the DSM-V and not regarded as paedophilia, and therefore, not within the scope of this research.

²¹ APA, 'Highlights of Changes from DSM-IV-TR to DSM-5' (2013) 18 <<http://www.dsm5.org/Documents/changes%20from%20dsm-iv-tr%20to%20dsm-5.pdf>> accessed 29 April 2015.

²² *DSM-5* (n 20) 685-686.

This distinction between paedophilia and paedophilic disorder is pivotal, as it provides a way of separating having sexual desires for children from actually acting on these desires and sexually interacting with children and/or feeling distress or impairment caused by recurring, intense sexual urges, fantasies or behaviours. In this respect, one can be a paedophile without having a paedophilic disorder and in order for paedophilia to be classified as a psychiatric condition, a person must

- i. feel personal distress about [his] interest, not merely distress resulting from society's disapproval, [criticism or rejection, or experience significant impairment in social, occupational, or other important areas of functioning]; or
- ii. have a sexual desire or behaviour that involves another person's psychological distress, injury, or death, or a desire for sexual behaviours involving unwilling persons or persons unable to give legal consent.²³

Relying on this determination, it can be argued that being a paedophile is not indicative of this person's need for medical treatment, imprisonment or any form of intervention. A paedophile has sexual desires for children but his paedophilic desires cannot be distressing for himself in terms of being uncontrollable or abnormal or harmful to himself or others and he can resist, on the surface, showing or expressing his desires by refraining from acting upon his paedophilic urges. Therefore, his condition is no longer classified as having a psychiatric condition or would no longer be considered as having a mental illness, i.e. paedophilic disorder. This indicates that the distinction between thinking (but not being distressed) and acting determines whether a paedophile has only

²³ APA, 'Paraphilic Disorders Fact Sheet' (American Psychiatric Publishing 2013) 1 <<http://www.dsm5.org/Documents/Paraphilic%20Disorders%20Fact%20Sheet.pdf>> accessed 18 April 2015.

atypical sexual interest or has a mental disorder (paedophilic disorder). However, according to O'Donohue, the definition and the diagnostic criteria in DSM-V for paedophilia and paedophilic disorder are unclear and lacking reliability and validity as a tool. He argues that a sexual interest toward children is a 'pathological, abnormal condition.'²⁴ Given the distinction between paedophilia and paedophilic disorder, the main problem is any sexual attraction to children, thus, it is irrelevant if someone is distressed by being attracted to children because 'this sexual attraction has the potential to cause significant harm to others and *is also not in the best interests of the individual*.'²⁵ Also, it is difficult to determine whether a person with paedophilic thoughts and fantasies has actually acted on those urges or not because it depends on self-report or prosecution.²⁶ He stresses that '[i]t certainly is far less problematic if the person has never acted on this sexual attraction (assuming this is possible in the broadest sense) but the sexual attraction itself is still problematic.'²⁷ Although such criticism touches upon a highly sensitive issue concerning the potential risk that paedophiles pose to society, it does not help to distinguish the mental makeup that is inherent to paedophilia from a psychiatric condition. Individuals with paedophilic interests can maintain full and consistent self-control and thus, they should not be forced to receive treatment, criminally prosecuted or legislated away. However, individuals with paedophilic disorder might have significant difficulties to maintain consistent behavioural control and this might cause distress or impairment in functioning and/or they might act on their paedophilic interests. Clearly, those individuals are in need

²⁴ William O'Donohue, 'A Critique of the Proposed DSM-V Diagnosis of Pedophilia' (2010) 39 Archives of Sexual Behaviour 587, 589.

²⁵ Ibid 589 (emphasis added).

²⁶ Ibid.

²⁷ Ibid 589-590.

effective treatment and/or should be subject to criminal prosecution.²⁸ Although DSM-V does not adequately and explicitly distinguish the psychiatric aspect of a paedophilic disorder from its potential criminal implications, it is stated in the APA press release that ‘APA stands firmly behind efforts to criminally prosecute those who sexually abuse and exploit children [...]. We also support continued efforts to develop treatments for those with a pedophilic disorder with the goal of preventing future acts of abuse.’²⁹ It is worth noting that the stance taken in this research project is, to certain extent, in line with APA’s statement arguing that paedophiles who have acted on their paedophilic urges and have committed sexual crimes against children should be criminally prosecuted and referred into treatment through the criminal justice system. However, they should be treated with humanity and respect for their dignity and appropriate measures should be taken to ensure their physical and psychological well-being.

From this point of view, and also for the purpose of this research project, paedophiles and PSOs are not synonymous. As discussed above, paedophiles do not necessarily act upon their sexual attractions, whereas PSOs have a psychiatric condition (paedophilic disorder) because they are not able to resist acting on their paedophilic sexual desires. This distinction is of the essence to identify the potential criminal implications of paedophilic disorder and the condition/mental state of the offenders. On that account, given the statements on paedophilia and paedophilic disorder, the discussion in this

²⁸ Fred S Berlin, ‘Pedophilia and DSM-5: The Importance of Clearly Defining the Nature of Pedophilic Disorder’ (2014) 42 *The Journal of American Academy of Psychiatry and the Law* 404, 406-407. It is worth noting that according to Berlin, paedophilia can be described as a sexual orientation because ‘experiencing ongoing sexual attractions to prepubescent children is, in essence, a form of sexual orientation’ (heterosexual or homosexual paedophilic orientation). *Ibid* 404. The APA had also made reference to the term Paedophilic Sexual Orientation and described paedophilia as sexual orientation in DSM-V, however, by issuing a correction, it was stated that “[s]exual orientation” is not a term used in the diagnostic criteria for pedophilic disorder and its use in the DSM-5 text discussion is an error and should read “sexual interest.” In fact APA considers pedophilic disorder a “paraphilia”, not a “sexual orientation”. This error will be corrected in the electronic version of DSM-5 and the next printing of the manual.’ APA, ‘APA Statement on DSM-5 Text Error, Pedophilic Disorder Text Error to Be Corrected’ (News Release, 31 October 2013) <<http://www.dsm5.org/Documents/13-67-DSM-Correction-103113.pdf>> accessed 2 September 2015.

²⁹ *Ibid*.

thesis will be based on the following definition: PSOs who commit sexual offences against children (generally age 13 years or younger) and are at least age 16 years of age and 5 years older than the children have a paedophilic disorder because the existence of a condition defined as paedophilia is accompanied by behavioural manifestation and this psychiatric condition entails personal harm, or risk of harm, to children.

To address the concerns over PSOs and their potential impact upon society, a significant number of treatment modalities and therapeutic interventions have been considered such as surgical castration, cognitive behaviour therapy (CBT) and community based treatment programmes.³⁰ However, human rights issues about some of these methods and the public outcry surrounding their inadequacy have paved the way for the consideration of using alternative methods for dealing with the concerns over PSOs. In *Janiga v Usti Nad Labem Regional Court, Czech Republic (Janiga case)*, which is about the extradition of a sex offender from the United Kingdom to the Czech Republic who could face pharmacotherapy, it is noted that

[t]reatment for sex offenders typically takes the form of psychological interventions [...]. Its focus is on assisting offenders to recognise the attitudes and behaviours that increase their risk of re-offending, as well as helping them to develop strategies to reduce their risk. But psychological therapy is not always effective. [...] [I]n some instances an individual's sexual arousal may be so strong that he finds it difficult to control his sexual fantasies, urges and behaviour. When this is the case the use of medication to reduce sexual drive may be of benefit. This is most effectively achieved by drugs that lower testosterone levels to those found in pre-pubescent

³⁰ See Wilson and Silverman (n 19).

males, mimicking what happens following physical castration, hence the use of the term ‘chemical castration’.³¹

Thus, pharmacotherapy has been introduced and discussed for PSOs in many European countries including France, Germany, Denmark, Sweden, Poland and Norway.³² Recently, in the United Kingdom, the use of pharmacotherapy for the treatment of certain sex offenders detained in prison is a topical issue given the recent government initiative in Nottinghamshire. There is an on-going pilot scheme at HM Prison Whatton in Nottinghamshire where around 100 paedophiles have volunteered to undergo voluntary chemical castration treatment.³³ Given that a number of European countries has been considering requiring or allowing pharmacotherapy for PSOs, this thesis attempts to offer a different justification for the use of pharmacotherapy in the treatment of PSOs, to introduce an alternative approach to the punishment of those offenders with pharmacotherapy and to explore the permissibility of pharmacotherapy within the scope of the ECHR.

Based on these objectives and the literature on the use of pharmacotherapy for PSOs, this research, in essence, is motivated by several factors. The first motivation of this study stems from an idea of depriving PSOs of their sexual liberty with the application of pharmacotherapy, which might be an effective way of dealing with those offenders.

³¹ [2011] EWHC 553 (Admin) [6]. In this case, the scientific and medical aspect of chemical castration is based on the report of Professor Don Grubin. See Don Grubin, ‘The Use of Medication in the Treatment of Sex Offenders’ (2008) 178 Prison Service Journal 37.

³² Raphaela Basdekis-Jozsa, Daniel Turner and Peer Briken, ‘Pharmacological Treatment of Sexual Offenders and Its Legal and Ethical Aspects’ in Karen Harrison and Bernadette Rainey (eds), *The Wiley Blackwell Handbook of Legal and Ethical Aspects of Sex Offender Treatment and Management* (Wiley-Blackwell 2013) 311.

³³ Considering the scope of this study, although the treatment programme in Nottinghamshire requires a close follow-up, since the practice is still on trial and the UK Government has not made a detailed statement regarding the procedure and its continuation and since any updated news on this issue has not been released, the Nottinghamshire case might provide a basis for further studies on chemical castration as a voluntary treatment option for PSOs. In addition, much to my regret, I have to note that although more information regarding the administration of chemical castration in Nottinghamshire was requested from the UK Ministry of Justice and HM Prison Service on 06 October 2012 and on 17 September 2013, no response to my request has been received.

At this stage, it seems worth stressing that the idea of Deprivation of Sexual Liberty (DoSL) is originated from the concept of deprivation of certain liberties which has been applied to some specific crimes in the criminal justice system. For instance, disqualification from driving or, in other words, suspension or revocation of the right to drive deprives a person of the use of his/her driving licence. Although I have no intention of making an analogy between deprivation of the right to drive and DoSL, the aim with this example is to indicate that the idea of *different types of incapacitative punishment to different types of crimes* has a place in the criminal justice system. Despite the differences between DoSL and deprivation of driving, the essential point of this analogy is to place emphasis on the idea that depriving the offender of certain liberties or rights can be necessary and reasonable to fulfill what is expected from punishment. In addition, driving deprivation is not applied to all driving offences rather it is for certain driving offences, such as causing death by careless/dangerous driving or driving under the influence of alcohol,³⁴ and the argument in this study is that DoSL via pharmacotherapy should only be applied to PSOs, not all sex offenders. Also, an analogy with a well-known method both in the medical realm and the criminal justice systems, which is Deprivation of Liberty (DoL), can elucidate the argument of DoSL. As a traditional practice, DoL applies to mental health detention as a part of medical treatment and to criminal detention as an essential element of the criminal justice system.³⁵ This method is also recognised by the Convention insofar as the right to liberty in Article 5 is one of the rights from which derogation is permitted under Article 15 and an interference with Article 5 can be justified on the basis of either ‘the lawful detention of a person after conviction by a competent court’ or ‘the lawful detention of

³⁴ See H Laurence Ross and Phillip Gonzales, ‘Effects of License Revocation on Drunk-Driving Offenders’ (1988) 20 Accident Analysis & Prevention 379; H Laurence Ross, ‘Are DWI Sanctions Effective?’ (1992) 8 Alcohol, Drugs and Driving 61; Victor Siskind, ‘Does License Disqualification Reduce Reoffence Rates?’ (1996) 28 Accident Analysis & Prevention 519.

³⁵ See note 1 in Chapter Two.

a persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants’. However, it has come under criticism that DoL falls short of managing paedophiles both in their treatment and punishment and a new understanding is needed to address the problems of PSOs resulting mainly from the inadequacy of the existing methods. Thus, the arguments in this study are that DoSL, which refers to the deprivation of a person’s liberty to perform any sexual activity by the imposition of a restriction on his ability to have a sexual relationship, can be considered as an alternative approach to resolve the problem of paedophilic sexual crimes and pharmacotherapy can be regarded as the most convenient and appropriate means of carrying out this deprivation.

However, applying a medical procedure to offenders, using medication for the management of the motivations or drives behind criminal behaviour, and engaging with the idea of ‘sexual liberty’ require the consideration of human rights. For this reason, the second motivation of this research project is the need to explore the admissibility of pharmacotherapy and its compatibility with fundamental human rights which will be pursued in light of the realisation of three essential elements: the ECHR, the ECtHR and the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT). The ECHR remains the most developed judicial system for the protection of fundamental human rights; the Court plays a key role in the interpretation of the Convention and determining the scope of the rights protected under the Convention; and the CPT reports clarify the procedure in more detail by giving much consideration to a particular regulation and by determining the standards. Thus, this research will seek to address human rights issues concerning the use of pharmacotherapy for PSOs and the deprivation of those offenders’ ability to perform

sexual intercourse within the context of the Convention, the Court's case-law and the Committee Reports.

In light of these considerations, this thesis is looking at the use of pharmacotherapy (drugs) with PSOs and, in particular, it asks two interrelated research questions:

- Should the use of pharmacotherapy with PSOs be seen as treatment or punishment, or both?
- Is the use of pharmacotherapy compatible with the ECHR and the jurisprudence of the ECtHR, in particular, whether involuntary use is permissible?

C. Theoretical Framework and Methodology

The principal hypothesis of this research is that pharmacotherapy can be a permissible state measure for PSOs, if it is used on justifiable grounds and if stringent safeguards and procedures are satisfied and implemented for its practice. In this research, I will attempt to identify these justifiable grounds, safeguards and procedures with respect to the Convention to ensure that offenders are not subject to a state intervention which humiliates or debases them and/or amounts to an unjustifiable interference with the Convention rights. Therefore, following a certain methodology is deemed important and necessary to identify potential problems concerning pharmacotherapy, to criticise those issues and to provide solutions and contribution to the literature and justifiable grounds for the use of pharmacotherapy.

Given that pharmacotherapy is a medical procedure, the content of this study will be both medical and legal in nature and thus, it will proceed mainly within the ethical, legal and theoretical frameworks. This research will not be conducted from a socio-legal perspective. Rather, since it seeks to develop an acceptable legal framework for the use of pharmacotherapy for PSOs within the jurisdiction of the European Convention, this will be achieved by adopting a critical and normative approach. Also,

since the Strasbourg Court's case-law constitutes a pivotal source for this research, the Court's decisions will be evaluated from a doctrinal approach. In this respect, this research essentially combines descriptive and evaluative dimensions with normative assessment and critiques with a view to examining this combination from an international human rights perspective. In this sense, various sources will be utilised to address the main concerns of this research and to support the main context of this study. The primary sources of this study will be the relevant Articles of the European Convention, the case-law from the European Court, the case-law of the English courts, the UK legislation, the CPT Reports, the Committee on Social Affairs, Health and Sustainable Development of the Parliamentary Assembly of the Council of Europe (PACE) Reports and the Convention of the Council of Europe on the Protection of Children against Sexual Exploitation and Sexual Abuse (the Lanzarote Convention). In addition, legal and medical journals, articles, books, and newspapers will be the secondary sources of this study.

D. The European Legal and Political Context for the Use of Pharmacotherapy

Sexual crimes against children and the policies adopted to combat such crimes remain a highly important and politically controversial issue across Europe.³⁶ Arguably, the advent of a number of high profile cases was instrumental in considering more effective measures largely because of the inefficiency of existing criminal sentencing policies in

³⁶ In the early 20th century, surgical castration was favoured by several European countries as a method of treating sex offenders. Since the 1960s, most jurisdictions have replaced this irreversible surgical method with its reversible equivalent, i.e., pharmacotherapy with anti-androgen drugs. Thomas Douglas and others, 'Coercion, Incarceration, and Chemical Castration: An Argument from Autonomy' (2013) 10 *Journal of Bioethical Inquiry* 393, 394. However, surgical castration has remained in limited use in Germany and in the Czech Republic despite the fact that the CPT has described surgical castration as 'degrading treatment' and have called for 'an immediate end' for its use in the treatment of sex offenders. See 'Report to the Czech Government on the Visits to the Czech Republic Carried Out by the CPT' (Strasbourg, 5 February 2009) <<http://www.cpt.coe.int/documents/cze/2009-08-inf-eng.pdf>> accessed 8 September 2015; 'Report to the German Government on the Visits to the Germany Carried Out by the CPT' (Strasbourg, 22 February 2012) <<http://www.cpt.coe.int/documents/deu/2012-06-inf-eng.htm>> accessed 8 September 2015. For a critique of the CPT reports on surgical castration, see John McMillan, 'The Kindest Cut? Surgical Castration, Sex Offenders and Coercive Offers' (2014) 40 *Journal of Medical Ethics* 583.

terms of preventing sexual recidivism.³⁷ For this reason, several European countries have introduced specific types of measures for some groups of sex offenders by establishing a more restrictive framework for preventive detention, such as registration or notification requirements, indefinite confinement of sex offenders or a range number of movement restrictions, and/or by adopting an approach which tends to focus on those offenders' treatment including comprehensive therapeutic programmes and medical interventions within a range of civil and penal settings, such as protective sexological treatment.³⁸ While most of the therapeutic programmes are prison-based (e.g. Sweden, Spain, France, Italy, Poland and Ireland),³⁹ and the treatment decision is made by the national courts, therapeutic context can range from treatment in specialised departments within psychiatric hospitals, such as Germany,⁴⁰ to out-patient facilities such as Belgium⁴¹ and Netherlands.⁴² This penological dualism between treatment and punishment has resulted in the integration of treatment interventions into the criminal justice settings and the adoption of pharmacotherapy (in conjunction with psychotherapy) for sex offenders who suffer from paedophilic disorder with the aim of suppressing those offenders' hormonal and sexual activity and preventing their reoffending.⁴³

While the use and availability of pharmacotherapy for certain sex offenders seems to differ around the world, the dominant approach in Europe is to offer pharmacotherapy

³⁷ See Philip Jenkins, 'How Europe Discovered Its Sex-Offender Crisis' in Joel Best (ed), *How Claims Spread: Cross-National Diffusion of Social Problems* (New York: Aldine de Gruyter 2001).

³⁸ Anne-Marie McAlinden, 'The Governance of Sexual Offending Across Europe: Penal Policies, Political Economies and the Institutionalization of Risk' (2012) 14 *Punishment and Society* 166, 174-75.

³⁹ *Ibid* 175.

⁴⁰ See, Friedemann Pfäfflin, 'Issues, Incidence, and Treatment of Sexual offenders in Germany' (1999) 14 *Journal of Interpersonal Violence* 372, 373, 384-86.

⁴¹ Paul Cosyns, 'Treatment of Sexual Abusers in Belgium' (1999) 14 *Journal of Interpersonal Violence* 396, 400.

⁴² Jos Frenken, Luk Gijs and Daan Van Beek, 'Sexual Offender Research and Treatment in the Netherlands' (1999) 14 *Journal of Interpersonal Violence* 347, 357-61.

⁴³ McAlinden (n 38) 175.

as an optional treatment (voluntary) either in penal or mental health settings.⁴⁴ Regarding the legal context within which requirements to undergo medical treatment are imposed, the use of pharmacotherapy has been employed either with the backing of medical law (i.e., mental health law), or under the provisions of criminal law including criminal sentencing and parole.⁴⁵ For instance, while in the Czech Republic, England and Wales, the use of pharmacotherapy is offered to offenders who have acted on their paedophilic urges and have been dealt with within the criminal justice system,⁴⁶ other countries have protocols in place to include offenders who are being treated within mental health settings or psychiatric facilities.⁴⁷ In England and Wales, the treatment of sex offenders with medication, which is offered on a voluntary basis through referral from prison or probation officers, has been in place since 2007 in order to reduce offenders' sexual urges through the use of medication, and to support them in successfully completing psychological treatment.⁴⁸ According to National Offender Management Service (NOMS), the preferred method of treatment for sex offenders is psychological interventions. However, in particular cases where 'individuals experience high levels of sexual arousal, or sexual rumination, which makes psychological treatments difficult' and where 'offenders continue to have intrusive deviant sexual fantasies or strong sexual urges that have not been effectively modified by

⁴⁴ Harrison, 'Legal and Ethical Issues' (n 16).

⁴⁵ Thomas Douglas, 'Criminal Rehabilitation Through Medical Intervention: Moral Liability and The right to Bodily Integrity' (2014) 18 *The Journal of Ethics* 101, 102-103.

⁴⁶ In England and Wales, sex offender treatments, including pharmacotherapy, are not generally part of overall health care commissioning arrangements. Although forensic psychiatry services may play a role in providing sex offender treatment programmes, assessment and treatment of sex offenders is regulated under the Criminal Justice and Court Services Act 2000. See, Harvey Gordon and Don Grubin, 'Psychiatric Aspects of the Assessment and Treatment of Sex Offenders' (2004) 10 *Advances in Psychiatric Treatment* 73. Also, in Denmark, the decision whether the offender is suitable and motivated to undergo pharmacotherapy is made by the Prison and Probation Service based on the results and approval of mental and physical examinations of the Danish Legal Medical Council. Lise Aagaard, 'Chemical Castration of Danish Sex Offenders' (2014) 11 *Bioethical Inquiry* 117, 117-18.

⁴⁷ Harrison, 'Legal and Ethical Issues' (n 16).

⁴⁸ Home Office, 'Review of the Protection of Children from Sex Offenders' (2007) 14 <<http://webarchive.nationalarchives.gov.uk/20080514110721/http://www.homeoffice.gov.uk/documents/CSOR/chid-sex-offender-review-130607?view=Binary>> accessed 14 May 2015.

psychological treatment', medical intervention can be useful. In these cases, depending on the needs of offenders, one of two types of medication will be used, including psychotropic or antilibidinal medications.⁴⁹ For instance, in Germany, testosterone-lowering (antilibidinal) medications, which are officially approved for sex offender treatment, are CPA or triptorelin (GnRH agonist) and they are used in addition to psychotherapy in German forensic-psychiatric institution on a voluntary basis.⁵⁰

Moreover, Belgium, Hungary, Italy, Denmark, Switzerland, Sweden and France already offer convicted PSOs the option of pharmacotherapy but only on a voluntary basis,⁵¹ whereas Poland has become the first country in Europe to impose involuntary pharmacotherapy for PSOs combined with psychotherapy.⁵² In 2009, Poland passed a law allowing involuntary pharmacotherapy for PSOs at any time up to 6 months before their expected release and these offenders can be forced to undergo pharmacotherapy in one of the hospitals designated to provide such treatment by the courts after a psychiatric consultation.⁵³ For the involuntary application of pharmacotherapy to those offenders, the government released a statement explaining that '[t]he purpose of this

⁴⁹ NOMS, 'Medical Treatment for Sex Offenders, Probation Circular 35/2007' (30 October 2007) 2-3 <<http://webarchive.nationalarchives.gov.uk/20091009071109/http://www.probation.justice.gov.uk/files/pdf/PC35%202007.pdf>> accessed 14 May 2015.

⁵⁰ Daniel Turner, Raphaela Basdekis-Jozsa and Peer Briken, 'Prescription of Testosterone-Lowering Medications for Sex Offender Treatment in German Forensic-Psychiatric Institutions' (2013) 10 *Journal of Sexual Medicine* 570, 570-71. The use of CPA was introduced in Europe in the 1970s to block the uptake of testosterone by androgen receptors. Andreas Hill and others, 'Differential Pharmacological Treatment of Paraphilias and Sex Offenders' (2003) 47 *International Journal of Offender Therapy and Comparative Criminology* 407, 412. Triptorelin, which is a synthetic decapeptide agonist, received approval in the European Union in 2007 for the 'reversible reduction of testosterone to castrate levels in order to decrease sexual drive in adult men with severe sexual deviants.' Peer Briken, Wolfgang Berner and the P278 Study Group, 'Double-Blind, Controlled, Clinical Trial Planned in Germany to Investigate the Efficacy of Psychotherapy Combined with Triptorelin in Adult Male Patients with Severe Pedophilic Disorders: Presentation of the Study Protocol' (2012) 49 *Israel Journal of Psychiatry and Related Sciences* 306, 307. Also for more information on medications for pharmacotherapy, see Chapter Two.

⁵¹ Olga Koshevaliska, 'Medical Pharmacologic Treatment (A.K.A. Chemical Castration) in the Macedonian Criminal Code' (2014) 4 *Balkan Social Science Review* 25, 29. See also, Karen Harrison, 'The Castration Cure' (2007) 175 *Prison Service Journal* 13.

⁵² Gabriela Baczynska, 'Poland Okays Forcible Castration for Paedophiles' *Reuters* (25 September 2009) <<http://www.reuters.com/article/2009/09/25/us-castration-idUSTRE58O4LE20090925>> accessed 2 September 2015.

⁵³ United States Department of State, Bureau of Democracy, Human Rights and Labor, 'Country Reports on Human Rights Practices for 2013, Poland 2013 Human Rights Report' (2013) <<http://www.state.gov/documents/organization/220529.pdf>> accessed 2 September 2015.

action is to improve the mental health of the convict, to lowered his libido and thereby reduce the risk of another crime being committed by the same person.’⁵⁴ However, it is pointed out by a number of critics that the involuntary use of pharmacotherapy is not likely to be possible due to the legal and ethical aspects of such medical intervention and Poland’s own constitution and international treaty obligations.⁵⁵ Involuntary pharmacotherapy in Poland, thus, has been critically described as ‘an unsuitable instrument’ or ‘the product of pure populism’ and argued that such involuntary medical intervention would be challenged in the European Court of Human Rights.⁵⁶ It is also worth noting that the use of pharmacotherapy for certain sex offenders has been the subject of regular medical and political debates mostly following a violent sexual crime against children carried out by a repeat sex offenders. For instance, France discussed to introduce pharmacotherapy in an involuntary form but due to the ethical and human rights concerns, the proposal was dropped.⁵⁷

E. Legal and Ethical Issues on the Use of Pharmacotherapy with PSOs

In the early 20th century, several European countries, including Denmark, Sweden, Norway, the Netherlands, Switzerland and Germany passed surgical castration legislation for high-risk sex offenders to prevent reoffending.⁵⁸ Although surgical castration has been significantly effective in reducing recidivism rates of sex offenders,

⁵⁴ ‘Chemical Castration in Poland No Sympathy’ *The Economist* (10 June 2010) <http://www.economist.com/blogs/easternapproaches/2010/06/chemical_castration_poland> accessed 2 September 2015.

⁵⁵ Kris Kotarski, ‘Poland’s Chemical Castration Debate: Is Poland’s Proposal to Force Chemical Castration on Certain Sex Offenders Inhumane, or and Innovative Rehabilitation Strategy?’ *The Guardian* (13 October 2009) <<http://www.theguardian.com/commentisfree/2009/oct/13/poland-chemical-castration-sex-offenders>> accessed 2 September 2015.

⁵⁶ Christina Hebel, ‘“An Unsuitable Instrument” for Sex Offenders: EU Politicians Angered By Polish Chemical Castration Plan’ *Spiegel Online* (25 September 2008) <<http://www.spiegel.de/international/europe/an-unsuitable-instrument-for-sex-offenders-eu-politicians-angered-by-polish-chemical-castration-plan-a-580284.html>> accessed 2 September 2015.

⁵⁷ John Lichfield, ‘Murder Sparks Demands for “Chemical Castration”’ *The Independent* (4 October 2009) <<http://www.independent.co.uk/news/world/europe/murder-sparks-demands-for-chemical-castration-1797312.html>> accessed 2 September 2015.

⁵⁸ John Gunn and Pamela J Taylor (eds), *Forensic Psychiatry: Clinical, Legal and Ethical Issues* (2nd edn, CRC Press 2014) 261.

since it is irreversible, mutilating, associated with a significant side-effect profile and poses many ethical problems, it has been restricted to severe, treatment-resistant single cases and pharmacotherapy has become an increasingly adopted treatment option for those offenders.⁵⁹ However, pharmacotherapy has also been subject to several debates and criticisms and the discussions mainly focus on whether such treatment is effective in terms of treating or alleviating those offenders psychiatric condition, keeping them from acting on paedophilic interests/urges and reducing recidivism rates; whether it should be on a voluntary or involuntary basis; whether it should only be used as a treatment or it should be seen as a means in the punishment of PSOs. This research project does not aim to look specifically at the effectiveness of pharmacotherapy treatment, but rather, assuming that pharmacotherapy treatment (in combination with psychotherapy) is effective in alleviating paedophilic interests and keeping offenders from acting on those interests, this thesis will look at the legal and ethical concerns over the use of pharmacotherapy with PSOs within the framework of human rights and argue that pharmacotherapy may infringe these with its effects upon the offenders' autonomy, integrity (physical and mental) and their sexual liberty. For this reason, this medical intervention requires the assessment of the human rights implications of its use.

When dealing with matter of morality and legality in the context of PSOs treatment and the use of pharmacotherapy, one of the most contentious issues is the offenders' consent whether it is free and informed, or whether it is obtained at all. If consent is not obtained, the use of pharmacotherapy for sex offenders may raise concerns that it could lead to an unjustified interference with autonomy and integrity and thus, this intrusive and invasive procedure could violate the rights of offenders.⁶⁰ As far as dignity, autonomy and integrity are concerned, Articles 3 and 8, ECHR, provide an immense

⁵⁹ Andreas Hill and others, 'Differential Pharmacological Treatment of Paraphilias and Sex Offenders' (2003) 47 International Journal of Offender Therapy and Comparative Criminology 407, 412.

⁶⁰ *VC v Slovakia* App no 18968 (ECtHR, 08 November 2011).

protection for these notions.⁶¹ According to the Court, '[w]here treatment humiliates or debases an individual, showing a lack of respect for, or diminishing, his or her human dignity, or arouses feelings of fear, anguish or inferiority capable of breaking an individual's moral and physical resistance, it may be characterised as degrading and also fall within the prohibition of Article 3.'⁶² States also have obligations to ensure that suffering which flows from naturally occurring illness is not made worse by measures taken which attribute to state responsibility.⁶³ In addition, the Court considers that the notion of personal autonomy (and self-determination) is an important principle and 'the imposition of medical treatment, without consent of a mentally competent adult [...] would interfere with a person's physical integrity in a manner capable of engaging the rights protected under Article 8 § 1 of the Convention.'⁶⁴ Thus, states have positive duties to ensure that medical treatment is applied in ways which are compatible with the rights under Articles 3 and 8, ECHR. However, even if the offenders' consent is obtained, it has been argued that there are still concerns over the issue of the offenders' consent including whether the consent is valid, i.e., voluntary and fully informed, and is not the result of the fear of extensive incarceration.⁶⁵ According to Rainey and Harrison, if the offender is given the choice between pharmacotherapy treatment and incarceration, the offender will probably be coerced into choosing the treatment on the grounds that 'it is the lesser of two evils' or '[it] will enhance his chances of parole.'⁶⁶ Also, since obtaining valid and fully informed consent to pharmacotherapy requires the

⁶¹ *Bensaid v the United Kingdom* App no 44599/98 (ECtHR, 06 January 2001); *Storck v Germany* App no 61603/00 (ECtHR, 16 June 2005); *Jalloh v Germany* App no 54810/00 (ECtHR, 11 July 2006); *Yordanova and others v Bulgaria* App no 25446/06 (ECtHR, 24 April 2012).

⁶² *Pretty v the United Kingdom* App no 2346/02 (ECtHR, 29 April 2002) para 52.

⁶³ *Ibid.*

⁶⁴ *Ibid* paras 61, 63.

⁶⁵ Basdekis-Jozsa, Turner and Briken, 'Pharmacological Treatment' (n 32) 309.

⁶⁶ Bernadette Rainey and Karen Harrison, 'Pharmacotherapy and Human Rights in Sexual Offenders: Best of Friends or Unlikely Bedfellows?' (2008) 3 *Sexual Offenders Treatment* <http://www.sexual-offender-treatment.org/2-2008_02.html> accessed 2 September 2015. Also see Harrison, 'Legal and Ethical Issues' (n 16).

sufficient understanding of the nature and effects of pharmacotherapy treatment including all the possible side effects medications,⁶⁷ the uncertainty of the length and appropriateness of pharmacotherapy treatment and its long-term side effects may undermine the essence of informed consent.⁶⁸

Regarding the validity of consent, which is an important issue in medical ethics, it is generally assumed to require that the individual retains sufficient mental ability to give consent, to understand the nature of procedure, its risks and expected results, possible alternatives of it and the prognosis, if treatment is not imposed. However, psychiatric illness may reduce the ability to give consent and medical intervention can be imposed in the absence of consent. For instance, in England and Wales, the MCA 2005 provides an important legislative framework and allows involuntary treatment to be imposed on the grounds of incompetence, medical necessity and the best interest principle.⁶⁹ If the offender is found to lack capacity to make medical decisions and to give consent, meaning that if at the material time, he is not able to make a decision for himself in relation to pharmacotherapy treatment because his psychiatric condition (paedophilic disorder) causes an impairment of, or a disturbance in the functioning of, the mind or brain, the imposition of involuntary pharmacotherapy can be ruled permissible by a court due to the medical necessity and the best interest of the offender. On that account, another critical issue regarding the use of pharmacotherapy with PSOs that needs to be addressed is whether the states can restrict the legality of consent of PSOs by reference to paedophilic disorder and its impacts on the offenders' ability to make a decision in relation to pharmacotherapy treatment, to understand all the risks involved and to

⁶⁷ Karen Harrison, 'The Use of Pharmacotherapy with High-Risk Sex Offenders' in Karen Harrison (ed), *Managing High Risk Sex Offenders in the Community: Risk Management, Treatment and Social Responsibility* (Cullompton: Willan Publishing, 2010) 121.

⁶⁸ Rainey and Harrison, 'Pharmacotherapy and Human Rights' (n 66).

⁶⁹ MCA 2005, c 9.

consider the prognosis, if treatment is not given, on the grounds of medical necessity and the offenders' best interests.⁷⁰

Another contentious issue concerning the use of pharmacotherapy for PSOs is that although pharmacotherapy is generally considered as a method of treatment for PSOs in Europe, it has been discussed that pharmacological treatment is not a cure, but rather an adjunct to psychological treatment to alleviate the symptoms of paedophilic disorder and to help offenders control or manage their deviant sexual urges and not act upon those urges.⁷¹ For this reason, there are controversies surrounding its use and whether pharmacotherapy should be used as a form of treatment (protective treatment) or it can be delivered as a part of punishment agenda. On this matter, Harrison argues that '[w]hether 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.'⁷² The reason is that if pharmacotherapy is used as a form of punishment, then it is likely that it will be ordered by a court or by some other criminal justice agency.⁷³ However, regarding the use of pharmacotherapy in the punishment of PSOs, it has generally been argued that this medical procedure may fall within the scope of inhuman or degrading punishment because of being disproportionate to the crime and violating offenders' mental and physical integrity.⁷⁴ Especially, given that there are serious side effects associated with the medication for pharmacotherapy, these negative effects can be seen as degrading

⁷⁰ See Walter J Meyer and Collier M Cole, 'Physical and Chemical Castration of Sex Offenders: A Review' (1997) 25 Journal of Offender Rehabilitation 1.

⁷¹ Grubin (n 31) 37, 42.

⁷² Harrison, 'Legal and Ethical Issues' (n 16).

⁷³ Karen Harrison and Bernadette Rainey, 'Morality and Legality in the Use of Antiandrogenic Pharmacotherapy with Sexual Offenders' in Douglas P Boer and others (eds), *International Perspectives on the Assessment and Treatment of Sexual Offenders: Theory, Practice, and Research* (Wiley-Blackwell 2011) 629.

⁷⁴ See *Vinter and others v the United Kingdom* App nos 66069/09, 130/10, 3896/10 (ECtHR, 09 July 2013).

and humiliating for the offender involved, even if this humiliation is only apparent to him.⁷⁵

In addition to these concerns, the availability and efficacy of pharmacotherapy and the selection of offenders are other contentious issues, especially, when deciding in which form and on which basis pharmacotherapy should be used.⁷⁶ The common approach is that the selection of offenders for pharmacotherapy treatment should be made on a medical, not legal, basis and offenders should undergo this medical intervention as long as it is safe and has a worthwhile effect on those offenders' deviant sexual urges.⁷⁷

Regarding its availability, under the Council of Europe Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse (the Lanzarote Convention) it is recognised that the use of pharmacotherapy is an effective measure and thus, it should be available and made accessible to the offenders who commit sexual crimes against children.⁷⁸ However, it still remains controversial whether it is possible to impose pharmacotherapy treatment on offenders who refuse to receive it; and how pharmacotherapy treatment can be integrated into the criminal justice system.

In light of these arguments, although pharmacotherapy treatment can make a difference in dealing with PSOs who have paedophilic disorder and commit sexual crimes against children under the influence of paedophilic urges, there are ethical and legal concerns surrounding its use and those concerns need to be addressed in order to treat offenders with respect and dignity. Therefore, this research will discuss the relevant issues regarding the use of pharmacotherapy for PSOs and make recommendations on how these concerns can be effectively addressed.

⁷⁵ *Tyrer v UK* App no 5856/72 (ECtHR, 25 April 1978) para 23.

⁷⁶ Harrison and Rainey, 'Morality and Legality' (n 73) 632-37.

⁷⁷ Harrison and Rainey, 'Morality and Legality' (n 73) 636.

⁷⁸ CETS No. 201 (opened for signature 25 October 2007, entered into force 1 July 2010). For the preventive intervention programmes or measures, see Explanatory Report to the Lanzarote Convention (12 July 2007) <<http://conventions.coe.int/Treaty/EN/Reports/Html/201.htm>> accessed 2 September 2015.

F. Literature Review and the Scope of the Research

There are many theoretical and empirical studies on PSOs, and the use of pharmacotherapy, its effectiveness, side-effects and legality and morality have been examined within the context of human rights, medical concerns and criminal justice. However, most of the studies have evaluated this medical procedure only as a treatment and considered its outcomes regarding whether it should be voluntary or mandatory and argued that if it is permeated into the criminal justice systems, it should be considered as an effective therapy within a rehabilitative model. In a recent work on legal and ethical aspects of dealing with sex offenders and treatment methods,⁷⁹ it is stressed that due to the danger and risk which PSOs pose, there has been a global prominence in terms of adopting populist punitiveness for public protection. However, while doing this, less emphasis has been placed on the needs of offenders and the balancing act between the rights of those offenders and public protection.⁸⁰ This recent work, therefore, generally includes a review of the legal and ethical aspects of using pharmacotherapy with PSOS, in particular, its side-effects and the question of informed consent discussing what safeguards need to be provided for the use of pharmacotherapy with PSOs suffering from uncontrollable deviant sexual urges; the theoretical discussions about the classification of sex offender treatment whether it should be considered as punishment or rehabilitation; the legal and ethical issues concerning sex offender treatment and the balance between public protection and the right of offenders; and the relationship between legal regulation, moral attitudes and punishment discussing alternatives to punitive strategies for PSOs.⁸¹

There has been a prevailing view in the literature that pharmacotherapy as treatment must be voluntary, and free and fully informed consent must be obtained, otherwise its

⁷⁹ Harrison and Rainey, *The Wiley-Blackwell Handbook* (n 32).

⁸⁰ *ibid* xvi-xxiii.

⁸¹ See *ibid*.

involuntary practice will undermine personal autonomy and thus, violate the rights of individuals.⁸² As is reiterated in the Strasbourg Court's case-law, the right to personal autonomy, the right to have one's medical decisions respected and the physical and psychological integrity of a person come within the protection of Articles 3 and 8, and the imposition of treatment to a capable adult person without obtaining free and informed consent deprives the person of his/her personal autonomy and bodily integrity and thus, raises an issue under Articles 3,⁸³ and interferes with the right protected under Article 8, ECHR.⁸⁴ Karen Harrison and Bernadette Rainey are renowned and leading UK academics in the field of legal and ethical aspects of sexual offender treatment, in particular, pharmacotherapy within the context of Convention rights. With several articles and edited books, they look at sex offender sentencing policies and legislations from an international perspective and discuss whether pharmacotherapy should be imposed as treatment for sex offenders suffering from uncontrollable paedophilic desires. Due to the medical nature of pharmacotherapy, Rainey and Harrison principally stress that fully informed and free (or non-coerced) consent is of the essence for the imposition of pharmacotherapy because of the recognition of the offenders' autonomy to make their own decision.⁸⁵ It is also noted in the report of CPT that even if a person is imprisoned, they should still as a matter of principle be placed in a position to give informed consent to pharmacotherapy.⁸⁶

While there is a wealth of research material on the voluntary use of pharmacotherapy, there is not well-described and comprehensive study that explains the amount of information provided to PSOs to obtain a valid informed consent and addresses the

⁸² More discussion of this in Chapter Two, Section Two.

⁸³ *VC v Slovakia* (n 60).

⁸⁴ *Pretty v the United Kingdom* (n 62); *VC v Slovakia* (n 60).

⁸⁵ Rainey and Harrison, 'Pharmacotherapy and Human Rights' (n 66).

⁸⁶ Report to the Government of the Slovak Republic on the Visit to the Slovak Republic Carried Out by the CPT from 24 March to 2 April 2009 (Strasbourg, 11 February 2010) para 124 <<http://www.cpt.coe.int/documents/svk/2010-01-inf-eng.htm>> accessed 28 October 2014.

concerns over the voluntariness and validity of consent in terms of the impacts of unknown (long-term or short-term) outcomes of pharmacotherapy on informed consent and prison environment on the voluntariness of the consent and its validity. The common acceptance has been that offenders must be informed about the purpose of pharmacotherapy, its possible risks and side-effects and the alternative methods but the amount of information and risk provided to the offenders has not been discussed in detail.⁸⁷ On the voluntariness and the validity of consent, it is generally stressed that offering pharmacotherapy as an alternative to further imprisonment renders the obtainment of truly voluntary consent impossible and thus, any additional punishment should not be linked to the offenders' refusal or pharmacotherapy.⁸⁸ Although Marco and Marco⁸⁹ and Vanderzyl⁹⁰ argue that when the alternative is prison, it is impossible to obtain voluntary consent, it is contended that if it is offered as an alternative to continuing imprisonment or existing punishment, pharmacotherapy does not vitiate the voluntariness and validity of consent.⁹¹ On this matter, Douglas and others argue that withholding pharmacotherapy on the ground that valid and informed consent is not obtained, which is important for the protection of autonomy, 'would have the paradoxical result of *restricting* autonomy'⁹² which is an interesting argument and is of the essence to justify the voluntariness and validity of imprisoned PSOs' consent to pharmacotherapy and thus, needs a better explanation with more details.

⁸⁷ See Chapter Two, Section Two.

⁸⁸ Kari A Vanderzyl, 'Castration as an Alternative to Incarceration: An Impotent Approach to the Punishment of Sex Offenders' (1994) 15 Northern Illinois University Law Review 107, 140. See also Douglas and others (n 36); Lene Bomann-Larsen, 'Voluntary Rehabilitation? On Neurotechnological Behavioural Treatment, Valid Consent and (In)appropriate Offers' (2013) 6 Neuroethics 65.

⁸⁹ Corey H Marco and Joni Michel Marco, 'Antabuse: Medication in Exchange for a Limited Freedom- Is It Legal?' (1980) 6 American Journal of Law and Medicine 295.

⁹⁰ Vanderzyl (n 88).

⁹¹ Kimberly A Peters, 'Chemical Castration: An Alternative to Incarceration *Comment*' (1993) 31 Duquesne Law Review 307, 317; Bomann-Larsen (n 88) 68, 74-75.

⁹² Douglas and others (n 36) 399.

Despite a wide literature supporting the voluntary use of pharmacotherapy with PSOs, only a few studies have touched upon the involuntary pharmacotherapy as treatment and addressed the medical, legal and ethical issues on its practice. On this issue, the literature in the US has generally discussed the use of mandatory pharmacotherapy within the context of Eighth Amendment, cruel and unusual punishment, and under the *Rennie* analysis,⁹³ and argued that the involuntary use of pharmacotherapy is a legitimate medical treatment because it has a therapeutic value, it is part of an accepted medical practice, its adverse effects are reversible and are not unduly harsh, and it is part of an ongoing psychotherapeutic programme.⁹⁴ Thus, pharmacotherapy does not fall within the scope of cruel and unusual punishment.⁹⁵ Whereas, Vanderzyl contends that involuntary pharmacotherapy fails to qualify as treatment under the *Rennie* test and must be considered as punishment.⁹⁶ It appears from the discussion in the literature that there is no clear distinction between the treatment and punishment form of involuntary pharmacotherapy. Also, the concerns over the limitation on informed consent and the interference with personal autonomy have not been discussed or addressed in depth. Only Miller⁹⁷ stresses the lack of cognitive capacity to give informed consent but he

⁹³ *Rennie* analysis was derived from the case of *Rennie v Klein* which was about involuntary treatment of a competent patient and the court established a four-part test to decide whether a given medical procedure serves as treatment or punishment. See, *Rennie v Klein* 653 F 2d 836 (1981).

⁹⁴ Kris A Druhm, 'Welcome to Draconia: California Penal Law 645, the Castration of Sex Offenders and the Constitution' (1997) 61 Albany Law Review 285; Edward A Fitzgerald, 'Chemical Castration: MPA Treatment of the Sexual Offender' (1990) 18 American Journal of Criminal Law 1. Raine argues that when it is used appropriately, pharmacotherapy is not a punishment and thus, does not violate the Eighth Amendment, however, excessive doses of medication might lead to the level of cruel and unusual. See Dennis Raine, 'The Use of Depo-Provera for Treating Male Sex Offenders: A Review of the Constitutional and Medical Issues' (1984) 16 University of Toledo Law Review 181.

⁹⁵ Mary Ann Farkas and Amy Stichman, 'Sex Offender Laws: Can Treatment, Punishment, Incapacitation, and Public Safety Be Reconciled?' (2002) 27 Criminal Justice Review 256, 272-74. Also see Peter J Gimino III, 'Mandatory Chemical Castration for Perpetrators of Sex Offenses Against Children: Following California's Lead' (1998) 25 Pepperdine Law Review 67; John F Stinneford, 'Incapacitation through Maiming: Chemical Castration, the Eighth Amendment, and the Denial of Human Dignity' (2006) 3 University of St. Thomas Law Journal 559; Laura S Chism, 'The Case for Castration: A "Shot" Towards Rehabilitation of Sexual Offenders' (2013) 37 Law and Psychology Review 193.

⁹⁶ See Vanderzyl (n 88) 126-131.

⁹⁷ Robert D Miller, 'Forced Administration of Sex-Drive Reducing Medications to Sex Offenders: Treatment or Punishment?' (1998) 4 Psychology, Public Policy, and Law 175.

does not go so far as to argue what he means with this argument and thus, there is a gap in the literature when it comes to examining the imposition of involuntary pharmacotherapy as treatment within the justifiable limits on autonomy and informed consent.

Regarding the use of pharmacotherapy as a means of punishment, by mostly comparing with surgical castration, it has been argued that even if pharmacotherapy is considered as punishment, it is not cruel, it is proportional to the seriousness of the crime and it is the least restrictive way of achieving the legitimate state goals.⁹⁸ Also, it has generally been contended that given its historical use, it is not an unusual punishment and is in accordance with the norms of contemporary society.⁹⁹ Whereas Vanderzyl¹⁰⁰ and Green¹⁰¹ argue that involuntary pharmacotherapy is a cruel and unusual punishment because it is degrading and inherently cruel, it is disproportionate to the crime, and it is more intrusive than incarceration. On this matter, Harrison argues that pharmacotherapy should neither be considered as solely treatment, nor be classified as only punishment, but rather seen as a ‘risk management strategy’ and should be used after ‘punishment has been served and in conjunction with other treatment techniques.’¹⁰² However, none of these arguments are helpful to make a clear distinction between the treatment and punishment forms of pharmacotherapy. Also, none of these discussions has considered the connection between philosophy and punishment and discussed pharmacotherapy within the context of theories of punishment and whether pharmacotherapy can be

⁹⁸ See Fitzgerald (n 94); Linda Beckman, ‘Chemical Castration: Constitutional Issues of Due Process, Equal Protection, and Cruel and Unusual Punishment’ (1998) 100 West Virginia Law Review 853.

⁹⁹ Christopher Meisenkothen, ‘Chemical Castration – Breaking the Cycle of Paraphiliac Recidivism’ (1999) 26 Social Justice 139, 146-147. Icenogle stresses that pharmacotherapy is neither cruel nor unusual and it is less intrusive than imprisonment. Thus, it can be used in lieu of incarceration. See Daniel L Icenogle, ‘Sentencing Male Sex Offenders to the Use of Biological Treatments: A Constitutional Analysis’ (1994) 15 Journal of Legal Medicine 279.

¹⁰⁰ Vanderzyl (n 88).

¹⁰¹ William Green, ‘Depo-Provera, Castration, and the Probation of Rape Offenders: Statutory and Constitutional Issues’ (1986) 12 University of Dayton Law Review 1.

¹⁰² Harrison, ‘Legal and Ethical Issues’ (n 16).

justified as a means of punishment under retributive and utilitarian theories and, if so, how this medical intervention can be integrated into the criminal justice system. Rather, the discussion on pharmacotherapy has revolved around the laws ordering pharmacotherapy and whether they seek retributive punishment for PSOs or they aim to solve the underlying problem by serving a rehabilitative purpose.¹⁰³ Although much research has favoured a rehabilitative approach to criminal justice for the use of pharmacotherapy and argued against the retributive use of it on the grounds of proportionality and therapeutic justifications, the possibility of reconciling utilitarian and retributive theories of punishment for the use of pharmacotherapy has never been considered. Also, another point which has never been considered in the literature but can change the traditional form of punishment for PSOs is that pharmacotherapy can be introduced as a new form of punishment which can serve both the retributive and utilitarian aims of punishment.

Lastly, the compatibility of pharmacotherapy for PSOs with the Convention rights has been subject to several studies. However, while these studies can be helpful to have a general view of this subject, they are, unfortunately, limited and provide little opportunity to come to a decisive conclusion as to whether the nature and the consequences of the use of pharmacotherapy amounts to a violation of the Convention rights, and to make suggestions regarding what should be done to put pharmacotherapy into place within the Member States and also to be compatible with the Convention. On this matter, Harrison and Rainey consider pharmacotherapy under Articles 3, 8 and 12, and discuss how dignity and consent underpin human rights implications of

¹⁰³ Jason O Runckel, 'Abuse It and Lose It: A Look at California's Mandatory Chemical Castration Law' (1997) 28 Pacific Law Journal 547; Jennifer M Bund, 'Did You Say Chemical Castration?' (1998) 59 University of Pittsburgh Law Review 157; J Michael Bailey and Aaron S Greenberg, 'The Science and Ethics of Castration: Lessons from the *Morse* Case' (1998) 92 Northwestern University Law Review 1225; Tanya Simpson, "'If Your Hand Causes You to Sin ...': Florida's Chemical Castration Statute Misses the Mark' (2007) 34 Florida State University Law Review 1221.

pharmacotherapy; whether it is a viable option for PSOs under the Convention and what legal and ethical safeguards need to be put into place in order not to be in violation of the Convention.¹⁰⁴ By giving a brief set of criteria, they argue that if pharmacotherapy is brought into force as a method of treatment in accordance with the certain criteria indicated under the Convention and set forth by the Strasbourg Court, it will probably be difficult to find states in violation of Convention rights.¹⁰⁵ In addition, Basdekis-Jozsa, Turner and Briken¹⁰⁶ discuss the legal aspects of using pharmacotherapy in the treatment of sex offenders under the Convention. They argue that pharmacotherapy limits offenders' ability to perform sexual intercourse which constitutes an interference with human rights, and the duties and obligations involved in human rights require the consideration of those offenders' rights. However, in their discussion concerning the legal and ethical issues of pharmacotherapy, they only look at the voluntary use of pharmacotherapy. Since they oppose the involuntary use of pharmacotherapy, they do not consider its applicability and justifiability under the Convention.

G. Structure of the Thesis

In aiming to address the permissibility of using pharmacotherapy for PSOs and the possibility of depriving them of their sexual liberty in light of the Convention, this thesis will consist of two-stage assessment. In the first stage, the focus will generally lie in the treatment and punishment forms of pharmacotherapy in order to explore and justify the admissibility of pharmacotherapy in both forms. In this respect, Chapter Two will present an analysis over the treatment aspect of pharmacotherapy in two main

¹⁰⁴ Karen Harrison and Bernadette Rainey, 'Suppressing Human Rights? A Rights-Based Approach to the Use of Pharmacotherapy with Sex Offenders' (2009) 29 Legal Studies 47; Harrison and Rainey, 'Morality and Legality' (n 73); Bernadette Rainey and Karen Harrison, 'Human Rights and Human Wrongs: A Rights Based Approach to the Punishment and Treatment of Sex Offenders' (2015) 13 Contemporary Issues in Law 229. Also, see Harrison, 'The Use of Pharmacotherapy' (n 67); Karen Harrison, *Dangerousness, Risk and the Governance of Serious Sexual and Violent Offenders* (Oxford: Routledge 2011).

¹⁰⁵ See Rainey and Harrison, 'Pharmacotherapy and Human Rights' (n 66).

¹⁰⁶ Basdekis-Jozsa, Turner and Briken, 'Pharmacological Treatment' (n 32).

parts: descriptive and critical review first, and theoretical and doctrinal considerations and discussions second. The descriptive part will provide general information about the definition of medical treatment, its purpose, the treatment of individuals with paedophilic disorder, in particular, the use of pharmacotherapy in the treatment of PSOs, and the distinction between treatment and punishment.

The second part will be devoted to the ethical and medical concerns over the use of pharmacotherapy in treating PSOs. The analysis will start with the voluntary use of pharmacotherapy for convicted PSOs and the discussion will generally focus on the obtainment of free and informed consent, the amount of information disclosed to the patient and the capacity to consent. Afterwards, the discussion will move on to consider the involuntary use of pharmacotherapy for PSOs which entails a discussion of limitations of informed consent. To ground just one of these limitations of informed consent for involuntary use of pharmacotherapy, it will be argued that the ability of PSOs to make an autonomous decision at the time it needs to be made for himself concerning his paedophilic disorder might be controversial because of not being able to have a rational understanding of his condition as a result of this mental disorder and to make the treatment decision for his particular condition. This chapter will also go into detail by discussing that what a justification-demanding constraint on present autonomy resulting from involuntary pharmacotherapy involves is the enhancement of the future autonomy of those offenders and the improvement of their capacity. By this means, offenders will become more autonomous, with a capacity to step back and adopt an attitude without being under the influence of uncontrollable paedophilic motivations or to behave in a manner guided by thoughts which are not accompanied by paedophilic urges/desires.

Chapter Three will look at the punishment aspect of pharmacotherapy as a state response to paedophilic sexual crimes within the context of two prominent theories of punishment: retributive and utilitarian theories. The first part of this chapter will be dedicated to a theoretical, detailed description and a critical analysis of the core principles and features of both theories. After the analysis of the definitions of punishment and its general justifying aims within the context of the utilitarian and retributive theories, i.e. an aim to inflict what an offender deserves, an aim to deter potential offenders, an aim to rehabilitate and/or incapacitate offenders or an aim to otherwise prevent further crimes, the consideration will be whether the use of pharmacotherapy satisfies the definitions and the general justifying aims of punishment. On this matter, the argument will be that using pharmacotherapy as a means of punishment can be justified on the grounds that: imposing pharmacotherapy can remove the unfair advantage, restore the balance of benefits and burdens disturbed, hold offenders accountable and responsible for the crime committed and convey the message to those offenders that their deviant sexual behaviours harm society and thus, they must face the disapproval (or condemnation) of society; and the application of pharmacotherapy covers not only the interests of offenders by treating their paedophilic sexual urges, relieving the impediment to their autonomy and enhancing their autonomy, but also the interests of the community by minimising the risk of re-offending, ensuring appropriate responses to the crimes and the safety of society.

The second part of Chapter Three will discuss the integration of pharmacotherapy into the criminal justice systems in more detail by developing the Action-Reaction Model. This model will be based on the idea that PSOs' actions get significant reaction from the members of society because paedophilic sexual offences are impulsive offences and the offenders are motivated by incontrollable, abnormal and irresistible urges. Under

the Action-Reaction model, it will be argued that in some instances, legislative action takes form according to the special circumstances and echoes the widespread social reaction to those circumstances existing in the country in order to gain public support, to build resilience in the community, to change the necessary norms and to direct the society's dialogue or affairs away from what they fear. In the case of PSOs, It is possible to reconcile retributive and utilitarian aims of punishment, since these are the very sorts of concerns which can be carried out by the imposition of DoSL. On that account, although there are more fundamental issues regarding the integration of pharmacotherapy into the criminal justice systems, Chapter Three will suggest that pharmacotherapy can be considered as a means of punishing PSOs, and an attempt to use it in their punishment can be justified.

After the examination and clarification of both treatment and punishment forms of pharmacotherapy, in the second stage, the focus will be on the rights protected under the Convention. Chapter Four will address the concerns over the use of pharmacotherapy in the treatment and punishment of PSOs in the context of Articles 3, 8 and, to a certain extent, 12. This assessment will be conducted in two steps, the first step will be on the definition of the right to sexual self-determination or sexual autonomy, in particular, the right to sexual liberty and will discuss that it can be subject to a certain level of control. The second step will involve an assessment of this medical intervention and the most relevant Convention rights. Firstly, under Article 3, the discussion will be on whether pharmacotherapy amounts to an inhuman or degrading treatment or punishment or it shows conformity with the standards established by the Court. For more clarification, these conformity standards will be examined more thoroughly in consideration of the literature and the discussions of scholars on this matter. Secondly, the focus will be on whether pharmacotherapy leads to an

interference with the right to private life, the right to engage in a sexual relation and the right to procreate. After it is established that using pharmacotherapy results in a failure to and/or a limitation on the exercise of the rights under Articles 8 and 12, the debate will move on to whether the interference can be justified. At this stage, the structure adopted for this assessment will follow the Court's approach in the cases under Article 8 and consist of the following questions: whether the interference results from pharmacotherapy is in accordance with the law; whether it pursues the legitimate aim(s) listed in Article 8(2); and whether it is in accordance with the law. Also, applying the proportionality test to the use of pharmacotherapy, it will be addressed whether the interference is proportionate to the legitimate aims under Article 8(2) and whether its use can be regarded within the margin of appreciation of the Member States. In light of these analysis, discussions, and considerations, I will address the concerns over the applicability of pharmacotherapy and will attempt to determine the requirements which should be met for pharmacotherapy in order to be permissible in the Member States.

Chapter Five, the concluding chapter, will highlight the key findings from the substantive chapters and present a concise summary of the main discussions of this research project. Also, in Chapter Five, the implications and limitations of the study will be discussed, some directions and suggestions for future work will be stressed and the DoSL argument will be explained more clearly to indicate that this new approach can make a real difference in dealing with PSOs and in the many contemporary debates about their treatment/punishment.

Overall, this thesis is mainly dedicated to the assessment of the use of pharmacotherapy as a means in the treatment/punishment of PSO and in the achievement of DoSL, and the relevant rights and interests surrounding its application. For its treatment form, if free and full informed consent is obtained from PSOs truly, to wit, without leaving any

room for doubt about the comprehension of the information given and voluntariness of the consent, the use of pharmacotherapy for the treatment of those offenders can still remain controversial due to the inherently coercive nature of the decision between pharmacotherapy and imprisonment which might render truly voluntary consent impossible. Whereas, if it is applied without obtaining consent, this coercive imposition of pharmacotherapy is permissible because the interference results from its involuntary application can be justified on autonomy-based and capacity grounds. For its punishment form and integration into the criminal justice systems, the severity of pharmacotherapy in terms of inflicting unpleasant and burdensome consequences on PSOs by depriving them of their sexual liberty appears to be a proportional response to the crime. In addition, pharmacotherapy increases the total happiness of society and the societal benefits outweigh the costs of pharmacotherapy to society by incapacitating and rehabilitating PSOs and preventing them from committing further crimes and allowing them to re-enter society safely. Thus, pharmacotherapy can be used in the punishment of PSOs and its integration into the criminal justice systems can be justified on retributive and utilitarian grounds. Regarding the permissibility of using pharmacotherapy in treatment/punishment of PSOs in light of the Convention, pharmacotherapy leads to concerns over the rights of offenders and the vehement position held against its use is that it constitutes an insidious form of governmental control over the offenders' physical and mental integrity and personal autonomy. However, if it is administered and practiced in accordance with the standards set out by the Court and in the Committee Reports and with the justification criteria listed in the Convention, pharmacotherapy can be applied to PSOs within European jurisprudence.

CHAPTER TWO

THE USE OF PHARMACOTHERAPY IN THE TREATMENT OF PSOs

Introduction

The ever-increasing demand for ensuring public safety and managing dangerous offenders particularly with mental dysfunction or behavioural disorder has become a common ground of several laws in the realm of criminal law and mental health law.¹ However, there is an ambiguity in the literature regarding the treatment of offenders, more specifically, of male sex offenders with paedophilic disorder. By virtue of this affiliation between crime and mental disorder, this chapter will consider how and to what extent a particular medical treatment can be applied to sex offenders who are afflicted with paedophilic desires and act on those desires.

The starting point of this chapter will be the definition of medical treatment, its purpose, the treatment of individuals with paedophilic disorder and the application of pharmacotherapy. Even though people with sexual behaviour disorders create an ‘extremely heterogeneous population’² and the legal definition of this type of individuals differs from state to state, the contemporary medical interventions tend to have several characteristics in common. Regarding the effectiveness of certain treatment methods, there has been an increasing trend for the use of pharmacological treatment in

¹ In the UK, under the MHA 1983, Part II, Sections 2 and 3, a person who is suffering from a mental disorder can be detained ‘in the interests of his own health or safety or with a view to the protection of other[s]’ including sexually dangerous offenders who suffer from mental disorder and pose danger to the others, especially after their prison terms are completed. See Ministry of Justice, ‘What Works with Sex Offenders?’ (May 2010) <<http://www.justice.gov.uk/downloads/information-access-rights/foi-disclosure-log/prison-probation/foi-75519-annex-a.pdf>> accessed 02 November 2014; Rebecca Lievesley and others, ‘The Use of Medication to Treat Sexual Preoccupation and Hypersexuality in Sexual Offenders’ (2013) 208 Prison Service Journal 17.

² Fabian M Saleh and Laurie L Guidry, ‘Psychosocial and Biological Treatment Consideration for the Paraphilic and Nonparaphilic Sex Offender’ (2003) 31 The Journal of American Academy of Psychiatry and the Law 486, 486.

conjunction with psychotherapy and/or behaviour modification with the aim of ameliorating the symptoms of paedophilic disorder by diminishing those individuals' abnormal sexual urges/desires, helping them control their deviant sexual interests and behaviours and addressing their particular needs.³ Thus, part two will focus on the meaning, origins, and application of pharmacotherapy and discuss its use as a sex-drive-reducing treatment with a special emphasis on the concerns and problems arising from its administration. However, depending on whether pharmacotherapy should be employed on a voluntary or involuntary basis, there is another particular concern about its practice. Treating PSOs with pharmacotherapy gives rise to an ambiguity regarding its adopted form, i.e. whether this technique seeks to treat PSOs or the intention behind this medical intervention is to punish them by taking advantage of medical improvement in an attempt to utilize it as a subsidiary punishment. This issue essentially derives from the difficulties in distinguishing treatment from punishment because the division between those two concepts is not clear in the field of furnishing medical intervention to prisoners. For this reason, part three will be devoted to the discussion of the distinction between treatment and punishment and it will be argued that there are certain criteria which might help to distinguish whether the aim of using pharmacotherapy is to treat PSOs or to punish them.

Another aspect of pharmacotherapy as treatment is that it may raise serious medical and ethical issues in terms of offenders' autonomy and their participation in treatment programmes, especially if the validity of consent is controversial, or if the manner of its imposition is compulsory. Given the particular situation of offenders, of being

³ Florence Thibaut and others, 'The World Federation of Societies of Biological Psychiatry (hereinafter, WFSBP) Guidelines for the Biological Treatment of Paraphilias' (2010) 11 *The World Journal of Biological Psychiatry* 604, 606. See also Lana Stermac and Stephen Hucker, 'Combining Cognitive-Behavioral Therapy and Pharmacotherapy in the Treatment of Pedophilic Incest Offenders' (1988) 6 *Behavioral Sciences and the Law* 257; Karen Harrison and Bernadette Rainey (eds) *The Wiley-Blackwell Handbook of Legal and Ethical Aspects of Sex Offender Treatment and Management* (Wiley-Blackwell 2013).

imprisoned, and the oppressive nature of prison, even if a medical intervention is carried out after the obtainment of the offenders' consent, there might be a problem concerning the validity of consent, i.e. to what extent the consent of those offenders can be regarded as valid or free and fully informed. On that account, in part four, the analysis will firstly consider the voluntary use of pharmacotherapy and the validity of offenders' consent. In addition, since the medications used for pharmacotherapy might lead to serious adverse side-effects, it will be discussed how much information must be disclosed to offenders to ensure that their consent is informed and voluntary, to wit, legally valid. Following this analysis and discussion, the focus will be moved onto the involuntary use of pharmacotherapy. Given the importance of autonomy, integrity and informed consent in the biomedical context, in the case of paternalistic medical interventions, there is always a conflict between autonomy and paternalism.⁴ So involuntary treatment becomes problematic with respect to these essential values and to the interests/rights of the person in question.⁵ Thus, it will be argued that although informed consent is essentially for the protection of autonomy, withholding treatment on the grounds of lack of consent (respecting present autonomy) might sometimes have the contradictory results of limiting (future) autonomy. Given that pharmacotherapy alleviates individuals' paedophilic urges, this subpart will cover two fundamental issues: (i) whether these urges can be regarded as an impediment to individuals' autonomy because they affect their ability to critically assess their preferences; and (ii) since the involuntary use of pharmacotherapy gives rise to a decrease in present autonomy, whether this decrease can be justified on the basis that it is of great importance for the promotion/enhancement of future autonomy. In this respect, the argument of this chapter will rely on the claim that pharmacotherapy can be imposed on PSOs both as

⁴ Gerald Dworkin, *The Theory and Practice of Autonomy* (Cambridge University Press 1988) 4-5.

⁵ Onora O'Neill, 'Some Limits of Informed Consent' (2003) 29 *Journal of Medical Ethics* 4, 4.

voluntary treatment or involuntary treatment, and although there are serious concerns over autonomy, integrity and informed consent arising from its practice which differ depending on whether it is voluntary or involuntary, in the end they can all be overcome.

A. Definition of Medical Treatment

It is important to begin with a definition of treatment in order to have a solid grasp of its purpose and function. The lexical meaning of treatment is ‘medical care for an illness or injury’⁶ or ‘the process of providing medical care.’⁷ Vaughin and Carroll define medical treatment by taking the Hippocratic Oath into account and state that the aim of medical treatment is ‘to help the sick and *to alleviate the pain and suffering of all individuals* regardless of their social status [...] [M]edical care should never be used as an instrument to injure patients, and physicians are duty bound to keep themselves *free from intentional wrongdoing and harm.*’⁸ Considering the general perception of Faden and Beauchamp on the principle of beneficence in medicine, medical treatment can also be described as

[t]he positive benefit the physician is obliged to seek is the *alleviation of disease and injury*, if there is a reasonable hope of cure. *The harms to be prevented, removed or minimized are the pain, suffering, and disability of injury and disease.* In addition, the physician is *of course enjoined from*

⁶ Catherine Soanes and Angus Stevenson (eds), *The Concise Oxford English Dictionary* (Oxford Reference Online, 12th edn, Oxford University Press 2008) "treatment *n.*".

⁷ MacMillan Dictionary <<http://www.macmillandictionary.com/dictionary/british/treatment>> accessed 2 November 2014.

⁸ Michael S Vaughin and Leo Carroll, ‘Separate and Unequal: Prison Versus Free-World Medical Care’ (1998) 15 *Justice Quarterly* 3, 3-4 (emphasis added).

*doing harm if interventions inflict unnecessary pain and suffering on patients.*⁹

In plain language, medical treatment simply ‘ameliorates the lives of sick people’¹⁰ and even though it is perhaps no wonder that treatment can be ‘painful or disagreeable’, the basic aim of treatment is ‘to relieve pain, correct disability, or combat an illness.’¹¹ Although another component of treatment is that treatment has to be done by an expert who has an ‘authority and a certain amount of power’,¹² this is not a key element because the intent of the actor can assign a different meaning to medical treatment.¹³ For instance, using pharmacotherapy for paedophiles is to lower their testosterone level and ameliorate their uncontrollable sexual deviation which essentially implies benefit to those individuals by alleviating the signs and symptoms of paedophilia. However, in the US, it has been utilised in punishing and controlling PSOs as a common, legally sanctioned punitive measure, even if it is imposed by doctors, psychiatrists, and psychologists or under their supervisions.¹⁴ As might be expected from this brief discussion, there is an indistinct line between punishment and treatment, especially when certain medical interventions become an issue of concern. Thus, this issue will be discussed later in more detail.

⁹ Ruth R Faden and Tom L Beauchamp, *A History and Theory of Informed Consent* (New York: Oxford University Press 1986) 12 (emphasis added).

¹⁰ Johnstone evaluates the meaning of ‘medical intervention’ by comparing it with ‘punitive intervention’. As he notes, medical intervention recuperates ill people’s lives while punitive intervention intends to deteriorate offenders’ lives. Gerry Johnstone, *Medical Concepts and Penal Policy* (Cavendish Publishing Limited 1996) 4.

¹¹ Karl Menninger, *The Crime of Punishment*, (New York: The Viking Press 1968) 88.

¹² Iain Crow, *The Treatment and Rehabilitation of Offenders* (Sage Publications 2004) 4.

¹³ Edward M Opton, Jr, ‘Psychiatric Violence against Prisoners: When Therapy is Punishment’ (1974) 45 Mississippi Law Journal 605, 608.

¹⁴ It is worthy to note that the US is one of the leading countries in the use of pharmacotherapy for PSOs where the discussions over pharmacotherapy have been going on for a long time and where most of the literature on this issue originates. For this reason, in this chapter, much of the focus on using pharmacotherapy for PSOs will be on the literature in the US.

B. Treatment of Individuals with Paedophilic Disorder

In the treatment of paedophilic disorder, there are, in general, three modalities which are surgical castration, psychotherapy and pharmacotherapy.¹⁵ Among those methods, psychotherapy in conjunction with pharmacotherapy is currently one of the most common ways of treating sexual behaviour disorder in many countries.¹⁶ These methods are broadly (1) the use of pharmacotherapy based on the process of using artificial hormones to decrease testosterone level and increase subjective control over irresistible sexual drives,¹⁷ and/or (2) the use of behavioural therapy or psychotherapy which helps patients overcome the cognitive disorders and rationalisations from which people with sexual behavioural disorder suffer such as extinguishing sexual feelings associated with children or rectifying the problem which causes abnormal sexual interests.¹⁸ On that account, hormonal and behavioural treatments have a significant impact in treating sex offenders,¹⁹ and pharmacotherapy in conjunction with psychotherapy can be considerably effective in managing those offenders.²⁰ It is also stressed that PSOs represent a high level of sexual obsession with coercive sexual interests and urges. Therefore, the use of any organic, biological, surgical or psychological treatment in order to reduce these uncontrollable, irresistible intrusive sexual behaviours emancipates

¹⁵ Ariel Rösler and Eliezer Witztum, 'Pharmacotherapy of Paraphilias in the Next Millennium' (2000) 18 Behavioral Sciences and the Law 43, 43.

¹⁶ Harvey Gordon and Don Grubin, 'Psychiatric Aspects of the Assessment and Treatment of Sex Offenders' (2004) 10 Advances in Psychiatric Treatment 73, 77-78.

¹⁷ Andreas Hill and others, 'Differential Pharmacological Treatment of Paraphilias and Sex Offenders' (2003) 47 International Journal of Offender Therapy and Comparative Criminology 407, 408.

¹⁸ Fred S Berlin and Edgar Krout, 'Pedophilia: Diagnostic Concepts Treatment, and Ethical Considerations' (1986) 7 American Journal of Forensic Psychiatry 13, 20-21, 23-25. Also, see Thibaut and others (n 3). For more information about the treatment of sex offenders in Germany, pharmacology and the 'law on voluntary castration and other methods of treatment', see Kai Sammet, 'Risking More Freedom? Cyproterone Acetate, Sexual Offenders and the German "Law on Voluntary Castration and Other Methods of Treatment"', 1960-1975' (2005) 40 Medizinhistorisches Journal 51.

¹⁹ Friedrich Lösel and Martin Schmucker, 'The Effectiveness of Treatment for Sexual Offenders: A Comprehensive Meta-Analysis' (2005) 1 Journal of Experimental Criminology 117, 136.

²⁰ Peer Briken and Martin Kafka, 'Pharmacological Treatments for Paraphilic Patients and Sexual Offenders' (2007) 20 Current Opinion in Psychiatry 609, 609.

the person from these abnormalities and helps this person gain control over his/her mind and behaviour, which will be discussed later in part four.²¹

Given that the effectiveness of incarceration has been questioned²² and other forms of treatment have been seen as controversial in terms of their consequences,²³ pharmacotherapy has started to gain ground. There is a wide range of literature on the effectiveness of this particular method which advocates that pharmacotherapy is an effective means of treatment for paedophilia because it assails the fundamental cause for this disorder. Flack stresses that '[pharmacotherapy] is effective for [...] male p[a]edophile because, although his sexual preferences will not change, his sexual drive will be significantly lowered and he will be less likely to carry out criminal sexual assaults.'²⁴ In this respect, the following part will provide some information regarding the nature of pharmacotherapy in order to address the concerns, discussions and critiques of this medical procedure.

1. Castration

In the more general sense, *Castration* can be defined as 'deprivation of the power of generation.'²⁵ It has been widely exercised on people throughout history with the aim of preventing unwanted procreation, for religious, medical or musical reasons, or it has been operated to punish criminals who committed such crimes as fornication,

²¹ John MW Bradford and Anne Pawlak, 'Effects of Cyproterone Acetate on Sexual Arousal Patterns of Pedophiles' (1993) 22 Archives of Sexual Behavior 629, 629-31.

²² Ovadia Ezra, *Moral Dilemmas in Real Life, Current Issues in Applied Ethics* (Netherlands: Springer 2006) 145-156; Kevin Bennardo, 'Incarceration's Incapacitative Shortcomings' (2014) 54 Santa Clara Law Review 1.

²³ See Lösel and Schmucker (n 19).

²⁴ Courtney Flack, 'Chemical Castration: An Effective Treatment for the Sexually Motivated Pedophile or an Impotent Alternative to Traditional Incarceration' (2006) 7 Journal of Law in Society 173, 182. See also Peer Briken, Andreas Hill and Wolfgang Berner, 'Pharmacotherapy of Paraphilias with Long-Acting Agonists of Luteinizing Hormone: A Systematic Review' (2003) 64 The Journal of Clinical Psychiatry 890; Hill and others (n 17).

²⁵ Harvey Marcovitch, *Black's Medical Dictionary* (42nd edn, A&C Black Publishers Limited 2010) 112. According to Stürup, '[c]astration is the removal of the testes [...] involves the cessation of hormonal production [...] with a concomitant sexual drive decreases which varies from person to person.' Georg K Stürup, 'Castration: The Total Treatment' in HLP Resnik and Marvin E Wolfgang (eds), *Sexual Behaviors: Social, Clinical, and Legal Aspect* (Brown and Company 1972) 361.

aggression or rape according to the *lex talionis* which means ‘an eye for an eye, a tooth for a tooth’.²⁶ This statement indicates that castration has been carried out on either voluntary or mandatory grounds. Hence the latter application of castration, which was considered as a method of punishment and/or an effective deterrent for sex offenders ‘under the eye-for-an-eye principle’, is not a recent trend.²⁷

Due to the strong sexual desires which might be difficult to control for certain people and on which those individuals cannot resist acting, some countries in the past took some special measures and proposed castration as an alternative to imprisonment.²⁸ In particular, several European countries such as Denmark, the Federal Republic of Germany, Norway, Sweden, and Switzerland practiced mandatory castration as a means of punishing convicted sex offenders.²⁹ In the mid-20th century, castration appeared as one type of legislative response to sex offenders to decrease the risk of future sex offences by changing sex offenders’ hormone levels –either chemically or surgically- and regulating their behaviours.³⁰ Testosterone is a steroid hormone from the androgen group found in both sexes, especially in the human male; as explained by Rubinow and Schmidt, its role is paramount in regulating ‘sexual desire, sexual thoughts, intensity of sexual feelings, and sexual activity’.³¹ Even though some studies indicate that the testosterone level in men with sexually abnormal thoughts is at the same level as that of the normal adult male,³² this normal testosterone level could still trigger some sexually

²⁶ Nikolaus Heim and Carolyn Hirsch, ‘Castration for Sex Offenders: Treatment or Punishment? A Review and Critique of Recent European Literature’ (1979) 8 Archives of Sexual Behavior 281, 282.

²⁷ Robert D Miller, ‘Forced Administration of Sex-Drive Reducing Medications to Sex Offenders: Treatment or Punishment?’ (1998) 4 Psychology, Public Policy, and Law 175, 178.

²⁸ Brian D Gallagher, ‘Now That We Know Where They Are, What Do We Do with Them?: The Placement of Sex Offenders in the Age of Megan’s Law’ (1998) 7 Widener Journal of Public Law 39, 80-81.

²⁹ John M MacDonald, *Rape: Offenders and Their Victims* (Thomas 1971) 305.

³⁰ Charles Scott and Elena del Busto, ‘Chemical and Surgical Castration’ in Richard G Wright (ed), *Sex Offender Laws: Failed Policies New Directions* (New York: Springer Publishing 2009) 291-92.

³¹ David R Rubinow and Peter J Schmidt, ‘Androgens, Brain, and Behavior’ (1996) 153 The American Journal of Psychiatry 974, 974-78.

³² See Harold C Seim and Margretta Dwyer, ‘Evaluation of Serum Testosterone and Luteinizing Hormone Levels in Sex Offenders’ (1988) 7 Family Practice Research Journal 175; Ariel Rösler and Eliezer

deviant thoughts due to the abnormality that certain people have, such as cognitive behavioural abnormality. In either case, therefore, the reduction in testosterone level can minimize abnormal sexual interests.³³

In essence, castration can be performed on men in three different ways: (i) through the surgical removal of both testes (Surgical Castration); (ii) through the administration of medication (pharmacotherapy); and (iii) through the use of nanotechnology (Nano-Castration).³⁴ However, given that nano-castration is a brand new issue and has not been well-grounded yet, given the invasive, permanent, irreversible and mutilating nature of surgical castration,³⁵ which depicts a brutal form of criminal punishment,³⁶ and given the scope of this study, the following part will mainly focus on pharmacotherapy.

1.1. Pharmacotherapy

The treatment of PSOs is complicated and includes a variety of aetiologies, individualised risk assessment, reduction and management needs and personal, legal and medical factors. Since this research project is designed to discuss the use of pharmacotherapy to reduce or eliminate sexual arousal and recidivism in PSOs, in the following part the focus

Witztum, 'Treatment of Men with Paraphilia with a Long-Acting Analogue of Gonadotropin-Releasing Hormone' (1998) 338 *The New England Journal of Medicine* 416.

³³ See Shelton E Hendricks and others, 'Brain Structure and Function in Sexual Molesters of Children and Adolescents' (1988) 49 *Journal of Clinical Psychiatry* 108; Richard C Howard, 'The Neurophysiology of Sexual Desire with Particular Reference to Paedophilia' (1995) 24 *Annals of the Academy of Medicine* 724.

³⁴ See Nicole A Vincent, 'On the Relevance of Neuroscience to Criminal Responsibility' (2010) 4 *Criminal Law and Philosophy* 77; Henry T (Hank) Greely, 'Direct Brain Interventions to "Treat" Disfavored Human Behaviors: Ethical and Social Issues' (2012) 91 *Clinical Pharmacology and Therapeutics* 163; Katrina L Sifferd, 'Changing the Criminal Character: Nanotechnology and Criminal Punishment' in Amedeo Santosuosso (ed), *Proceedings of the Young Scholar Symposium on Law and Science* (European Centre for Law, Science and New Technologies, University of Pavia Press 2012); Nicole A Vincent, 'Neurolaw and Direct Brain Intervention' (2014) 8 *Criminal Law and Philosophy* 43.

³⁵ Daniel L Icenogle, 'Sentencing Male Sex Offenders to the Use of Biological Treatments' (1994) 15 *Journal of Legal Medicine* 279, 280.

³⁶ Kari A Vanderzyl, 'Castration as an Alternative to Incarceration: An Impotent Approach to the Punishment of Sex Offenders' (1995) 15 *Northern Illinois University Law Review* 107, 107. According to the Advisory Committee on Bioethics, surgical castration is not a viable alternative for the treatment of sex offenders anymore because the chemical substitutes for this surgical operation can achieve the same results. Advisory Committee on Bioethics, 'Opinion no. 39 of December 18th 2006 on Hormonal Treatment of Sex Offenders' (13 October 2006)

<<http://www.health.belgium.be/eportal/Healthcare/Consultativebodies/Committees/Bioethics/Opinions/index.htm>> accessed 2 November 2014.

will be on the medications for managing PSOs behaviours and reducing their sexual drive which is defined by Leiblum and Rosen as ‘a subjective feeling state that may be triggered by both internal and external cues, and that may or may not result in over sexual behaviour.’³⁷

By means of medical improvements and advances in chemical suppression methods, deviant sexual urges can be controlled or resisted through the use of pharmacological agents,³⁸ which is the ‘pharmacological equivalent of surgical castration.’³⁹ It has been argued that testosterone is associated with sexual arousal and the use of pharmacotherapy can result in a reduction of sexual arousal by decreasing or inhibiting testosterone level which can also reduce the motivation for sexually offending in PSOs.⁴⁰ A reduction in testosterone level can also diminish or inhibit potency, sperm production, frequency and pleasure of masturbation and sexual frustration.⁴¹ By reducing an offender’s frustration and anger levels, he can be more relaxed and amenable to other treatment options, such as psychotherapy, with the use of pharmacotherapy.⁴² In this respect, the aims of pharmacotherapy can generally be described as follows: the suppression of deviant sexual fantasies, urges and behaviours and the reduction of the risk of recidivism and further victimisation.⁴³

Mainly, two groups of pharmacological agents have been used for the treatment of PSOs, including the use of anti-libidinals, which are also classified as ‘antiandrogens’ or

³⁷ Sandra R Leiblum and Raymond C Rosen, ‘Introduction: Changing Perspectives on Sexual Desire’ in Sandra R Leiblum and Raymond C Rosen (eds), *Sexual Desire Disorders* (New York: Guilford Press 1988) 5.

³⁸ William L Baker, ‘Castration of the Male Sex Offender: A Legally Impermissible Alternative’ (1984)

³⁹ *Loyola Law Review* 377, 380-81.

⁴⁰ Miller (n 27) 188.

⁴¹ Matthew Fanetti and others, *Forensic Child Psychology: Working in the Courts and Clinic* (Wiley 2015) 182.

⁴² Jackie Craissati, *Managing High Risk Sex Offenders in the Community: A Psychological Approach* (New York: Routledge 2004) 150.

⁴³ See Peter Weiss, ‘Assessment and Treatment of Sexual Offenders in the Czech Republic and in Eastern Europe’ (1999) 14 *Journal of Interpersonal Violence* 411.

⁴⁴ John MW Bradford, ‘The Neurobiology, Neuropharmacology, and Pharmacological Treatment of the Paraphilias and Compulsive Sexual Behaviour’ (2001) 46 *The Canadian Journal of Psychiatry* 26, 30.

‘androgen antagonist’, such as medroxyprogesterone acetate (MPA or Depo-Provera), cyproterone acetate (CPA), luteinising hormone-releasing hormone (LHRH) agonist, gonadotropin-releasing hormone (GnRH) agonist, and psychotropic medications such as selective serotonin reuptake inhibitors (SSRIs).⁴⁴ It is noted that while anti-androgens ‘act by breaking down and eliminating testosterone and inhibiting the production of luteinizing hormone through the pituitary gland, which in turn inhibits or prevents the production of testosterone’⁴⁵, psychotropic medications, SSRIs, inhibit the reuptake of serotonin and thus, increase serotonin concentration levels which leads to a reduction in the frequency and intensity of sexual fantasies, sexual urges and resulting deviant behaviour.⁴⁶ Study results on these clinical medications indicate that sexually abnormal thoughts and behaviours can also be reduced by using psychoactive medications, which have less serious side-effects⁴⁷ and also have a paramount role in treating not only male paedophiles, but also the female one who could not undergo MPA treatment.⁴⁸ However, even if there is such an equivalent for female sex offenders, further clinical trials are required to demonstrate their long-term effects.⁴⁹ Also, what this research study seeks to do is confined to the use of pharmacotherapy for male sex offenders.

⁴⁴ Hill and others (n 17) 408.

⁴⁵ Fanetti and others (n 40) 182.

⁴⁶ See Yaser Adi and others, ‘Clinical Effectiveness and Cost-Consequences of Selective Serotonin Reuptake Inhibitors in the Treatment of Sex Offenders’ (2002) 6 Health Technology Assessment 1.

⁴⁷ Hill and others (n 17) 409.

⁴⁸ John MW Bradford and Neil S Kaye, ‘The Pharmacological Treatment of Sexual Offenders’ Psychopharmacology Committee Newsletter Column
<<http://www.courtpsychiatrist.com/pdf/pharmacological%20treatment%20sex%20offenders.pdf>>

accessed 29 November 2014.

⁴⁹ Fabian M Saleh and Fred S Berlin, ‘Sex Hormones, Neurotransmitters, and Psychopharmacological Treatments in Men with Paraphilic Disorder’ (2008) 12 Journal of Child Sexual Abuse 233, 245-47.

1.1.1 Anti-libidinal and Psychotropic Medications

a. MPA

MPA was manufactured under the trade name Depo-Provera and was chemically formed in 1954.⁵⁰ Although it was initially presented in 1959 as a treatment of gynaecological disorders,⁵¹ this anti-androgenic drug was first used to decrease inappropriate compulsive sex drives in 1958.⁵² MPA is synthetic progesterone which causes a decrease in the production of testosterone level in order to affect a person's abnormal sexual drive.⁵³ It is noted that the use of MPA as a treatment of paedophiles, who are the class of sex offenders suffering from abnormal and uncontrollable deviant sexual fantasies and urges, alters their compulsive sexual behaviours and drives.⁵⁴ One research study of sex offenders -paedophiles, rapists and exhibitionists- compares MPA treatment with group and individual therapy. While those who were treated with parenteral MPA at a dose of 500 milligram per week had an 18% recidivism rate, others who received only therapy had a 58% recidivism rate.⁵⁵ MPA has also tranquillising effect which can help to calm the offenders and provide relief from urges which were previous uncontrollable and irresistible.⁵⁶

⁵⁰ Philip J Henderson, 'Section 645 of the California Penal Code: California's "Chemical Castration" Law- A Panacea or Cruel and Unusual Punishment?' (1998) 32 University of San Francisco Law Review 653, 654.

⁵¹ William Green, 'Depo-Provera, Castration, and the Probation of Rape Offenders: Statutory and Constitutional Issues' (1986) 12 University of Dayton Law Review 1, 5.

⁵² John MW Bradford, 'The Antiandrogen and Hormonal Treatment of Sex Offenders' in William L Marshall, D Richard Laws and Howard E Barbaree (eds), *Handbook of Sexual Assault: Issues, Theories, and Treatment of the Offender* (New York: Plenum Press 1990) 301-302.

⁵³ For more information, see Thibaut and others (n 3) 621-22.

⁵⁴ Edward A Fitzgerald, 'Chemical Castration: MPA Treatment of the Sexual Offender' (1991) 18 American Journal of Criminal Law 1, 2-3. MPA has been applied in two different forms, including parenteral form (as by intramuscular or intravenous injection) or oral form. Saleh and Berlin (n 49) 238-39, 241. Although the recommended doses are 50-300 milligram per day or 300-500 milligram per week, for complete suppression the dose could be 500-1000 milligram per week, especially when it is used for paraphiliacs. Rösler and Witztum, 'Pharmacotherapy' (n 15) 47.

⁵⁵ Walter J Meyer, Collier M Cole and Evangeline Emory, 'Depo Provera Treatment for Sex Offending Behavior: An Evaluation of Outcome' (1992) 20 Bulletin of the American Academy of Psychiatry & the Law 249, 249. For a discussion over the reliability of the results, see Thibaut and others (n 3).

⁵⁶ John T Melella, Sheldon Travin and Ken Cullen, 'Legal and Ethical Issues in the Use of Anti-Androgens in Treating Sex Offenders' (1989) 17 Bulletin of the American Academy of Psychiatry and the Law 223, 225.

b. CPA

While MPA is the main anti-androgen used in the USA as a sexual disorder treatment,⁵⁷ it was abandoned in Europe due to the benefit/risk ratio.⁵⁸ The medication of choice in Europe, Canada and the Middle East is CPA,⁵⁹ which is a ‘synthetic steroid’ and ‘registered in more than 20 countries for the moderation of sexual drive in adult men with sexual deviations [...]’⁶⁰ and is also called Androcur.⁶¹ The mechanisms of action of MPA and CPA are essentially different but both are equally effective in reducing testosterone level⁶² and suppressing deviant sexual behaviours.⁶³ It is noted that ‘[d]irect CPA binding to all androgen receptors (including brain receptors) blocks intracellular testosterone uptake and metabolism.’⁶⁴ Also, as a strong progestational action, CPA leads to a reduction in GnRH and LH release.⁶⁵ It is reported that CPA is more effective than other agents in terms of decreasing ‘plasma testosterone concentration and level of sexual arousal’, which are observed by measuring changes in penile circumference and blood flow to the penis (Phallometric Test), and the ‘frequencies of masturbation, sexual tension and sexual fantasies’.⁶⁶ The daily and weekly oral or parenteral dosage consumption of CPA is less than MPA and the recidivism rates of sex offenders treated with MPA (27%) are higher than those of CPA (6%).⁶⁷ CPA may be applied either by injection (200-400

⁵⁷ Gordon and Grubin (n 16) 77.

⁵⁸ Thibaut and others (n 3) 622.

⁵⁹ Walter J Meyer and Collier M Cole, ‘Physical and Chemical Castration of Sex Offenders’ (1997) 25 *Journal of Offender Rehabilitation* 1, 8; Rösler and Witztum, ‘Pharmacotherapy’ (n 15) 45.

⁶⁰ Thibaut and others (n 3) 628.

⁶¹ Lösel and Schmucker (n 19) 136.

⁶² Craissati (n 41) 150.

⁶³ Linda S Grossman, Brian Martis and Christopher G Fichtner, ‘Are Sex Offenders Treatable? A Research Overview’ (1999) 50 *Psychiatric Services* 349, 351-53.

⁶⁴ Thibaut and others (n 3) 628.

⁶⁵ For more information, see WJ Jeffcoate and others, ‘The Effect of Cyproterone Acetate on Serum Testosterone, LH, FSH and Prolactin in Male Sexual Offenders’ (1980) 13 *Clinical Endocrinology* 189.

⁶⁶ Gordon and Grubin (n 16) 77. Also, see John MW Bradford, ‘Organic Treatment for the Male Sexual Offender’ (1988) 528 *Annals of the New York Academy of Sciences* 193.

⁶⁷ Meyer and Cole (n 58) 9-12, table 2:3. However, some of these studies were criticised due to the research design issues. See Howard Zonana and others, ‘Pharmacological Treatment of Sex Offenders’, in Howard Zonana and others (eds), *Dangerous Sex Offenders: A Task Force Report of the American Psychiatric Association* (Washington, DC: American Psychiatric Association 1999).

mg once weekly or every 2 weeks) or as tablets (50 and 100 mg, 50-200 mg/day).⁶⁸ Also, since individuals can surreptitiously take artificial testosterone to vitiate the effects of CPA (or MPA) and can increase their testosterone levels, it is suggested that CPA can be used together with GnRH or LHRH agonists to prevent artificial testosterone from being activated and to suppress the testosterone production in the body.⁶⁹ There is evidence that reduction of dosage or discontinuation of treatment after 6-12 months with CPA does not result in a reoccurrence of the deviant sexual interests and behaviours.⁷⁰

The first clinical use of CPA in sex offenders was carried out in Germany and it was reported that CPA showed a reduction in sexual drive, erection and the ability to orgasm and was efficient in 80% of deviant sexual behaviours.⁷¹ Cooper and others also reported that using 100 mg/day of CPA for 12 weeks with one patient resulted in a decrease in plasma testosterone, disappearance of morning erections and inability to masturbate to orgasm.⁷² Based on these outcomes, an extensive research was conducted including 9 men and it was found that CPA has a significant action in reducing sexual interest and physiological arousal.⁷³ In later research carried out by Cooper and others in 1992, it was reported that 200 mg/day of CPA is more effective and efficient than 100 mg/day.⁷⁴ Thibaut and others conducted an extensive review among the 10 open and double- or single-blind cross over studies, which included 900 male subjects, and noted that CPA (50-300 mg/day per oral or intramuscular 300-600 mg every 1 or 2 weeks) resulted in a

⁶⁸ Thibaut and others (n 3) 628.

⁶⁹ Hill and others (n 17) 418.

⁷⁰ Craissati (n 41) 151.

⁷¹ U Laschet and L Laschet, 'Pharmacotherapy of Sex Offenders with Cyproterone Acetate' (1971) 4 *Pharmacopsychiatry Neuropsychopharmacol Advanced Clinical Research* 99 cited in Thibaut and others (n 3) 628.

⁷² See AJ Cooper and others, 'Antiandrogen (Cyproterone Acetate) Therapy in Deviant Hypersexuality' (1972) 120 *British Journal of Psychiatry* 59.

⁷³ See AJ Cooper, 'A Placebo-Controlled Trial of the Anti-Androgen Cyproterone in Deviant Hypersexuality' (1981) 22 *Comprehensive Psychiatry* 458.

⁷⁴ See AJ Cooper and Z Cernovsky, 'The Effects of Cyproterone Acetate on Sleeping and Waking Penile Erections in Pedophiles: Possible Implication for Treatment' (1992) 37 *Canadian Journal of Psychiatry* 33.

remarkable decrease of sexual fantasies or activities (self-report) and frequency of masturbation and a complete loss of deviant sexual behaviour in about 80-90% of cases within 1-3 months. Morning erections, ejaculations and spermatogenesis were also diminished and for most patients, 100 mg/day or 100-200 mg/day of CPA was sufficient. The authors of these studies suggested that depending on dosage, 'CPA could be used as a chemical castration agent or as a reducer of sexual drive, allowing erecting ability in non-deviant sexual behaviour.'⁷⁵ Bradford and Pawlak also reported that when sex offenders, who were sexually aggressive and had poor control over their sexual behaviour, were on CPA, their anxiety and irritability reduced, they were less sexually preoccupied and were able to control their behaviour.⁷⁶

Despite the effectiveness of these medications, there have been a significant number of side-effects associated with them, including depression, insomnia, hot flushes, abdominal pain, hypertension, weight gain and fatigue. The use of CPA also leads to some serious side-effects, including generalised weakness, thromboembolic phenomena, hepatocellular damage, a decrease in sexual hair and beard growth,⁷⁷ adrenal insufficiency or hyperplasia, hypertension, kidney dysfunction, decreased glucose tolerance, and pituitary dysfunction.⁷⁸ Due to the high rates in the withdrawal from CPA treatment, it should be prescribed in conjunction with psychotherapy and there must be regular monitoring of the liver and endocrine function.⁷⁹ It is noted that one or two months after medication is discontinued, the treatment effects of CPA are completely reversible.⁸⁰ However, a few of potentially adverse side-effects can be irreversible, such as 'infertility and abnormal

⁷⁵ Thibaut and others (n 3) 628, 629-31.

⁷⁶ Bradford and Pawlak (n 21).

⁷⁷ Rösler and Witztum, 'Pharmacotherapy' (n 15) 46.

⁷⁸ Thibaut and others (n 3) 633. For review of CPA side-effects, see David RP Guay, 'Inappropriate Sexual Behaviours in Cognitively Impaired Older Individuals' (2008) 6 *The American Journal of Geriatric Pharmacotherapy* 269.

⁷⁹ Gordon and Grubin (n 16) 77.

⁸⁰ Thibaut and others (n 3) 632.

spermatozoa (slowly reversible), breast enlargement (common and may be permanent), mood changes [...].⁸¹

c. GnRH and LHRH Analogues

GnRH and LHRH analogues ‘act initially at the level of the pituitary to stimulate LH [luteinizing hormone, and FSH , follicle stimulating hormone] release, resulting in a transient increase in serum testosterone levels (flare up).’⁸² When long acting LHRH (and GnRH) analogues’ application is continued, they suppress ‘reversibly the pituitary-gonadal axis by a down regulation of the gonadotrophic cells. Secretion of LH and FSH is inhibited, testosterone and dihydrotestosterone drop to castration levels.’⁸³

GnRH and LHRH agonists have been used in prostate cancer treatment because they are significantly effective to reduce the testosterone level and the reported side-effects of these agonists, particularly GnRH agonist, are less serious than other pharmacological interventions.⁸⁴ Thus, they are highly recommended as an alternative to MPA treatment.⁸⁵ In fact, according to Rösler and Witztum, although it is necessary that the beneficial effects and the side-effects of long acting GnRH analogues must be documented by more controlled studies, they are ‘currently the most effective and promising medications available to treat men with paraphilia, and have the fewest side-effects compared to any other antiandrogen in use.’⁸⁶

Concerning the use of LHRH agonist and the response of LH to LHRH in paedophiles, Gaffney and Berlin reported that there was an association between paedophilic disorder

⁸¹ Craissati (n 41) 151.

⁸² Thibaut and others (n 3) 628, 633.

⁸³ Hill and others (n 17) 412.

⁸⁴ P Michael Conn and William F Crowley, ‘Gonadotropin-Releasing Hormone and Its Analogues’ (1991) 324 *The New England Journal of Medicine* 93, 93-94, 99; Rösler and Witztum, ‘Pharmacotherapy’ (n 15) 43, 48-49.

⁸⁵ Scott and del Busto (n 30) 303. In addition, Thibaut and others argue that ‘MPA and CPA have shown inconsistent results in the treatment of sex offenders. Poor treatment compliance is a major concern with oral CPA. Because of a substantial number of side-effects, [...] there is a need for other effective treatment with fewer side-effects.’ On that account, it is supported that GnRH is more effective in the treatment of sex offenders with fewer side-effects. Thibaut and others (n 3) 633-35, 637, 641-45.

⁸⁶ Rösler and Witztum, ‘Pharmacotherapy’ (n 15) 49.

and a hormonal imbalance (hypothalamic-pituitary-gonadal dysfunction in paedophilic patients). When LHRH inhibitors were applied to paedophiles, those individuals responded with a considerable increase of LH (compared with non-paedophilies), and therefore LHRH inhibitors could be effective in controlling deviant sexual behaviours of paedophiles.⁸⁷ Saleh, Niel and Fishman also supported that leuprolide acetate (luteinizing hormone-releasing-hormone agonist) showed promise in terms of diminishing paraphilic symptoms in adult patient. They carried out a study on six young adult patients with paraphilia treated with leuproliden and found that there was a reduction in sexually deviant interests and urges following leuprolide treatment.⁸⁸

Thibaut and others treated 6 men with paraphilia with administering GnRH (triptorelin) for 7 years and noted that 5 of them stopped deviant sexual behaviours.⁸⁹ In an uncontrolled observational study, 30 men with severe long lasting paraphilia (25 with paedophilia) were treated with long acting GnRH analogue (monthly injections of 3.75 mg of triptorelin) in combination with supportive psychotherapy for 8-42 months. It was reported that continuous application of GnRH together with supportive psychotherapy was effective in reducing paraphilic activities, sexual desires, the frequency of masturbation, and inhibiting deviant sexual fantasies and urges. They became able to

⁸⁷ Gary R Gaffney and Fred S Berlin, 'Is there Hypothalamic-Pituitary-Gonadal Dysfunction in Paedophilia? A Pilot Study' (1984) 145 *British Journal of Psychiatry* 657. See also Jerald Bain and others, 'Sex Hormones in Paedophiles: I Baseline Values of Six Hormones, II The Gonadotropin Releasing Hormone Test' (1988) 1 *Sexual Abuse: A Journal of Research and Treatment* 443.

⁸⁸ Fabian M Saleh, Tracey Niel and Marc J Fishman, 'Treatment of Paraphilia in Young Adults with Leuprolide Acetate: A Preliminary Case Report Series' (2004) 49 *Journal of Forensic Science* 1343. For more study including positive results on using LHRH, see Richard B Krueger and Meg S Kaplan, 'Depot-Leuprolide Acetate for Treatment of Paraphilias: A Report of Twelve Cases' (2001) 30 *Archives of Sexual Behaviour* 409; Fabian M Saleh, 'A Hypersexual Paraphilic Patient Treated with Leuprolide Acetate: A Single Case Report' (2005) 31 *Journal of Sex and Marital Therapy* 433; Justine M Schober and others, 'Leuprolide Acetate Suppresses Pedophilic Urges and Arousability' (2005) 34 *Archives of Sexual Behavior* 691.

⁸⁹ Florence Thibaut, Bernard Cordier and Jean-Marc Kuhn, 'Effect of a Long-Lasting Gonadotrophin Hormone-Releasing Hormone Agonist in Six Cases of Severe Male Paraphilia' (1993) 87 *Acta Psychiatrica Scandinavica* 445. Also see, Florence Thibaut, Bernard Cordier and Jean-Marc Kuhn, 'Gonadotrophin Hormone Releasing Hormone Agonist in cases of Severe Paraphilia: A Lifetime Treatment?' (1996) 21 *Psychoneuroendocrinology* 411. It is worth stressing that there are three analogues of GnRH available which are 'Triptorelin', 'Leuprorelin' and 'Goserelin'. Among these three analogues, Triptorelin is the commonly used one in Europe for the reversible decrease in plasma testosterone to castration levels to reduce drive in sexual deviations. Thibaut and others (n 3) 633.

control their sexual behaviours and once the maximal effects were achieved, not a single sexual offence was committed during treatment. Regarding the hormone and testosterone levels, during treatment, there was a remarkable decrease in serum LH and testosterone concentrations which also remained low as long as GnRH was applied regularly. In men who discontinued treatment, the serum testosterone concentration returned to the base line within 8 weeks. Testicular volume decreased progressively during treatment and the reported side-effects were mainly erectile failure, hot flashes, and decrease in bone mineral density in a few men.⁹⁰ It was noted that the prevention of the decrease in bone mineral density could be possible by the administration of calcium and vitamin D, or bisphosphonates such as alendronate.⁹¹

In general, GnRH and LHRH agonists as well as CPA leads to a considerable decrease in sexual desires, erection, ejaculation and orgasm, however, it is noted that in CPA, these results may be dose related.⁹² It is also argued that GnRH agonists and LHRH inhibitors are more specific and complete in terms of suppressing testosterone synthesis and releasing with less side-effects than CPA.⁹³ Some reports concluded LHRH and GnRH agonists have proven effective and successful when other anti-libidinal agents have failed.⁹⁴ Thibaut and others support the treatment with GnRH over that with CPA on the grounds that GnRH agonist, in particular, triptorelin is more potent, has fewer side-effects and the compliance with it can be very high.⁹⁵ Czerny, Briken and Barner carried out a study to investigate the differences in efficacy of CPA and LHRH among 2,070 patients in 67 German forensic psychiatric institutions. They noted that some patients had

⁹⁰ See Rösler and Witztum, 'Treatment' (n 32).

⁹¹ Rösler and Witztum, 'Pharmacotherapy' (n 15) 49. For a proposal of protocols for the use of LHRH agonists in the treatment of paraphilias to avoid serious side-effects, see Hill and others (n 17).

⁹² Hill and others (n 17) 415.

⁹³ Peter J Fagan and others, 'Pedophilia' (2002) 288 *Journal of the American Medical Association* 2458; Michael H Miner and Eli Coleman, 'Advances in Sex Offender Treatment and Challenges for the Future' (2001) 13 *Journal of Psychology and Human Sexuality* 5.

⁹⁴ See AJ Cooper and Z Cernovsky, 'Comparison of Cyproterone Acetate (CPA) and Leuprolide Acetate (LHRH agonist) in a Chronic Pedophile: A Clinical Subject Study' (1994) 36 *Biological Psychiatry* 269.

⁹⁵ Thibaut, Cordier and Kuhn, 'Gonadotrophin Hormone' (n 89).

previously been treated CPA and received LHRH afterwards because CPA was not sufficient to reduce sexual aggressive impulsiveness. The results indicated that after the administration of LHRH, the intensity of sexual urges and the frequency of sexual fantasies were significantly decreased and patients who were treated with an LHRH agonist did not later received CPA. Moreover, patients treated with LHRH agonist showed few side-effects, including hot flashes and lethargy, whereas under CPA more side-effects were observed, such as weight gain, gynecomastia and thromboembolia. Also, while CPA is applied in oral doses of 100-600 mg, or doses of 400-700 mg weekly for intramuscular injection, LHRH is administered in long-acting monthly or 3-monthly injection forms and this can be an advantage for the use of LHRH considering compliance.⁹⁶

d. SSRIs

Serotonin is a neurotransmitter in the central nervous system which has impact impacts on brain functions such as 'autonomic function, motor activity, hormone secretion, cognition, and complex processes associated with affection, emotion [...]'.⁹⁷ SSRI, as a psychotropic drug, suppresses the reuptake of serotonin and increases the level of serotonin concentration in the synaptic cleft.⁹⁸ The most common SSRI drugs are fluoxetine (prototype), paroxetine, fluvoxamine, sertraline, citalopram, escitalopram.⁹⁹

These psychotropic drugs are primarily for the treatment of depression and anxiety disorders but it is also useful in some mild cases of paraphilias.¹⁰⁰ Since 1990s, SSRIs

⁹⁶ J P Czerny, P Briken and W Berner, 'Antihormonal treatment of Paraphilic Patients in German Forensic Psychiatric Clinics' (2002) 17 *European Psychiatry* 104. For similar results and arguments, see Machiel Polak and Henk Nijman, 'Pharmacological Treatment of Sexually Aggressive Forensic Psychiatric Patients' (2005) 11 *Psychology, Crime and Law* 457.

⁹⁷ Mingyan Zhou, Karen Engel and Joanne Wang, 'Evidence for Significant Contribution of a Newly Identified Monoamine Transporter (PMAT) to Serotonin Uptake in the Human Brain' (2007) 73 *Biochemical Pharmacology* 147, 147.

⁹⁸ Stan Bardal, Jason Waechter and Doug Martin, *Applied Pharmacology* (China: Saunders Elsevier 2011) 369.

⁹⁹ Ibid.

¹⁰⁰ See Bradford, 'The Neurobiology' (n 43).

have been used in the treatment of paraphilia and sexual impulsiveness,¹⁰¹ and the rationale for using SSRI is based on its inhibitory sexual effects and the similarities between obsessive-compulsive-behaviours and paedophilic behaviours.¹⁰² Hills and others suggest that in mild cases with strong deviant sexual desires and urges and any risk of sexual crimes, SSRI together with psychotherapy should be taken into consideration, 'if the paraphilia is less severe (no hands-on offences, fetishism, exhibitionism), and if the paraphilic patient shows additional symptoms such as anxiety, social phobia, depression, severe feelings of guilt, obsessions, and compulsions because these belong to the well-established target symptoms for SSRI treatment.'¹⁰³ It is noted that this psychotropic medication is well tolerated even on a long term basis because for some patients, its effectiveness in terms of reducing overall sexuality is almost the same with anti-hormonal medications with less severe side-effects. Thus, the use of SSRI as the first choice treatment of mild paedophilia is considered as justifiable when psychotherapy alone does not lead to the desired effects.¹⁰⁴

The possible mechanisms of action of this psychotropic drug are described as it inhibits sexual activities and decreases impulsiveness, obsessive-compulsive behaviours/characteristic, underlying depressive symptoms and testosterone serum levels (indirectly).¹⁰⁵ In a study observing the efficacy and effectiveness of nefazodone, a serotonin as well as not-adrenaline reuptake inhibitor, it is reported that SSRIs can effectively decrease sexual obsessions and compulsions with fewest side-effects on

¹⁰¹ Hill and others (n 17) 409.

¹⁰² Florence Thibaut, 'Pharmacological Treatment of Paraphilias' (2012) 49 *Israel Journal of Psychiatry Related Science* 297, 300.

¹⁰³ Hill and others (n 17) 416.

¹⁰⁴ Daniel Turner, Raphaela Basdekis-Jozsa and Peer Briken, 'Prescription of Testosterone-Lowering Medications for Sex Offender treatment in German Forensic Psychiatric Institutions' (2013) 10 *Journal of Sexual Medicine* 570, 574. Turner, Basdekis-Jozsa and Briken recommend that while SSRIs together with psychotherapy are effective in patients with mild paraphilias, anti-libidinal medications in combination with psychotherapy are effective in patients with severe paraphilias and/or sexual deviant fantasies/behaviour and with a high risk of recidivism with sexual crimes. *Ibid.*

¹⁰⁵ Hill and others (n 17) 409.

sexual urges and arousal,¹⁰⁶ and thus ‘it is unlikely that this effect is due only to the general inhibitory effect of this drug.’¹⁰⁷ Other positive impacts of these psychotropic medications involve a diminishing of low self-esteem and vulnerability and a decrease in irritability, anxiety and depression.¹⁰⁸ SSRIs are mostly used in the USA and Canada for the treatment of sex offenders.¹⁰⁹ Also, given the serotonergic agents used and reported, ‘fluoxetine and sertraline have received the most attention and appear effective in case reports and open clinical trials of out-patients with paraphilic-related disorders and paraphilic disorders.’¹¹⁰

The first improvement of paraphilic symptoms is usually apparent after 2 to 4 weeks (maximum after 2 or 3 months) of SSRI treatment and it can be prescribed in the usual dosages for depressive disorders. It is noted that smaller doses of SSRIs can be sufficient to decrease paraphilic symptoms.¹¹¹ However, it can be necessary to increase the dose to individuals with obsessive-compulsive disorder in case of insufficiency or lack of efficacy of usual dosage.¹¹² The side-effects of SSRIs are rare and only a few are highly serious, including hyperthermia, muscle rigidity, myoclonus and rapid fluctuations in mental status, such as confusion, irritability or extreme agitation. The other non-serious ones involve sexual dysfunction (inhibition of sexual function and arousal), gastrointestinal distress, agitation and insomnia¹¹³

Many studies have indicated that SSRIs are considerably effective in reducing sexual desires, activities, fantasies, the frequency of masturbation, sexual deviant behaviours of paraphilics and also in treating individuals with obsessive-compulsive sexual

¹⁰⁶ Eli Coleman and others, ‘Nefazodone and the Treatment of Nonparaphilic Compulsive Sexual Behavior: A Retrospective Study’ (2000) 61 *The Journal of clinical Psychiatry* 282, 282-83.

¹⁰⁷ Hill and others (n 17) 409.

¹⁰⁸ Martin P Kafka, ‘The Role of Medications in the Treatment of Paraphilia-Related Disorders’ (2001) 16 *Sexual and Relationship Therapy* 105, 107.

¹⁰⁹ Turner, Basdekis-Jozsa and Briken (104) 575.

¹¹⁰ Kafka (n 108) 107.

¹¹¹ Hill and others (n 17) 411.

¹¹² Thibaut and others (n 3) 645.

¹¹³ Bardal, Waechter and Martin (n 98) 370.

deviances.¹¹⁴ In an open, uncontrolled, retrospective study, 16 patients with different paraphilias and comorbid psychiatric disorders were treated with SSRIs in combination with supportive or more intensive psychotherapy (mean treatment duration 23 months, range 2 to 78). It was reported that there was a remarkable decrease in paraphilic fantasies and the frequency of masturbation and the patients' overall treatment satisfaction was high even if there were high rates of sexual dysfunction as side-effects.¹¹⁵ A systematic review of the available evidence on effectiveness of using SSRIs in the treatment of sex offenders was conducted by Adi and others, Commissioned by the Health Technology Assessment Program at Birmingham University, UK. With the use of psychometric tests, it was reported that the improvements were statistically remarkable except one study, which involved 13 patients and only 3 patients experienced positive change. Also, while subjects were on either fluoxetine or sertraline, they indicated a level of improvement.¹¹⁶ However, it has been criticised that some of the studies on the effects of SSRIs in paraphilic patients relied on small samples, short follow-up periods and they were not double-blind or placebo controlled.¹¹⁷ Rösler and Witzum recommend that more randomized studies (carefully designed double-blind studies with a large number of subjects) are necessary in order not to overestimate the effects of SSRIs on paraphilia.¹¹⁸

1.1.2. The Algorithm for Pharmacotherapy Treatment

Regarding the integration of different and partially preliminary findings on medications into the practical guidelines for pharmacological treatment, there have been several attempts to formulate and conceptualise a treatment algorithm for paedophilic disorder.

¹¹⁴ See Peer Briken, Andreas Hill and Wolfgang Berner (n 24); C Kraus and others, 'Selective Serotonin Reuptake Inhibitors (SSRI) in the Treatment of Paraphilia: A Retrospective Study' (2007) 75 *Fortschritte der Neurologie Psychiatrie* 351 (in German); Nancy C Raymond, Joe E Grant and Eli Coleman, 'Augmentation with Naltrexone to Treat Compulsive Sexual Behaviour: A Case Series' (2010) 22 *Annals of Clinical Psychiatry* 56.

¹¹⁵ Hill and others (n 17) 410.

¹¹⁶ Adi and others (n 46).

¹¹⁷ Hill and others (n 17) 409.

¹¹⁸ Rösler and Witzum, 'Pharmacotherapy' (15) 53.

Considering the different types of medications available and within each type the variety of drugs which can be used, a hierarchical order of medication is suggested for an effective treatment of sexually deviant behaviours to identify the best type of medication for individuals with paedophilic disorder and the duration and severity of treatment. Since not every sex offender is an appropriate candidate for pharmacotherapy, even if this treatment has the advantage of being reversible once stopped, this hierarchical order of medication is of the essence to facilitate the diagnostic process, to provide a reasonable starting place for the treatment of paedophilic disorder, to help clinicians select appropriate and effective pharmacological interventions and to establish the treatment requirements. It is also essential to address the human rights discussions over the use of pharmacotherapy for PSOs with respect to medical necessity, appropriateness of treatment and suitability of offenders for pharmacotherapy. This hierarchy of medication can be seen in Table 1.¹¹⁹

¹¹⁹ Hill and others (n 17) 417.

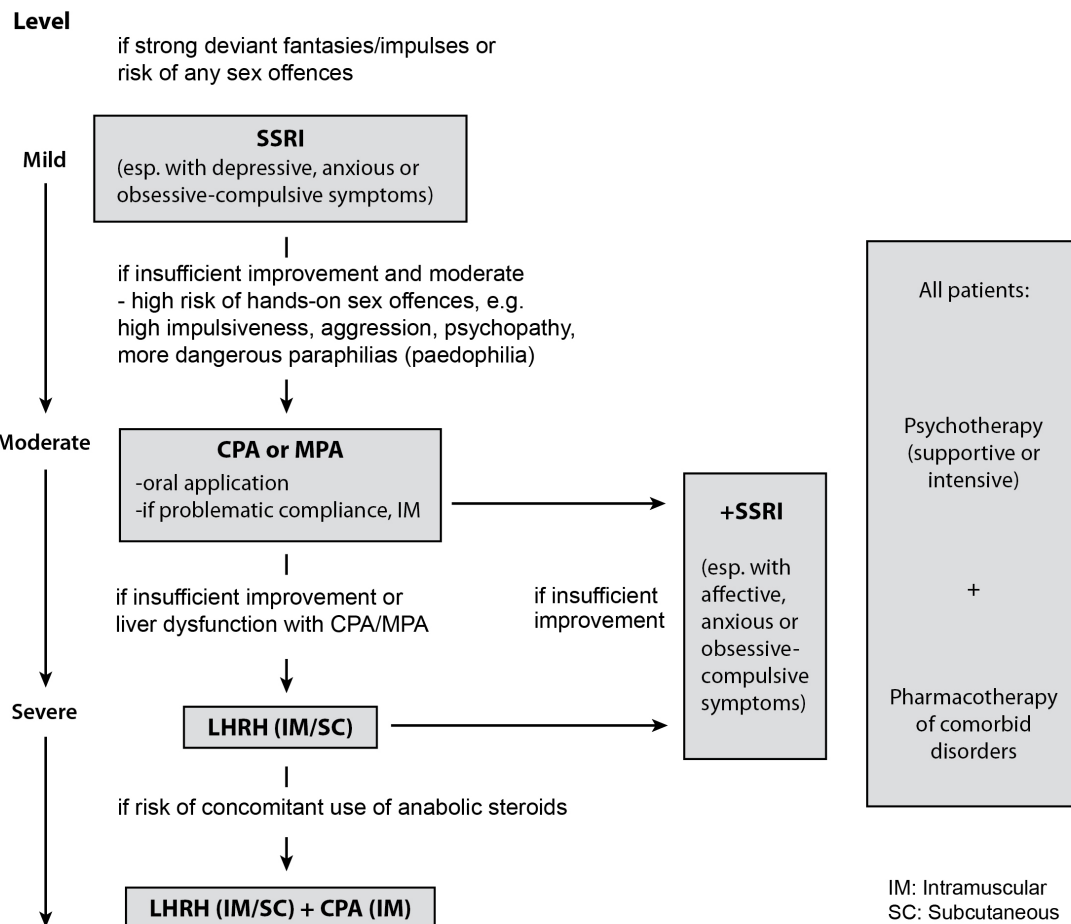


Table 1: Algorithm for Pharmacotherapy Treatment of Sexually Deviant Behaviours

Also, in conformity with this algorithm for pharmacotherapy, Bradford introduced a scheme with a six-level treatment structure concerning the severity and criminological risk factors of paraphilia¹²⁰ which starts with exclusive cognitive-behavioural treatment and relapse prevention programmes, Level One. At Level Two, pharmacological treatment starts with SSRIs and, if the SSRIs are not effective in 4 to 6 weeks, at Level Three, a low dose of CPA or MPA will be added to treatment. Then progressing to strong reduction of testosterone level by oral application of CPA or MPA at Level Four, and intramuscular application of CPA or MPA at Level Five. At Level Six, a complete reduction of testosterone to castration level is carried out by giving CPA intramuscularly

¹²⁰ Thibaut and others (n 3) 646.

or providing LHRH agonist.¹²¹ Similar to this scheme, Hill and others have also formulated an algorithm for pharmacotherapy of paedophiles by integrating levels of severity and comorbid conditions, within a comprehensive treatment plan, in which psychotherapy and pharmacotherapy for comorbid disorders are applied to all subjects. According to them, a treatment programme for paedophiles should start with psychotherapy and pharmacological treatment of comorbid disorders. In the case of strong deviant fantasies and any risk of sexual crimes, SSRIs treatment should be considered in combination with psychotherapy because these psychotropic medications are well-tolerated even on a long term basis, do not cause a complete loss of sexuality as much as anti-hormonal medications and have been proved effective with less severe side-effects. If SSRIs are not sufficient and if there is a moderate to high risk of sexual crimes, CPA (or MPA) should be applied. Since side-effects of these anti-hormonal medications are dose related, individuals should be monitored carefully to minimise these negative effects. If there is a case with unreliable compliance in medication, CPA (or MPA) should be applied intramuscularly. Although there is a relatively small database and short clinical experience with LHRH agonists in paedophiles, it seems that these agonists can be an effective alternative especially when CPA and SSRIs failed or CPA caused serious side-effects. The combination of anti-hormonal medication with an SSRI should be considered for paedophiles with insufficient improvement under anti-hormonal agents or a LHRH agonist alone. If there is a high risk of sexual crimes and a case with unreliable treatment compliance, a combination of LHRH agonists and CPA can be considered as an option. It is noted that LHRH agonists may lead to osteoporosis so the application of calcium and vitamin D or biphosphonates should be considered.¹²²

¹²¹ Bradford, 'The Neurobiology' (n 43) 30.

¹²² Hill and others (n 17) 417-18.

As is seen from the description above, there is a hierarchy of side-effects and also a suggested hierarchy in which the different types of drugs should be used in the treatment of paedophilia. These hierarchies have also importance while discussing the human rights implications of pharmacotherapy treatment for PSOs. However, it is worth noting that medical, legal and ethical issues resulting from the application of pharmacotherapy and the side-effects of medications will be considered in a later section of this chapter and in Chapter Four. At this point, the discussion will focus on the distinction between treatment and punishment forms of pharmacotherapy. While paedophilia may be limited to sexual fantasies, desires and impulses, paedophilic behaviours and acting on paedophilic interests are the primary concern of both mental health and criminal justice systems. However, due to the rehabilitative function of both punishment and treatment, which has been a predominant feature of the criminal justice system's response to offending,¹²³ and due to the procedural matters and, especially in certain instances, the common element that both punishment and involuntary treatment share, which is coercion, the line between punishment and treatment is blurred.¹²⁴ For this reason, before discussing the ethical and medical issues surrounding the use of pharmacotherapy with PSOs, the following part of this chapter will attempt to give a picture of the overlap between treatment and punishment and will provide information on how these two concepts can be distinguished from each other, especially, in the case of pharmacotherapy.

C. The Distinction between Treatment and Punishment

As far as the ambiguity between punishment and treatment is considered, this blurred line can cause concerns where the distinction between punishment and treatment is important, as is often the case for imprisoned offenders with mental illnesses or behavioural disorders. While punishment is described generally as a response to an

¹²³ Herbert L Packer, *The Limits of the Criminal Sanction* (Stanford University Press 1968) 26.

¹²⁴ Jacqueline Klein, 'A Theory of Punishment: The Use of Mechanical Restraints in Psychiatric Care' (2012) 21 *Southern California Review of Law and Social Justice* 47, 64.

offender's 'socially inappropriate behavio[u]r'¹²⁵ which breaks the legal rules, medical treatment for offenders, especially for a condition that underlies or encourages their criminal behaviours, derives from the idea of altering his thoughts, feelings or behaviours by the use of surgery, drugs, and/or psychotherapy.¹²⁶ However, this description of medical treatment is not sufficient to distinguish it from punishment since rehabilitation has been considered as an important element/goal of criminal punishment where the aim is to alter the offender's behaviours and thoughts and to make him a better person for his reintegration into society by the use of counselling or drug treatment.

On this matter, Opton argues that the most essential elements of medical treatment are that it requires the 'request of a patient' (i.e. consent) and it has to be carried out for the benefit of him/her.¹²⁷ However, the 'request of a patient' criterion *per se* is not a distinctive feature or is certainly not applicable to all situations, such as in the case of unconscious patients, children or those who lack mental capacity. Since these patients are not able to make requests, any medical procedure imposed on them cannot necessarily be characterised as punishment. Moreover, even though the punitive approach is based on the assumption that the incapacitative effect of punishment keeps people away from committing crimes and this effect can be interpreted as a benefit for individuals, it cannot be regarded as treatment. For example, if a person is diagnosed with prostate cancer, depending on the stage and the severity of the disease, a vasectomy can be performed. In this case, vasectomy is for the patient's benefit and is done at his request.¹²⁸ On the other hand, if a medical procedure is in compliance with

¹²⁵ Ibid 56.

¹²⁶ Crow (n 12) 5, 7-8.

¹²⁷ Opton (n 13) 608.

¹²⁸ See Ronald K Ross, Annlia Paganini-Hill and Brian E Henderson, 'The Etiology of Prostate Cancer: What does the Epidemiology Suggest?' (1983) 4 The Prostate 333; Janet L Stanford and others, 'Vasectomy and Risk of Prostate Cancer' (1999) 8 Cancer Epidemiology, Biomarkers & Prevention 881.

domestic laws and is imposed by legal authority, such as a court order, in order to punish an offender who has committed a misdeed, this procedure cannot be named as medical treatment, in fact it is called punishment or a punitive/preventative measure,¹²⁹ such as the imposition of a vasectomy operation on an offender convicted of statutory rape as a means of punishment on the grounds of preventing future criminal acts, promoting general welfare and maintaining the order and safety of members of the public.¹³⁰ However, there might be some limited circumstances in which vasectomy can also be carried out in the absence of an individual's request (consent) for his best interests by a court order. For instance, in the case of *Re A*, the Court of Appeal refused the request of A's mother concerning the vasectomy operation of A, who lacked capacity to make decision, on the grounds that it was not in the best interest of him to undergo a vasectomy operation.¹³¹ However, it was held that vasectomy

could only be carried out if it was in the best interests of the patient. The concept of best interests related to the mentally incapacitated person and [was] not limited to best medical interests, but encompassed medical, emotional and all other welfare issues. On an application for approval of [vasectomy] operation, it was the judge, not the doctor, who made the decision that it was in the best interests of the patient that the operation be performed.¹³²

¹²⁹ Opton (n 13) 608-609.

¹³⁰ Although it is beyond the scope of this study to more fully review the use of vasectomy, it is worth pointing out that this medical procedure does not affect sexual drive or behaviour, it only prevents conception as a result of such criminal behaviour. However, the purpose of using vasectomy as punishment was to eliminate future genetically based problems and to prevent individuals who were more prone to commit crimes and manifestly unfit from continuing their kind. Miller (n 27) 178.

¹³¹ According to the Court of Appeal, there was evidence that A did not want to undergo the vasectomy operation even if he was not able to understand its implications. *Re A* [2000] 1 FLR 549, 554.

¹³² Ibid 549. Also, for more information about 'best interests' principle, see MCA 2005, c 9, pt 1, s 4.

It is worth noting that in the case of *Re A*, the Court did not merely consider whether the vasectomy operation was for the benefit of the person concerned. Rather the Court looked beyond the benefit of the operation and held that even if the vasectomy operation could have certain benefits for the person in question, it could only be performed in the absence of consent by a court order only if it is the best interest of the patient, meaning that when the current and future interests of the person are considered, the vasectomy operation should be the best course of action for him. From this point of view, Opton's determination is not sufficient or complete to make a clear distinction between treatment and punishment. A more complete description of treatment could be achieved by including the exceptional situations where it is not possible to obtain patient's consent. In this regard, it can be claimed that treatment requires the consent of the patient and must be performed for the patient's benefit, and in the absence of consent, it should fall into the possible exceptions to the consent requirement, which require specific justification(s) for the treatment to be applicable, such as lack of decision-making capacity or emergency situations where the wishes of the person concerned are not known and where the treatment is in the best interests of the person concerned.

From a different perspective, Ross argues that treatment, in substance, does not seek the imposition of either suffering or the expression of disapproval. Rather the main purpose is to make a desirable alteration in the state of the individuals' health. As an example of medical treatment, 'a person who feels criminal tendencies of some kind of welling up inside him reports to a clinic in order to have the appropriate pills prescribed for their removal.'¹³³ However, some treatment methods can also cause limitations on and/or interference with the patients' rights which can be regarded as experiencing suffering or

¹³³ Alf Ross, *On Guilt, Responsibility and Punishment* (University of California Press 1975) 38.

unpleasantness, which is very much the same with punishment. For this reason, the disapproval element is crucial for distinguishing punishment from treatment.¹³⁴

However, ‘disapproval’ can be a highly controversial term and not every expression of disapproval can be regarded within the context of punishment. Therefore, ‘condemnation’ is suggested as a more appropriate term for the distinction between treatment and punishment. According to Greenawalt, punishment consists of an unpleasant (or unwanted) consequence in conjunction with condemnation. An unpleasant consequence alone does not have a distinctive character because ‘[p]unishment involves designedly harmful consequences that most people would wish to avoid. Medical treatment and other forms of therapy may also be painful, but their unpleasantness is an unfortunate contingent fact; pleasing or painless substitutes, if available, would be preferred.’¹³⁵ In a similar vein, Packer argues that

[t]here is surely a difference between life imprisonment at hard labor inflicted on a convicted murderer, and the involuntary hospitalization of a person suffering from manic-depressive psychosis. [...] Thirty days in jail for disorderly conduct is much less unpleasant than a lifetime in the locked ward of a state mental hospital. [...] [Since] Punishment may be more painful than Treatment (as is usual), or it may be less painful; [...] the degree of painfulness involved does not constitute the difference.¹³⁶

According to him, the essential distinctive features between punishment and treatment are ‘the difference in justifying purposes’ and, in the case of punishment, ‘the nature of the relationship between the offending conduct [wrongdoing] and what we do to the

¹³⁴ Ibid.

¹³⁵ Kent Greenawalt, ‘Punishment’ (1983) 74 The Journal of Criminal Law and Criminology 343, 344.

¹³⁶ Packer (n 123) 25-26.

person who has engaged in it',¹³⁷ which, to some extent, implies condemnation. In this respect, he notes that punishment deals with the criminal behaviour of a person with the aim of preventing the recurrence of such behaviour and/or imposing what the criminal deserves, whereas treatment does not deal with the conduct, in fact, it concerns with the person and aims to enhance individuals' health and wellness. Punishment seeks the betterment of the person but 'as an intermediate mode of ensuring that certain conduct will not take place', not his/her health and well-being.¹³⁸ Packer's arguments indicate that one should not automatically come to the conclusion that treatment would be less painful than punishment or the offender would not be better off as a consequence of punishment. The distinction between treatment and punishment is essentially based on the aim(s) that lies behind the particular method, even if the means for the achievement of this particular method is the same. For instance, the essential aim of treatment is to help the person in question and, seemingly, it is not for the aim of doing anything about the criminal conduct. Although the criminal conduct of a mentally ill person might necessitate the imposition of treatment, the justification for its application relies on the fact that it will ameliorate the welfare of the person.¹³⁹

In a similar vein, Bayles points out three elements to differentiate punishment from treatment. Punishment is for the 'discrete item of behaviour', 'prevention of the occurrence of specified sorts of behaviour' and 'responsibility of the crime committed', whereas treatment focuses on the 'condition of status' and 'the alteration or change of a state', and any responsibility for the status is irrelevant.¹⁴⁰ Also, according to Smith and Meyer, the difference between punishment and treatment depends on 'whether the person or persons providing the "treatment" intend for it to be punishment, whether it is

¹³⁷ Ibid.

¹³⁸ Ibid 26-27.

¹³⁹ Ibid 25-26.

¹⁴⁰ Michael Bayles, 'Dismantling the Criminal Law System' in Wade L Robison (ed), *The Legal Essays of Michael Bayles* (Kluwer Law International 2002) 2-3.

directly related to the patient's misconduct, whether it is stigmatizing, how intrusive it is, how it is perceived by the patient, and whether the patient agrees to it.'¹⁴¹ However, in certain cases, it would not be plausible to attribute a role to the perception or to the agreement of the patient in making a distinction between treatment and punishment. For instance, lack of capacity or some psychiatric treatments with adverse side-effects might lead to confusion in the perception of the intervention. Therefore, taking subjective elements into consideration in distinguishing treatment from punishment could be misleading.

1. Pharmacotherapy: Treatment or Punishment?

Regarding the use of pharmacotherapy for PSOs, the aforementioned considerations such as the consent requirement, the underlying purpose and the infliction of pain, while important, are not sufficient to make a distinction between punishment and treatment concepts of pharmacotherapy. In both concepts, pharmacotherapy might alter the offenders' thoughts, interests, desires; the consent of a patient might not be needed for both concepts; or both concepts might inflict pain or unpleasantness on the offenders. However, the claim here is that the underlying reason for the application of pharmacotherapy and the justification(s) for its use can be pivotal to distinguish medical treatment from punishment, whether it is retributive, preventive, deterrent and/or incapacitative or the overall purpose is only to alleviate or to prevent deterioration in the condition of the person. In the case of medical intervention, the concepts of autonomy, consent and medical paternalism become an issue of concern due to the importance of the respect for individuals' autonomous decisions, free choices and self-determination. On that account, (informed) consent can be considered as an important element, albeit not a substantial one, to draw a distinction between treatment and punishment. As an

¹⁴¹ Steven R Smith and Robert G Meyer, *Law, Behaviour, and Mental Health: Policy and Practice* (New York University Press 1987) 627.

example, Beauchamp and Childress point out that ‘prisoners and mentally retarded individuals often have diminished autonomy. [However] [m]ental incapacitation limits the autonomy of the retarded person [called internal constraint], whereas coercive institutionalization constrains the autonomy of prisoners [external constraint].’¹⁴² Although both constraints might give rise to an interference with the autonomous decision-making process of individuals, external constraint mainly raises concerns over the validity of consent. In the case of internal constraints, the person’s ability to make a decision, in particular the match between the person’s ability and the particular decision that he confronts, is in question and thus, an intervention in medicine can be justified on the ground that the person concerned is incapable of expressing consent and making a decision.¹⁴³ In this respect, the valid, free and informed consent argument, to some extent, can clarify the concerns over the concept of pharmacotherapy, arguing that if pharmacotherapy is used for the treatment of paedophilia, consent is an essential element and must be obtained and if not, then the imposition of pharmacotherapy must be justified on the basis of medical considerations. In such a case, internal constraints on decision-making ability, such as paedophilic disorder, could be the justification for not seeking consent and the justification for the imposition of pharmacotherapy in the absence of consent could be the best interests of the person concerned. On the other hand, if pharmacotherapy is imposed as punishment, consent might no longer be an issue of concern because the justification of punishment does not depend on the approval of the offenders.¹⁴⁴ As Packer puts it, punishment is for either the prevention of the recurrence of the criminal behaviour or the infliction of suffering which it is believed is deserved for past transgression, or both, and thus, the punishment concept of

¹⁴² Tom L Beauchamp and James F Childress, *Principles of Biomedical Ethics* (6th edn, Oxford University Press 2009) 58.

¹⁴³ Other exceptions to the informed consent requirement and those will be assessed later in part four.

¹⁴⁴ The justification of punishment will be assessed in detail in Chapter Three.

pharmacotherapy does not require the obtainment of consent or additional justification for the lack of consent.

One may argue that using pharmacotherapy for PSOs is not for the good (best interest) of the offenders but for public protection and thus, its imposition could not be carried out in the absence of the offenders' consent by a court order as treatment. However, as discussed in Chapter One, a person with paedophilic disorder might feel personal distress about his paedophilic interests and significant impairment in many important areas of life and/or engage in sexual behaviours with children. In this respect, given that the sexual attraction to children is not in the best interests of individuals with paedophilic disorder, as will be discussed in the following section, the use of pharmacotherapy, to a certain extent, can serve the good of not only society but also the offenders including their medical, emotional and some other welfare issues by relieving the symptoms of paedophilic disorder, increasing their future autonomy, helping them be more autonomous and law-abiding individuals and decreasing their probability to commit a crime (acting on his paedophilic urges) and likelihood to end up in prison. In addition, in Chapter Four, the argument will be that there can be a medical necessity for the imposition of pharmacotherapy on PSOs because the use of pharmacotherapy is directed to offenders' underlying condition by treating and/or alleviating their psychiatric condition and, as a protective sexological treatment, it can protect offenders from acting on their paedophilic urges, promote their well-being and safety, and significantly improve their life.

Pharmacotherapy has been used as treatment for paedophiles in several countries.¹⁴⁵ In the case of PSOs, however, it should be clarified whether the intention behind pharmacotherapy is to treat them or to impose additional punishment. For instance, the

¹⁴⁵ See Rösler and Witztum, 'Pharmacotherapy' (n 15); Briken and Kafka (n 20); Frederico D Garcia and Florence Thibaut, 'Current Concepts in the Pharmacotherapy of Paraphilias' (2011) 71 *Drugs* 771.

court's imposition of pharmacotherapy is not a determinant/distinctive feature because the court can issue an order requiring the offender to undergo such practice either as a method of treatment or punishment. Whereas the procedures that are being pursued to apply pharmacotherapy and the intentions of those applying it can be useful to make a distinction between treatment and punishment forms of pharmacotherapy. In this respect, if pharmacotherapy is for the discrete item of conduct, not for a condition that underlies the criminal behaviour, and its imposition is intended to make the offender suffer the consequences of his behaviour, pharmacotherapy will be regarded as punishment. But quelling paedophilic offenders' sex drives and helping them to control their compulsive sexual urges with using pharmacotherapy will be regarded as treatment, if the objective behind its application is simply the alleviation/treatment of those individuals' ailments and the improvement of their lives quality.

Since this chapter is devoted to the treatment aspect of pharmacotherapy and its punishment aspect will be discussed in Chapter Three more thoroughly, the discussion will move on to consider the legal and ethical principles of medical practice, in particular, the informed consent principle and its justification and the concerns over the use of pharmacotherapy in treating PSOs.

D. Ethical and Medical Issues in the Use of Pharmacotherapy in Treating PSOs

1. The Importance of Autonomy and Integrity in Medical Ethics

With respect to the etymology of autonomy, *autos* (self) and *numos* (rule or law) was first used in the Greek city-state in order to provide the citizens with independency whilst making their own regulation, not to be under the influence or control of any ruling power or authority.¹⁴⁶ Within the moral context, Rhodes and Strain argue that autonomy is related to three concepts.

¹⁴⁶ Dworkin, *The Theory* (n 4) 12-13.

(1) [A]utonomy is a self-regulating ideal that instructs one to be a good ruler over oneself and to abide by the conclusions of one's own reasoning. [...] (2) [It] tells us how we should treat others who are autonomous; we should "respect their autonomy." [...] (3) For those who are not currently autonomous but who may become autonomous in the future or be restored to autonomy, we should promote or restore their autonomy. [...] We should sometimes paternalistically interfere with nonautonomous others acting on their own preferences and do so for their own good, even when we can expect them not to welcome the interference.¹⁴⁷

In the medical realm, autonomy plays a pivotal role in the decision-making process because '[t]he autonomous person is self-governing; she lives her life according to a self-chosen or self-ratified plan. [...] We might identify the idea of an autonomous life with the idea of a life that is voluntarily chosen.'¹⁴⁸ For instance, in the case of *Chester v Afshar* (hereinafter *Chester*), Lord Steyn noted that 'every individual of adult years and sound mind has a right to decide what may or may not be done with his or her body. Individuals have a right to make important medical decisions affecting their lives for themselves.'¹⁴⁹ Also, as stated by the Ontario Court of Appeal in the case of *Malette v Shulman* '[t]he right to determine what shall be done with one's own body is a fundamental right in our society. The concepts inherent in this right are the bedrock

¹⁴⁷ Rosamond Rhodes and James J Strain, 'Affective Forecasting and Its Implications for Medical Ethics' (2008) 17 Cambridge Quarterly Healthcare Ethics 54, 58-59.

¹⁴⁸ Richard Arneson, 'Autonomy and Preference Formation' in Jules Coleman and Allen Buchanan (eds), *In Harm's Way: Essays in Honor of Joel Feinberg* (Cambridge University Press 1991) 47.

¹⁴⁹ [2004] UKHL 41 [14] (Lord Steyn).

upon which the principles of self-determination and individual autonomy are based.’¹⁵⁰

In this respect, personal autonomy is, on the whole, self-determination or self-rule that is ‘freedom to develop one’s self—to increase one’s knowledge, improve one’s skills, and achieve responsibility for one’s conduct [...] [and] to lead one’s own life, to choose among alternative courses of action so long as no injury to others results’ which constitutes the positive concept of autonomy.¹⁵¹ Also, it is, at minimum, ‘free[dom] from both controlling interference by others and from limitations’; an autonomous individual is free to act according to a self-chosen plan.¹⁵²

Rawls stresses that ‘acting autonomously is acting from principles that we would consent to as free and equal rational beings’,¹⁵³ and this brings along a closely related interest in health care which is integrity. Integrity essentially refers to self-determination in terms of what will be done with an individual’s physical body,¹⁵⁴ and, as is the case with autonomy, it has two components: mental and bodily integrity. Mental integrity is characterised as freedom from ‘an intrusion upon the mind that would be offensive even if it could be accomplished in the absence of any physical contact at all.’¹⁵⁵ Bodily integrity refers to ‘freedom from invasion upon the material substance of the person’.¹⁵⁶ On that account, informed consent to medical treatment takes its foundation from both individual autonomy and personal integrity.¹⁵⁷ The importance of consent is also stressed by the ECtHR by referring to personal autonomy and integrity, and it is noted that

¹⁵⁰ *Malette v Shulman et al.* [1991] 2 Medical Law Review 162, 166. This statement has also been approved by the UK courts, see *Re T* [1992] EWCA Civ 18 [39].

¹⁵¹ Thomas Szasz, *The Ethics of Psychoanalysis: The Theory and Method of Autonomous Psychotherapy* (New York: Syracuse University Press 1988) 22.

¹⁵² Beauchamp and Childress (n 142) 58.

¹⁵³ John Rawls, *A Theory of Justice* (Cambridge: Harvard University Press 1971) 516.

¹⁵⁴ James Bopp and Richard E Coleson, ‘A Critique of Family Members as Proxy Decisionmakers without Legal Limits’ (1996) 12 Issue in Law and Medicine 133, 135.

¹⁵⁵ Stephan Beyer, ‘Comment, Madness and Medicine: The Forcible Administration of Psychotropic Drugs’ 1980 Wisconsin Law Review 497, 505.

¹⁵⁶ *Ibid* 520.

¹⁵⁷ A note on terminology, I henceforth use the term integrity to refer both mental and bodily integrity.

[t]he very essence of the Convention is respect for human dignity and human freedom and the notions of self-determination and personal autonomy are important principles underlying the interpretation of its guarantees. [...] In the sphere of medical assistance, [...] the imposition of medical treatment without the consent of a mentally competent adult patient would interfere with his or her right to physical integrity [...].¹⁵⁸

In this respect, due to the ‘irremediably subjective character of the [decision-making] process [...]’,¹⁵⁹ individuals should have the power to make their own decisions independent of its rationality. Because individuals are in a better position to decide what is good for them and ‘the policy of respecting individual autonomy, even though it might in some instances produce unwise choices, is most likely to promote the individual’s best interests and achieve the individual’s highest potential.’¹⁶⁰ A medical treatment can be called ‘intrusive’ when the patient is not considered as a participant rather s/he is considered as a ‘passive recipient of procedures and substances’ and his thoughts, personality and behaviours are subject to some essential alterations. Since anti-androgenic medications lead to physical and mental changes, including thoughts, desires, urges and behaviours, it is clearly intrusive if the medical expert is not taking the decision of the patient into consideration and ‘not working with the patient but is working on the patient.’¹⁶¹

¹⁵⁸ *Jehovah’s Witnesses of Moscow and others v Russia* App no 302/02 (ECtHR, 10 June 2010) para 135.

¹⁵⁹ Stephan Beyer (n 155) 521.

¹⁶⁰ Bruce J Winick, ‘On Autonomy: Legal and Psychological Perspectives’ 37 Villanova Law Review 1705, 1714. Regarding the rationality of the decision and the right to make autonomous decisions, see Immanuel Kant, *Foundations of the Metaphysics of Morals* (Lewis White Beck tr, Indianapolis: Bobbs-Merrill 1959) 59-67.

¹⁶¹ Stephan Beyer (n 155) 534.

Given the importance of integrity that individuals have freedom from both mental and physical governmental intrusion and of autonomy that individuals have freedom to function independently without being controlled by others and have their own self-governance, all medical interventions must respect the values, preferences and convictions of patients, of course in the absence of overriding grounds of justification. On that account, consent is requisite for the enhancement of decision-making, the assurance of self-determination, the preservation of self-governance and the protection of freedom from external forces. Since pharmacotherapy involves hormone-suppressing medications and is an ever-changing and evolving treatment method, individuals ought to be informed about the benefits, side-effects, consequences, alternatives and risks of it in order to make a clear decision about the treatment and their situation and to provide consent. Therefore, the following section will give a detailed analysis of the requirements for informed consent for pharmacotherapy.

1.1. Autonomy, Consent and Voluntary Pharmacotherapy for PSOs

1.1.1. Informed Consent

When a medical intervention is being performed and the involvement of patients in the medical decision-making process is possible, the obtainment of informed consent becomes a process that is necessary to be carried out. Although the doctrine of informed consent is a ‘creature of law’, the moral and legal contexts concerning this doctrine are not ‘sharply separated’.¹⁶² For this reason, in this part, the informed consent doctrine will be considered, essentially, within the context of philosophical discussions, but the practical contexts of informed consent will also be included.

According to Dworkin, ‘informed consent is justified in terms of privacy, self-determination, loyalty, autonomy, freedom, integrity, dignity and benefits.’¹⁶³ Thus, the

¹⁶² Dworkin, *The Theory* (n 4) 101.

¹⁶³ *Ibid* 103.

disclosure of information and the competent adult patient's agreement are the essential components of *informed consent* because it makes an 'individual to be his own master [...] to depend on [himself], not on external forces of whatever kind [...] to be the instrument of [his] own [...].'¹⁶⁴ In this respect, when all the different perspectives are considered, including legal, ethical and medical principles, as a unified whole, informed consent can be defined as;

legal rules that prescribe behavior[s] for physicians and other healthcare professionals in their interactions with patients and provide for penalties, under given circumstances, if physicians deviate from those expectations; to an ethical doctrine, rooted in our society's cherished value of autonomy, that promotes patients' right of self-determination regarding medical treatment; and to an interpersonal process whereby these parties interact with each other to select and appropriate course of medical care.¹⁶⁵

Faden and Beauchamp suggest that the concept of informed consent is formed by the patients' choice among their options instead of leaving patients no choice but to accept a medical professional's proposal. According to them, (1) a patient should accept a medical treatment based on the comprehension of all essential and relevant information over the treatment, (2) his/her consent should not be under the influence of any external factors which could affect the decision-making process, and (3) the consent should include the permission of the patient and it must be intentional for the purpose of the medical intervention.¹⁶⁶ Simply, a free and informed consent should include three

¹⁶⁴ Isaiah Berlin, *Four Essays on Liberty* (Oxford: The Clarendon Press 1969) 131.

¹⁶⁵ Jessica W Berg and others, *Informed Consent, Legal Theory and Clinical Practice* (2nd edn, New York: Oxford University Press 2001) 3.

¹⁶⁶ Faden and Beauchamp (n 9) 54.

conditions: understanding, intentionality, and voluntariness.¹⁶⁷ As is seen from the imputed content and meaning of informed consent, this concept must be for the improvement of the patient's condition by making him/her well-informed before undergoing a medical intervention or entering the decision-making process.¹⁶⁸

Within the legal context, in the UK, the rule of informed consent has substantial foundations in the case-law. In *Airedale NHS Trust v Bland*, which was about the discontinuation of life-sustaining treatment, the House of Lords referred to the importance of self-determination in health care decisions and Lord Goff of Chieveley noted that

the principle of self-determination requires that respect must be given to the wishes of the patient, so that if an adult patient of sound mind refuses, however unreasonably, to consent to treatment or care by which his life would or might be prolonged, the doctors responsible for his care must give effect to his wishes, even though they do not consider it to be in his best interests to do so. To this extent, the principle of the sanctity of human life must yield to the principle of self-determination [...].¹⁶⁹

The Strasbourg Court also holds that full and informed consent requires a full understanding of the 'nature and consequences of the procedure.'¹⁷⁰ It should be ensured that individuals receive all the necessary information which facilitates their

¹⁶⁷ Ibid 241-269.

¹⁶⁸ Katz argues that all the 'risks and benefits as well as available alternatives' of a particular medical intervention must be communicated to the patients and to put them in a situation to make a decision whether they give consent or not. Jay Katz, *The Silent World of Doctor and Patient: With a New Foreword by Alexander Morgan Capron* (The Johns Hopkins University Press 2002) 49-50. According to Annas and Densberger, the information, which can be influential in the patients' decision-making process, has to be given to the patient. George J Annas and Joan E Densberger, 'Competence to Refuse Medical Treatment: Autonomy vs. Paternalism' 15 University of Toledo Law Review 561, 568.

¹⁶⁹ [1993] 1 FLR 1026, 1036.

¹⁷⁰ *VC v Slovakia* App no 18968/07 (ECtHR, 08 November 2011) para 38.

decision-making process and enables them to give informed consent to treatment or refuse it.¹⁷¹ Moreover, in *RR v Poland*, the Court implicitly refers to the notion of informed consent by linking it to individual autonomy and notes that the effective exercise of the right to access to information about one's own health 'is often decisive for the possibility of exercising personal autonomy, [...] by deciding, on the basis of such information, on the future course of events relevant for the individual's quality of life (e.g. by refusing consent to medical treatment or by requesting a given form of treatment).'¹⁷²

1.1.2. The Amount of Information Disclosed to Patient

As a general rule, Article 5 of the Convention on Human Rights and Biomedicine,¹⁷³ which is an international treaty drafted by the Council of Europe focused on bioethics, requires that for the obtainment of free and informed consent, the person 'shall beforehand be given appropriate information as to the purpose and nature of the intervention as well as on its consequences and risks.' Regarding the amount of information provided to patients to obtain a valid informed consent,¹⁷⁴ in *Re T*, the court laid emphasis on obtaining consent from an adult who was mentally and physically capable of exercising this requirement and noted that patients must be given appropriately full information regarding the nature and the likely risks of treatment proposed.¹⁷⁵

¹⁷¹ Ibid para 54.

¹⁷² App no 27617/04 (ECtHR, 26 May 2011) para 197.

¹⁷³ The Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine, CETS No. 164 (Oviedo, opened for signature 4 April 1997, entered into force 1 December 1999).

¹⁷⁴ In *Blyth v Bloomsbury Health Authority*, a woman patient was prescribed the injection of Depo-Provera and suffered severe side-effects of this hormonal contraceptive treatment. The appeal court held that the amount of information disclosed to the patient should depend on 'the circumstances, the nature of the inquiry, the nature of the information which is available, its reliability, relevance, the condition of the patient and so forth.' However, the general viewpoint of the appeal court in this particular case was not adopted in later decisions of English Courts. *Blyth v Bloomsbury Health Authority HA* [1993] 4 Med LR 151 (CA) (decided 1987).

¹⁷⁵ *Re T* (n 150) [5], [35]. See also General Medical Council, 'Good Medical Practice Explanatory Guidance, Consent: Patients and Doctors Making Decisions Together' (2 June 2008)

More specifically, in *Sidaway v Bethlem Royal Hospital Governors* (hereinafter, *Sidaway*),¹⁷⁶ the plaintiff claimed that although she consented to the operation, she had not been informed about all the possible risks inherent in the operation performed, where there was an inherent small 2% risk of spinal cord injury. The House of Lords upheld the Court of Appeal judgement that it was not necessary to inform the patient about every risk (only sufficient information for the patients to reach a balanced judgement such as to what extent a procedure is necessary, what the alternatives and the common or serious consequences of the procedure are) because consent did not require a detailed disclosure of remote side-effects. However, Lord Scarman dissented from this decision and considered the case with respect to ‘material information’.¹⁷⁷ Referring to the ‘prudent patient’ test and the ‘medical factors’, in particular, ‘the degree of probability of the risk materialising’, ‘the seriousness of possible injury’ and ‘the character of the risk’, he argued that

English law must recognise a duty of the doctor to warn his patient of risk inherent in the treatment which he is proposing: [...]. The critical limitation is that the duty is confined to material risk. The test of materiality is whether in the circumstances of the particular case the court is satisfied that a reasonable person in the patient’s position would be likely to attach significance to the risk. Even if the risk be material, the doctor will not be

<http://www.gmc-uk.org/GMC_Consent_0513_Revised.pdf_52115235.pdf> accessed 3 April 2014.

¹⁷⁶ [1985] 1 All ER 643 (HL). Also, see Alasdair Maclean, ‘From Sidaway to Pearce and Beyond: Is the Legal Regulation of Consent Any Better Following a Quarter of a Century of Judicial Scrutiny?’ (2012) 20 Medical Law Review 108.

¹⁷⁷ *Sidaway* (n 176) (Lord Scarman). More information on the materiality of risk, see José Miola, ‘On the Materiality of Risk: Paper Tigers and Panaceas’ (2009) 17 Medical Law Review 76.

liable if upon a reasonable assessment of his patient's condition he takes the view that a warning would be detrimental to his patient's health.¹⁷⁸

Since the approach adopted in *Sidaway* is now outdated, the Court of Appeal decision on *Pearce v United Bristol Healthcare NHS Trust* (hereinafter, *Pearce*), which is about the extent/level of risk imparted to the patient and the application of the 'Bolam test'¹⁷⁹, is important to frame the amount of information for informed consent.¹⁸⁰ In *Pearce*, the plaintiff alleged that if she had been informed about *all the possible risks* of her pregnancy, the treatment to be applied, the alternative methods and complications, she would have taken the course which posed the least amount of risk to her and to the baby. However, the medical expert did not provide the patient with the information regarding all possible risks and the patient 'has been deprived of the opportunity to make a proper decision about what course [...] she should take in relation to treatment [...].'¹⁸¹ Referring to *Sidaway*, in particular to Lord's Bridge's approach regarding the need to warn of 'significant risks', Lord Woolf MR noted that 'if there is a significant risk which would affect the judgement of a reasonable patient, then in the normal course it is the responsibility of a doctor to inform the patient of that significant risk [...] so that the patient can determine for him or herself to what course he or she should adopt.'¹⁸² In other words, given Lord Bridge's caveat in *Sidaway*, the disclosure of any 'significant

¹⁷⁸ *Sidaway* (n 176) (Lord Scarman).

¹⁷⁹ The Bolam test was first set out in the case of *Bolam v Friern HMC* and the court held that if a medical treatment was performed in accordance with a respected body of medical opinion, then the practitioner who performed the procedure fulfilled the required standard of care in law, meaning that the standard of care is a matter of medical judgement. *Bolam v Friern Barnet Hospital Management Committee* [1957] 1 WLR 582. Regarding the disclosure of risk in medical practice and the consent requirement, Bolam test was the starting point of this issue which was in favour of paternalistic approach in medical decision-making and prudent doctor-standard. However, this approach went through significant changes over the following decades.

¹⁸⁰ [1999] 48 BMLR 118.

¹⁸¹ *Ibid* [21].

¹⁸² *Ibid*. Also Lord Woolf MR stressed that 'the doctor, in determining what to tell a patient, has to take into account all the relevant consideration, which include the ability of the patient to comprehend what he has to say to him or her and the state of the patient at the particular time, both from the physical point of view and an emotional point of view.' *Ibid* [23].

risk' which will affect the evaluation and decision of a reasonable patient is 'obviously necessary'.¹⁸³ For this reason, 'where there is what can realistically be called a "significant risk", then, in the ordinary event [...] the patient is entitled to be informed of that risk.'¹⁸⁴ Whereas given the recommended course of action and the extent of risk, in the case of *Pearce*, the risk of stillbirth was very small like 0.1-0.2% as to make non-disclosure of this particular risk defensible. On this matter, Lord Woolf argued that '[e]ven looked at comprehensively [the risk] comes to something like 0.1 to 0.2 per cent. The doctors called on behalf of the defendant did not regard that risk as significant, nor do I.'¹⁸⁵ It appears from this decision that medical expert(s) judgement is important for the determination of the level of risk, whether a particular treatment poses a significant risk to the patients' health. If it is of the opinion that the medical intervention carries a significant risk to the patient which might affect the decision of a reasonable patient, the conflict between the doctor's desire to give proper medical care and duty to treat the patient and the patient's request or expressed healthcare preferences should be addressed by applying the reasonable/prudent patient standard.

Also, in *Chester*, the discussion was on whether the patient was duly informed about the procedure, including the 'small (1%-2%) but unavoidable risk that the proposed operation, however expertly performed, might lead to seriously adverse result [...]'.¹⁸⁶ The patient claimed that she was not informed about an unavoidable risk (1%-2%) that the surgery would have a considerably adverse result and if she had been warned, the treatment may not have taken place. On this matter, the majority recognised that '[...] medical paternalism no longer rules [...]'.¹⁸⁷ In particular, Lord Steyn noted that

¹⁸³ *Sidaway* (n 176) (Lord Bridge).

¹⁸⁴ *Pearce* (n 180) [23].

¹⁸⁵ *Ibid* [24].

¹⁸⁶ *Chester* (n 149) [5].

¹⁸⁷ *Ibid* [16] (Lord Steyn).

[a] surgeon owes a legal duty to a patient to warn him or her in general terms of possible serious risks involved in the procedure. [...] In modern law medical paternalism no longer rules and a patient has a prima facie right to be informed by a surgeon of a small, but well established, risk of serious injury as a result of a surgery.¹⁸⁸

The *Chester* decision indicates that it would be unjust for a patient if s/he suffered an injury as a result of a medical procedure in which the patient was not duly warned and the risks were not outlined including the foreseeable (1%-2%) but unavoidable ones. *Chester* is also important because the majority ignored the usual test for causation, which is the 'but for' test; Rather the emphasis was placed on the need to protect patient autonomy as a matter of policy even if doing so meant disregarding the usual rules of causation.¹⁸⁹ Although it would be inaccurate to assert that *Chester* completely addressed the issues concerning the patient's rights in the medical decision-making process, the patient right of autonomy and dignity has been more extensively recognised. In this respect, physician(s) are compelled to inform the patient about any possible significant adverse results of a proposed medical procedure, including a small but substantive risk of serious adverse outcomes.

1.1.3. Respecting Patient Autonomy and Capacity to Consent

The protection and the promotion of autonomy depends on the promotion of meaningful decision-making and the purpose of or justification for requiring informed consent to treatment is therefore to ensure that the meaningful decision-making is facilitated and

¹⁸⁸ Ibid.

¹⁸⁹ It is worth noting that despite the approach taken in *Chester*, the House of Lords reverted to the traditional principles, and in the case of *Gregg v Scott*, the normal strict rules of causation reappeared. In *Gregg v Scott*, the House of Lords denied the plaintiff claim because the plaintiff was not able to satisfy the traditional test of causation which shows that *Gregg v Scott* and *Chester* cases are irreconcilable in terms of respecting human rights, autonomy and dignity. See *Gregg v Scott* [2005] UKHL 2.

autonomous authorization is given by the patient.¹⁹⁰ As is noted by the ECtHR, medical treatment without the consent of a mentally competent adult patient or without respect to the patient's own needs and preferences would be incompatible with 'the requirement of respect for human freedom and dignity, one of the fundamental principles on which the Convention is based [...]'¹⁹¹ and with the promotion of autonomy of 'moral choice for patients.'¹⁹² In this respect, since the protection of autonomy and the enhancement of autonomous decisions are substantial justifications for the application of informed consent procedure and are viewed as so prominent, they must be respected regardless of their irrationality.¹⁹³ As an example, in *Re T*, it was quoted that the right to choose medical treatment 'is not limited to decisions which others might regard as sensible. It exists notwithstanding that the reasons for making the choice are rational, irrational, unknown or even non-existent.'¹⁹⁴ On that account, the irrationality of the decision should not be linked to the capacity of the person in question because under the doctrine of informed consent, the patient must be sufficiently informed to make a decision which is rational and meaningful for him/her, not for others.¹⁹⁵ Thus, individuals should be allowed to make autonomous choices for themselves without being coerced or interfered with.¹⁹⁶

However, the irrationality of the decision might lead to further inquiry concerning the capacity of the person in question and whether he is able to make a specific decision

¹⁹⁰ Helen Aveyard, 'The Requirement for Informed Consent Prior to Nursing Care Procedures' (2002) 37 *Journal of Advanced Nursing* 243, 245.

¹⁹¹ *VC v Slovakia* (no 170) para 107.

¹⁹² *Ibid* para 114.

¹⁹³ David John Harris, Michael O'Boyle and Colin Warbrick, *Law of the European Convention on Human Rights* (2nd edn, Oxford University Press 2009) 399. See also Elizabeth Wicks, 'The Right to Refuse Medical Treatment under the European Convention on Human Rights' (2001) 9 *Medical Law Review* 17.

¹⁹⁴ *Re T* (n 150) [3].

¹⁹⁵ In a similar vein, Wicks notes that '[i]f autonomy has a value that value is to be found in the choices available to the individual, not acting rationally. Many of our choices, both trivial and major, [might be] irrational; they are no less worthy of respect for this.' Elizabeth Wicks, *The Right to Life and Conflicting Interests* (Oxford University Press 2010) 181.

¹⁹⁶ James Wilson, 'Is Respect for Autonomy Defensible?' (2007) 33 *Journal of Medical Ethics* 353, 353.

about his medical condition at the time it needs to be made for himself. The MCA 2005, section 2(1) defines capacity with respect to the individuals' ability to make a decision about a particular issue, at a particular time. As provided by section 2(4) any lack of capacity claim must be showed *on the balance of probabilities*, that 'the individual lacks capacity to make a particular decision, at the time it needs to be made', to wit, 'being able to show that it is more likely than not that the person lacks capacity to make the decision in question.'¹⁹⁷ The MCA 2005, Section 2(3) states that the establishment of lack of capacity should not be made with regard to the age, appearance, condition or behaviour of the person in question. However, if any lack of capacity is claimed by reason of irrationality, which although this does not necessarily mean that a person lacks capacity, it is a factor to be taken into account when an assessment of capacity is being made, it should be showed on the balance of probabilities and the Act lays down a test of capacity for the determination of it which is a two-stage test of capacity.¹⁹⁸ In this respect, the test requires the assessment of two critical issues including (i) whether the person in question has 'an impairment of, or a disturbance in the functioning of, their mind or brain' and (ii) whether 'the impairment or disturbance mean[s] that the person is unable to make a specific decision when they need to' because the impairment or disturbance might render the person unable to understand the information relevant to the decision, to retain that information, to weight or to use that information as part of the decision-making process and to communicate the decision made.¹⁹⁹ The information relevant to a decision includes the particular nature of the decision concerned, the aim

¹⁹⁷ Department for Constitutional Affairs, *Mental Capacity Act 2005 Code of Practice, Issued by the Lord Chancellor on 23 April 2004 in accordance with sections 42 and 43 of the Act* (Crown Copyright 2007) 44.

¹⁹⁸ Ibid 40-63.

¹⁹⁹ Ibid 44-45. MCA 2005 (n 132) ss 2 and 3. For a criticism of the two-stage test for the assessment of capacity, see Catriona Mackenzie and Wendy Rogers, 'Autonomy, Vulnerability and Capacity: A Philosophical Appraisal of the Mental Capacity Act' (2013) 9 *International Journal of Law in Context* 37.

for which the decision is necessary, and the potential consequences of making or not making the decision.²⁰⁰

The argument concerning PSOs could be that paedophilic disorder may lead to impairment in having normal social relationship and affectionate sexual relationship. Even if some offenders enjoy offending in the sense of enjoying participating in behaviours or conduct that the law has criminalised, know full well what they are doing and do not want to receive pharmacotherapy treatment, this could be resulting from their psychiatric condition. On that account, if a PSO does not think that he is in need of treatment for his deviant, uncontrollable sexual desires, this decision could be regarded as an indication that paedophilic disorder is an impediment to his rational decision-making and thus, renders him unable to make a rational decision concerning his particular situation and what he needs. In other words, a PSO may not be able to make an autonomous decision about his condition at the time it needs to be made for himself concerning his paedophilic disorder because this psychiatric condition can cloud his ability and, to some extent, impair his judgement to understand the specific treatment decision required. As discussed in Chapter One, paedophiles and PSOs are not synonymous because paedophiles do not necessarily act upon their sexual attractions, whereas PSOs suffer from paedophilic disorder because of having fantasies or urges towards children and not being able to refrain themselves from engaging in paedophilic behaviours. In addition, those offenders might feel distress or experience significant impairment in functions in certain areas which could be construed as impediment to their ability to make a rational decision about their particular situation and their needs. In this respect, even if it is possible to inform a PSO regarding the treatment of his

²⁰⁰ MCA 2005 (n 87) sub-s 3(4). For more information about the test for the assessment of capacity under MCA 2005, see Camilla Herbert, 'Mental Capacity' in Laura H Goldstein and Jane E McNeil (eds), *Clinical Neuropsychology: A Practical Guide to Assessment and Management for Clinicians* (Wiley-Blackwell 2013).

particular deviancy, paedophilic disorder itself may lead to disturbance of his mental state and impair his ability to make treatment decisions about his psychiatric condition. However, it is worth stressing that if paedophilia is a sexual preference, as in the case of homosexuality, it is surely difficult to say that because they are not consenting to restrict their sexual choice they are therefore lacking capacity and cannot make rational decisions. At this point, it should be noted that DSM-II listed homosexuality as a mental disorder and, in 1973, it was removed from the list of mental disorders and replaced by the category of ‘Sexual Orientation Disturbance’.²⁰¹ In 1980, DSM-III replaced Sexual Orientation Disturbance with ‘Ego Dystonic Homosexuality’.²⁰² However, Ego Dystonic Homosexuality did not appear in the DSM-IV²⁰³ and homosexuality was categorised under ‘Sexual and Gender Identity Disorder’ which has been converted to ‘Gender Dysphoria’ under DSM-V.²⁰⁴ Also, homosexual intercourse had been a criminal offence in many countries and people who had involved a homosexual activity had been forced to undergo a treatment programme. For instance, as a result of the Buggery Act 1533, committing buggery with another man had been illegal and punishable by death penalty in the UK. In 1861, Section 62 of the Offences against the Person Act had replaced the death penalty with the life in prison sentence and homosexuality had been sentenced to life in prison. In 1885, the Criminal Law Amendment Act –or an Act to make further provision for the protection of women and girls, the suppression of brothels, and other purposes– had widened buggery to any homosexual activity between men. In the not too distant past, the Criminal Law Amendment Act 1885 was brought to agenda in 2009 by

²⁰¹ APA, ‘Homosexuality and Sexual Orientation Disturbance: Proposed Change in DSM-II, 6th Printing, Page 44, Position Statement (Retired)’ (Document Reference No. 730008, 1973) <http://www.torahdec.org/downloads/dsm-ii_homosexuality_revision.pdf> accessed 16 June 2015.

²⁰² *Diagnostic and Statistical Manual of Mental Disorders, DSM-III* (3rd edn, American Psychiatric Association 1980).

²⁰³ *Diagnostic and Statistical Manual of Mental Disorders, DSM-IV-TR* (4th edn, American Psychiatric Association 2000).

²⁰⁴ *Diagnostic and Statistical Manual of Mental Disorders, DSM-5* (5th edn, American Psychiatric Association 2013).

the Prime Minister, Gordon Brown. The reason why it became a current issue was that in 1952, Alan Turing (1912-1954), who was one of the most important mathematicians in the UK history, was convicted of ‘gross indecency’ because of having homosexual intercourse with another man and he was forced into a therapy programme which also included pharmacological treatment.²⁰⁵ Gordon Brown, who was Prime Minister of the UK, issued an apology on behalf of the government and noted that ‘his treatment was of course utterly unfair [...] ... Alan and the many thousands of other gay men who were convicted as he was convicted under homophobic laws were treated terribly. Over the years millions more lived in fear of conviction. ... I am proud to say sorry to a real war hero.’²⁰⁶ As is seen in Turing’s case, although a particular (sexual) behaviour could be considered as abnormal or even a mental disorder at a certain time period, in a different period of time, this behaviour could become normal. However, it should be borne in mind that this is not an argument so as to support sexual liberalisation. Although paedophilia is a sexual interest, just like homosexuality or heterosexuality, paedophilic disorder can cause personal harm or individuals with paedophilic disorder can harm others, in particular, children by acting on their paedophilic urges, because children under certain ages have no legal capacity and are not able to consent any form of sexual activity. For this reason, when an involuntary treatment is imposed on a person assuming that he has a mental disorder, or has an impairment or disturbance which affects his ability to make a specific decision at the time it needs to be made in terms of his sexual preferences, from a medical paternalism perspective, the point to be considered could be whether his mental state or impairment in his decision-making ability poses risk to himself and/or others. In this respect, when a PSO is considered to

²⁰⁵ For more information on Alan Turing’s life, see Andrew Hodges, *Alan Turing: The Enigma* (New York: Walker & Company 2000).

²⁰⁶ See Gordon Brown, ‘Gordon Brown: I’m Proud to Say Sorry to a Real War Hero’ *The Telegraph* (10 September 2009) <http://www.telegraph.co.uk/news/politics/gordon-brown/6170112/Gordon-Brown-Im-proud-to-say-sorry-to-a-real-war-hero.html#disqus_thread> accessed 15 June 2015.

pose a risk to himself and/or to others as a result of paedophilic disorder which impairs his ability to control his sexual impulses and to adequately care for himself rather than simply motivating him to commit sexual crime against children, this impairment arguably might render him unable to make a specific decision and to give fully informed and free consent about a particular treatment. On that account, involuntary treatment may therefore be in his best interest.

1.1.4. Free and Informed Consent for Pharmacotherapy: Side-Effects and Voluntary/Valid Consent

When pharmacotherapy is applied to PSOs who are capable of making an autonomous decision about pharmacotherapy, their consent for this medical intervention must be free and well-informed in order to promote their autonomy and integrity and eliminate the infliction of any unwarranted intrusion. For this reason, they ought to be informed about the process and the benefits, consequences, alternatives, risks and side-effects of pharmacotherapy so they are able to come to an opinion concerning their health and the treatment. In addition, if their decision is considered irrational, especially if they refuse to undergo pharmacotherapy, this decision must be also respected and should not be linked to a lack of capacity. However, as is mentioned above, the decision which is considered irrational might lead to further inquiry regarding their ability to make a specific decision about their paedophilic disorder at the time it needs to be made. Since the discussion over the decision-making ability of PSOs and involuntary pharmacotherapy is one of the main concerns of this chapter, it will be addressed in depth after the examination of a number of concerns over voluntary pharmacotherapy which are : (i) the side-effects of the medication; and (ii) the validity (or voluntariness) of imprisoned offenders' consent.

1.1.4.1. Concerns over the Side-Effects of Pharmacotherapy

As discussed above, pharmacotherapy has been heavily criticised in that offenders might go through some significant health problems because there is a considerable uncertainty about its side-effects and lack of knowledge concerning its long-term effects.²⁰⁷ For this reason, such practice is regarded as ‘intrusive and invasive’,²⁰⁸ even if it can effectively suppress those offenders’ uncontrollable sexual desires and decrease the intensity and frequency of their abnormal sexual thoughts and fantasies.²⁰⁹

Hill and others argue that the some of the medications’ side-effects are dose-related and if its use and the dosage are reviewed in a careful manner, the side-effects will probably be decreased and, in some cases, individuals might even experience non-deviant sexual behaviour.²¹⁰ In support of this, Thibaut and others suggest that with close and careful monitoring of the patient and the treatment process, the dosage can be adjusted and some side-effects can be avoided.²¹¹

Studies indicate that most of the side-effects are treatable and/or reversible and the most serious are rarely experienced.²¹² In other words, the unpleasant side-effects are more likely to occur as long as the medication is continued and they will reverse themselves overtime by adjusting the dosage, especially if there are serious health concerns and medical risks associated with the medications and there is a necessity to avoid those concerns and risks. In addition, they can be avoided by taking additional precautions²¹³

²⁰⁷ For more information, see Grossman, Martis and Fichtner (n 63).

²⁰⁸ Larry Helm Spalding, ‘Florida’s 1997 Chemical Castration Law: A Return to the Dark Ages’ (1998) 25 Florida State University Law Review 117, 124. See also Melella, Travin and Cullen (n 56).

²⁰⁹ Fitzgerald (n 54) 7.

²¹⁰ Hill and others (n 17) 415-416.

²¹¹ Thibaut and others (n 3) 633.

²¹² Karen Harrison, ‘The High Risk Sex Offender Strategy in England and Wales: Is Chemical Castration an Option?’ (2007) 46 The Howard Journal of Criminal Justice 16, 21. See also Luk Gijs and Louis Gooren, ‘Hormonal and Psychopharmacological Intervention in the Treatment of Paraphilias: an Update’ (1996) 33 The Journal of Sex Research 273.

²¹³ Rösler and Witzum, ‘Pharmacotherapy’ (n 15) 46; Mary Ann Farkas and Amy Stichman, ‘Sex Offender Laws: Can Treatment, Punishment, Incapacitation, and Public Safety Be Reconciled?’ (2002) 27 Criminal Justice Review 256, 267.

or the risks and hazards of side-effects can be minimised by the use of alternative pharmacological strategies.²¹⁴

In response to the arguments about the side-effects and unknown consequences of pharmacotherapy and the fulfilment of informed consent, Cowan and Bertsch argue that in every type of treatment there is a limited uncertainty because unforeseen results can occur almost in every medical procedure.²¹⁵ In fact, there is always a degree of inherent risks with which people are faced whenever they take medication.²¹⁶ According to Fitzgerald, if the offenders give consent, despite the fact that they are informed about all these short and long term uncertainties and side-effects, the informed consent requirement would be fulfilled.²¹⁷ In addition he posits that ‘the existence of uncertainty does not negate informed consent [...]’²¹⁸ because, all in all, informed consent requires the communication of all benefits and consequences of the treatment, including any possible complications, between the offender and the physician.

According to Harrison and Rainey, the unknown long-term consequences of pharmacotherapy might lead to concerns over the validity of consent because the offenders will never be fully informed about the risks of treatment.²¹⁹ However, in response to this issue, they refer to the theory of responsabilization, to wit, ‘individuals – theoretically in return for greater individual freedom and reduced regulation- are expected to a large extent to “manage their own risks” by both refraining from criminal

²¹⁴ Thibaut and others (n 3) 643.

²¹⁵ Dale H Cowan and Eva Bertsch, ‘Innovative Therapy’ (1984) 5 *Journal of Legal Medicine* 218, 220.

²¹⁶ Dennis H Rainear, ‘The Use of Depo-Provera for Treating Male Sex Offenders: A Review of the Constitutional and Medical Issues’ (1984) 16 *University of Toledo Law Review* 181, 195-199. For instance, in case of chemotherapy, although this medical procedure leads to some serious results which are not certain and foreseeable, the existence of those results does not nullify or invalidate informed consent. Suzanne Audrey and others, ‘What Oncologists Tell Patients about Survival Benefits of Palliative Chemotherapy and Implications for Informed Consent: Qualitative Study’ (2008) 337 *British Medical Journal* 492, 493.

²¹⁷ Fitzgerald (n 54) 20.

²¹⁸ *Ibid.*

²¹⁹ Karen Harrison and Bernadette Rainey, ‘Morality and Legality in the Use of Antiandrogenic Pharmacotherapy with Sexual Offenders’ in Douglas Peter Boer and others (eds), *International Perspectives on the Assessment and Treatment of Sexual Offenders: Theory, Practice and Research* (Wiley-Blackwell 2011) 628.

behaviour and protecting themselves against crime’,²²⁰ which allows for conditional consent due to the prison environment and true motivations of the offenders undergoing treatment.²²¹ In the case of sex offenders and the use of pharmacotherapy, ‘it would appear that sex offenders, in order to gain greater freedom (and if they are suitable for medication), should be given the opportunity to undertake such treatment, even if their consent may be conditional.’²²² Given that the attainment of greater freedom is also related to the advancement and enhancement of (future) autonomy, this issue will be discussed in more detail under involuntary pharmacotherapy for PSOs.

Concerning the amount of information disclosed to offenders, it is noted that validity of consent is not only a practical matter of obtaining a form signed by the patient, but also it is about the possession of sufficient understanding of the nature of the treatment, and its beneficial effects and potential side-effects. Harrison and Rainey hold that ‘offenders should be fully informed of all aspects of the treatment, including the drugs which are to be used, the effects and [...] the side-effects of these drugs, the length of time he will be on such medication and, if appropriate, other potential treatment options.’²²³ As is discussed above, the established principle regarding the disclosure of information for the patients is that medical paternalism is no longer an acceptable attitude toward competent adult patients as a matter of English law. On that account, regarding the side-effects of pharmacotherapy, it can be suggested that offenders ought to be informed about not only sufficient information to make a balanced decision for the imposition of pharmacotherapy but also small (like 1-2%) and unavoidable risks and side-effects that the medications might cause seriously adverse results.

²²⁰ Hazel Kemshall and Mike Maguire, ‘Sex Offenders, Risk Penalty and The Problem of Disclosure to the Community’ in Amanda Matravars (ed), *Sex Offenders in the Community: Managing and Reducing the Risks* (Routledge 2011) 107.

²²¹ Harrison and Rainey, ‘Morality and Legality’ (n 219) 629, 638.

²²² Ibid 629.

²²³ Ibid 628.

Regarding the exceptions to informed consent, one can also argue that therapeutic privilege represents one of these exceptions which ‘allows the physician to withhold information from a patient when to provide it would clearly harm the patient’ especially if it is thought that the information provided could cause a significant level of distress and thus, affect the patients’ decision.²²⁴ As is stressed in *Chester*, although there might be an exceptional case in which ‘objectively in the best interests of the patient [the doctor] may be excused from giving a warning’, this exception is of limited scope because it is the patient’s right to be informed.²²⁵ Otherwise, not only the validity of consent becomes questionable, but also any unexpected side-effects experienced by the offender might end in the withdrawal of consent and the discontinuity of the treatment. On this matter, there is also another controversy surrounding pharmacotherapy and its side-effects (of which not all side-effects are known or certain) that whether all possible and reported side-effects must be disclosed to the patients, including the uncertainties, or only the well-established ones. Although the general assumption is often in line with the disclosure of all the possible side-effects of the proposed treatment including the small but unavoidable risks, the question concerning which side-effects need to be disclosed and which do not is beyond the scope of this research project.

1.1.4.2 Concerns over the Voluntariness and the Validity of Consent for Pharmacotherapy

Using pharmacotherapy with PSOs has also received much criticism regarding the voluntariness/validity of the convicted offenders’ consent due to the prison environment and the coercion inherent to imprisonment. In the Nuremberg Code 1947, voluntariness is considered as an ‘absolutely essential’ condition and it is noted that individuals must

²²⁴ Harold I Schwartz and David M Mack, ‘Informed Consent and Competency’ in Richard Rosner (ed), *Principles & Practice of Forensic Psychiatry* (2nd edn, Taylor & Francis: CRC Press 2003) 101. See also *VC v Slovakia* (n 170) para 103.

²²⁵ *Chester* (n 149) [16] (Lord Steyn).

be able to exercise ‘free power of choice’ without being forced, constrained, coerced or deceived.²²⁶ Also, in *Re T*, it is held that if a person is subjected to an undue influence or if his consent is given under pressure or duress exerted by another person, this may vitiate the decision and thus, his consent to a particular treatment may not be valid.²²⁷ In this respect, offering a convicted PSO pharmacotherapy can lead him to assume that consenting to such practice might grant him an early release from prison which may give rise to concerns over the validity and voluntariness of his consent. In fact, the situation of the offender can be regarded as a strong incentive to consent to pharmacotherapy and thus, one can argue that the external feature (being in prison) and the absence of clear identification between internal and external intentions undermine the voluntariness of the consent and its validity. On that account, if the treatment refusal resulted in facing further incarceration or an additional punishment, i.e. the extension of prison sentence, in this case, his consent would not be voluntary. The reason is that a threat, either implicit or explicit, which makes the offender worse off than he is, is considered as *coercion* and the additional punishment to which the offender will be exposed in the case of his treatment refusal undermines the principle that the consent must be given ‘free of coercion’.²²⁸ Deciding freely whether or not to undergo a particular treatment is one of the essential steps of informed consent and, for O’Neill, the function of informed consent is to limit deception or coercion.²²⁹

Green argues that an offender is faced with two options when pharmacotherapy is offered as an alternative to *further imprisonment* and it cannot be said that the offender

²²⁶ *Trials of War Criminals Before the Nuremberg Military Tribunals under Control Council Law No. 10* (Washington, DC: US Government Printing Office, 1949) 181-82.

²²⁷ *Re T* (n 150).

²²⁸ Schwartz and Mack (n 224) 97. Also, see Charles L Scott and Trent Holmberg, ‘Castration of Sex Offenders: Prisoners’ Rights versus Public Safety’ (2003) 31 *The Journal of the American Academy of Psychiatry and the Law* 502, 508.

²²⁹ O’Neill (n 5) 5. Regarding the criteria for the exceptional use of coercion, which are incapacity, harm and proportionality, see Axel Liégeois and Marc Eneman, ‘Ethics of Deliberation, Consent and Coercion in Psychiatry’ (2008) 34 *Journal of Medical Ethics* 73.

can make a decision freely. He will consent to the alternative -he would not otherwise have consented- because his loss of liberty will always be in the back of his mind. Under such a situation, offenders can even be willing to ‘barter their bodies’.²³⁰ In a similar vein, Vanderzyl notes that ‘the doctrine of informed consent requires a knowledgeable and voluntary decision to undergo treatment, yet offering a convicted offender [pharmacotherapy] as an alternative to a lengthy prison sentence constitutes an inherently coercive practice rendering truly voluntary consent impossible.’²³¹ Douglas and others also support the idea that ‘[a]n offender offered the choice between [pharmacotherapy] and further incarceration cannot give valid consent to [pharmacotherapy]. [...] *Therefore*[,] [pharmacotherapy] should not be offered as an alternative to further incarceration.’²³²

Conversely, Fitzgerald supports the idea that offering pharmacotherapy as treatment ‘does not constitute duress which vitiates the voluntariness of the paraphiliacs consent.’²³³ Also, Bomann-Larsen argues that despite the coercive circumstances of imprisonment, an offender’s consent to a particular medical intervention can still be regarded as a valid consent, even if it is offered as an alternative to further incarceration or a condition of early release. However, the validity of consent depends on two factors: (i) the treatment offer must be a genuine and an appropriate one (a form of treatment for the benefit of the offender) and not a threat, such as increasing the length of sentence, if the offer is not accepted; and (ii) the treatment offer should address the problem for

²³⁰ Green (n 51) 16-17.

²³¹ Vanderzyl (n 36) 140.

²³² Thomas Douglas and others, ‘Coercion, Incarceration, and Chemical Castration: An Argument from Autonomy’ (2013) 10 *Bioethical Inquiry* 393, 397. Also, for those who support the argument that offering a choice between further incarceration and pharmacotherapy does not make the offenders’ consent invalid, see Connie S Rosati, ‘A Study of Internal Punishment’ [1994] *Wisconsin Law Review* 123; Lene Bomann-Larsen, ‘Voluntary Rehabilitation? On Neurotechnological Behavioural Treatment, Valid Consent and (In)appropriate Offers’ (2013) 6 *Neuroethics* 65.

²³³ Fitzgerald (n 54) 21.

which the offender was convicted.²³⁴ In a similar vein, but from a different angle, Peters holds the view that offering pharmacotherapy to offenders does not affect the voluntariness of their consent so long as if it is offered as an alternative to imprisonment before they are incarcerated. The reason is that the prison environment might erode the decision-making ability of those individuals whilst making a decision between pharmacotherapy and long-term incarceration. In this way, the possibility of the vitiation of the offenders' voluntariness will be avoided.²³⁵ In addition, Berlin argues that

[j]ust because the consequences of one's decision may be unpleasant (e.g., having to take medication injections or go to jail) does not mean that a person somehow loses the capacity to choose. A cancer patient sometimes has to decide between dying [and] taking very unpleasant chemical agents, yet he still has the capacity and right to choose for himself. Similarly, convicted criminals are not diminished in their capacity to decide simply because the decisions are difficult.²³⁶

The refusal of pharmacotherapy, being subject to an extended custodial sentence and the pressure on consent were also discussed in *Janiga* case.²³⁷ The *Janiga* case was about the extradition of an offender from the UK to Czech Republic who had been ordered to undergo pharmacotherapy as preventative treatment in Czech Republic. It was noted that pharmacotherapy without consent would amount to inhuman and degrading

²³⁴ Bomann-Larsen (n 232) 68, 74-75.

²³⁵ Kimberly A Peters, 'Chemical Castration: An Alternative to Incarceration' (1993) 31 *Duquesne Law Review* 307, 317.

²³⁶ Fred S Berlin, 'Ethical Use of Antiandrogenic Medications' (1981) 138 *The American Journal of Psychiatry* 1515, 1516. See also Rodney Uphoff, 'Depo-Provera for the Sex Offender: A Defense Attorney's Perspective' (1986) 22 *Criminal Law Bulletin* 430.

²³⁷ [2011] EWHC 553 (Admin).

treatment (Article 3) and the violation of right to private life (Article 8), whereas with consent, there would be no breach of Articles 3 and 8, ECHR. However, the appeal court did not appear to consider whether any extension of custodial sentence in the case of a refusal of pharmacotherapy would affect the appellant's decision-making process and his consent to the treatment. Rather, the court accepted the submissions of the judicial authority that 'on a refusal of treatment the sentence may be prolonged'²³⁸ and did not make any determination on the substantive issues.

It is also worth noting that even if there is no additional punishment or further incarceration, offering pharmacotherapy can still affect the voluntariness of the offenders' consent due to the pressure that they feel in the process of making a decision between undergoing pharmacotherapy and continuing their imprisonment.²³⁹ This pressure can also render the consent invalid. This can be called the *undue inducement barrier* which refers to the fact that 'the offer of something good distorts people's reasoning abilities to such a degree that they undertake something that exposes them to unreasonable risks, the kind of risks they would not do were they more sober and reasoning clearly, or to forsake deeply held values.'²⁴⁰ Although undue inducement has often been considered with the context of biomedical research and payment to research subjects, in the case of pharmacotherapy, assuming that accepting this offer will give PSOs a 'get out of jail free card', it can also be considered as undue inducement. The reason is that the assumption that there is a chance to get an early release clouds the rational judgement and allures the offender to accept the offer because his attention is

²³⁸ Ibid [21].

²³⁹ Shaw argues that 'allowing the offender some say in the matter still shows respect for his preferences, even though the offender's options are limited. Furthermore, limiting the offender's options can be justified by the need to protect society and by the value of reforming the offender and restoring him to the community. The "consent requirement" strikes a balance between these interests and the offender's interest in not being forced to receive biomedical interventions.' Elizabeth Shaw, 'Direct Brain Interventions and Responsibility Enhancement' (2014) 8 Criminal Law and Philosophy 1, 18.

²⁴⁰ Ezekiel J Emanuel, 'Undue Inducement: Nonsense on Stilts?' (2005) 5 The American Journal of Bioethics 9, 9.

fixated on the benefits of undergoing pharmacotherapy. In order not to cause any misunderstanding or misassumption and not to give rise to undue inducement, it should be clearly stressed to offenders that undergoing pharmacotherapy will not *automatically* provide them with an opportunity for early release. In other words, if there is not any (direct) prospect of benefitting from early release, the continuing imprisonment will not affect the voluntariness of the decision. However, there might be a possibility of reducing the length of imprisonment on the grounds that the offenders treated with pharmacotherapy are better equipped for probation and are able to reintegrate into society (which will be assessed and decided by the probation service when considering whether the offenders are suitable to be released into the community). In this respect, PSOs might be released on parole if the Probation Service and the Prison Service are convinced that offenders treated with pharmacotherapy are less likely (or even unlikely) to re-offend and to pose danger to society.²⁴¹ The assessment of the effectiveness of pharmacotherapy for PSOs in terms of reducing their recidivism, controlling or managing their abnormal and irresistible sexual urges and behaviours ought to involve working with other professionals such as medical experts, psychiatrists and psychologists. In other words, voluntary pharmacotherapy can be a condition for early release on parole or a condition of probation for PSOs, if the assessment of the extent of the risk indicates that the effectiveness of chemical castration for those offenders satisfies the risk assessment criteria and the offenders meet the conditions of probation.

²⁴¹ For instance the Criminal Justice and Court Services Act 2000 sets out the National Probation Service for England and Wales. Section 1 states the tasks of the National Probation Service which is to assist the courts ‘in determining the appropriate sentences to pass, and making other decisions, in respect of persons charged with or convicted of offences, and the supervision and rehabilitation of such persons.’ As is set out in Section 2, the aims of the Probation Service are the protection of the public, the reduction of re-offending, the proper punishment of offenders, ensuring offenders’ awareness of the effects of crime on the victims of crime and the public, the rehabilitation of offenders.

1.2. Involuntary Pharmacotherapy for PSOs

1.2.1. Limitations of Informed Consent

As is discussed above, although the voluntary use of pharmacotherapy leads to a number of concerns, they can be addressed if a more cautious approach is taken in terms of medical, ethical and legal considerations. However, what if a PSO does not want to volunteer for the imposition of pharmacotherapy and this decision is a result of paedophilic disorder which affects or impairs the ability of the offender to make a decision and renders the offender incapable of making an informed choice about the treatment for his psychiatric condition? Greene argues that although informed consent provides an immense protection for ‘the right to governs the integrity of one’s own body’, it has exceptions.²⁴² For instance, informed consent can be limited or completely obliterated in the presence of some ‘possible exceptions to respecting patients’ autonomy’ and ‘exceptions to the requirement of informed consent’.²⁴³ According to Dworkin, there are certain values which are of

fundamental moral importance and of crucial significance to any person [...] includ[ing] dignity, health, well-being, integrity, security. It is possible that in order to promote any of these values it may be necessary to sacrifice some autonomy. It is also possible that promotion of autonomy in the long run requires sacrificing autonomy in the short run.²⁴⁴

Within the medical context, if a decision concerning one’s own health is not taken by this person but rather by experts, this refers to a ‘denial of autonomy’. The reason is that

²⁴² Doug Johnson-Greene, ‘Evolving Standards for Informed Consent: Is It Time for an Individualized and Flexible Approach’ in Jeffrey E Barnett and others, ‘Informed Consent: Too Much of a Good Thing or Not Enough’ (2007) 38 Professional Psychology: Research and Practice 179, 183.

²⁴³ Dworkin, *The Theory* (n 4) 114-120.

²⁴⁴ Ibid 114.

an individual's body is 'irreplaceable and inescapable' and ignoring his wishes regarding his own body is an 'insulting denial of autonomy.' However, if this denial is justified on the grounds of enhancing the benefit of the body, in this case paternalism will appear to have 'the strongest claim in the medical context.'²⁴⁵ In this respect, there are, in general, four exceptions to the informed consent requirement which permit medical intervention to be imposed in the absence of consent: (1) (temporarily or permanently) not 'being in the maturity of one's faculty'²⁴⁶ such as being 'very young or very ill, mentally impaired, demented or unconscious, or merely frail or confused'; (2) public health policies; (3) the dissemination of personal information –the information of third party- to medical professionals; and (4) being under duress or constraint.²⁴⁷

Given that the preservation or the enhancement of future autonomy is of the essence for the justification of paternalistic medical intervention, this justifying reason can arguably apply to cases in which the person suffers from a disorder or dysfunction, in particular, paedophilic disorder. Although mental disorder does not automatically call a patient's capacity into question,²⁴⁸ suffering from paedophilic disorder can be perceived as an impediment to his autonomy which raises concern over the decision-making ability of the person in question. A person who has been found unable to 'perform certain obligations and duties, [...] whose interests are to be secured and rights protected is viewed as not in a position to [...] make certain important decisions',²⁴⁹ it can be assumed that the person concerned also might not be in a position of giving a consent to a particular medical treatment. In this respect, as is noted in the MCA 2005 Code of

²⁴⁵ Ibid 113.

²⁴⁶ According to Mill, the phrase of 'not being in the maturity of one's faculty' refers to 'children', 'young persons below the age' and 'those who are still in a state to require being taken care of by others [...].' John Stuart Mill, *On Liberty* (2nd edn, Boston: Ticknor and Fields 1863) 24.

²⁴⁷ O'Neill (n 5) 4-5. Dworkin groups these exceptions under 'emergency', 'incompetence', 'waiver', and 'therapeutic privilege'. Dworkin, *The Theory* (n 4) 115-116

²⁴⁸ *Re C* (Adult: Refusal of Treatment) [1994] 1 All ER 819.

²⁴⁹ Dworkin, *The Theory* (n 4) 85.

Practice, a medical intervention can be carried out in the best interest(s) of the person whose decision-making ability to make informed decisions about care and treatment services or his health and safety is impaired, however, it must be the least restrictive of his/her rights.²⁵⁰

At this stage, it is worth noting that as discussed above, pharmacological agents mainly decrease the strength of sexual urges and preoccupation associated with paedophilic disorder. Therefore, attempting to use some pharmacotherapy strategies to create sexual dysfunction, to reduce paedophilic sexual urges and to inhibit paedophilic sexual behaviours appears to be effective for PSOs. However, while pharmacotherapy treatment can diminish paedophilic sexual desires and urges, it cannot modify their form.²⁵¹ In other words, pharmacotherapy cannot cure sexual proclivity and does not alter PSOs' sexual interests or preferences, but rather it can empower offenders to have some degree of control over their deviant sexual desires and their life and enhance their autonomy. Seto argues that '[t]here is no evidence to suggest that pedophilia can be changed. Instead, interventions are designed to increase voluntary control over sexual arousal, reduce sex drive [...].'²⁵² Harrison and Bernadette also suggest that even if pharmacotherapy is not a cure for paedophilic disorder, it can help offenders to control their deviant sexual behaviours and prevent reoffending and thus, its use must be available.²⁵³ On this matter, as discussed in Chapter One, PSOs experience difficulties in controlling their behaviours, urges and fantasies and this may cause significant distress or impairment in social, occupational, or other areas of functioning. In this respect, although pharmacotherapy is not a cure, it can surely relieve PSOs' stress and

²⁵⁰ Department for Constitutional Affairs (n 197) 20.

²⁵¹ See, Gijs and Louis Gooren (n 212).

²⁵² Michael C Seto, 'Pedophilia' (2009) 5 Annual Review of Clinical Psychology 391, 391.

²⁵³ Harrison and Rainey, 'Morality and Legality' (n 219) 635.

impairment by alleviating the symptoms of paedophilic disorder and strengthening their ability to have some degree of control over their paedophilic urges.

1.2.2. An Argument for Lack of Capacity and Coercive Treatment

In England and Wales, the MCA 2005 provides an important legislative framework for individuals who lack capacity and lays out principles that apply to the decisions made or actions taken under the Act. The Act states that '[...] a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain. It does not matter whether the impairment or disturbance is permanent or temporary.'²⁵⁴ In this case, as is mentioned above, the person concerned will be subject to the two-stage capacity test and it will be determined whether he is able to make a decision.

As an example to the issue of being in a condition of lack of capacity and receiving a treatment for this particular condition, it was stated in an English case (*Re E*) that due to the particular condition of an anorexic patient, this person is not capable of making a decision about his/her medical condition.²⁵⁵ Concerning the ability of an anorexic patient to make a true choice, it was held that

[t]here is no doubt that E has an impairment of, or a disturbance in the functioning of, the mind or brain in the form of her anorexia. Equally it is clear that [...] she can understand and retain the information relevant to the treatment decision and can communicate her decision. However, there is strong evidence that E's obsessive fear of weight gain makes her incapable

²⁵⁴ MCA 2005 (n 132) sub-ss 1(1) and 1(2).

²⁵⁵ *Re E* (Medical treatment: Anorexia) [2012] EWHC 1639 (COP). Also, see *Re W* (A Minor: Medical Treatment) [1992] 4 All ER 627.

of weighing the advantages and disadvantages of eating in any meaningful way. [...] The need not to gain weight overpowers all other thoughts.²⁵⁶

In addition, in the case of *NHS Trust v L and others*, L was suffering from anorexia nervosa and Judge King declared that she was completely satisfied that L had the capacity for some medical treatments but not for the ones in relation to treatment for her condition, anorexia.²⁵⁷

These judgments can be interpreted as a recognition that an anorexic patient has a sufficient understanding to be informed and to make an informed decision, however, she is not capable of making a particular decision to undergo a treatment programme regarding her disorder because the disease itself created a wish not to be treated. In *Re E*, the court noted that

E does not have the mental capacity to make the decision about treatment by forcible feeding and that the court must make the decision that is in her best interests. [...] The hope is that, with refeeding, E will reach the point where her weight stabilises at a more normal level and leads her to recover the capacity to take decisions for herself.²⁵⁸

At this stage, it is worth noting that the analogy between anorexia nervosa disorder and paedophilic disorder is made to argue that both disorders may cause distress or impairment in social, occupational, or other important areas of functioning. In this

²⁵⁶ *Re E* (n 255) [48]-[49]. Also, in *Re W*, it is noted that ‘it is a feature of anorexia nervosa that [it] is capable of destroying the ability to make an informed choice. It creates a compulsion to refuse treatment or only to accept treatment which is likely to be ineffective. This attitude is part and parcel of the disease and the more advanced the illness, the more compelling it may become.’ *Re W* (n 255) 637.

²⁵⁷ [2012] EWHC 2741 (COP) [56].

²⁵⁸ *Re E* (n 255) [70], [72]. As is also mentioned in *Re W*, ‘[i]t is a peculiarity of this disease that the disease itself created a wish not to be cured or only to be cured if and when the patient decides to cure himself or herself, which may well be too late.’ *Re W* (n 255) 639.

sense, when treatment of anorexia nervosa becomes an issue of concern, an anorexic patient may not be able to give informed consent and the imposition of a particular treatment can be justified on the ground that anorexia nervosa impairs the patient's capacity to understand the disorder and/or cause impaired judgement concerning his/her condition and its treatment. A similar assessment, but from a slightly different perspective, can be made for PSOs and one can argue that those individuals may be in a state of psychological and behavioural difficulties which actually influence their decision-making process in terms of refraining from acting on their paedophilic desires, not approaching a child in an improper manner and receiving treatment for their paedophilic disorder. However, the difference lies in the point that unlike anorexia nervosa disorder, the ability to control sexual urges may not be equated with capacity. Paedophilic urges and desires may affect autonomy but I do not go further and argue that individuals with paedophilic disorder lack mental capacity. Instead, my argument is that PSOs may be clouded as to decide what is in their best interests due to the paedophilic disorder because this particular disorder may constitute an impediment to make autonomous decisions for their own good. For this reason, since there is a moral certainty that uncontrollable or irresistible deviant sexual urges affect PSOs' autonomy, the decision made by those individuals concerning the treatment of paedophilic disorder with, arguably, impaired autonomy can be controversial, which will be discussed more thoroughly in the following part.

1.2.3. Justified Constraints on Present Autonomy for the Enhancement of Future Autonomy and Involuntary Pharmacotherapy

It is worth noting that the claim made here is not that every PSO's decision-making capacity is clouded, his autonomy is impaired and thus, he is unable to provide consent for a medical procedure. Rather, the argument is that some of PSOs' decisions are

clouded concerning their sexual desires because paedophilic disorder affects, in one way or another, those offenders' present autonomy and, not always but sometimes, puts them into a state that their condition does not need to be treated and leads them to commit sexual crimes against children. On that account, the autonomy-based argument made here is meant to be applied only to PSOs whose ability to make autonomous decisions is impaired and who are clouded as to decide what is in their best interests. Given that uncontrollable and abnormal sexual desires make some PSOs think that they do not have a medical condition that needs to be treated and motivates them to commit crime, which can be considered as an impediment to autonomy, pharmacotherapy can help alleviate those desires and, by these means, increase their autonomy. Whereas, withholding pharmacotherapy from those offenders on the ground that informed consent is not obtained 'would have the paradoxical result of *restricting* [their] autonomy.'²⁵⁹ The reason for this paradox is that 'the very point of obtaining consent is, arguably, to protect autonomy.'²⁶⁰

In the matter of acting as an autonomous agent or exercising autonomous decisions, Dworkin argues that

[a]utonomy should have some relationship to the ability of individuals, not only to scrutinize critically their first-order motivations but also to change them if they so desire. [...] The idea of autonomy is not merely an evaluative or reflective notion, but includes as well some ability both to alter one's preferences and to make them effective in one's actions and, indeed, to make them effective [...]. [Thus,] autonomy is conceived of as a second-

²⁵⁹ Douglas and others (n 232) 399.

²⁶⁰ Ibid. However, it should be noted that the desires are impediments to autonomy not because they are irrational, immoral or abnormal; rather they are the result of hormonal imbalance that the PSOs suffer from.

order capacity of persons to reflect critically upon their first-order preferences, desires, wishes, and so forth and the capacity to accept or attempt to change these in light of higher-order preferences and values. By exercising such a capacity, persons define their nature, give meaning and coherence to their lives, and take responsibility for the kind of person they are.²⁶¹

From this point of view, if a person's actions are driven by his desires and he does not have the ability to control those desires, then his autonomy is ambiguous and he can even be called non-autonomous.²⁶² The reason is that autonomy is not only the capacity to reflect upon one's own desires but also the ability to change or control them in order not to be alienated to the authentic self. Giving priority to the enhancement or prevention of first-order considerations is to disregard the essential characteristics of individuals which is 'their ability to reflect upon and adopt attitudes toward their first-order desires, wishes, intentions.'²⁶³ In other words, even though autonomy refers to the subject's choices, which are regardless of 'external constraints', there is more to it than that because autonomy requires the ability to critically assess first-order motivations and, if it is desired, to change them in accordance with second-order desires, preferences or motivations. In case of any conflict between first-order and second-order volitions, '[s]ay one is envious but does not want to be [an] envious person', an autonomous person is able to resist being motivated by such feeling.²⁶⁴

²⁶¹ Dworkin, *The Theory* (n 4) 16-17, 20.

²⁶² For more information in support of this argument, see Harry G Frankfurt, *The Importance of What We Care About* (Cambridge University Press 1988); Marya Schechtman, 'Self-Expression and Self-Control' (2004) 17 Ratio 409.

²⁶³ Dworkin, *The Theory* (n 4) 15.

²⁶⁴ Ibid 16. As an example to first-order and second-order volitions, Dworkin refers to the desire to smoke, first-order desire, and also the desire not to have the desire to smoke, second-order desire. In this context, the autonomous person is the one who can act in accordance with his second order desires, which is to give up smoking. The reason is that a person may not want to be motivated by certain desires and

On this matter, Frankfurt argues that the words ‘to desire’ and ‘to want’ are interchangeable, however, in some cases, what a person desires is not a genuine or autonomous desire because of his/her condition. According to him, if what he has done is not what he wanted to do because of affected desire, this indicates that there is a conflict between free will and desires.²⁶⁵ On that account, Caplan supports the idea that in some cases, forced medication can be justified if it is for enhancing autonomy which he calls ‘infringing autonomy to create autonomy’ or ‘to restore the capacity for autonomy’.²⁶⁶ Also, Douglas and others argue that

desires that motivate sexual offences will often qualify as impediment to autonomy [...]. [I]t is very plausible that, if chemical castration would attenuate these desires, it would increase autonomy. [...] Where [pharmacotherapy] increases future autonomy overall, either by removing internal barriers (such as irrational, inauthentic, compulsive desires) or external ones (such as restrictions on free movement), it might seem counterproductive to withhold chemical castration so as not to violate the consent requirement. One reason to respect that requirement is to protect the autonomy of the individual concerned, but in these cases [pharmacotherapy] seems to be the option most conducive to autonomy.²⁶⁷

From this point of view, the preservation of autonomy, in the event of involuntary pharmacotherapy, could be possible on the grounds that there are ‘certain kinds of

want to be alienated from those desires. In this respect, the autonomous person is the one who has the ‘capacity to reflect upon [his] motivational structure and to make changes in that structure [...] but also [...] some ability to alter [his] preferences and to make then effective in action.’ Ibid 108.

²⁶⁵ Harry G Frankfurt, ‘Freedom of the Will and the Concept of a Person’ (1971) 68 *The Journal of Philosophy* 5, 7-12. Also see, Schechtman (n 262).

²⁶⁶ Arthur L Caplan, ‘Ethical Issues Surrounding Forced, Mandated, or Coerced Treatment’ (2006) 31 *Journal of Substance Abuse Treatment* 117, 117-118.

²⁶⁷ Douglas and others (n 232) 399.

reasons for complying' with its practice and 'it is more than just a matter of what the agent does; it is also a matter of why he does.'²⁶⁸ Concerning this issue, however, one might question whether the state can decrease the present autonomy for the enhancement of future autonomy and, if so, then to what extent this decrease is reasonable and justifiable.

Given the PSOs and the blurred line between the protection of those individuals' right to take irrational decisions and the questioning their autonomy on the basis of their irrational decision-making, paedophilic disorder, arguably, may render those individuals unable to understand, retain and weigh information about their condition to make a decision and arrive at a choice. Therefore, involuntary pharmacotherapy can be justified on the basis that it is in their best interests because PSOs can reap the benefit of its application (assurance of improvement or prevention of deterioration in their mental health and enhancement of their autonomy). Although disregarding one's decision and imposing involuntary pharmacotherapy clash with the value of autonomy and self-determination, Caplan argues that 'self-determination sometimes requires mandatory treatment as a way to create or enable autonomy.'²⁶⁹ Although one can base compulsory pharmacotherapy on the grounds of utilitarian motives and considerations –that it serves the purpose of the greatest good for the greatest number of individuals which is the promotion of public good and public safety– and this justification of the denial of autonomy and self-determination can be of great importance, arguably that it is not sufficient to override one's autonomy. Regarding autonomy-restricting desires, Caplan's argument is that compulsory treatment might be justifiable if it is for the restoration or reestablishment of personal autonomy or for the enhancement of the capacity for autonomy rather than being only for the promotion of utilitarian motives and

²⁶⁸ Gerald Dworkin, 'Autonomy and Behavior Control' (1976) 6 *The Hastings Center Report* 23, 23-24.

²⁶⁹ Caplan (n 266) 117.

considerations.²⁷⁰ He notes that ‘if [...] the capacity for self-determination comes into existence or rather, returns, that is, if the medication is enhancing the ability to be autonomous, then I think that could serve as an ethical argument that would allow mandating treatment [...] albeit temporary.’²⁷¹ In this respect, some of PSOs can be forced to undergo pharmacotherapy in the name of autonomy because they are clouded as to what is in their best interest in the same way that some of anorexic patients are to make decisions about their treatment. Also, the temporary and reversible nature of pharmacotherapy can justify its compulsory application and make it a suitable and appropriate treatment for PSOs. Considering that committing a crime is a token for those offenders that they are motivated or driven, in fact, coerced, by their uncontrollable desires, pharmacotherapy can enable them to resist the coercion, which results from those sexual desires, by restoring their present autonomy (and their capacity) instead of interfering with it.²⁷²

Taking the argument a bit further, regarding the line between mandatory treatment and the enhancement of autonomy, this line can be drawn according to the relation (or difference) between the present decrease and the future gain in autonomy. In other words, the justifiability of involuntary pharmacotherapy depends on whether the future gain overrides the present decrease in autonomy or not. Given Dworkin’s example of

²⁷⁰ Ibid 118.

²⁷¹ Ibid. It is also worthy of note that Caplan’s argument on ‘infringing autonomy to create autonomy’ is inspired from Mill’s example of the ‘bridge’ which is forcibly stopping a person who is crossing a condemned bridge without knowing the risks would not amount to an infringement of autonomy. Mill (n 246) 186. In this respect, if the means are available, it would be justifiable to force treatment on a person who is motivated by his desires in order to rectify his situation and regenerate his capacity for autonomy.

²⁷² It is worthy noting that the use of pharmacotherapy may be seen as in the best interest of PSOs, and under the MCA 2005, the involuntary use of it can be justified on the ground that paedophilia impairs or disturbs the functioning of their mind and all reasonable steps which are in their best interest must be taken. However, given the other treatment options for paedophilia such as cognitive behavioral therapy, it is controversial that the involuntary use of pharmacotherapy can be considered as the only necessary option to serve their best interest. Also, a more comprehensive research is required to address the question whether the application of the best interest principle can be considered for the enhancement of (future) autonomy.

smoking,²⁷³ it is hard to claim that the desire to smoke constitutes a significant hindrance to present autonomy or a serious threat or impediment to self-determination. Although easing someone's desire to smoke or stopping him/her smoking is essential to a long and health life which also increases the time s/he has autonomy, any compulsory intervention in order to address this desire and alleviate it in the future would result in very serious impediment to present autonomy and the future gain in autonomy would fall short of justifying the present decrease. However, in the case of PSOs, the situation is the other way around. The reason is that the uncontrollable sexual urges themselves have a strong impact on those offenders' criminal behaviour and generate a significant impediment to present autonomy and self-determination. Thibaut and others note that '[s]ex offenders employ distorted patterns of thinking which allow them to rationali[s]e their behaviour, including beliefs such as children can consent to sex with an adult and/or victims are responsible for being sexually assaulted.'²⁷⁴

Given the effects of these desires in self-control capacity, admittedly, they constitute a serious impediment to the offenders' autonomy and give rise to the commission of sexual crimes against children. As Douglas and others suggest, the restriction of present autonomy, therefore, can be justified on the grounds that the future gain in autonomy will considerably override the present decrease. According to them, considering the cases in which autonomy is restricted, such as substantial cognitive impairment, 'it is often thought acceptable to tolerate some active reduction in present autonomy in order to enhance future autonomy.'²⁷⁵ One can deduce that pharmacotherapy alleviates the desires which constrain the offenders' autonomy and thus, it is more conducive to the promotion of paedophilic offenders' autonomy than incarceration. Because incarceration does not make PSOs more autonomous; on the contrary, they will be

²⁷³ See (n 264).

²⁷⁴ Thibaut and others (n 3) 615.

²⁷⁵ Douglas and others (n 232) 400.

deprived of certain rights and freedoms following a criminal conviction, meaning that they will be more constrained than they would have been if pharmacotherapy were applied.

Conclusion

In this chapter, it has been established that pharmacotherapy is not a cure for paedophilia but it has therapeutic effects on the symptoms of this particular disorder and thus, it can be used for PSOs' treatment either voluntarily, or involuntarily. When it is used in the form of voluntary treatment, although it leads to concerns about the voluntariness and the validity of offenders' consent, those concerns can be allayed if the conditions regarding its application are clearly defined and understood, such as pharmacotherapy should not be presented or seen as get-out-of-jail card. When pharmacotherapy is used as mandatory treatment, the claim is that its involuntary imposition can be justified on the ground of autonomy-based arguments. It has been argued throughout this chapter, pharmacotherapy does not only provide an opportunity for offenders to control their deviant sexual desires and behaviours, but it also increases their overall autonomy by alleviating internal impediments to autonomy and removing the external ones, such as the length of incarceration. For this reason, involuntary pharmacotherapy can be a justifiable medical practice on the grounds that the active decrease in or the constraint on present autonomy is for the enhancement of future autonomy. Considering the unpleasant side-effects of pharmacotherapy, as is mentioned above, those side-effects are dose-dependent, reversible and treatable and they can be avoided by alternative or additional medication. On that account, probably (but arguably) concerns over those side-effects can be overcome and addressed.

As discussed above, making a medical intervention compulsory, especially to offenders, might lead to concerns over the intention behind it, whether it is a treatment or

punishment, and the underlying objectives of its application. Admittedly, in addition to its treatment purpose, the involuntary pharmacotherapy can also attain the goals of punishment, such as retribution, incapacitation and rehabilitation. Also, given the fact that pharmacotherapy deprives offenders of their sexual liberty, which will be discussed more thoroughly in the following chapters, this deprivation element raises a perception that its practice might constitute punishment. Since involuntary pharmacotherapy straddles the border between punishment and treatment, a further clarification concerning its punishment form is also important for its justification. Therefore, in the following chapter, the discussion will revolve around its punishment aspect and it will be addressed whether pharmacotherapy can be integrated into the criminal justice system and be used as a means to punish PSOs. If so, assuming that a certain degree of harmonisation might be required, what kinds of changes are necessary in order to make pharmacotherapy a part of traditional punishment?

CHAPTER THREE

THE USE OF PHARMACOTHERAPY IN THE PUNISHMENT OF PSOs

Introduction

Child sexual abuse has been recognised as a specific issue of concern for many years because of having a serious impact on victims and families, and in some respects, on the whole society. For this reason, the centrality of the sentencing philosophy of incarceration and incapacitation for this type of offence has been debated within the criminal justice system. It has been claimed that although imprisonment may deter some sex offenders, there are no solid indications that on its own it has a therapeutic effect or rehabilitation function for PSOs.¹ As a response to this particular matter, some criminal justice systems have taken a stance on preventive strategy and social control in order to avert sexual crimes as part of their sex offender management process.² The last two decades have seen a significant shift towards law reform in several jurisdictions such as the USA, Czech Republic, Germany, Poland, Moldova, Russia, the UK, South Korea and the Scandinavian nations to enable the imposition of preventative measures including medical treatments as a response to paedophilic sexual offences.³ Pharmacotherapy has thus become a matter of discussion for crime prevention and the management of PSOs.⁴

¹ See Pamela K Hicks, 'Commentary, Castration of Sexual Offenders: Legal and Ethical Issues' (1993) 14 *Journal of Legal Medicine* 641; William Winslade and others, 'Castrating Pedophiles Convicted of Sex Offenses Against Children: New Treatment or Old Punishment?' (1997-1998) 51 *Southern Methodist University Law Review* 349; Marnie E Rice and Grant T Harris, 'Treatment for Adult Sex Offenders' in Karen Harrison and Bernadette Rainey (eds), *The Wiley-Blackwell Handbook of Legal and Ethical Aspects of Sex Offender Treatment and Management* (Wiley-Blackwell 2013).

² As an example to the preventive strategy and social control stance, Part 2 of the Sexual Offence Act 2003, comprises the notification requirement for sex offenders and sexual offences prevention orders. In this respect, the Act enables the police officers to monitor and manage sex offenders by registering the personal information of these offenders', which is also called registration and management of sex offenders.

³ Raphaela Basdekis-Jozsa, Daniel Turner and Peer Briken, 'Pharmacological Treatment of Sexual Offenders and Its Legal and Ethical Aspects' in Harrison and Rainey, *The Wiley-Blackwell Handbook* (n 1) 311.

⁴ See *ibid.*

In Chapter Two, it has been established that pharmacotherapy can be practiced in a mental health setting as a form of involuntary treatment for PSOs. It has also been discussed that the line between (involuntary) medical treatment and criminal punishment can be blurred when it comes to offenders with mental health issues and psychiatric conditions. As a response to this concern, the argument has been that in the case of using pharmacotherapy for PSOs, the underlying reason for its application and justification(s) for its use could be pivotal to distinguish medical treatment from criminal punishment. When pharmacotherapy is used within a mental health setting as an involuntary treatment, its application must be medically necessary for the condition that is being treated and it should be justified on the basis of medical considerations. Also, the pain that pharmacotherapy treatment involves is an unfortunate contingent fact; painless or less painful substitute of it, if available, would be preferred. However, if pharmacotherapy is used as part of punishment and embedded in the criminal justice system's response to PSOs, as will be discussed in greater detail later in this chapter that the objective behind its application involves the intentional infliction of pain, deprivation or of something unpleasant and its deliberate imposition requires different justification. On that account, Chapter Three argues the application of pharmacotherapy within a criminal justice setting and attempts to replace some traditional sentencing policies by the use of pharmacotherapy to respond to and deal with PSOs and that its integration can be regarded as a proportionate response to crime committed and an effective measure to prevent those individuals from reoffending and being incarcerated, to make offenders more law-abiding individuals and to reintegrate them into society. At this stage, it will be discussed that as an unpleasant consequence, it is DoSL itself that is the punishment element of pharmacotherapy, meaning that when pharmacotherapy is integrated into the criminal justice systems, the argument behind its integration is that

the deprivation of an offender's freedom to have sexual thoughts, desires or fantasies and to engage in a sexual activity, which is something greatly valued, is the punishment element of this medical intervention.

Contemporary penal systems resort to and benefit from rehabilitation programmes to improve the offenders' control over their deviant sexual urges and behaviour. However, it is argued that some of those programmes have a dismal record of effectively and efficiently rehabilitating PSOs or they do not bring the offenders to understand or recognise the wrong that they have done.⁵ Therefore, more effective and efficient (even more radical) interventions have become the main topic of discussions, i.e. the integration of pharmacotherapy into criminal justice systems with the aim of altering PSOs' thoughts and/or behaviours to something more controllable and autonomous. This medical intervention, however, might be opposed by some punishment theorists on the basis that a coercive medical intervention does not respect the offenders' autonomy, which is of the essence for the protection of their dignity and physical security,⁶ and thus, the problem is that the justification of its use in their punishment is controversial. In fact, according to those theorists, the underlying reason for this technique is to treat individuals merely as means, and when punishment moulds the will of an offender to accept certain values, then his autonomy (especially moral autonomy) would be interfered with because he would not remain free to choose his own ends.⁷ Yet other arguments against the use of pharmacotherapy would be that it is disproportionate to the crime committed or by its very nature, its retributive function would be

⁵ R Anthony Duff, 'Penal Communications: Recent Work in the Philosophy of Punishment' (1996) 20 *Crime and Justice* 1, 81.

⁶ Tony Ward and Kendra Syversen, 'Human Dignity and Vulnerable Agency: An Ethical Framework for Forensic Practice' (2009) 14 *Aggression and Violent Behavior* 94, 98.

⁷ Frances E Gill, *The Moral Benefit of Punishment: Self-Determination as a Goal of Correctional Counseling* (Lexington Books 2003) 31-32.

counterproductive because one size cannot possibly fit all.⁸ On these issues, it has been established in Chapter Two that the use of pharmacotherapy respects to offenders' autonomy and dignity because the interference with autonomy posed by involuntary pharmacotherapy is justifiable, in general, to enhance the (future) capacity and autonomy of PSOs and to restore or advance their capacity which is necessary and essential for self-control, in particular, of irresistible sexual urges. Given this justification for involuntary pharmacotherapy, its practice does not only meet the retributive function of punishment, but also serves the utilitarian aims of punishment. In this respect, this chapter will examine the issue of using pharmacotherapy within the process of sentencing PSOs as a state response to sex offending and address the following questions: Is it possible to integrate involuntary pharmacotherapy into criminal justice policies? Under which circumstance(s) might it be possible to use pharmacotherapy in their punishment of PSOs? How can existing penal systems accommodate such medical practice?

Considering the contribution of moral philosophy to the problem of defining the concept and the aims of punishment and of justifying it, the examination of pharmacotherapy will be carried out through the assessment of this implementation within the frame of the theories of punishment. The aim with this assessment is to find out whether the infliction of pharmacotherapy is concordant with the aims/justification(s) of punishment, and to what extent criminal justice policies can reap the benefits of involuntary pharmacotherapy. Therefore, the starting point of this chapter will be the definition of punishment. Following this, in the second place, theoretical or philosophical debates over the 'justification of punishment' will be assessed with a particular emphasis on *retributive* and *utilitarian* theories in order to

⁸ See Kari A Vanderzyl, 'Castration as an Alternative to Incarceration: An Impotent Approach to the Punishment of Sex Offenders' (1995) 15 Northern Illinois University Law Review 107.

address the issue whether punishment should be a proportional reciprocity to the offenders' interaction or it should treat and/or rehabilitate them, or both. In the last part, it will be argued that pharmacotherapy can be used as a means of punishment for PSOs because it is more effective in preventing crime than traditional methods of punishment including incarceration and is a proportionate sentence (not disproportionately severe or lenient), which can provide a full justification for pharmacotherapy.⁹ The argument is that incarceration does not alone suffice to alter the subsequent criminal behaviour of PSOs which often results from impaired capacity and/or non-autonomous decisions. Whereas, the use of pharmacotherapy within the criminal justice system might have two-pronged benefits; not only is it essential for a removal of the internal barriers, to wit, abnormal and irresistible sexual interests, desires and urges, and for rendering those offenders more autonomous, but also for an earlier removal of the external barriers, to wit, the removal of restriction on the right to liberty, right to private life, freedom of movement and freedom of association. In addition, given the harshness and duration dimensions, using pharmacotherapy as a means of punishment can be a proportionate response to the crime committed. Since pharmacotherapy involves suffering, DoSL, it will be argued that this deprivation is consistent with the limits of desert and also with values prevalent among the public, its expectations and perceptions regarding the relationship between punishment and crime. On that account, in this chapter, the argument is that it may be acceptable or permissible if the criminal justice system benefits from the opportunity of using pharmacotherapy in the punishment of PSOs and makes use of it in the interests of the offenders and of others.

⁹ It is worth noting that there is no universal application of a precise and complete scale of proportional punishment because a particular jurisdiction can choose certain anchoring points of a penalty scale within the acceptable ranges. Regarding the argument of proportionality, this thesis argues that the deprivation resulting from pharmacotherapy (DoSL) is not an excessive (or cruel) punishment.

A. Punishment

Although all crimes generate a reaction from society, sexual crimes provoke a significant emotional reaction from the public, and this reaction mounts up when a child becomes the victim of this particular crime.¹⁰ Given the importance of healing and restoring the victims and satisfying society's demands for the prevention of these specific crimes, criminal justice systems have employed several precautions and, mostly, focused on longer periods of incarceration.¹¹ For instance, in the UK, under the Criminal Justice Act 2003, a sexual offender who falls into the category of 'dangerous offender' was given one of three sentences: imprisonment for life; imprisonment for public protection; or an extended sentence.¹² However, these provisions are abolished and the Legal Aid, Sentencing and Punishment of Offenders (LASPO) Act 2012, Section 122 introduces the New Mandatory Life Sentence which is not a straight replacement for imprisonment for public protection but provides a new route to imposing imprisonment for life by including a 'two strikes policy', and Section 124 introduces the New Extended Sentence which can only be imposed where the conditions established under Section 124 are met.¹³ Under the provisions of the Act, a

¹⁰ Adam Sampson, *Acts of Abuse: Sex Offenders and the Criminal Justice System* (London: Routledge 1994) xi.

¹¹ Sarah Brown, *Treating Sex Offenders: An Introduction to Sex Offender Treatment Programmes* (Willan 2005) 1; Dany Lacombe, 'Consumed with Sex: The Treatment of Sex Offenders in Risk Society' (2008) 48 *The British Journal of Criminology* 55, 55-56.

¹² CJA 2003, c 5, pt 12, ss 224-227. For more information, see Andy Bickle, 'The Dangerous Offender Provisions of the Criminal Justice Act 2003 and Their Implications for Psychiatric Evidence in Sentencing Violent and Sexual Offenders' (2008) 19 *The Journal of Forensic Psychiatry & Psychology* 603.

¹³ LASPO 2012, pt 3, c 5, ss 122, 124. Under Section 122, there are two conditions for the imposition of the new mandatory life sentence: the defendant must be convicted of serious sexual and violent offences (sentence condition) and the defendant must previously have been convicted of a specified offence (previous offence condition). The court may avoid imposing the new mandatory life sentence if there are particular circumstances concerning the current offence, previous offence or the offender which 'would make it unjust to do so in all the circumstances.' Under Section 124, the new extended sentence for adults can be imposed where the following conditions are met: the defendant has been convicted of a specified offence (the previous offence condition), the court considers that the defendant presents a substantial risk to the public of serious harm through re-offending by committing a further specified offence (the seriousness condition), and the court is not required to impose a sentence of imprisonment for life. One can argue that this new legislation may be limited considering the conditions that must be met and thus, it can address the concerns over the offenders' rights and the prison population.

mandatory life sentence will apply to PSOs convicted of a second very serious sexual or violent crime. If they do not come under the ‘two strikes rule’, they will receive an extended determinate sentence and thus, they have to serve at least two-thirds of their sentence (and may be detained until the end of it), rather than being released from prison after serving half their sentence, which is intended to replace the imprisonment for public protection sentence under which prisoners deemed a danger to society could be detained indefinitely.

Moreover, with the aim of addressing public reaction to sex offenders and preventing those offenders from reoffending, a majority of states have established sex offender laws with the aim of providing new regulations and treatment programmes rather than solely imprisonment-based systems. For instance, in Europe, the USA and Canada, the combination of imprisonment with different methods such as registration, community notification, civil commitment, electronic monitoring, residence restrictions, prohibitions of sex offenders from public places or pharmacotherapy sets a remarkable precedent for these kinds of regulations.¹⁴ To that end, and due to the scope of this study, the question of “what is punishment?” will be assessed with a special emphasis upon pharmacotherapy in order to find out whether it is possible to embed such medical practice in the definition(s) of punishment and whether the criminal justice system can use it as a means of punishment for PSOs.

The word ‘punishment’ has been ascribed different meanings by scholars and philosophers and also defined and justified from a variety of perspectives. It may be

¹⁴ Michael Petrunik and Linda Deutschmann, ‘The Exclusion-Inclusion Spectrum in State and Community Response to Sex Offenders in Anglo-American and European Jurisdictions’ (2007) 52 *International Journal of Offender Therapy and Comparative Criminology* 499, 499. Also, see Joanna Davidson, ‘Sex Offender Registration – a Review of Practice in the United Kingdom, Europe and North America’ Hallam Centre for Community Justice Briefing Paper (January 2009) <<https://www.shu.ac.uk/assets/pdf/hccj-SexOffenderRegBriefPaper.pdf>> accessed 20 March 2014; Amy L Anderson and Lisa L Sample, ‘Public Awareness and Action Resulting from Sex Offender Community Notification Laws’ in Richard D Hartley (ed), *Snapshots of Research: Reading in Criminology and Criminal Justice* (Sage Publications 2011).

argued that ‘punishment’ has not attained a unique and universally accepted definition,¹⁵ and therefore as far as punishment is analysed, the definition and justification issues vary from one theory to another. As Gerber and McAnany note, there are several arguments about ‘definition, justification, and kinds of punishment’ in the literature,¹⁶ and the reason for that is because of the gap between the traditional understandings of punishment and what is used as a method for indispensable compliance or for obligatory respect.¹⁷ According to Radzinowicz, the change in public sensitivity and awareness, the developments in science and the fully formed police force have helped cause alterations of the understanding of punishment.¹⁸ Although the term lacks a unique meaning, it is still possible to highlight the basic arguments and shared points emphasised by different philosophers of different theories. On that account, punishment apparently has two essential dimensions: the first of these is about the definition of punishment which is the intrinsic and indispensable feature of punishment and will be evaluated in the first section, and the second is about the purpose of punishment which will be assessed profoundly within the axis of theories of punishment. By virtue of these essential dimensions, although there is an overlap between the definition of punishment and the aim of punishment in terms of how it is justified, the chapter construes punishment and its aim(s) with respect to Armstrong’s ‘logical priority’ idea which purports a logical order of the evaluation of punishment in

¹⁵ As Armstrong notes, ‘[t]he first problem is over the meaning of the word “punishment”, and is thus a definitional [...] issue. [...] [I]n the case of “punishment” there is no such universally acceptable answer [...]’ KG Armstrong, ‘The Retributive Hits Back’ (1961) 70 *Mind* 471, 473.

¹⁶ Rudolph J Gerber and Patrick D McAnany, ‘The Philosophy of Punishment’ in Norman Johnston, Leonard Savitz and Marvin E Wolfgang (eds), *The Sociology of Punishment and Correction* (2nd edn, John Wiley & Sons 1970) 349.

¹⁷ Rudolph J Gerber and Patrick D McAnany, ‘Punishment: Current Survey of Philosophy and Law’ (1967) 11 *Saint Louis University Law Journal* 491, 520.

¹⁸ For further information, see Leon Radzinowicz, ‘Changing Attitudes Towards Crime and Punishment’ (1959) 75 *Law Quarterly Review* 381. McPherson also remarks that due to the philosophical pursuit and practical reasons, the meaning of punishment cannot find a common denominator. Thomas McPherson, ‘Punishment: Definition and Justification’ (1967) 28 *Analysis* 21, 21.

the manner that ‘first to decide what punishment is, *then*, to decide whether [it] is ... justifiable or not.’¹⁹

1. Definitions of Punishment

The central philosophical debate over punishment is not about its existence, but rather over how to define it. While there is confusion resulting from conflicting definitions, it is generally accepted that punishment is a ‘response to something that has happened.’²⁰ Generally speaking, -regardless of the purpose of punishment- punishment denotes ‘the infliction by the state of consequences normally considered unpleasant, on a person in response to his having been convicted of a crime.’²¹ Kant, who developed the retributive theory of punishment, views punishment as an infliction of ‘pain upon a [...] [person] on account of a [c]rime committed by him.’²² In his seminal work, named ‘Leviathan’, Hobbes also stated that punishment ‘is an evil inflicted [...] on him that hath done [...] [which is] a transgression of the law.’²³ As the father of utilitarianism, if we set aside Bentham’s argument about ‘what punishment is for’ or ‘how punishment can be justified’,²⁴ punishment, from his perspective, is also defined as ‘[...] all punishment is mischief: all punishment in itself is evil.’²⁵

From a slightly different perspective, Bedau and Kelly define punishment as an ‘authorized imposition of deprivations — of freedom or privacy or other goods to which the person otherwise has a right, or the imposition of special burdens [...].’²⁶ However,

¹⁹ Armstrong (n 15) 476.

²⁰ George P Fletcher, ‘What is Punishment for?’ (1994) 5 Contemporary Legal Issues 101, 101.

²¹ Andrew von Hirsch, *Doing Justice: The Choice of Punishment* (1st edn, New York: Hill and Wang 1976) 35.

²² Immanuel Kant, *The Philosophy of Law: An Exposition of the Fundamental Principles of Jurisprudence as the Science of Right* (W Hastie tr, T & T Clark 1887) 194.

²³ Thomas Hobbes, *Leviathan, or, The Matter, Forme and Power of a Commonwealth, Ecclesiastical and Civil* (Michael Oakeshott ed, Oxford: Basil Blackwell 1955) 202.

²⁴ The justification of punishment and its aims will be evaluated in Section Two.

²⁵ Jeremy Bentham, *An Introduction to the Principles of Morals and Legislation* (Oxford: Clarendon Press 1789) 170.

²⁶ Hugo Adam Bedau and Erin Kelly, ‘Punishment’ in Edward N Zalta (ed), *The Stanford Encyclopedia of Philosophy*, (Spring edn, 2010) <<http://plato.stanford.edu/entries/punishment/>> accessed 30 November 2014 (emphasis added).

the traditional formulation of punishment has been more likely to use the imposition or infliction of pain instead of imposition of deprivation.²⁷ At this point, Hart's understanding of punishment comes into prominence which includes the following standards defining the concept of punishment in terms of five elements:

- i. It must involve pain or other consequences normally considered unpleasant.
- ii. It must be for an offence against legal rules.
- iii. It must be of an actual or supposed offender for his offence.
- iv. It must be intentionally administered by human beings other than the offender.
- v. It must be imposed and administered by an authority constituted by a legal system against which the offence is committed.²⁸

Bearing this definition in mind, Hart points out that the main aim of punishment is composed of determining standards of behaviour and inserting penalties for any violation or for deviation, and then leaving individuals to make their own decisions about whether to offend or not.²⁹ However, while Hart sees that punishment should include 'pain', Flew avoids using the word 'pain', because, according to him, any physical pain has to be avoided while defining the word of punishment and his central point is instead, 'an evil, an unpleasantness to the victim' is all that has to be.³⁰ However, Hart supports the use of the term 'unpleasantness' (in addition to pain) but his

²⁷ Ibid.

²⁸ HLA Hart, *Punishment and Responsibility: Essays in the Philosophy of Law* (2nd edn, Oxford University Press 2008) 4-5. For Flew's and Benn's definition on punishment, see Antony Flew, 'The Justification of Punishment' (1954) 29 *Philosophy* 291; Stanley I Benn, 'An Approach to the Problems of Punishment' (1958) 33 *Philosophy* 325.

²⁹ Hart (n 28) 23.

³⁰ Flew (n 28) 293.

particular concern is that punishment as a matter of fact should involve ‘normally considered unpleasant’ consequences.³¹ Steiker argues that under this assumption ‘many things that the state can and does require its citizens to do will be “normally considered unpleasantness,” from mandatory inoculation, to conscription into the army, to payment of income taxes.’³² However, in response to this argument, it is noted that ‘[i]t is not only pain that is characteristic of punishment, it is pain inflicted because of wrong done and [...] [i]t is not only that the man suffers pain, but that he suffers it as a consequence and sign of the condemnation of his act [...]’.³³ McCloskey also indicates that the unpleasantness of punishment and the unpleasant treatments that states enforce are different: ‘punishment differs from quarantining, social surgery, etc., in that with these the evil is not an essential, deliberately intended part of the activity, in that if the evil could miraculously be avoided, the quarantining and social surgery would remain.’³⁴ In this respect, the unpleasantness administered through punishment must be construed, at least, as ‘an essential part of what is intended and not merely incidental to some other aim’ which might be added as the sixth element to the Hart’s definition of punishment.³⁵ Falcón y Tella and Falcón y Tella remark that ‘[t]he state intentionally causes suffering, unpleasantness, pain or evil to the offender with a specific end in view, or as a means to that end.’³⁶ Thus, punishment as an unpleasant consequence has to be intentionally applied or added to the situation in response to the behaviour deemed wrong.

However, slightly contrary to these definitions, Primoratz argues that defining punishment ‘as a pain or suffering’ imposed on a wrongdoer is too narrow a

³¹ Hart (n 278 4.

³² Carol S Steiker, ‘Punishment and Procedure: Punishment Theory and the Criminal-Civil Procedural Divide’ (1997) 26 *The Annual Review of Criminal Procedure* 775, 800-801.

³³ AC Ewing, ‘Punishment as a Moral Agency: An Attempt to Reconcile the Retributive and the Utilitarian View (1927) 36 *Mind* 292, 295.

³⁴ HJ McGloskey, ‘The Complexity of the Concepts of Punishment’ (1962) 37 *Philosophy* 307, 323.

³⁵ Stanley I Benn and RS Peters, *Social Principles and the Democratic State* (London: Allen and Unwin 1959) 174.

³⁶ María José Falcón y Tella and Fernando Falcón y Tella, *Punishment and Culture: A Right to Punish?* (Martinus Nijhoff Publishers 2006) 8.

definition.³⁷ In today's modern civilised countries, since it is hard to mete out any punishment which imposes any physical or mental suffering or pain on an offender, it is mostly *a deprivation of a good that the offender has a desire to keep* such as a certain amount of money or liberty.³⁸ Apparently, Primoratz's understanding of punishment represents a system of *imposing unwanted things on an offender*, which can be ascribed as an 'evil [which] is taken in a formal sense' with the aim of *depriving him of something to which he attaches a value*.³⁹ Given the aforementioned definitions of punishment, which, in general terms, is about the imposition of suffering, pain or unpleasantness, one can argue that deprivation of a good cannot be directly correlated with this type of identification of punishment. However, it can be accepted as a general rule that *either imposing unwanted things or depriving someone of a good can cause emotional or physical pain*, and, in substance, this is what the intention behind the infliction of punishment is. Yet if people are willing to be subjected to any determined punishment, imposing punishment on this person, in some way, might refer to the satisfaction of his wills and thus, it can no longer be regarded as punishment.⁴⁰ It seems that Primoratz is questioning the meaning of punishment by asking whether it deprives offenders of any desired things or not, because no one would willingly be deprived of something valued. At this point, rather than giving a detailed description of Kant's understanding of punishment, it is worthy to briefly note that Kant also views punishment merely as an unwilling infliction. His pivotal concern is that no one wants to be punished; only a 'punishable action' can be willed to be done.⁴¹ Hence, if someone commits a crime with the intention of being punished, punishment will lose its meaning

³⁷ Igor Primoratz, *Justifying Legal Punishment* (Reprinted, New Jersey: Humanities Press 1997) 1. See also Joel Feinberg, 'The Expressive Function of Punishment', in Michael Tonry (ed), *Why Punish? How Much?: A Reader on Punishment* (Oxford University Press 2011) 113.

³⁸ Primoratz (n 37) 2.

³⁹ *ibid*.

⁴⁰ *ibid* 3.

⁴¹ Kant, *The Philosophy of Law* (n 22) 201.

because, in this case, there will be no pain which can be meted out on a person or fall short of being accepted as punishment due to its concept or severity.

A related issue on this topic, which has increasingly captured the attention of states as a major way of dealing with offenders for almost 200 years, is the deprivation of liberty by which modern society punishes individuals who have acted against the law.⁴² In the traditional sense, incarceration includes the deprivation of freedom and some other goods which ensures that the imposition of pain, evil, unpleasantness, etc. on an offender owing to the wrongdoing is carried out.⁴³ Slobogin and Fondacaro state that under the concept of punishment, this type of liberty deprivation inflicts suffering on individuals because of causing harm.⁴⁴ Also, Swartz argues that deprivation of liberty can be regarded as a ‘pain’,⁴⁵ even if there are some training programmes provided in prisons in favour of offenders to gain new skills which cannot be conceived of as an unpleasant consequence.⁴⁶ Similarly, Gerber and MacAnany support the idea that training or rehabilitative programmes for offenders do not generate a ‘painful’ or ‘disvaluing’ punishment.⁴⁷ In this sense, programmes in prisons are designed to help offenders to improve their skills or to deal with their problems which give cause for committing crimes. Therefore, while the prison sentence as a punishment refers to pain or suffering for those convicted of crimes, the rehabilitative programmes (rehabilitation)

⁴² Matthew L Molineux and Gail Elizabeth Whiteford, ‘Prisons: From Occupational Deprivation to Occupational Enrichment’ (1999) 6 *Journal of Occupational Science* 124, 124. For further information about the history of prison and punishment, see David Rothman and Norval Morris (eds), *The Oxford History of the Prison: The Practice of Punishment in Western Society* (Oxford University Press 1995)

⁴³ Gerry Johnstone, ‘Restorative Justice and the Practice of Imprisonment’ (2007) 174 *Prison Service Journal* 15, 15.

⁴⁴ Christopher Slobogin and Mark Fondacaro, ‘Rethinking Deprivations of Liberty: Possible Contributions from Therapeutic and Ecological Jurisprudence’ (2000) 18 *Behavioral Sciences and the Law* 499, 500.

⁴⁵ Wolff and Hardy argue that the assessments over the nature of pain shares the same points that ‘pain is a “passion of the soul”, a feeling state or a “quale”, and not a specific sensation’. Harold G Wolff and James D Hardy, ‘On the Nature of Pain’ (1947) 27 *Physiological Reviews* 167, 167. From the medical standpoint, both physical and mental pains have simply been defined ‘in terms of reactions to noxious stimulation’. James D Hardy, ‘The Nature of Pain’ (1956) 4 *Journal of Chronic Diseases* 22, 22.

⁴⁶ Louis H Swartz, ‘Punishment and Treatment of Offenders’ (1967) 16 *Buffalo Law Review* 368, 371.

⁴⁷ Gerber and McAnany, ‘Punishment’ (n 17) 522.

actually represent the purpose of punishment, which is one of the justifications for imposing punishment on offenders. In the case of sex offenders, treatment programmes provided for those offenders in prisons are based on cognitive-behavioural model that tackle their beliefs, behaviours and/or perceptions as related to their sexual interests, desires and preferences. The objective of those programmes is to treat their sexual deviance, to help them develop internal controls by promoting their ability and willingness to manage their deviant desires in a way that will diminish the likelihood that they will reoffend. However, some of those programmes could be classified as (physically and emotionally) painful, especially, when offenders have to engage in the process of dealing with and changing their sexually deviant patterns as an integral part of the difficult journey towards treatment.⁴⁸ As discussed in Chapter Two, the purpose of treatment is to alleviate or prevent the deterioration in the offender's condition which lies behind the criminal behaviour. Even if a particular treatment programme inflicts pain or unpleasantness on offenders, it is not for the aim of doing anything about the criminal conduct but rather it concerns with the offender and aims to enhance his health and wellness. On that account, it can be argued that sex offender treatment programmes do not generate a painful or disvaluing punishment. However, I do not intend here an assessment of the treatment programmes for sex offenders, rather I argue whether the use of pharmacotherapy can be considered as a part of treatment programmes provided in prison for PSOs. In this respect, since the objective of the programmes in prison is to address the offenders' problems, in particular, the ones which make them turn to crime, and to facilitate their integration into society, voluntary pharmacotherapy can be considered within the context of these programmes and the pain resulting from voluntary pharmacotherapy does not entail a disproportionate punishment.

⁴⁸ R Emerson Dobash and Russell P Dobash, *When Men Murder Women* (Oxford University Press 2015) 181.

1.1. The Place of Pharmacotherapy in the Definitions of Punishment

As is discussed in Chapter Two, pharmacotherapy lowers sex drive and, at some point, takes away the ability to perform sexual intercourse by decreasing erection, semen production and orgasm and reducing fantasies to zero, or almost zero. By doing so, this medical intervention substantially deprives offenders of their sexual liberty (because of not being able to carry out sexual acts while they are on medication). In this respect, the arguments in this chapter are whether this deprivation caused by the use of involuntary pharmacotherapy can be integrated as part of the punishment for PSOs, and whether this integration constitutes a new understanding of punishment for their crime and brings a new approach to the criminal justice system. The commonly acceptable formula of punishment, which is the imposition of suffering on an offender for blameworthy behaviour or the imposition of unwanted things which deprives the offender of something to which he attaches a value, may provide a basis for involuntary pharmacotherapy. Given the deprivation element inherent in pharmacotherapy (DoSL), one can support the position that this deprivation can be put into practice in conjunction with (or in place of) DoL as a means of punishment for PSOs. As stressed above, punishment is often identified as a means to deprive offenders of a good that they have a desire to keep. These arguments on punishment indicate that deprivation is often considered as a means of imposing punishment because the infliction of the authorized punishment is intended to cause some form of deprivation (or pain) for the person being punished.

Since sexual liberty is a freedom or right and since pharmacotherapy can be considered as a means to deprive offenders of this liberty, the claim here is that the deprivation which results from the use of pharmacotherapy (DoSL) can be inserted into the

definitions of punishment.⁴⁹ On that account, DoSL with the use of pharmacotherapy can form part of punishment for PSOs. Admittedly, sexual liberty is not absolute, meaning that governments can be justified in limiting this liberty (by prohibiting certain form of sexual behaviours or criminalising them) with the aim of protecting and promoting the interests of others, its deprivation can be regarded as punishment because of constituting a burden for offenders. For instance, imprisoned offenders can be deprived of their sexual liberty by virtue of their incarceration or of the security or the prevention of crime and disorder such as the denial to allow an offender conjugal visits who are placed in disciplinary or administrative segregation. However, if a person is deprived of his liberty to perform sexual intercourse with the use of medication, this deprivation must be just and proportionate and the interference resulting from the use of medication must meet certain requirements and be justified by some other reason than protection and promotion of others' interests otherwise it may constitute a violation of human rights. In this study, the examination of the use of pharmacotherapy for PSOs is essentially based on the rights protected under the Convention. For this reason, it will be discussed more thoroughly in the following chapter that the exercise of sexuality can be restricted with pharmacotherapy in response to PSOs' sexual deviation, which affects those offenders ability to control their thoughts, sexual interests and behaviours and leads to child molestation, and to the harm they cause, only if its practice meets the requirements indicated in the Convention and in the Court's case-law.

However, one can argue that some PSOs may be willing to be released from and be free of their paedophilic desires/urges. In this respect, being subject to pharmacotherapy might be considered as the satisfaction of their wills and thus, it becomes controversial whether pharmacotherapy as a means to deprive offenders of their sexual liberty can be

⁴⁹ For a discussion on sexual liberty and DoSL, see Chapter Four.

regarded as punishment or not. As discussed above, pharmacotherapy treatment provided for PSOs helps them gain self-control over their deviant sexual urges and behaviours, and removes the internal constraints on autonomy by suppressing those offenders' deviant sexual desires and freeing them from those desires. Thus, these effects of pharmacotherapy are autonomy-enhancing and cannot be conceived of as an unpleasant consequence but rather represent the rehabilitative purpose of punishment. However, even if pharmacotherapy treatment may please some offenders by treating or ameliorating their condition (paedophilic disorder), in the meantime, those offenders will, to some extent, be deprived of their sexual freedom which is the inherent sexual rights of humans and is greatly valued by human beings. In other words, pharmacotherapy can result in loss of sexual desire or the loss of ability to engage in sexual activity and it is the DoSL that is the punishment element resulting from the imposition of pharmacotherapy. Bearing this deprivation element in mind, the argument is that when pharmacotherapy is integrated into the criminal justice systems as a part of PSOs' punishment, DoSL can comprise the punishment element of those offenders' sentence and thus, its imposition might require a reduction in their prison term to avoid additional suffering. In this respect, even if PSOs may be willing to be released from their paedophilic motivations or be relieved from the symptoms of paedophilic disorder, since there is an unpleasant consequence meted out on those offenders, DoSL via pharmacotherapy as punishment will not lose its meaning or it does not fall short of being accepted as punishment.

Regarding DoSL and the use of pharmacotherapy, as discussed above, DoSL with pharmacotherapy can specifically be intended as a measure only for PSOs due to the fact that it is only compatible with paedophilic sexual offences. In this sense, modern criminal justice systems can answer the question of 'how we deal with some specific

sex offenders' with the incorporation of DoSL within DoL. Since pharmacotherapy is regarded as a means for the administration of DoSL, much in the same way that prisons are used for DoL, as Harrison and Rainey put it, it can be conceived as a 'component of punishment'.⁵⁰ In this respect, one can draw a conclusion that DoSL with pharmacotherapy fulfils the core features of punishment and fits into the definitions of punishment indicated above and thus, it can be imposed on PSOs in combination with (or in lieu of) incarceration as complementary punishment or a component of punishment. However, presenting a descriptive analysis of punishment is only one out of several concerns. The discussion is to be continued as to what the aim of punishment should be: (i) to reduce future crimes by deterring, incapacitating and/or rehabilitating offenders or (ii) to penalize the guilty to the extent that s/he deserves so as to preserve justice or both. Thus, in the following part, I will venture an in-depth examination of the questions to what extent pharmacotherapy is an acceptable -proportionate, just, deterrent, etc.- measure within the general framework of the theories of punishment.

2. Theories of Punishment

The theory of punishment is often divided into two categories and construed under the rubrics of *retributive* and *utilitarian theories* and each theory is attempting to solve different problems/concerns in different ways.⁵¹ Also, the extension of the definition of punishment depends on how each theory justifies the use of punishment and describes the aim(s) of punishment. In this respect, it is significant to discuss the purpose of punishment for the following three reasons: (i) to highlight some arguments and shared points about the aim of punishment construed from different perspectives and theories; (ii) to throw light on the idea of using pharmacotherapy within the criminal justice

⁵⁰ Karen Harrison and Bernadette Rainey, 'Suppressing Human Rights? A Rights-Based Approach to the Use of Pharmacotherapy with Sex Offenders' (2009) 29 Legal Studies 47, 55.

⁵¹ It is worth noting that since the debates over the purpose of punishment are too wide to assess comprehensively; and the justification of punishment is multi-dimensional, throughout this part of this chapter, a special emphasis will be given to utilitarian and retributive theories of punishment.

systems and discussing the extent to which it addresses the question of ‘what punishment is for’ and whether it serves the purposes of punishment; and (iii) to clarify the implementation of pharmacotherapy and find out, whether or not, it can be used in punishing PSOs.

2.1. Retributive Theory of Punishment

It is essential to mention briefly the retributive definition of punishment by touching upon the different approaches among retributive theorists in order to comprehend the justification of punishment from a retributive perspective. According to Kant, who is regarded as the founding father of the theory of retribution in punishment, punishment represents a system of morality and such morality stems from Positive Law. Indeed, Kant elucidates the ‘Principle of Retaliation’ with his following remarkable quote: ‘If you slander another, you slander yourself; if you steal from another, you steal from yourself; if you strike another, you strike yourself; if you kill another, you kill yourself.’⁵² In a similar way, Hawkins defines punishment simply as ‘reflection’.⁵³ His description is that the infliction of ‘suffering on an offender’ is like ‘adding the evil of suffering to the evil of the offence [...]’⁵⁴ which represents Kant’s notion of punishment, to wit, the application of the ‘Principle of Retaliation’, which is that of ‘Like with Like’. In terms of what punishment is, under this theory there is a remarkable connection between crime and punishment; punishment is the infliction of suffering on offenders on the grounds that they deserve to be punished or made to pay damages.⁵⁵

Throughout the development of the idea of retributive theory of punishment, it has been accepted that punishment has three integral parts in terms of its purpose; ‘Desert’,

⁵² Kant, *The Philosophy of Law* (n 22) 196.

⁵³ DJB Hawkins, ‘Punishment and Moral Responsibility’ in Stanley E Grupp (ed), *Theories of Punishment* (Indiana University Press 1971) 13-14.

⁵⁴ *ibid* 14.

⁵⁵ Herbert Morris, *On Guilt and Innocence: Essays in Legal Philosophy and Moral Psychology* (University of California Press 1976) 34.

‘Justification’ and ‘Proportionality’. In this sense, it seems almost a truism that retributivism is concerned about three main issues: (i) the purpose of punishment is that ‘a person who has committed a crime’ should be punished because he has ‘deserved’ it; (ii) ‘a person has committed a crime’ and, bearing this statement in mind, punishment is justified simply by the offender’s guilt. In other words, ‘he has broken a law’ is a ‘necessary and sufficient’ element for the justification of punishment; and (iii) unjust results can be avoided by the ‘principle of proportionality’ which means that punishment should fit the crime and should be equivalent in kind to the offence.⁵⁶ As far as these concerns are analysed, it can be briefly inferred that retributive theory is essentially ‘backward looking’⁵⁷ because it gets to grips with ‘the person who has done the bad act’⁵⁸ and this person’s ‘blameworthiness’⁵⁹ on the grounds that offenders who committed the same crime and acted with the equal culpability should be meted out ‘equally severe’ punishments.⁶⁰

The leading modern advocate of retribution and desert theory, Andrew von Hirsch, asserts that ‘desert’ is an essential element before being punished because it is connected with the person whether s/he deserves to be punished or not, which is the first dimension of desert.⁶¹ In addition, ‘desert’ has another dimension which is about the severity of punishment. After the determination of the offender’s guilt, the severity of punishment meted out has to be considered regarding how much more severe

⁵⁶ In essence, punishment has to be ‘coercive or invasive’ and thus it has to be justified because of the moral values that individuals have. For this reason, ‘morally desirable’ punishment is not only the one that the people get what they deserve but also it should be ‘properly proportional to their crimes’. Jeffrie G Murphy, ‘Does Kant Have a Theory of Punishment?’ (1987) 87 *Columbia Law Review* 509, 510-530. Also, see Thomas E Hill, ‘Kant on Wrongdoing, Desert, and Punishment’ (1999) 18 *Law and Philosophy* 407; Morris J Fish, ‘An Eye for an Eye: Proportionality as a Moral Principle of Punishment’ (2008) 28 *Oxford Journal of Legal Studies* 57.

⁵⁷ DF Thompson, ‘Retribution and the Distribution of Punishment’ (1966) 16 *The Philosophical Quarterly* 59, 59.

⁵⁸ Ronald J Rychlak, ‘Society’s Moral Right to Punish: A Further Exploration of the Denunciation Theory of Punishment’ (1991) 65 *Tulane Law Review* 299, 300.

⁵⁹ Benn (n 28) 333.

⁶⁰ Richard S. Frase, ‘Punishment Purposes’ (2005) 58 *Stanford Law Review* 67, 68.

⁶¹ von Hirsch, *Doing Justice* (n 21) 45-55.

punishment is deserved and how it should fairly reflect the degree of condemnation.⁶²

Ashworth argues that ‘if punishment conveys blame, it would seem logical that the quantum of punishment should bear a reasonable relation to the degree of blameworthiness of the criminal conduct.’⁶³ He also states that in addition to ‘desert’ another element of punishment is ‘preventive’ which refers the notion that punishment is a kind of ‘censuring response’ and deters individuals from committing further crimes.⁶⁴ On this matter, Lewis posits that ‘the concept of Desert is the only connecting link between punishment and justice’ and just or unjust punishment can only be assessed on the grounds of whether it is ‘deserved or undeserved’.⁶⁵ For this reason, the deterrent effect of punishment is not a matter of concern for justice.⁶⁶

According to modern retributivists or desert theorists, desert and the principle of proportionality are the essential elements for the determination of punishment. Punitive sanctions should be arranged mainly by taking into account ‘the seriousness of the offen[c]e of which the offender has been convicted and the number and seriousness of his prior convictions’. In other words, ‘*severity of punishment should be commensurate with the seriousness of the wrong*’.⁶⁷ By referring to Beccaria’s understanding of punishment, von Hirsch supports the idea that punishment should be classified in such a manner as to conform to the severity of the crimes and he prefers to call the

⁶² *ibid* 66-76.

⁶³ Andrew von Hirsch, ‘Censure and Proportionality’ in R Anthony Duff and David Garland (eds), *A Reader on Punishment* (New York: Oxford University Press 1994) 118.

⁶⁴ Andrew Ashworth, ‘Desert’ in Andrew von Hirsch, Andrew Ashworth and Julian Roberts (eds), *Principled Sentencing: Readings on Theory and Policy* (3rd edn, Hart Publishing 2009) 102-103.

⁶⁵ CS Lewis, ‘The Humanitarian Theory of Punishment’ (1953) 6 *Res Judicatae* 224, 225.

⁶⁶ *ibid*. However, according to Duff, condemnation or censure needs to be expressed to the offender who deserves punishment in order to induce a recognition and feeling of guilt and to show the offender that his wrongdoing is taken seriously. Duff, ‘Penal Communications’ (n 5) 31, 75.

⁶⁷ von Hirsch, *Doing Justice* (n 21) 60-61, 66.

proportional and deserved punishment (the principle of proportionality) ‘commensurate deserts’.⁶⁸

In addition to desert theory, another main component of retributive theory is called ‘unfair advantage’.⁶⁹ If a person commits a crime, this indicates that he profits from his disobedience, and this unfair gain does not only affect the victim, but also others who obey the rules.⁷⁰ Davis states that offenders would gain unfair advantages over others who obey the rules by committing crimes and punishment refers to the termination of these unfair advantages, thus, it can be called ‘fair price’.⁷¹ On that account, the inflicted punishment ‘restores the equilibrium by imposing a counterbalancing disadvantage on the violator.’⁷² However, given the dimensions of desert theory, it is claimed that this restoration can also be achieved by the second dimension of desert theory: ‘the principle of proportionality’.⁷³ The principle of proportionality requires that punishment must be proportionate in its severity to the gravity of the crime, meaning that excessive or unfair punishment must be avoided.⁷⁴ For this reason, there is no need to discuss unfair advantage separately.

Turning back to the backward looking perspective of retributive theory and desert theory, the essential point is mainly considered as the ‘seriousness’ of the crime committed. Regarding Kant’s statements on crime, one of the worst crimes is ‘murder’.

⁶⁸ Notably, von Hirsch uses the principle of commensurate deserts for the ranking of penalties. With respect to this principle, punishment has to be graded according to the crime-seriousness. See von Hirsch, *Doing Justice* (n 21) 132-140. See also Andrew von Hirsch and Nils Jareborg, ‘Gauging Criminal Harm: A Living-Standard Analysis’ (1991) 11 *Oxford Journal of Legal Studies* 1.

⁶⁹ The unfair advantage is another model under the retributive punishment theory which essentially begins from Rawls’s hypothetical contract idea. See John Rawls, *A Theory of Justice* (Cambridge: Harvard University Press 1971).

⁷⁰ Jeffrie G Murphy, ‘Three Mistakes about Retributivism’ (1971) 31 *Analysis* 166, 167.

⁷¹ Michael Davis, ‘How to Make the Punishment Fit the Crime’ (1983) 93 *Ethics* 726, 743-45; John Finnis, *Natural Law & Natural Rights* (2nd edn, Oxford University Press 2011) 263. For a criticism on the fairness theory, see David Dolinko, ‘Mismeasuring “Unfair Advantage”: A Response to Michael Davis’ (1994) 13 *Law and Philosophy* 493.

⁷² von Hirsch, *Doing Justice* (n 21) 47.

⁷³ *ibid* 67.

⁷⁴ Andrew von Hirsch, ‘Proportionality in the Philosophy of Punishment’ (1992) 16 *Crime and Justice* 55, 56.

He clearly states that ‘whoever has committed Murder, must *die*.’⁷⁵ For rape, pederasty, and bestiality, he denotes that:

[T]he former two would have to be punished by castration and the last by expulsion for ever from civil society, because the individual has made himself unworthy of human relations. These crimes are called unnatural, because they are committed against all that is essential to Humanity. To punish them by *arbitrary* penalties, is literally opposed to the conception of a Penal Justice. But even then the criminal cannot complain that wrong is done to him, since his own evil deed draws the punishment upon himself [...].⁷⁶

However, von Hirsch suggests that not only the harm that the offence caused and the degree of the offender’s culpability, but also the offender’s criminal record -the number and severity of the previous crimes that he committed before- must be taken into account throughout the determination of the severity of punishment.⁷⁷ However, as is seen from the later works of von Hirsch, he modified this strict approach into a more flexible one by saying that

[p]roportionality sets priorities among sentencing aims. [...] [I]t is more important to have proportionality ordered sanctions than to seek other objectives –say, incapacitating offenders who are deemed higher risks. [...]

⁷⁵ Kant, *The Philosophy of Law* (n 22) 198.

⁷⁶ *ibid* 243.

⁷⁷ von Hirsch, *Doing Justice* (n 21) 60-61, 66. However, in a later work, he softened his claim on offenders’ criminal record and noted that more weight must be attached to the seriousness of the current crime than the prior record. See Andrew von Hirsch, ‘Recent Trends in American Criminal Sentencing Theory’ (1983) 42 Maryland Law Review 6.

A possibility would be to relax desert constraints to a limited extent. Proportionality would ordinarily determine comparative punishment levels, but substantial upward deviations might possibly be permitted in extraordinary cases, to restrain especially dangerous individuals. [...] These approaches still make desert the primary determinant of the ordering of penalties, but leave some extra scope for ulterior aims.⁷⁸

Bearing this more flexible version of desert theory in mind, it is worthy to stress two models which, to some extent, indicate the same points supported by von Hirsch and can also be considered as a rough guide for proportionate punishment (identifying which levels of punishment proportionate). These models are the ‘Morris Model’ and the ‘Bottoms-Brownsword Model’. The first model can simply be called ‘limited desert’ or ‘limiting retributivism’, which is slightly different from what is meant by retributive theory of punishment.⁷⁹ According to Morris, the notion of desert provides a transition between the upper and lower limits of deserved or allowable punishment⁸⁰ or, as Frase calls it, ‘upper and lower limits of desert’.⁸¹ By referring to ‘upper limits’ he argues that ‘[n]o sanction greater than that “deserved” by the last crime, or series of crimes, for which the offender is being sentenced should be imposed.’⁸² In addition, ‘lower limits’

⁷⁸ Andrew von Hirsch and Andrew Ashworth, *Proportionate Sentencing: Exploring the Principles* (Oxford University Press 2005) 7.

⁷⁹ As von Hirsch and Ashworth note, this kind of conception can be considered as ‘mix model’ because it reflects the basic principles of retributive and utilitarian theories of punishment. However, due to its content, von Hirsch and Ashworth do not support this type of understanding of punishment, but rather offer a similar model, namely ‘modified desert model’ which seems more compatible with desert-based understanding of retributive theory. See *ibid* 161-164, 180-185.

⁸⁰ Marc Miller and Norval Morris, ‘Predictions of Dangerousness: Ethical Concerns and Proposed Limits’ (1986) 2 *Notre Dame Journal of Law, Ethics and Public Policy* 393, 396; Marc Miller and Norval Morris, ‘Predictions of Dangerousness: An Argument for Limited Use’ (1988) 3 *Violence and Victims* 263, 267. Also, Morris notes that punishment should include three main principles which are ‘parsimony’, ‘dangerousness’ and ‘desert’. Norval Morris, ‘The Future of Imprisonment: Toward a Punitive Philosophy’ (1974) 72 *Michigan Law Review* 1161, 1162.

⁸¹ Richard S Frase, ‘Limiting Retributivism’ in von Hirsch, Ashworth and Roberts (eds) (n 64) 135.

⁸² Morris, ‘The Future of Imprisonment’ (n 80) 1173.

purports that punishment does not go beyond the seriousness of the committed crime.⁸³ For instance, due to the discretionary power of the decision-makers (judges), there might be different decisions in similar cases depending on the offender's personal characteristics or special circumstances.⁸⁴ Morris addresses this issue by adopting the idea of 'prediction of dangerousness'⁸⁵ and its key elements are 'the type and magnitude of harm predicted and the predicted level of risk or the rate of that harm, the product of these variables being a measure of total harm that at some point many in our society would agree constitutes dangerousness.'⁸⁶ To sum up, Morris supports the following three submissions for the purpose of punishment in order to secure the individual justice and protect community: (i) it is not necessary to inflict punishment or to extend the prison term regarding the 'prediction of dangerousness', if the punishment could be 'justified as a deserved punishment' without taking prediction into account; (ii) with respect to 'upper and lower limits of desert', punishment can be determined considering the 'predictions of dangerousness'; and (iii) on the grounds of the accuracy of prediction, which should be provided by 'reliable evidence', that 'with a closely similar criminal record and convicted of a closely similar crime' if one poses much higher dangerousness, namely 'base expectancy rate', than the other, the former one may get more severe punishment than the latter.⁸⁷ However, Floud argues that 'prediction of dangerousness' is an unacceptable policy because it is an 'ambiguous concept' and is not a monolithic or an objective concept with a standard determination.⁸⁸ In response to

⁸³ Norval Morris, *The Future of Imprisonment* (University of Chicago Press 1974) 60.

⁸⁴ Andrew von Hirsch, 'Incapacitation' in von Hirsch, Ashworth and Roberts (eds) (n 64) 79.

⁸⁵ Norval Morris, 'Incapacitation within Limits' in von Hirsch, Ashworth and Roberts (eds) (n 64) 91.

⁸⁶ In addition, 'dangerousness' is defined as an 'intentional behavio[u]r that is physically dangerous to the person or threatens a person or persons other than the perpetrator in effect, to assaultive criminality.' Norval Morris and Marc Miller, 'Predictions of Dangerousness' (1985) 6 *Crime and Justice* 1, 11.

⁸⁷ Morris, 'Incapacitation Within Limits' (n 85) 91.

⁸⁸ Jean Floud, 'Dangerousness and Criminal Justice' (1982) 22 *The British Journal of Criminology* 213, 213-14. For more information about 'prediction on dangerousness' and misfortunate situation regarding the 'false positives problems', see Jean Floud and Warren Young, *Dangerousness and Criminal Justice* (London: Heinemann 1981).

this argument, Morris and Miller stress that even though the reliability of ‘prediction of dangerousness’ is inaccurate, there is an incontrovertible fact that ‘prediction of dangerousness’ has a vital contribution to the criminal justice system, in particular, in the decision-making process.⁸⁹ They argue that ‘implicit predictions of future behavior are made at every point in the criminal justice system where physical danger to the person is threatened [...]’ and ‘explicit predictions of such behaviour have been part of the criminal law for centuries [...] includ[ing] prosecutorial decisions, bail and pretrial detention, and sentencing schemes [...]’.⁹⁰ Therefore, a legal system which does not include the role of predictions of dangerousness would be called ‘self-deceptive’.⁹¹ In addition, Morris’s model essentially offers a solution to the prison problem.⁹² The concept of dangerousness as a determinant of the decision to imprison could provide convenience to adequately separate the dangerous prisoners from the rest and, by doing so; it could reduce the present excessive use of imprisonment for non-dangerous offenders.⁹³ Even if the prediction of dangerousness is disputed because of allowing for the imposition of additional measures, such as further extension of imprisonment, and increasing the severity of punishment and what is deserved,⁹⁴ this increase in punishment can be justified on the grounds of being between the upper and lower limits of deserved punishment.

In a similar vein, Bottoms and Brownsword suggest a model which is based on extending the punishment beyond a deserved sentence on the grounds of ‘vivid danger’, namely the Bottoms-Brownsword Model (for ease of exposition, hereinafter ‘the B-B

⁸⁹ For further information, see Miller and Morris, ‘Ethical Concerns’ (n 80).

⁹⁰ *ibid* 393.

⁹¹ *ibid* 395.

⁹² Morris, ‘The Future of Imprisonment’ (n 80) 1161.

⁹³ *ibid* 1173.

⁹⁴ *ibid* 1165.

Model’).⁹⁵ In essence, their argument is based on Dworkin’s rights theory which means that individuals have to be treated with equal concern and respect by the state. According to Dworkin, a person should only be treated (or detained) against his/her will, if s/he presents a vivid danger, ‘not whenever we calculate that it would probably reduce crime if we did’.⁹⁶ In other words, when competing rights become an issue of concern due to the vivid danger that the person might harm either him/herself or others, a right can be confined only if there is a ‘more pressing right’. Bottoms and Brownsword place emphasis on ‘dangerousness’ while they are addressing the issue of competing rights within the framework of ‘punishment’ and the ‘right to release’. Their understanding of ‘dangerousness’ has two steps: (i) to detect that any rights are in peril; and (ii) to solve the problem which results from ‘competing right’.⁹⁷ In this respect, an offender’s desert-based rights can only be overridden in the case of vivid danger that he might harm himself or someone else. In light of this model, a cogent argument can be made that with a narrowly drawn exception, it would not cause any unjust punishment, if the principle of proportionality is breached by inflicting an extra ‘protective sentence’ on an offender if s/he poses a ‘vivid danger’ to others. This vivid danger is determined with respect to a test which consists of ‘seriousness’, ‘temporality’, which can be broken down into ‘frequency’ of temporality and ‘immediacy’ of temporality, and ‘certainty’ in order to hold a balance between the offender’s rights and somebody else’s rights.⁹⁸ In this respect, Bottoms and Brownsword support the idea that the vivid danger clause constitutes a ‘powerful reason’ for the justification of a protective sentence, however, ‘protective sentences would only *very exceptionally* be justified, the

⁹⁵ Anthony E Bottoms and Roger Brownsword, ‘Incapacitation and “Vivid Danger”’ in von Hirsch, Ashworth and Roberts (eds) (n 64) 83-84.

⁹⁶ Ronald Dworkin, *Taking Rights Seriously* (London: Duckworth 1978) 11.

⁹⁷ Anthony E Bottoms and Roger Brownsword, ‘The Dangerousness Debate After the Floud Report’ (1982) 22 *British Journal of Criminology* 229, 239.

⁹⁸ *ibid* 240.

justification lying in the anticipated depth of the offender's violation of the rights of others outweighing the depth of the known violation of the offender's rights.'⁹⁹

According to von Hirsch, on the grounds of Dworkin's rights theory, although 'the B-B Model' is based on the idea of competing rights rather than conflict of rights, and the distinction between 'vivid danger' and 'predictions of dangerousness' is not clear and still unsolved, the B-B Model can be an acceptable application in terms of extending the sentences of specific dangerous offenders.¹⁰⁰

In light of these considerations, in the case of PSOs, punishment is about forcing offenders to confront their wrongdoings by depriving them of their unjust/unfair advantage over others which was gained by the misuse of sexual freedom and violation of a legal rule. On that account, the argument here is that retributive punishment can be achieved by the application of pharmacotherapy because it concerns with the crime committed and the motives which cause and drive the offender to commit crime because of being captive of paedophilic sexual desires. As is noted earlier, retributive theory considers punishment is the best response to wrongdoing and wrongdoer on the condition that it must be proportionate to offence. Kant suggests that punishment should not be used '*merely as a means to promote some other good for the criminal himself or for civil society*, but instead it must in all cases be imposed on him only on the ground that he has committed a crime [...].'¹⁰¹ The reason for that is because of 'the idea of the will of every rational being, as *a universally legislating will*',¹⁰² meaning that if individuals act so that through their principles (maxims), which is at the same time

⁹⁹ *ibid.*

¹⁰⁰ For further information about von Hirsch's arguments on the B-B Model, see von Hirsch and Ashworth, *Proportionate Sentencing* (n 78) 50-61; Andrew von Hirsch and Andrew Ashworth, 'Extending Sentences for Dangerousness: Reflection on the Bottoms-Brownsword Model' in von Hirsch, Ashworth and Roberts (eds) (n 64) 85-89.

¹⁰¹ Immanuel Kant, *Foundations of the Metaphysics of Morals* (Lewis White Beck tr, Indianapolis: Bobbs-Merrill 1959) 100 (emphasis added).

¹⁰² Immanuel Kant, *Groundwork of the Metaphysics of Morals* (Revised edn, Cambridge University Press 2012) 4:432, 44.

regarded as their will, they can be the legislator of their universal law.¹⁰³ In this respect, being a legislator of universal law requires us to set aside the motives, especially the contingent ones, and to act in conformity with the principles which reflect the autonomous will because '[a] will whose maxims necessarily harmonize with the laws of autonomy is a *holy*, absolutely good will.'¹⁰⁴ As discussed in Chapter Two, paedophilic sexual urges might generate an impediment to individuals' autonomy and to their ability to make autonomous decisions. For this reason, the capacity of PSOs to reflect their autonomous choices/decisions concerning the alleviation of this particular impediment to their autonomy can be controversial. With respect to Kantian ethics and understanding of punishment, one may object that pharmacotherapy is used 'as a means to promote some other good for the criminal himself or for civil society'. However, there is yet another consideration that has to be taken into account. Pharmacotherapy certainly helps offenders control the paedophilic motives (and to set aside those motives in order to be the legislator of their universal law) and advance their autonomy, which is of the very essence of the permissibility of their actions because, according to Kant, 'an action that can be consistent with the autonomy of the will is *permissible*; one that does not agree with it is *impermissible*.'¹⁰⁵ In this sense, in order to overcome the impediment to autonomy and make autonomous decisions (or for permissible actions), the administration of pharmacotherapy can be considered within the retributive justice which, in some way, fits the crime and is equivalent in kind to the offence, and not merely but additionally involves the promotion of some other good for the offender and society.

Assuming for the sake of argument that DoSL via pharmacotherapy fits the crime, given the seriousness of the crime and the offenders' motive in committing the crime,

¹⁰³ *ibid* 4:421, 34.

¹⁰⁴ *ibid* 4:439, 51.

¹⁰⁵ *ibid*.

pharmacotherapy can be an appropriate and effective way to quell PSOs' sex drives and prevent them from reoffending. On this matter, Meisenkothen asks a rhetoric question: 'what could be more fitting than diminishing the sex drive in order to quell compulsive fantasies that give rise to crime?'¹⁰⁶ He supports the idea that greater control can be achieved over the pharmacotherapy process. Also, pharmacotherapy is commensurate with other forms of punishment for other serious crimes. If anything, allowing an offender to avoid prison by quelling compulsive irresistible sexual desires that give rise to crime, removing the eternal and internal constraints, and making them more autonomous individuals cannot be deemed disproportionate, excessive or severe punishment.¹⁰⁷ However, one may object that suitability for drug therapy is based on clinical assessment of paedophiles and medical suitability, whereas just desert is based on the seriousness of the crime. In response to this objection, although it is, to some extent, true that there are no different pharmacotherapy treatments for PSOs so the same medical intervention would be given even for less serious PSOs, as indicated in Chapter Two, the algorithm for pharmacotherapy treatment of sexually deviant behaviours and the algorithm for six levels of treatment for different categories of paedophiles (depending on the seriousness of the offenders' condition) can address the concerns on the length of and the severity of pharmacotherapy treatment and how the sentencing of those offenders would work (See Table 2 and Table 3 below). Although the seriousness of crime and the severity of paedophilic disorder are independent of each other, as is indicated in Table 3, both are required for gauging punishment because there is a connection between the level of pharmacotherapy and DoSL, and the level of pharmacotherapy treatment depends on the severity of the symptoms of paedophilic disorder (X, S₁, T, Y, R refer to low level of severity; 6X, S₆, 6T, 6Y, 6R refer to high

¹⁰⁶ Christopher Meisenkothen, 'Chemical Castration – Breaking the Cycle of Paraphiliac Recidivism' (1999) 26 Social Justice 139, 146.

¹⁰⁷ Ibid 147.

level of severity).¹⁰⁸ In this respect, since PSOs are deprived of their sexual liberty while undergoing pharmacotherapy, the length and the severity of this medical intervention can be taken into consideration as a determinant factor while estimating the reduction in the length of imprisonment and making the pain of the punishment (DoL in combination with DoSL) proportionate to the crime. This argument also indicates that as the offenders overcome internal constraints and develop internal controls, the external constraints imposed to manage those offenders (imprisonment) will become less necessary. Thus, the argument here is that given that it is the DoSL that is the punishment element, the imposition of pharmacotherapy in lieu of or in return for a reduction of any other punishment can be an effectual way of adjusting the proportionality between crime and punishment. In this respect, the punishment for PSOs (the imposition of DoSL in conjunction with DoL) can be determined by considering the severity of paedophilic disorder and the level of their treatment which are essential for the determination of the seriousness of DoSL and the amount of reduction in the length of imprisonment and for the imposition of proportionate punishment.

¹⁰⁸ It is worth noting that the argument in favour of integrating pharmacotherapy within criminal justice systems is that insofar as pharmacotherapy can be considered as a component of punishment and DoSL can be punitive. However, since the discussion here will limit itself to the theoretical level of discourse, the application of pharmacotherapy in practice in terms of how it would work and how much of the sentence (imprisonment) an offender should serve in order not to be subject to disproportionate punishment is beyond the scope of this thesis and requires further research.

Scenario	Offender (O)	Crime	DoL (X)	Severity of PD (S)	Level of Treatment (T)	DoSL (Y)	Reduction of imprisonment (%) (R)	Punishment (DoL+DoSL)
SCENARIO 1	O ₁	Least Serious	X	S ₁	T	Y	- % R	X - %R + Y
	O ₂	Most Serious	6X	S ₆	6T	6Y	- % 6R	6X - %6R + 6Y

Scenario	Offender (O)	Crime	DoL (X)	Severity of PD (S)	Level of Treatment (T)	DoSL (Y)	Reduction of imprisonment (%) (R)	Punishment (DoL+DoSL)
SCENARIO 2	O ₁	Least Serious	X	S ₆	6T	6Y	- % 6R	X - %6R + 6Y
	O ₂	Most Serious	6X	S ₁	T	Y	- % R	6X - %R + Y

PD: Paedophilic Disorder

Table 2: Integration of Pharamcotherapy into the Criminal Justice Systems: Imposition of DoSL in return for a Reduction in the Length of Incarceration

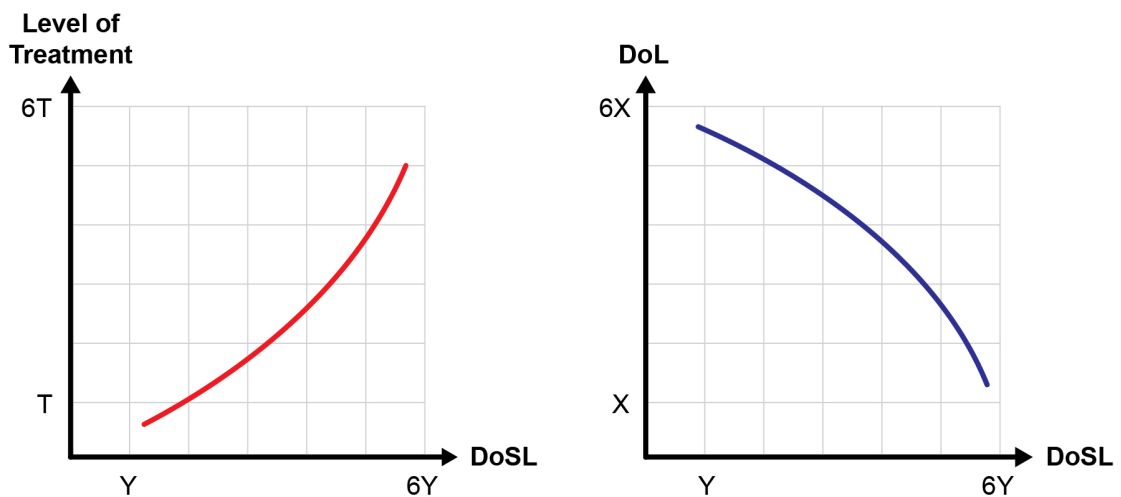


Table 3: The connection between the level of pharmacotherapy treatment, DoSL and DoL

However, in addition to the concerns over the use of pharmacotherapy and offenders' autonomy, there is another problem surrounding pharmacotherapy: how to justify the infliction of deprivation which is inherent in pharmacotherapy, DoSL. This problem moves the discussions over pharmacotherapy further and requires an assessment of it within the context of proportionate punishment. On this matter, it is noted that 'a punishment should be proportionate to what justifies it.'¹⁰⁹ Although the standard

¹⁰⁹ Jesper Ryberg, *The Ethics of Proportionate Punishment: A Critical Investigation* (Kluwer Academic Publishers 2012) 12.

formulation of proportionality refers to the relationship between punishment and crime whether punishment fits, matches or simply is proportionate to the crime (or to what the offender deserves), which can be called the strict version of retributive proportionality, the description of the notion of proportionality depends on its justification, how one theory justifies its imposition and considers proportionality in punishment.¹¹⁰ For this reason, the discussion over the use of pharmacotherapy and its proportionality in terms of the nature and amount of the punishment will be carried out after the assessment of the utilitarian justification of punishment with a special emphasis on the Morris Model and B-B Model.

2.2. Utilitarian Theory of Punishment

Within this theory, the imposition of pain on an actual or a potential offender (or in some cases on an innocent individual) with the aim of preventing further crimes is a generally accepted purpose. For Seidman, as a matter of course utilitarian theorists do not dream of a crime-free society. Rather the notion is the allocation of resources for the prevention of crime to a certain extent at which ‘the marginal cost of prevention equals the marginal cost of the crime prevented.’¹¹¹ To put it simply, the aim is to minimize the amount of the ‘costs of crime and crime prevention’.¹¹² However, ascribing a meaning to the purpose of punishment on the grounds of prevention has been argued as unjust due to its immoral character.¹¹³ As Bittner and Platt put it, meting out punishment with the aim of prevention is ‘inherently unjust’ because infliction of suffering on a person – even if he committed a crime- with the intent of convincing others not to commit any

¹¹⁰ *ibid.*

¹¹¹ Louis Michael Seidman, ‘Soldiers, Martyrs, and Criminals: Utilitarian Theory and the Problem of Crime Control’ (1984) 94 *The Yale Law Journal* 315, 316.

¹¹² *ibid* 320.

¹¹³ Johannes Andenaes, ‘The Morality of Deterrence’ (1970) 37 *The University of Chicago Law Review* 649, 649.

crimes does not cohere with the moral aspect of punishment.¹¹⁴ However, unlike retributive theory, utilitarian theory of punishment does not see any necessary connection between ‘offence’ and ‘offender’ but rather it looks beyond this and seeks the *utility of punishment*. Thus, utilitarian theory does not treat people as ends in themselves; rather people are means to the achievement or improvement of happiness. Bentham defines the utility principle in his classic work, called *Introduction to the Principles of Morals and Legislation*, which is one of the cornerstones of classic utilitarian theory, as

property in any object, whereby it tends to produce benefit, advantage, pleasure, good, or happiness, (all this in the present case comes to the same thing) or (what comes again to the same thing) to prevent the happening of mischief, pain, evil or unhappiness to the party whose interest is considered: if the party be the community in general, then the happiness of the community: of a particular individual, then the happiness of that individual.¹¹⁵

Rather than entering into all the details of his understanding of punishment, it may be briefly argued that according to Bentham, in order to support the interest of the community, ‘the sum total of [an individual’s] pleasure’ has to be augmented or ‘the sum total of his pain’ has to be decreased because the community comes into existence in the presence of individuals.¹¹⁶ In this sense, mischief should be exempted from the community to increase the total happiness. However, as is mentioned above, in

¹¹⁴ Egon Bittner and Anthony M Platt, ‘The Meaning of Punishment’ (1966) 2 *Issues in Criminology* 79, 93.

¹¹⁵ Bentham (n 25) 2.

¹¹⁶ *ibid* 3.

Bentham's case, punishment is mischief or evil and the only way to confirm the existence of this mischief is as far as it assures the prevention of some greater mischief or evil. Therefore, (i) if there is not any mischief or evil; (ii) if it is not possible to exclude mischief; (iii) if the evil of the offence seems less than the evil of punishment; or (iv) if there is a possibility that mischief can stop or be excluded without doing anything, according to Bentham, the infliction of punishment is 'groundless' 'inefficacious' 'unprofitable' or 'needless'.¹¹⁷ In a nutshell, Bentham focuses on accepting the existence of punishment in terms of turning mischief or evil into good. This reflects that punishment can only be appreciated if its effects outweigh the effects of mischief for the sake of producing benefit, advantage, pleasure, good, or happiness. On that account, utilitarian theorists refer to the term punishment in order to cover the consequences of imposing punishment on an offender which is essentially called the 'forward looking' notion of utilitarian theory that is contrary to the dominant assumption of the retributive meaning of punishment.¹¹⁸

As for the utilitarian aspect of punishment, the adopted principle mostly focuses on the prevention or the reduction of further crimes by the use of punishment, and a focus which is in line with this adopted principle has been considered as morally acceptable and defensible argument by the supporters of this theory. According to the utilitarian theorists, this principle can be carried out by four causal mechanisms which lead to a better/safer society by promoting public welfare and maximising the happiness of all by decreasing crimes and preventing further offences: (i) Deterrence (Specific Deterrence

¹¹⁷ *ibid* 170-177.

¹¹⁸ Some of the other scholars who agree with this statement are as follows: Hugo Adam Bedau, 'Retribution and the Theory of Punishment' (1978) 75 *The Journal of Philosophy* 601; Murphy, 'Three Mistakes' (n 70); Hyman Gross, *A Theory of Criminal Justice* (New York: Oxford University Press 1979); Thomas E Hill (n 56); Kris Gledhill, 'Preventive Sentences and Orders: The Challenge of Due Process' (2011) 1 *Journal of Commonwealth Criminal Law* 78.

and General Deterrence); ¹¹⁹ (ii) Rehabilitation; (iii) Incapacitation; and (iv) Denunciation.¹²⁰ Among these four mechanisms it is argued that deterrence is the most salient feature of the utilitarian theory of punishment and the basic premise of this mechanism is that ‘punishment, as an infliction of pain, is unjustifiable unless it can be shown that more good [the prevention or reduction of future crimes] is likely to result from inflicting than from withholding it.’ ¹²¹ It may be observed that this consequentialist aim is quite different from others by virtue of the fact that it is based on the influence of laws on potential offenders in society and plays an important role as a threat by ‘modifying the “price of crime” for all offenders’.¹²² In this context, punishment is relied on as an example of indicating the consequences in case of committing the same crime. On the other hand, rehabilitation seeks to change offenders’ behaviour, which drives them to break the law by committing crimes; incapacitation inhibits offenders from re-offending for prescribed periods of time;¹²³ and denunciation is the ‘expressive function’¹²⁴ of punishment in order to promote the social values of law-abiding society and social cohesion by assuring that the system works.¹²⁵ Among these four mechanisms, rehabilitation, incapacitation and, conceivably, specific deterrence are the ones that are particularly relevant to the discussion in this research.

¹¹⁹ However, from Frase’s point of view, specific and general deterrence does not fall into the category of deterrence and should be assigned to different categories on the grounds that general deterrence is intended to be an effective crime-control method, in particular, for members of society or specifically some groups tend to pose a potential risk to harm or of committing further offences. On the other hand, the aim of specific deterrence is to prevent a particular offender from committing further crimes with the aim of decreasing recidivism rates to zero, or nearly zero. Frase, ‘Punishment Purposes’ (n 60) 70-71. On the contrary, following Frase’s argument, Ball evaluates specific and general deterrence under the same heading as an effect of punishment. Ball states that both mechanisms seek to prevent crime and build a fear on actual or potential offenders. John C Ball, ‘The Deterrence Concept in Criminology and Law’ (1955) 46 *The Journal of Criminal Law, Criminology, and Political Science* 347, 347.

¹²⁰ Rychlak (n 58) 300.

¹²¹ Herbert L Packer, *The Limits of the Criminal Sanction* (Stanford University Press 1968) 39.

¹²² Isaac Ehrlich, ‘On the Usefulness of Controlling Individuals: An Economic Analysis of Rehabilitation, Incapacitation and Deterrence’ (1981) 71 *The American Economic Review* 307, 311.

¹²³ Julian Roberts and Andrew Ashworth, ‘Deterrence’ in von Hirsch, Ashworth and Roberts (eds) (n 64) 40.

¹²⁴ Frase, ‘Punishment Purposes’ (n 60) 72.

¹²⁵ Rychlak denotes that contrary to the deterrent effect of punishment, the denunciation mechanism focuses on law-abiding citizens of society, rather than actual or potential offenders. For further information on ‘Denunciation Theory’, see Rychlak (n 58).

The reason is that these three mechanisms seek to inhibit offenders or their conduct by (i) ‘isolating [them] from the larger society, thereby preventing [them] from committing crimes in that society’¹²⁶ or rendering them incapable of acting on their criminal impulses, motivations or tendencies; (ii) reforming them through treatment or any other method ‘which changes that part of the actor or his character that contributed to his criminal conduct’;¹²⁷ or (iii) deterring them from committing crime in the future by making them understand the consequences of reoffending. It is worth noting that although incapacitation bears a resemblance to deterrence in terms of preventing offenders from committing crimes, incapacitation substantially aims to deprive offenders of ‘the opportunity to continue harming others or at least restraining them in order to diminish their ability to do so.’¹²⁸ Whereas, the deterrent purpose of punishment can be served if the offenders think that the pain to be suffered from punishment outweighs the pleasure to be derived from committing crime and come round to a recognition of the importance or benefits of becoming law-abiding individuals.¹²⁹ According to Robinson and Darley, there is evidence that potential offenders, including PSOs, are less likely to think about the consequences of their behaviours and to control their attitudes and also those offenders ‘often are risk-seekers, rather than risk-avoiders, and as a group are more impulsive than the average.’¹³⁰ Given

¹²⁶ Alfred Blumstein, Jacqueline Cohen and Daniel Nagin, *Deterrence and Incapacitation: Estimating the Effects of Criminal Sanctions on Crime Rates* (Washington: National Academy of Sciences 1978) 3.

¹²⁷ Paul H Robinson, ‘Hybrid Principles for the Distribution of Criminal Sanctions’ (1988) 82 Northwestern University Law Review 19, 19.

¹²⁸ David Shichor, *The Meaning and Nature of Punishment* (Waveland Press 2006) 37. According to Williams, Gibbs and Erickson, the confusion between incapacitation and deterrence arises from the ‘inhibitory effect’ of both mechanisms. For instance, increasing the length of prison sentence for a particular crime can fall within the context of both incapacitation and deterrence mechanisms and what makes the difference is whether individuals are aware of the penalties. If not, then it is hard to claim that an increase in prison sentence length has a deterrent effect on offenders. Kirk Williams, Jack P Gibbs and Maynard L Erickson, ‘Public Knowledge of Statutory Penalties’ (1980) 23 The Pacific Sociological Review 105, 107.

¹²⁹ Shlomo Shoham, ‘Sentencing Policy of Criminal Courts in Israel’ (1960) 50 Journal of Criminal Law and Criminology 327, 330.

¹³⁰ Paul H Robinson and John M Darley, ‘Does Criminal Law Deter? A Behavioural Science Investigation’ (2004) 24 Oxford Journal of Legal Studies 173, 179.

that PSOs are motivated by urges they are unable to control but they know what they are doing and know that it is wrong, it appears that their act is intentional and their perception is in favour of violation instead of compliance.¹³¹ This argument indicates that the threat of harsher punishment for any conviction or the deterrent effect of severe punishment might sometimes fail to make certain offenders think about their further actions and the consequences of their conducts more cautiously. In these cases, rehabilitation and incapacitation become more crucial and for certain offenders, for their management and reintegration into society, these mechanisms can be considered as the most important element of utilitarian punishment.

From a different perspective, Rychlak categorises utilitarian punishment into two parts: (i) ‘the effects of punishment on potential lawbreakers’, including deterrence, rehabilitation and incapacitation, and (ii) ‘the effects of punishment on law-abiding society’, including reformation, resignation and retaliation.¹³² For the first category, he argues that punishment serves the aims of ‘maintaining stability, providing for the common protection, and advancing society in accordance with the majority’s wishes’ by ‘modifying the behavior of potential lawbreakers in at least three ways: By deterring people from engaging in crime, by rehabilitating lawbreakers, and by isolating dangerous people away from the rest of society.’¹³³ The latter categorisation becomes an issue of concern, if society fails to impose punishment on an offender or if the innocent individuals are subjected to punishment. In these cases, punishment has an impact upon not only the likely law breakers but also the ones who are not inclined to break the

¹³¹ *ibid* 174. For instance, in *R v Kingston*, where the person has given way to his paedophilic motivations and committed indecent assault on a 15-year-old boy after being involuntarily intoxicated, it was found that the necessary intent was present when the act committed, meaning that he had *mens rea* or guilty mind which suffices for crimes of basic intent. See [1995] 2 AC 355.

¹³² Rychlak (n 58) 308-321.

¹³³ *ibid* 308.

law.¹³⁴ By means of these features, utilitarian punishment can pursue the improvement of society and maximise utility and happiness because it does not only consist of subjecting (or the threat of subjecting) offenders (or individuals) to punishment but also it includes the alteration of offenders' incentive structure and attitudes towards committing crime by the help of therapies, training programmes and/or medical interventions.

Admittedly, rehabilitation and, to certain extent, incarceration play a key role in preventing crimes because these elements of punishment focus mostly upon criminal behaviours and recidivism rates of convicted offenders and provide opportunity to alter or control their behaviours.¹³⁵ However, these mechanisms have been subject to many objections, perhaps most notably rehabilitation, on the ground that it is not value-free and not on par with proportionality of punishment. For instance, Gerber and McAnany consider the idea of rehabilitation as punishment a 'tarnished' idea.¹³⁶ As they put it, the most serious charges generally focus on the length of the rehabilitation process criticised owing to its indeterminate nature and the concept reviewed as an 'invitation to personal tyranny and denial of human rights'.¹³⁷ Ashworth discusses the following five possible objections regarding the rehabilitation mechanism: (i) rehabilitative techniques do not contend with the entire causal factors apart from the offender's character and propensities; (ii) the state plays an authoritative role in the rehabilitation process; (iii) it causes a disproportionate discretion over the determination of an offender's status during the ongoing process; (iv) the deprivation of liberty or restriction caused by rehabilitation is out of proportion; and (v) its effectiveness does not achieve the level of

¹³⁴ *ibid* 314.

¹³⁵ Ehrlich (n 122) 314.

¹³⁶ Gerber and McAnany, 'The Philosophy of Punishment' (n 16) 353.

¹³⁷ *ibid* 354.

satisfaction.¹³⁸ In addition, Duff stresses that if punishment aimed at rehabilitation (or reform) is to treat the offender as a responsible moral agent, it should attempt ‘to bring him to face up to, to recognise and to repent, the wrong that he did: the wrongdoing that makes rehabilitation and reform necessary.’¹³⁹ However, many of the rehabilitative and reformatory programmes, especially for sex offenders, do not get them to understand that and why they need to be rehabilitated or reformed.¹⁴⁰

Moreover, according to von Hirsch, the aim of traditional rehabilitation is to alter ‘an offender’s personality, outlook, habits, or opportunities so as to make him/her less inclined to commit crime’.¹⁴¹ However, he questions the effectiveness of treatment programmes and argues that the imposition of *different punishments for similar crimes* by virtue of rehabilitation cannot be approved because there is a possibility that rehabilitation does not work properly.¹⁴² As an example, the National Probation Service’s publication on information for sentencers in 2003 indicates an important point that rehabilitation programmes, including behaviour programmes and drug programmes, *could* (but not certainly) reduce re-offending.¹⁴³ Also, concerning reducing offending and improving rehabilitation, the Home Office and Ministry of Justice point out that ‘[r]eoffending has been too high for too long, despite significant government spending on offender management in the last decade.’¹⁴⁴ Contrary to these objections, the Humanitarian theory, which is a variation of utilitarian theory but which supports the

¹³⁸ Andrew Ashworth, ‘Rehabilitation’ in von Hirsch, Ashworth and Roberts (eds) (n 64) 6-8.

¹³⁹ Duff, ‘Penal Communications’ (n 5) 81.

¹⁴⁰ Ibid.

¹⁴¹ Ashworth, ‘Rehabilitation’ (n 138) 1.

¹⁴² von Hirsch, *Doing Justice* (n 21) 12.

¹⁴³ See Gabriel Garton Grimwood and Gavin Berman, ‘Reducing Reoffending: The “What Works” Debate’ (2012) House of Commons Library Research Paper 12/71, 20 <www.parliament.uk/briefing-papers/RP12-71.pdf> accessed 30 November 2014.

¹⁴⁴ See Home Office, Ministry of Justice, The Rt Hon Norman Baker MP and Andrew Selous MP, ‘Reducing Reoffending and Improving Rehabilitation’ (11 June 2014) <https://www.gov.uk/government/policies/reducing-reoffending-and-improving-rehabilitation#bills-and-legislation> accessed 11 August 2014.

idea of treating offenders rather than punishing them,¹⁴⁵ holds that if there is a possibility to treat a thief by any rehabilitation programme, this person beyond any doubt should be compelled to receive the treatment.¹⁴⁶ The objectives of rehabilitation are to reform the offenders and place them back into society as much safer individuals, which is one of the forward looking purposes of utilitarian theory as it seeks to change offenders' dysfunctional thoughts and/or maladaptive assumptions through the punishment meted out. Although the humanitarian theory sounds like it calls for the abolition of punishment, which it does not, it essentially implies that the ideal practice is treatment, not punishment because it is not fair to treat all as equal.¹⁴⁷ For this reason, according to Menninger, the criminal justice system needs more specific reforms such as individualized sentencing.¹⁴⁸ In this respect, a compulsory treatment programme may be regarded as one of these specific reforms by virtue of being part of the practice of punishment, inflicting pain on offenders and also helping those offenders reform themselves, their behaviours and their lives.

Mackenzie argues that although utilitarian and humanitarian theories advocate therapy and treatment as a part of punishment, there is a slight difference concerning the aim of therapy and treatment that both theories seek. On this matter, she notes that '[i]f the penologist is concerned to maximise benefit, so that he is considering the majority, then he is a utilitarian. If, on the other hand, he focuses his attention on the individual criminal, I call him a *humanitarian*.'¹⁴⁹ Simply, humanitarian theory focuses on the benefits of any therapy or treatment to the interests of the offenders, not society, and

¹⁴⁵ Mark Tunic, *Punishment: Theory and Practice* (California: University of California Press 1992) 99.

¹⁴⁶ Lewis (n 65) 224. As one of the supporters of the humanitarian theory of punishment, Menninger argues that the resources would be better used reforming the criminals: "Let no feelings of cave-man vengeance influence us. Let us rather help him who did so human a thing." Karl Menninger, *The Crime of Punishment* (New York: Viking Press 1968) 199.

¹⁴⁷ Menninger (n 146) 92.

¹⁴⁸ *ibid* 63, 70.

¹⁴⁹ Mary Margaret Mackenzie, *Plato on Punishment* (University of California Press 1981) 34-35.

seeks the reformation of those offenders and thus, it is also called a theory of reform.¹⁵⁰ However, given the social reasons which urge the reformation of the offenders, which can also be called the aim or justification of punishment, humanitarian and utilitarian theories resemble each other in many aspects but with only one difference. The humanitarian emphasis on offenders promotes individualism, meaning that it seeks to make contribution to individuals for their own sake, whereas utilitarian theory gives the utmost priority to the notion of public interest and serves the interests of the majority in society, which makes it more pluralistic.¹⁵¹ Within the context of both theories, imposing a medical practice on an offender as a component of punishment is conceivably possible (and justifiable) because this type of punishment will promote overall human happiness by making the offender a better man and maximising the overall outcome.

It is worth remarking that concerning the difference between punishment and treatment, humanitarian theory cannot make a clear distinction between these concepts because this theory considers that the treatment process for the offender must be as coercive as punishment. This approach can be problematic in terms of autonomy, because although punishment is autonomy infringement, the justification of its imposition also justifies the interference with autonomy whereas humanitarian theory treats crime as a disorder which needs treatment. In other words, regardless of whether there is an impediment to individuals' autonomy, this theory supports the idea that compulsory treatment can be imposed on offenders for their benefit which, as is discussed in Chapter Two, certainly conflicts with the principle of autonomy and gives rise to concerns over its justification. Morris argues that the logic behind the idea of curing offenders of their deviant

¹⁵⁰ *ibid* 51.

¹⁵¹ For more information the humanitarian theory, see Norval Morris and Donald Buckle, 'The Humanitarian Theory of Punishment A Reply to C. S. Lewis' (1953) 6 *Res Judicatae* 231; JJC Smart, 'The Humanitarian Theory of Punishment' (1953) 6 *Res Judicatae* 368; Lewis (n 65); Menninger (n 146); Mackenzie (n 149) 51-67.

tendencies includes some alterations of them against their will because their criminal conduct is an indication of some disorder which affects and normalises their conception of 'wrong' and makes them believe that it is 'right'.¹⁵² He also discusses that

[w]hen we treat an illness we normally treat a condition that the person is not responsible for. He is 'suffering' from some disease and we treat the condition, relieving the person of something preventing his normal functioning. When we begin treating persons for actions that have been chosen, we do not lift from the person something that is interfering with his normal functioning but we change the person so that he functions in a way regarded as normal by the current therapeutic community. We have to change him and his judgments of value. In doing this we display a lack of respect for the moral status of individuals, that is, a lack of respect for the reasoning and choices of individuals.¹⁵³

However, as discussed earlier, not all sex offenders are motivated by sexual desires and can be subject to anti-androgen hormone treatment because pharmacotherapy can be effective for offenders who have paedophilic tendencies. Since paedophilia might constitute an impediment to autonomy and raise concern over the capacity to make a decision regarding the treatment of this particular condition; involuntary pharmacotherapy treatment must be considered for only those who lack capacity or whose capacity is in question. If treatment becomes a dominant approach in criminal justice, this might undermine the entire concept of punishment and also human rights and its forcible imposition would be hard or all but impossible to be justified within the

¹⁵² Morris (n 55) 42-43.

¹⁵³ *ibid.*

context of the principles of punishment or the principles of medical ethics. Since not all criminals are non-responsible, psychologically disturbed and in need of treatment, a treatment model in lieu of punishment in terms of dealing with wrongdoing would not be appropriate and righteous unless it fits within the context of justice. Punishment with the aim of rehabilitation, incapacitation or specific deterrence should balance an emphasis on imposing pain or suffering on an offender or depriving an offender of something to which he attached a value and an emphasis on treating him to promote his rights/interests and the interests of others.

Given that the use of pharmacotherapy disables paedophiles or disqualifies those offenders to repeat certain criminal behaviours or to reoffend, the incapacitation element of punishment is also of vital importance to consider. Malsch and Duker argue that incapacitation refers to the ‘sanctions or interventions that aim to impede, restrict or make impossible certain actions, without necessarily being accompanied by measures that aim at other goals and effects, such as retribution, rehabilitation, restoration [...]’.¹⁵⁴ In this respect, incapacitation, which is considered as ‘a type of preventive measure’, is not only accompanied by imprisonment but also by other measures which aim to hinder offenders from committing further crimes by controlling their conducts and their lives including medical interventions.¹⁵⁵ It is also noted that since rehabilitation aims at ‘reducing individual recidivism through imposition of specific positive incentives’ and since incapacitation is crucial for certain offenders ‘where the extent of individual responsiveness to incentives is low and the rate of recidivism is high’, efficient and effective control of specific types of offences requires the adoption

¹⁵⁴ Marijke Malsch and Marius Duker, ‘Introduction’ in Marijke Malsch and Marius Duker (eds), *Incapacitation: Trends and New Perspectives* (Ashgate Publishing 2012) 2.

¹⁵⁵ Jelle A Troelstra and others, ‘Incapacitation: Anti-libidinal Medication in the Treatment of Sex-Offenders’ in Malsch and Duker (eds) (n 154) 133.

of both rehabilitative and incapacitating practices.¹⁵⁶ Considering that paedophilic crimes are committed under the influence of uncontrollable/irresistible sexual desires or situational pressure, the rehabilitative and incapacitating effects of pharmacotherapy appear to have a dual effect on offenders. It can improve the offenders' lives by enabling them to control their sexual inclinations and urges, and can make a relapse into further paedophilic crimes impossible by removing the ability to do so. Alleviating paedophiles' uncontrollable/abnormal sexual desires or removing their undesired behaviours, taking away their opportunity to reoffend, preventing further crimes with the help of medications, bringing those offenders back to society and securing safety in the society make pharmacotherapy an effective measure to treat and to control those offenders in a practical and positive way. Troelstra and others argue that if incapacitation refers to a reduction in reoffending or an elimination of risk of recidivism, in the case of PSOs, this can be achieved by pharmacotherapy, if this medical intervention is applied properly. However, according to them, its use within the criminal justice system must be in compliance with the principle of proportionality and the requirements of humanity concerning the treatment of sex offenders and it should be applied following a thorough psychiatric and medical assessment, otherwise it would be controversial that pharmacotherapy is a convenient form of incapacitation or rehabilitation.¹⁵⁷

Overall, the idea behind utilitarian punishment, in particular, rehabilitation and incapacitation elements, is supposed to reduce crime by impeding an offender from committing any further crime or by altering his state and/or behaviours such that they will be less apt to cause criminal harm. These elements at large attempt to process offenders in a way that will remove the physical/psychological constraints which

¹⁵⁶ Ehrlich (n 122) 314, 319.

¹⁵⁷ Troelstra and others (n 155) 142.

motivate them to commit a crime and also which can be regarded as an indication of future dangerousness. Putting a restriction on one's ability to perform sexual intercourse can be considered within the frame of incapacitation and following this, the rehabilitation element of punishment which attempts to remove the impediments to one's autonomy and enable him to have control over the constraints to his psychological/physical state can be fulfilled by the practice of pharmacotherapy. Rather than restricting all aspects of a person's life (which is carried into effect by incarceration), pharmacotherapy merely limits a person's sexual activity by specifically focusing on the criminal behaviour and the state of the offender. On this matter, Ehrlich is of the opinion that incarceration is deficient on several important grounds. For instance, prison walls can prevent offenders from participating in criminal activity but do not grasp their inner world (their criminal thoughts/motivations). Also, given that imprisonment might lead to a decrease in 'legitimate knowledge and skills' and might have a hardening effect on offenders, this may result in reoffending after release from prison.¹⁵⁸ In response to these deficiencies, the argument here is that DoSL with the use of pharmacotherapy can tackle both the offenders' inner sexual deviancy and the expression of these deviant thoughts (criminal behaviours) and decrease the likelihood of reoffending.

As is discussed in the previous chapter, the conflict internal to PSOs' motivational structure constitutes an impediment to control/overcome paedophilic sexual urges and to reflect autonomous decisions (or to be autonomous) and thus, results in committing crimes. Referring to surgical castration, Sifferd argues that involuntary castration 'take[s] away a whole category of first order desires [...] also make[s] ineffective –in a sense, [it] might as well erase- their second order preferences' because its effects are

¹⁵⁸ Ehrlich (n 122) 315.

permanent.¹⁵⁹ Given that involuntary castration renders offenders' second order preferences 'unnecessary, or ineffective' permanently and 'first order desires for sex no longer arise', this might lead to a violation of autonomy.¹⁶⁰ However, involuntary pharmacotherapy does not take away a whole category of first-order desires or make their second-order preferences permanently ineffective. Rather it stops offenders from acting upon first-order desires (paedophilic urges) and gives them the ability to control their desires and behaviours by making them able to critically assess their first-order motivations and rendering them able to control these motivations or change them in light of higher-order motivations. After the use of pharmacotherapy, offenders' first order motivations will be changed or they will be able to review their desire based on second-order motivations which is of the essence to control first-order motivations and to be more autonomous. On this matter, Bomann-Larsen holds that

[p]re-intervention, [the offender's] inclination to abuse [children] conflicted with his higher-order pro-attitudes, so it seems there was already a deficit in his capacity for autonomy. In fact, he may therefore be more autonomous post-intervention, because his behaviour now at least is the result of his own choice.¹⁶¹

In this respect, using pharmacotherapy within the criminal justice system can be justified on the grounds that the person who does not have the capacity to manage the conflict between first-order and second-order motivations, and the capacity to reflect

¹⁵⁹ Katrina L Sifferd, 'Changing the Criminal Character: Nanotechnology and Criminal Punishment' in Amedeo Santosuosso (ed), *Proceedings of the Young Scholar Symposium on Law and Science* (European Centre for Law, Science and New Technologies, University of Pavia Press 2012) 16.

¹⁶⁰ *ibid* 15-16.

¹⁶¹ Lene Bomann-Larsen, 'Voluntary Rehabilitation? On Neurotechnological Behavioural Treatment, Valid Consent and (In)appropriate Offers' (2013) 6 *Neuroethics* 65, 72, fn 19.

critically upon and hold second-order considerations will gain the power to control his life and behaviours and will become more autonomous. It can also be argued that the use of pharmacotherapy within the criminal justice system does not go beyond what is necessary in order to restore the particular behaviour and to maintain social order. In the case of PSOs, the dangerousness of those offenders or the risk of recidivism might lead to further incarceration or even indeterminate prison sentences. Curbing the deviant sexual urges of PSOs by applying pharmacotherapy would be beneficial not only in ensuring the security of individuals, but within a utilitarian perspective, this option also provides financial settings for policy makers, especially when the costs of incarceration is taken into account which is a major political and economic concern for the states and also for the tax payers. Overall, using pharmacotherapy serves the purposes of utilitarian theory by covering not only the interests of offenders, but also the interests of the community by treating their paedophilic sexual urges and enhancing their autonomy, minimising the risk of re-offending and ensuring appropriate responses to crime and the safety of society.

In light of these discussions, the argument in the following part rests on the claim that pharmacotherapy can be integrated within the criminal justice system in return for at least some reduction in the length of imprisonment. By taking the retributive and utilitarian aims of punishment into consideration, in particular, the proportionality principle of punishment, the consequentialist justifications of punishment (incapacitation and rehabilitation) and the connection between the offender and society, its values, perceptions and expectations, the following part will discuss that pharmacotherapy can be used as a means of punishment for PSOs.

B. Criminal Justice Approach to PSOs Treatment Issues

As a general review of the theories and models mentioned in this chapter, it seems that attempts to clarify the purpose of punishment and to justify the institution of punishment take different paths from different starting points. Each theory assesses the aim of punishment and its justification regarding the importance given to moral values and the expectations from its imposition. The discussions are as to whether offenders have to be impeded or discouraged from committing further crimes or they have to be punished according to what they deserve with respect to the committed crime. Especially, when rehabilitation and, in some cases, incapacitation become an issue of concern, the discussion mainly revolves around the effectiveness of those concepts, the proportionality of the punishment and the human rights of offenders. The reason is that some treatment programmes or medical interventions imposed on offenders under the name of rehabilitation and/or incapacitation may fall short of clear and convincing evidence regarding its effectiveness or may give rise to additional pain/suffering or deprivation. Duff argues that punishment should aim to persuade the offender ‘to confront, to understand, and to repent what he has done’ which aims at the offender’s self-reform in order to make him understand the wrong he has done and make him recognise that his conducts and attitudes need to be reformed for the future.¹⁶² Therefore, in this part the incorporation of pharmacotherapy into the criminal justice systems for the punishment of PSOs will be discussed on the ground that if it imposed on PSOs, it can condemn offenders for committing crime, can benefit to the community, can bring offenders to understand the wrongness of their behaviour and can help them recognise the need for reform.¹⁶³

¹⁶² Duff, ‘Penal Communications’ (n 5) 52.

¹⁶³ According to Duff, the central aim of punishment is to communicate to offenders the condemnation that they deserve for their wrongdoing. Punishment as communicative offer should not only impose pain or burden on offenders for their crimes, constitute a deserved response to the crime committed and bring

When the nature of sex offences, the increase in the number of sex crimes being reported and recorded, and inadequate and insufficient solutions to this type of crimes are considered,¹⁶⁴ there has been a general belief that members of the public are under a threat from sex offenders which often leads to a moral panic.¹⁶⁵ Such a panic has engendered changes to be made in the way of sentencing sex offenders.¹⁶⁶ Concerning the regulations made to control and to prevent sex crimes such as registration, civil commitment or electronic monitoring, it may be argued that the reactions of members of the public, their perceptions and expectations were followed by extraordinary and/or severe punishments.¹⁶⁷ Also, these reactions have had a significant impact on the pattern

consequential benefits but also persuade offenders to realise and repent the wrongfulness of their behaviour, and so to realise the need to reform themselves and to reconcile themselves with community. Punishment as communication appears to be an adequate concept to base the use of pharmacotherapy in the punishment of PSOs on. However, this concept of punishment does not address the question of how far punishment respect the autonomy of offenders whose criminal behaviours are motivated by the conflict internal to their motivational structure which constitutes an impediment to control their behaviours and to reflect autonomous decisions. Rather, he supports that punishment should treat and address offenders as 'rational moral agents', respect the privacy of offenders' moral character and their autonomy, and instead of coercively invading the deepest aspect of their moral personality, it should persuade offenders to reform themselves and to repent what he has done. See Duff, 'Penal Communications' (n 5). A discussion on capacity and criminal liability, see R Anthony Duff, 'Choice, Character, and Criminal Liability' (1993) 12 *Law and Philosophy* 345; R Anthony Duff, 'Penal Communities' (1999) 1 *Punishment and Society* 27; R Anthony Duff, *Punishment, Communication, and Community* (Oxford University Press 2001) 75-170.

¹⁶⁴ For more information about research statistics on the prevalence of child sexual abuse in the UK, see UK National Statistics, Violent and Sexual Crime <<http://www.statistics.gov.uk/hub/crime-justice/crime/violent-and-sexual-crime/index.html>> accessed 14 May 2014; National Society for the Prevention of Cruelty to Children, Statistics on Child Sexual Abuse <<http://www.nspcc.org.uk/>> accessed 14 May 2014. For the reoffending rates of child sex offenders, see Ministry of Justice, Collection: Reoffending Statistics (20 August 2013) <<https://www.gov.uk/government/collections/reoffending-statistics>> accessed 14 May 2014.

¹⁶⁵ McCartan holds that in today's world, paedophilic sexual abuse is a 'major social crisis' because of its occurrence and the frequency with which it occurs. Therefore, current policies concerning PSOs are 'a combination of strongly held beliefs and relatively few facts [...] leading to public safety and criminal justice problems.' Kieran F McCartan, 'Current Understanding of Paedophilia and the Resulting Crisis in Modern Society' in Jayson M Carroll and Marta K Alena (eds) *Psychological Sexual Dysfunctions* (New York: Nova Biomedical 2008) 51-53.

¹⁶⁶ For instance, Thomas argues that in the UK, media coverage of and public reaction to paedophilia can be deemed as one of the main reasons for the shift in government policy on sex offenders. See, Terry Thomas *Sex Crime: Sex Offending and Society* (2nd edn, Willan Publishing 2005).

¹⁶⁷ For a more comprehensive analysis of the trends of adopting harsher sentencing policies due to the increasing concern for security (security fears) and moral panic, see Julian V Roberts and Loretta J Stalans, *Public Opinion, Crime, and Criminal Justice* (Westview Press 1999); David Garland, *The Culture of Control: Crime and Social Order in Contemporary Society* (Oxford University Press 2001); Michael Tonry, *Thinking about Crime: Sense and Sensibility in American Penal Culture* (Oxford University Press 2004).

of sentencing offenders.¹⁶⁸ Among these sentencing policies, the most controversial one is pharmacotherapy, although, a significant number of studies indicate that its effectiveness is incontrovertible in terms of recidivism rates.¹⁶⁹ On that account, the argument here is that pharmacotherapy can be adopted by the states and integrated into the criminal justice system with the aim of meeting the needs and the expectations of society and PSOs, and the goals of punishment. Also, it can bring PSOs to understand and repent the crime they have committed, help direct their attention onto what he has committed and why he has committed and render them more adequate at responding to moral wrongfulness of their criminal behaviours.¹⁷⁰ At this stage, I will use a model namely the *Action-Reaction Model* inspired from Newton's 'Third Law of Motion' in Physics to indicate that as a criminal justice policy and a legislative response to moral panic over PSOs and to security fears, pharmacotherapy is a direct and quick way to combat certain criminal behaviours more effectively and hinder offenders from exhibiting such behaviours, which renders its application attractive to states.

1. Action-Reaction Model

'To every action, there is an equal and opposite reaction.'¹⁷¹ This statement briefly indicates that every action is accompanied by an equal magnitude of reaction but in contrary directions.¹⁷² In terms of punishment, regardless of a few exceptions, admittedly, if a man acts against the law (commits a crime), there must be a reaction

¹⁶⁸ Concerning the public perception of and response to paedophilic sexual abuses and the generation of moral panic surrounding paedophilia see David C Wilson and Ian Silverman, *Innocence Betrayed: Paedophilia, the Media and Society* (Wiley Publishing 2002); Martha-Marie Kleinhans, 'Criminal Justice Approaches to Paedophilic Sex Offenders' (2002) 11 *Social and Legal Studies* 233.

¹⁶⁹ For a comprehensive study on the outcomes of pharmacotherapy in terms of recidivism rates, see Walter J Meyer, Collier Cole and Evangeline Emory, 'Depo Provera Treatment for Sexual Offending Behaviour: An Evaluation of Outcome' (1992) 20 *Journal of the American Academy of Psychiatry and the Law* 249; Christopher Meisenkothen, 'Chemical Castration – Breaking the Cycle of Paraphiliac Recidivism' (1999) 26 *Social Justice* 139; Friedrich Lösel and Martin Schmucker, 'The Effectiveness of Treatment for Sexual Offenders: A Comprehensive Meta-Analysis' (2005) 1 *Journal of Experimental Criminology* 117.

¹⁷⁰ Duff, 'Penal Communications' (n 5) 52.

¹⁷¹ JO Perrine, 'The Third Law of Motion' (1916) 16 *School Science and Mathematics* 14, 14.

¹⁷² VF Lenzen, 'Newton's Third Law of Motion' (1937) 27 *Chicago Journals* 258, 258.

(punishment) for this unlawful action. Although this statement seems that, *prima facie*, the action-reaction model refers to a retributive theory of punishment because of considering the act and the expression or consequences of this act, this model is more than that. Because, in addition to this consideration, however, with respect to certain requirements and conditions such as the dangerousness of the offenders and the upper and lower limits of deserved punishment, it also has utilitarian dimensions including rehabilitation and incapacitation of offenders.

Within this model, the argument here is that the action represents the act of the wrongdoer, to wit, wrongdoing/crime; and the equal and opposite reaction implies punishment. However, it should be noted that this reaction sometimes includes not only the response of the legislative branch of the governments to any infraction of the law, but also –in the event of sexual crimes, it could be inevitably- the continuing panic of members of the public over crimes and the pressure exerted by media and society because they often prompt the governments to adopt alternative but more permanent, comprehensive and fundamental solutions.¹⁷³ Also, the social reaction can be thought to stem from not only the crime itself but also indecisive, inadequate and/or defective government policies. Therefore, punishment can arguably be a combination of different reactions, to wit, social reaction, and legislative reaction, because for certain crimes, legislative reaction is sometimes stimulated by increasing concern of society over crimes or by the public outcry for harsher sentences. In other words, there can be a connection between the legal and societal response to the offenders and the crime committed in terms of punishment. The response derived from society's reaction can be

¹⁷³ In a similar way but from a slightly different standpoint, Duff reconciles punishment with community and argues that the community figures 'as the victim of crime', 'as an agent of crime prevention', 'as a locus of punishment' and 'as the offender's proper place'. On that account, punishment as a mode of moral communication can constitute appropriate modes of moral communication between the normative community and legal-political community. For more information, see Duff, 'Penal Communities' (n 5); Duff, *Punishment, Communication, and Community* (n 163) 35-79.

called an 'implicit reaction' (or 'indirect reaction'). Given that this implicit reaction can promote legislative initiatives and can be associated with a punitive turn, one can argue that social reaction plays a key role in the formation of legislative reaction, which can be called explicit reaction (or direct reaction), and the determination of punishment. To put it another way, society has a manipulative effect on policymaking which indirectly shapes the legislative agenda and/or affects legislative outcomes in terms of taking an action requiring the solution of a particular problem. In this sense, public reaction is a matter that triggers or stimulates the legislative reaction, specifically, if there is a great danger and an enormous public outcry for the protection from any serious harm caused by a particular crime.¹⁷⁴ At this point, public reaction comes to occupy a pivotal role in the legislative process; essentially in the determination of the punishment or of the severity of the punishment and thus, the legislative reaction inevitably reflects the demands of society in order to address the concerns or deal with the substantial existing problems. According to Welch, the statements made by politicians and law enforcement officials to address the fear of members of the public are 'demagogic'. The concept of moral panic gives rise to provoke the punitive sanctions. Although these punitive sanctions are not proportional to the crime and ignore 'the root causes of crime and violence', they are mostly justified under the strategy of preventing further crime or deterring individuals from committing crime.¹⁷⁵ As is seen from Welch's assessments, the effects of social reaction are undeniable and unavoidable, especially, when there is a need to take immediate preventive measures, even if, in some cases, this results in disproportionate punishment. In this sense, the terms of 'social reaction' and 'moral panic' can be used to substitute each other within the context of 'social problems or

¹⁷⁴ Andrew Rutherford, 'Sexual Offenders and the Path to a Purified Domain' in David Downes and others (eds), *Crime, Social Control and Human Rights: From Moral Panics to States of Denial, Essays in Honour of Stanley Cohen* (Willan Publishing 2007) 68-69.

¹⁷⁵ Michael Welch, 'Moral Panic, Denial, and Human Rights: Scanning the Spectrum from Overreaction to Underreaction' in David Downes and others (eds) (n 174) 95.

societal risks'.¹⁷⁶ Although it is noted that 'a moral panic is an exaggerated concern about some "social problem"',¹⁷⁷ to some extent, it is a useful term to indicate the extent of public concern about certain offenders and the threat posed by those offenders. Garland argues that the sexual abuse of children is so real and visible and thus, the existing panic is reasonable and is not exaggerated.¹⁷⁸ In a similar vein, Harrison denotes that '[t]he existence of and the harm caused by "dangerous offenders" is arguably one of the most persistent moral panics' in today's world.¹⁷⁹

Since the protection of public from harm, the prevention of crime and the management of dangerous offenders have become a great concern for governments, the traditional sentencing policy concerning those offenders has been replaced with indeterminate sentencing.¹⁸⁰ This indicates that the 'initial moral panic' arouses public attention and, subsequently, puts the problem on the political agenda because the revealed character of moral panic is to pave the way for social reaction which serves to attract legislative attention to such a problem which needs to be addressed. Also, one can argue that in some cases, in order to understand the seriousness of the situation and to take immediate measures, the exaggerated social reaction caused by moral panic can be more effective than the rational reaction, although it is not empirically easy to assess the latter. In addition, even if there is not any direct evidence to claim or illustrate that current societies are under more threat by PSOs than they have ever been, arguably, the increase in the risk awareness of the frequency of the paedophilic sexual offences creates uncertainty and anxiety for individuals. This uncertainty and anxiety, to a certain

¹⁷⁶ David Garland, 'On the Concept of Moral Panic' (2008) 4 *Crime Media Culture* 9, 9.

¹⁷⁷ Elizabeth M Armstrong and Ernest L Abel, 'Fetal Alcohol Syndrome: The Origins of a Moral Panic' (2000) 35 *Alcohol & Alcoholism* 276, 277.

¹⁷⁸ David Garland, 'On the Concept of Moral Panic' (n 176) 16. For more information about moral panic and the law on paedophile crimes in Britain, see Chas Critcher, 'Media, Government and Moral Panic: The Politics of Paedophilia in Britain 2000-1' (2002) 3 *Journalism Studies* 521.

¹⁷⁹ Karen Harrison, 'Dangerous Offenders, Indeterminate Sentencing, and the Rehabilitation Revolution' (2010) 32 *Journal of Social Welfare & Family Law* 423, 423.

¹⁸⁰ *ibid.*

extent, transforms into societal reaction which is reciprocated by the governments in the reconsideration of response to PSOs. From this point of view, it can be claimed that the shift in sex offender sentencing policies from imprisonment to other alternative methods in addition to (or in lieu of) imprisonment, including the consideration of integrating pharmacotherapy into the criminal justice system, is the result of the combination of social and legislative reactions, not completely the direct result of legislative response.¹⁸¹

2. Equal and Opposite Reaction

From the ‘equal reaction’ perspective, it becomes appropriate to point out that punishment must be proportionate to the seriousness of the crime within the general principle of proportionality as is the case with the retributive theory of punishment. Although the concept of retribution views punishment as effecting a connection between the offender and society’s values which the offender has breached and retributive theorists posit that imposition of punishment on an offender is a duty and a moral right of society, it does not show regard for the needs of society. Bittner and Platt note that the main aim of retributive punishment is ‘to reveal the evil and heinous character of crime, and to re-establish the balance of right and wrong in the cosmos’ rather than to confer some social benefits, meaning that punishment is a ‘moral denunciation of undesirable conduct’.¹⁸² However, as is mentioned above, there is an argument asserted by the critics of the retributive theory that this theory does not take the instrumental value of punishment into consideration. The purport of this critique is

¹⁸¹ In a similar way but within the context of a different issue, Almond and Colover discuss the movement towards criminalization of work-related death, the imposition of criminal liability following work-related deaths and how community reaction shapes and enforces the law within the immediate political context. They argue that large-scale work-related deaths ‘represent significant indicators of social risk and [...] [t]his leads to a public demand for “something to be done”, which poses a challenge for politicians who need to show their responsiveness to concerns of this sort. [...] [T]he law is one channel through which action to reassure the citizenry can be taken.’ Paul Almond and Sarah Colover, ‘Community and Social Regulation: The Criminalization of Work-Related Death’ (2012) 52 *British Journal of Criminology* 997, 997.

¹⁸² Bittner and Platt (n 114) 90.

that from a retributive perspective, punishment does not intend to protect society, deter or reform offenders; but rather it is just an expression of the ‘moral judgements of society’.¹⁸³ Regarding this matter, the action-reaction model is based on the premise that pharmacotherapy as a legislative reaction to PSOs can be proportionate to the crime, but also it can meet the needs of social reaction. On that account, the action-reaction model has another important element which is ‘opposite reaction’.

As regards to the opposite reaction element, the consideration is mainly about the future consequences of punishment. Within the context of this element, the social and legislative reactions have to be considered together, especially for sex offences, because these offences raise a huge outcry among members of the public and the opposite reaction concept pertains to the offenders themselves and to the very effective form of punishment or to the most appropriate means of punishing and deterring their criminal activities. For this reason, punishment should not only provide a certain retributory satisfaction by being proportional to the crime, but it should also meet the needs of the social reaction. First of all, victims of sexual offences carry ‘psychological and physical scars’ for life that might never heal.¹⁸⁴ Secondly, there is a significant increase in the fear of being a sexual crime victim.¹⁸⁵ In fact, as some research indicates, there is an increasing belief that people are at risk of being a victim of sexual crimes.¹⁸⁶ Thirdly, it is most likely impossible to guarantee that a sex offender can be successfully deterred and will never commit any sexual crimes after release from prison.¹⁸⁷ Although the pattern of harsher sentencing of sex offenders has been supported by governments, due

¹⁸³ *ibid* 91.

¹⁸⁴ Sampson (n 10) xiii.

¹⁸⁵ See Andy Myhill and Jonathan Allen, ‘Rape and Sexual Assault of Women: The Extent and the Nature of the Problem, findings from the British Crime Survey’ (Home Office Research Study 237, March 2002) <http://www.iiav.nl/epublications/2002/rape_and_sexual_assault_of_women.pdf> accessed 1 December 2014.

¹⁸⁶ Home Office Standing Committee on Crime Prevention, *Fear of Crime*, (London: Home Office, 1990) cited in Sampson (n 10) 23.

¹⁸⁷ Sampson (n 10) 121.

to the existing risk of reoffending and recidivism rates, the panic over sexual offending still continues to rise.¹⁸⁸ As Sampson puts it, ‘sexual crime cannot be treated in the same way as most other crimes and [it] demands particular adaption on the part of the criminal justice system.’¹⁸⁹ On the grounds of these facts, the incapacitating and rehabilitative effects of punishment have widely gained acceptance specifically for sex offenders because of assuring happiness, peace and quietude for the majority.¹⁹⁰ In a similar vein, Hutcheson holds the same utilitarian approach by stating that ‘[s]ince the end of punishment is the general safety, the precise measure of human punishment is the necessity of preventing certain crimes for the public safety, and not always the moral turpitude of actions; [though] this often is proportioned to the detriment arising from crimes.’¹⁹¹ For instance, in terms of the utilitarian theory of punishment, there is not any precise measure of punishment, i.e. when severe punishments can be prescribed for lenient crimes, light sentences can be meted out to serious offences regardless of the gravity of the crimes. Bearing this in mind, however, this deterrent intent of punishment has not been well-received by other theorists on the basis of being inherently unjust.¹⁹² Given these arguments, which are for and against the utilitarian and retributive understandings of punishment, the action-reaction model offers the combination of these two essential theories in order to preserve the strengths of each of the selected theories while eliminating the weaknesses of those by arguing that punishment must be an equal and opposite reaction. Since in this research, the main concern is the use of

¹⁸⁸ See Karen P Munk and others, ‘Fear of Child Sex Abuse: Consequences for Childcare Personnel in Denmark’ (2013) 65 *Nordic Psychology* 19.

¹⁸⁹ Sampson (n 10) 60.

¹⁹⁰ Bittner and Platt (n 114) 92.

¹⁹¹ Francis Hutcheson, *A system of Moral Philosophy in Three Books, Volume II* (London; Sold by A Millar ... and by T Longman ... 1755) 333.

¹⁹² Hutcheson notes that ‘severe punishments are necessary too for small guilt whensoever there is danger of such frequent transgression as might be destructive to a state in certain exigencies.’ *ibid* 334. In addition, Westermarck supports the idea of severe punishment, in particular, where the strong impulse is in need of being prevented. Edward Westermarck, *The Origin and Development of the Moral Ideas* (2nd edn, London: Macmillan 1912) 83.

pharmacotherapy for PSOs, the action-reaction model provides a framework to justify its use in the criminal justice system. Herein, it should be noted that although attempts at reconciliation of retributive and utilitarian theories have previously been made at different points and named *inter alia* as ‘Compromise Theory’¹⁹³, ‘Mix Theory’¹⁹⁴ or ‘Middle Way’¹⁹⁵, these endeavours have never been based on a particular punitive measure, apart from incarceration. Whereas the reconciliation of retributive and utilitarian theories of punishment under the action-reaction model is based on the use of pharmacotherapy which is considered as an alternative to further or continued incarceration (or in return for a reduction in the length of incarceration) and an effective and proportional punishment for PSOs. Regarding the effectiveness and proportionality of pharmacotherapy, although these two elements (effectiveness and proportionality) are mostly based on a determination of a person’s culpability as well as his conduct and the impact of punishment on the person’s future conduct, at this juncture, it is simply used in the meaning of whether the severity of the punishment is proportionate to the gravity of the crime, and whether it is an effective way of preventing further reoffending and meeting the expectations of society including offenders and victims. More specifically, weighing the crime against the penalty should not exceed what is necessary to achieve the objectives of punishment. Thus, punishment must be a suitable means to a permissible end and necessary to achieve the intended objective through the use of the least restrictive means to further the permissible end in order not to unjustly interfere with the rights of individuals. As is discussed in Chapter Two, pharmacotherapy removes internal impediments by advancing PSOs’ future autonomy and helping them control their deviant sexual urges which cannot be achieved by solely incarcerating

¹⁹³ David Wood, ‘Retribution, Crime Reduction and the Justification of Punishment’ (2002) 22 Oxford Journal of Legal Studies 301, 317.

¹⁹⁴ Raymond Koen, ‘State Punishment and Human Rights in South Africa’ (1999) 10 Stellenbosch Law Review 184, 193.

¹⁹⁵ Primoratz (n 37) 137.

them. Also, this medical intervention is of the essence to remove the external barriers by using it as an alternative to further incarceration, to wit, the removal of restrictions on free movement. Concerning external barriers, incarceration (DoL), includes restrictions on freedom of movement, association, expression and, in some cases, on sexual liberty due to the fact that even if prisoners have the right to receive conjugal visits, such visits can be restricted or withheld on security grounds (see Chapter Four). Thus, pharmacotherapy also plays a key role in the removal of most of external barriers to the enjoyment of fundamental human rights. In support of this argument, Ryberg and Peterson note that life imprisonment (or lifelong incarceration) can be more severe than medical interventions, and thus, if the first one is justified, the latter can be too.¹⁹⁶ Also, Shaw argues that medical intervention which causes alteration of physical and mental integrity is more alarming than imprisonment but under greater scrutiny, its imposition could be permissible.¹⁹⁷ In this respect, pharmacotherapy appears to be a suitable and necessary means to prevent further crimes, and when it is used in return for a reduction of any further/other penalties, it is the least restrictive way of achieving the objectives of punishment and a proportional means to a permissible end. Regarding the proportionate punishment argument, one can object that the deprivation inherent in pharmacotherapy, which is DoSL, might render its use in the punishment of PSOs as disproportionately severe punishment for the crime committed. However, as noted above, depriving PSOs of their liberty to perform sexual intercourse by the imposition of pharmacotherapy can be considered as a component of their punishment and adjusting punishment in accord with the crime by taking DoSL into account can address the concerns over its proportionality.

¹⁹⁶ Jesper Ryberg and Thomas S Petersen, 'Surgical Castration, Coercion and Ethics' (2014) 40 *Journal of Medical Ethics* 593, 593-94.

¹⁹⁷ Elizabeth Shaw, 'Offering Castration to Sex Offenders: The Significance of the State's Intentions' (2013) 40 *Journal of Medical Ethics* 594, 594-95.

In addition, it is worth touching upon the models mentioned above, which are Morris Model and B-B Model, for more clarification regarding the action-reaction model, in particular, the equal reaction, and the use of pharmacotherapy in return for a reduction in continued imprisonment. Since the seriousness of crime is one of the important elements for the determination of proportionate punishment but this study does not attempt to engage in an examination of the seriousness of paedophilic sexual crimes, the upper and lower limits of deserved punishment and dangerousness of offenders arguments can, at least, be used as a rough guide to address the concerns over the proportionality of crime and the harshness of pharmacotherapy. The common point of these two models is the risk or the danger that the offenders pose in terms of their likelihood of committing offences. On this matter, both models, expressly or tacitly, refer to the upper and lower limits of deserved punishment concerning the dangerousness (prediction of dangerousness or vivid danger) of offenders. Also, as is noted above, in the process of decision-making, the discretionary power of the decision-makers gives rise to different perceptions in the same cases and the reasoning for the imposition of different sentences for the same crimes is often pursuant to the dangerousness of the offender. From this point of view, if an offender poses a threat to others, this might result in further incarceration within the context of upper and lower limits of allowable punishment or *vice versa*. In a more general sense, given the central argument of the B-B Model, for the sake of the protection of a more pressing right (or the rights of others), a right can be subjected to restrictions by means of criminal punishment. Thus, one can argue that the prediction of dangerousness concerning PSOs and the protection of a more pressing right (or rights) would increase the probability of continued imprisonment, if pharmacotherapy were not considered as an option for reducing the danger posed by those offenders. However, in the case of PSOs,

incarceration (or, in other words, restriction on the right to liberty) *per se* does not break the cycle of sexual crimes. Whereas pharmacotherapy has the potential to break this cycle by decreasing uncontrollable and abnormal sexual urges and desires associated with criminal behaviours. Also, depending on the effectiveness of this medical intervention and the offenders' personal situation, the application of pharmacotherapy can affect the amount of time that PSOs will spend in prison on the grounds that it decreases the occurrence of uncontrollable and abnormal sexual behaviours and diminishes their risk of reoffending. Given the fact that the employment of pharmacotherapy has a profound effect on lowering this risk, the reduction in the length of prison term can be based on not only the deprivation that pharmacotherapy involves but also this low risk, however, as long as this reduction is in accordance with the upper and lower limits of deserved punishment. Therefore, shortening the length of imprisonment in return for imposing pharmacotherapy can be justified on the grounds that the severity of punishment fits the crime (in terms of pain/suffering imposed on offenders) and it serves the maximisation of utility and the minimisation of harm (an equal and opposite reaction). In support of this argument, Douglas and others argue that 'there are, in many cases, reasons for the state to tailor the length of an offender's incarceration to his risk of re-offending, and since undergoing [pharmacotherapy] might lower this risk in some cases, the state could have good reason to respond by reducing the length of incarceration.'¹⁹⁸

Also, when three submissions of the Morris Model for the purpose of punishment with the aim of securing the individual justice and protecting community are taken into account, (i) it is not necessary to impose pharmacotherapy on every sex offender on the ground of the prediction of dangerousness or the vivid danger because it is only effective

¹⁹⁸ Thomas Douglas and others, 'Coercion, Incarceration, and Chemical Castration: An Argument from Autonomy' (2013) 10 Bioethical Inquiry 393, 398.

in lowering the risk of PSOs; (ii) the duration of the use of pharmacotherapy must be determined on case by cases basis concerning the offenders' need and their rate of progress; and (iii) the accuracy of prediction must be fairly high and the determination must be based on reliable evidence, including medical experts' decisions. In this respect, the test offered by Bottoms and Brownsword, which consists of 'seriousness', 'temporality' and 'certainty' could be of vital importance for the amount of reduction in the length of incarceration. On that account, using pharmacotherapy as a means of punishment for PSOs can maximise the benefit and the interests of society by promoting the greatest good for or the least harm to the greatest number and what is the best and most beneficial for the offenders themselves (opposite reaction). In addition, when the length of the time that PSOs spend in prison is reduced in return for applying pharmacotherapy, this can also make the punishment proportional to the crime, i.e. not more than what the offenders deserve (equal reaction).

Conclusion

In light of these considerations, the claim here is that the action-reaction model is based on the idea of the use of pharmacotherapy as an alternative to further incarceration which can entail a reasonable proportionality between the seriousness of the crime and harshness of punishment and contribute to overall welfare. Since certain sex offenders are likely to reoffend, the application of pharmacotherapy can be a plan of action in the field of crime prevention. As is mentioned above, the action-reaction model requires an equal and opposite reaction. Given the deprivation of performing sexual intercourse and the lowered risk as the result of pharmacotherapy and the positive consequences of this medical intervention in terms of rehabilitation and incapacitation of PSOs, prevention of future crimes and protection of society, pharmacotherapy can be recognised as an equal and opposite reaction (punishment) to the crime. In this respect, the argument here is

that given the PSOs and the effects of pharmacotherapy on those offenders' sexual motivations and sexual deviance, pharmacotherapy can be considered as a component of punishment and imposed on PSOs in return for a reduction in their prison term. Moreover, since paedophilic sexual crimes are committed under the influence of abnormal sexual inclinations, pharmacotherapy is of the essence for this type of impulsive offences because of its rehabilitative and treating activity on offenders. Lastly, as a response to the argument that the rehabilitative and treating effect of pharmacotherapy might require time to take effect, PSOs will also be incapacitated while undergoing this medical intervention which is a direct and quick way of impeding offenders from committing further crimes until their paedophilic incentives and motivations are brought under control. Also, the use of pharmacotherapy in return for a reduction in the length of incarceration leads to an earlier removal of the external barriers, i.e. the removal of the restriction on the right to liberty, the right to private life, freedom of movement and freedom of association, and renders those offenders more autonomous. Therefore, when PSOs and the use of pharmacotherapy in their punishment are taken into account, 'the equal and opposite reaction (or punishment) to the crime' aim of the action-reaction model can be served. Because, given the discussions in this chapter, this medical intervention can be regarded as a retributive, proportional, rehabilitative and incapacitating means of punishing those offenders which affects a connection between the offenders and society's values and meets the need of offenders, victims and society.

However, since the use of pharmacotherapy deprives offenders of the right to perform sexual relationship, sexual liberty becomes an issue of concern and, at least, two questions are immediately apparent: (i) What is sexual liberty? To what extent is it possible to put restriction on certain offenders' right to exercise sexual autonomy or to

perform sexual intercourse? (ii) Assuming that certain offenders can be deprived of their sexual liberty, how much decrease in the amount of time that offenders spend in prison is likely to result from the application of pharmacotherapy in addition to incarceration? The latter question is beyond the scope of this study and requires more detailed evaluation, and it should be subject to a further study. Whereas, regarding the first question, since pharmacotherapy deprives a person of having a sexual relationship by suppressing his sexual impulses, the right to sexual liberty is one of the key concerns of this study and it should be looked at more extensively. Thus, in the following chapter, the discussion will revolve around the scope of sexual liberty in order to address the concerns whether this liberty can be subject to a restriction on the grounds that the intrinsic badness of a sexual behaviour can justify the state in depriving certain offenders of their sexual liberty. In other words, can PSOs be deprived of the liberty to perform sexual intercourse with the application of pharmacotherapy? Is pharmacotherapy a permissible means of dealing with PSOs? And is the use of pharmacotherapy for PSOs compatible with the rights protected under the Convention?

CHAPTER FOUR

THE COMPATIBILITY OF PHARMACOTHERAPY WITH THE EUROPEAN CONVENTION ON HUMAN RIGHTS

Introduction

Given that the Convention imposes a duty on the Member States to take necessary and proportionate measures, in this chapter, the focal point of the discussion is to examine whether the use of pharmacotherapy for PSOs is compatible with the Convention. As discussed in previous chapters, one of the most controversial issues regarding pharmacotherapy is whether it should be applied on a voluntary or an involuntary basis. In a recent case concerning the application of pharmacotherapy to a patient detained in a psychiatric hospital, the Court has identified an important point that if the examination of the facts does not give sufficient elements to the Court to establish beyond a reasonable doubt that the informed consent requirement is not satisfied and the person in question is subjected to forced medication, it will be found that the use of pharmacotherapy does not amount to a violation of the Convention rights.¹ For this reason, the discussion on the compatibility of pharmacotherapy with the Convention will revolve around its use with PSOs, in particular, its involuntary application, and the most relevant Convention rights associated with this medical intervention which are likely to be the prohibition of inhuman or degrading treatment or punishment, Article 3, the right to respect for private and family life, Article 8, and the right to marry and to found a family, Article 12.

Since pharmacotherapy has an impact upon a person's sexual liberty (DoSL), first of all, an attempt will be made to define this liberty and explore its meaning within the scope of the Convention with the aim of indicating in which context the Court defines the

¹ See *Dvořáček v Czech Republic* App no 12927/13 (ECtHR, 06 November 2014) (translated from French by the author).

scope of the right to engage in a sexual relation and whether this liberty can be subject to limitation. Following this clarification and assessment, since the imposition of pharmacotherapy is likely to be challenged concerning the rights of PSOs under Articles 3, 8 and 12, it will be discussed whether the imposition of pharmacotherapy on PSOs engages or interferes with these rights. Given that not all the Convention rights are written in the same way and subject to similar protection assessments/standards, this discussion will proceed in two parts. In the first part, the focus will be on Article 3 which is an absolute/unqualified right and the extent of its protection is equal to its scope as its limitation cannot be justified.² According to Gewirth, '[a] right is absolute when it cannot be overridden in any circumstances, so that it can never be justifiably infringed and it must be fulfilled without any exceptions.'³ Addo and Grief note that 'the notion of "absolute right" conveys the impression that potential violators such as governments and their agents should enjoy only *limited discretion* in respect of such a right.'⁴ On that note, it will be discussed whether the imposition of pharmacotherapy is permissible within the context of Article 3 which grants the states only limited discretion to decide how to treat PSOs.

In the second part, the focus will be on the rights under Articles 8 and 12 which can be subject to limitations on the basis of the reasons indicated in the Convention and/or specified by the Court called relative/qualified rights.⁵ After it is inferred that the use of pharmacotherapy interferes with the rights indicated in Articles 8 and 12, the assessment will be carried on examining whether this interference is justifiable on the grounds that pharmacotherapy satisfies the criteria for the protection of these

² Aharon Barak, *Proportionality: Constitutional Rights and Their Limitations* (Cambridge University Press 2012) 27.

³ Alan Gewirth, 'Are There Any Absolute Rights?' (1981) 31 *The Philosophical Quarterly* 1, 2.

⁴ Michael K Addo and Nicholas Grief, 'Does Article 3 of the European Convention on Human Rights Enshrine Absolute Rights?' (1998) 9 *European Journal of International Law* 510, 516 (emphasis added).

⁵ Barak, *Proportionality* (n 2) 27.

fundamental human rights indicated in the Convention and held by the Court. In this regard, the analysis of the justifiability and permissibility of pharmacotherapy for PSOs under Article 8 will be conducted within the framework of the following concerns: When will the use of pharmacotherapy for PSOs be in accordance with law? Will the legal guidelines or regulations concerning the use of pharmacotherapy pursue a legitimate aim? To what extent will the use of pharmacotherapy be said to be necessary in a democratic society or will the operation of this procedure respond to the pressing social need? Following this, the argument will be on the margin of appreciation and the proportionality test. First, it will be discussed whether the use of pharmacotherapy is considered as proportionate to the legitimate aim(s) pursued, and therefore the interference is necessary in a democratic society. Second, since a certain degree of discretion is granted to the states, especially when there is difficulty in identifying uniform European conception, the focus will be on to what extent the use of pharmacotherapy falls within the margin of appreciation of the member States. With respect to Article 12, the discussion will be that since the right to marry and to found a family is also concerned with the ability to procreate and to engage in sexual activities, on which grounds the use of pharmacotherapy can be considered as justified under Article 12.

Overall, this chapter will argue that the right to sexual liberty is not an absolute right and PSOs may be deprived of this liberty with the imposition of pharmacotherapy. Since pharmacotherapy is a medical procedure, this medical intervention should be offered on a voluntary basis, meaning that the free and informed consent requirement needs to be satisfied. However, according to the Court, in certain cases, involuntary medical treatment is permitted. On that account, it will be argued that involuntary pharmacotherapy can be used as a means to deal with PSOs by the member States, if the

requirements indicated in the Convention and the standards established by the Court are satisfied.

A. Sexual Liberty under the ECHR

1. Right to Sexual Liberty

Sexual liberty is a broad term and it encompasses not only sexual activities but also sexual preferences, health, reproductive freedom and so on. Having regard to this, the right to sexual liberty can be interpreted as a ‘negative right’, limitations on state power not to coerce or discriminate individuals, and also a ‘positive right’, a substantive freedom to be recognised and be protected.⁶ However, this research takes only one aspect of sexual liberty into account, which is being in liberty to engage in sexual activities, and argues that this liberty can be subject to a restriction, if this limitation is justified.

Jansen considers sexual intercourse as ‘an inevitable part of our lives and identities, no matter how we choose to deal with it [...]’.⁷ According to him, ‘sex is at the basis of our very existence, not only for the biological aspect of procreation, but also because of its connection to our deepest sense of self. [Thus] [s]ex is one of the most private aspects of who we are.’⁸ Appel defines sexual liberty within the context of personal autonomy and notes that individuals have right to make their own sexual decisions without being interfered by the state authorities and society.⁹ In this respect, sexual liberty is for the most part considered as an individual liberty within the context of private life and is generally recognised by virtue of the related rights protected by domestic and international law. In addition, it has been argued that this form of liberty has

⁶ Jacob M Appel, ‘Sex Rights for the Disabled?’ (2010) 36 *Journal of Medical Ethics* 152, 153.

⁷ Yakaré-Oulé Jansen, ‘The Right to Freely Have Sex? Beyond Biology: Reproductive Rights and Sexual Self-Determination’ (2007) 40 *Akron Law Review* 311, 311.

⁸ *Ibid* 312.

⁹ Appel (n 6) 152.

increasingly come to be regarded as a ‘fundamental element of human rights’.¹⁰ On this matter, the Health, Action, Empowerment, Rights and Accountability (HERA) organisation points out that

[s]exual rights are a fundamental element of human rights. They encompass the right to experience pleasurable sexuality, which is essential in and of itself and, at the same time, is a fundamental vehicle of communication and love between people. Sexual rights include the right to liberty and autonomy in the responsible exercise of sexuality.¹¹

In this context, there has been a growing concern over the recognition of individuals’ sexual liberty interests as a right, especially, in choosing their own partners or, in some instances making their own sexual decisions or expressing their sexual preferences independent of any interference from the state and/or society.

Since this study analyses the rights of PSOs, the restriction of their rights and its justifiability within the frame of the ECHR and the ECtHR case-law, the right to engage in sexual activities will be subject to the same analysis. Although there are no sexual rights mentioned in the Convention, issues concerning the exercise of sexuality have generally been brought under Articles 8 and 12.¹² However, given the Court’s case law, the right to sexual self-determination¹³ or sexual autonomy,¹⁴ ‘i.e. the freedom to determine one’s own sexual experiences, to choose how and with whom one expresses

¹⁰ Jennifer Oriel, ‘Sexual Pleasure as a Human Right: Harmful or Helpful to Women in the Context of HIV/AIDS?’ (2005) 28 Women’s Studies International Forum 392, 393.

¹¹ HERA Action Sheets (USA: International Women’s Rights Coalition 2004) <<http://www.users.interport.net/i/w/iwhc/hera/action.htm>> accessed 12 December 2014.

¹² See *Schalk and Kopf v Austria* App no 30141/04 (ECtHR, 26 June 2010).

¹³ *Van Kuck v Germany* App no 35968/97 (ECtHR, 12 June 2003).

¹⁴ *MC v Bulgaria* App no 39272/98 (ECtHR, 04 December 2003).

oneself sexually’,¹⁵ has mainly been interpreted within the context of Article 8. In fact, the right to sexual freedom has been considered not only as a right of freedom from ‘pressure, force and coercion’, but also as ‘a right to enjoyment of sexual relations’, especially under the right to respect for private life.¹⁶ For instance, in the case of *Dudgeon v the United Kingdom*, which was about the prohibition of the particular acts of gross indecency between males and buggery, sexual autonomy was considered as a right to freely choose to engage in sex and it was stressed by the Court that ‘the restriction on the applicant’s right to respect for his private sexual life give[s] rise to a breach of Article 8 [...]’.¹⁷ This decision indicates that a criminal prohibition on sexual activities might interfere with Article 8 because consensual sexual activity counts as a fundamental right and is within the protection of the personal and private life of the individuals. According to the Court, ‘Article 8 concerns rights of central importance to the individual’s identity, self-determination, physical and moral integrity, maintenance of relationships with others [...]’.¹⁸ In this respect, since sexual liberty is one of the most intimate parts of an individual’s life, self-determination and personal integrity, there will be an interference with Article 8 where sexual autonomy is at stake, such as criminalising or prosecuting some forms of sexual behaviour or preventing individuals from leading the sexual life according to their preferences.¹⁹ In addition, in *MC v Bulgaria*, which is about the establishment and application of an effective criminal law system for punishing all forms of sexual abuse and rape, the Court stresses the importance of effective protection of individual’s sexual autonomy. It is noted that the positive obligations of the member States under Article 8 must be seen as ‘requiring the

¹⁵ Venla Roth, *Defining Human Trafficking and Identifying Its Victims: A study on the Impact and Future Challenges of International, European and Finnish Legal Responses to Prostitution-Related Trafficking in Human Beings* (Martinus Nijhoff Publishers 2011) 240.

¹⁶ Maria Eriksson, *Defining Rape: Emerging Obligations for States under International Law?* (Martinus Nijhoff Publishers 2011) 262.

¹⁷ App no 7525/76 (ECtHR, 22 October 1981) para 69.

¹⁸ *Yordanova and others v Bulgaria* App no 25446/06 (ECtHR, 24 April 2012) para 118(ii).

¹⁹ *Smith and Grady v the United Kingdom* App nos 33985/96, 33986/96 (ECtHR, 27 September 1999).

penalisation and effective prosecution of any non-consensual sexual act [...]²⁰ in order to protect individuals' sexual self-determination and integrity. Also, in *X and Y v the Netherlands*, which is about the rape of a mentally disabled girl and the deficiencies in criminal proceeding, it is stressed that the concept of private life under Article 8 'covers the physical and moral integrity of the person, including his or her sexual life [...]²¹ and 'there may be positive obligations inherent in an effective respect for private or family life.'²² Apparently, the ECtHR has generally read sexual liberty into the right to respect for private life and family life, under Article 8 which imposes both negative and positive obligations on States not to interfere with individual's sexual autonomy and to take appropriate steps for its protection. Thus, in this part, the focus regarding the right to engage in a sexual relationship will be on Article 8, ECHR.

2. Limitations on the Right to Sexual Liberty

Regarding this study's intended use of sexual liberty, according to the Court, right to sexual liberty is not an absolute right and its scope depends on; (i) 'whether the act takes place in public or in private, (ii) 'whatever the age or relationship of the participants involved', and (iii) 'whether or not the participants are consenting'.²³ The Court came up with this clarification in the case of homosexual acts which were treated as criminal offence under the law of Northern Ireland and the applicant alleged that he was the victim of a breach of Article 8. The Court held that the interference was "in accordance

²⁰ *MC* (n 14) para 166.

²¹ App no 8978/80 (ECtHR, 26 March 1985) para 22.

²² Ibid para 23. It is worth noting that the Court has also found a positive duty on the part of the states to protect individuals, especially, children from sexual abuse under Article 3. The member States have a responsibility to prevent sexual abuses against children by taking adequate measures to prevent further abuse and to protect those who are at risk. According to the Court, '[a] failure to take reasonably available measures which could have had a real prospect of altering the outcome or mitigating the harm is sufficient to engage the responsibility of the State.' *E and others v the United Kingdom* App no 33218/96 (ECtHR, 26 November 2002) para 99. See also *A v the United Kingdom* App no 95599/94 (ECtHR, 23 September 1998); *Z and others v the United Kingdom* App no 29392/95 (ECtHR, 10 May 2001).

²³ *Dudgeon* (n 17) para 39. Given the States' affirmative duty to protect their citizens from harm especially when it reaches the level of severity covered under Article 3, according to the court, the severity of an act (whether the Article 3 threshold is reached) is also related to the age of the victim. See *A* (n 22) para 22.

with the law” and it served the ‘legitimate aims’ indicated under Article 8(2), which were the protection of morals and the protection of the rights and freedoms of others. Regarding whether the legislation was ‘necessary in a democratic society’ for the achievement of the indicated aim, the Court acknowledged a certain level of control over sexual activities with the aim of providing safeguards for certain group of individuals. However, since the interference was not proportionate to the legitimate aims pursued because of its ‘breadth and absolute character’, a breach of Article 8 was found.²⁴ This judgement indicates that some degree of control over individuals’ sexual activities, independent from whether it is homosexual/heterosexual activities, can be exerted by the states through the operation of criminal law. Also, given the positive obligation under Article 8, the states should put in place effective and efficient criminal law provisions to protect individual’s sexual autonomy, including children and other vulnerable individuals.²⁵ On that account, depriving a PSO of his sexual liberty with the aim of protecting certain group of individuals, especially children, from those offenders would be considered as a certain level of control and DoSL could be justified on the grounds of protecting the rights and freedoms of others (and/or public morals) and preventing crime. However, given that there must be a balance between the rights of offenders and the interests of the state (and/or others), the interference resulting from the imposition of pharmacotherapy by virtue of its breadth should not be disproportionate to the aims pursued, e.g. depriving only PSOs of their sexual liberty rather than all sex offenders.

In *Laskey, Jaggard and Brown v UK*, the Court states that adults can engage in a sexual relationship in private places without force, exploitation or abuse because ‘sexual [...] activity concern[s] an intimate aspect of private life’, including homosexual activities

²⁴ *Dudgeon* (n 17) paras 42-62. According to the Court, the restriction imposed on the applicant ‘by reason of its breadth and absolute character, [was], quite apart from the severity of the possible penalties provided for, disproportionate to the aims sought to be achieved.’ Ibid para 61 (emphasis added).

²⁵ *MC* (n 14) para 150.

consensual sado-masochistic activities.²⁶ However, referring to the degree of injury or wounding resulted from the sexual activities, the Court notes that in deciding whether or not to prosecute, the Member States are entitled to consider not only ‘the actual seriousness of the harm caused’, but also ‘the potential for harm inherent in the acts on question.’²⁷ Therefore, sexual activities which involve serious injuries and wounds do not benefit from a complete immunity under the notion of private life. The reasons are that the states have obligations ‘to protect health or morals’, ‘to punish acts of violence, [...] irrespective of the consent of the victim’ and also ‘to prohibit activities because of their potential danger.’²⁸ *Laskey and others v UK* was about the criminal proceeding against the applicants by reason of their sado-masochistic activities and, according to the Court, the interference was carried out in accordance with law, it was in pursuance of a legitimate aim listed under Article 8(2), ‘protection of health’, and it was ‘necessary in a democratic society’.²⁹ This judgement can be regarded as the states are entitled to prohibit not only actual, but also the *potential danger*³⁰ and they have a duty to regulate sexual activities which ‘involve the infliction of physical harm’ through their criminal law.³¹ In this respect, ‘posing a potential danger’ might be a (sufficient) justifiable reason for the states to impose restriction on PSOs right to perform sexual intercourse and to deprive them of their sexual liberty.

Concerning the limitations on the right to sexual liberty, the Court also states that some forms of sexual conduct can be regulated and be subject to restriction by the state authorities. In fact, if there is a need for the protection of individuals, especially those who are vulnerable “because they are young, weak in body or mind, inexperienced, or

²⁶ App nos 21627/93, 21826/93, 21974/93 (ECtHR, 19 February 1997) para 36.

²⁷ Ibid para 46.

²⁸ Ibid para 40.

²⁹ Ibid para 51.

³⁰ Ibid para 40.

³¹ Ibid para 43.

in a state of special physical, official or economic dependence” [...] some form of legislation is “necessary” to protect particular sections of society as well as the moral ethos of society as a whole [...].³² Given the disparate cultural groups and moral climates within the different states, according to the Court, the national authorities are in a better position to decide *which requirements are needed*, especially, when sexual matters become an issue of concern, and thus this is an area where the states have discretion to determine how to resolve those matters.³³

In this regard, it appears from the Court’s case-law that sexual liberty can be subject to limitation (or government intrusion), if this limitation serves the aims indicated under Article 8, is necessary in a democratic society, is proportional to the legitimate aim(s) pursued, does not have a broad character and is for the prevention of serious injuries/wounds or of potential danger. Especially, when there is a need to protect a particular section of society, such as children, and/or the moral values of society against an actual or a potential danger, the states have a degree of discretion to determine how to solve this problem. On that account, DoSL can be considered by the Member States as a measure to deal with PSOs and to achieve certain objectives. However, since the main concern of this chapter is whether the state can restrict the right to engage in a sexual activity (or deprive PSOs of their sexual liberty) with the use of pharmacotherapy (in return for a reduction in the length of incarceration), the burning question is whether the application of pharmacotherapy, *per se*, interferes with the rights of those offenders under the Convention. Thus, the following section will discuss whether pharmacotherapy is a justifiable and permissible means of dealing with PSOs and depriving their sexual liberty under the Convention.

³² *Dudgeon* (n 17) para 49. For the states’ duty to protect individuals, especially, who are young and vulnerable, from sexual abuse under Article 3, see *See A* (n 22).

³³ *Dudgeon* (n 17) paras 52, 56-57.

B. Does the Use of Pharmacotherapy Fall within the Scope of the ECHR and Violate the Convention Rights?

As is discussed in Chapter Two, in medical practice, individual autonomy and personal integrity are fundamental elements of one's identity and informed consent to medical treatment takes its foundation from these two fundamental notions. They also are the very essence of the Convention and thus, must be respected and ensured.³⁴ Given that the right to freedom from inhuman or degrading treatment or punishment and the right to respect for private life, Articles 3 and 8, have been interpreted as encompassing the right to autonomy³⁵ and personal integrity,³⁶ the right to receive or refuse medical treatment also comes under the protection of these rights.³⁷ Although these notions (autonomy and integrity) are not absolute, such as in the case of compulsory vaccination and mandatory seat belt laws, and the right to medical treatment is not expressly indicated in the Convention, they all are substantially protected under the Convention.

Given the discussions on the voluntary use of pharmacotherapy and the validity of consent in Chapter Two, perhaps it will be too simplistic to note that if pharmacotherapy is offered on a voluntary basis and if there is informed consent, no issue will arise under the Convention.³⁸ For instance, in *Dvořáček v Czech Republic*,³⁹ the applicant was a patient in a psychiatric hospital and complained that the state authorities compelled him to submit to pharmacotherapy treatment, and thus he was subjected to involuntary

³⁴ *Jehovah's Witnesses of Moscow and Others v Russia* App no 302/02 (ECtHR, 10 June 2010) para 135.

³⁵ See *Bensaid v the United Kingdom* App no 44599/98 (ECtHR, 06 January 2001); *Storck v Germany* App no 61603/00 (ECtHR, 16 June 2005); *Jalloh v Germany*, App no 54810/00 (ECtHR, 11 July 2006); *Yordanova and others* (n 18).

³⁶ See *Jalloh* (n 35).

³⁷ P Havers and C Neenan, 'Impact of the European Convention on Human rights on Medical Law' (2002) 78 *Postgraduate Medical Journal* 573, 573-74. See also *Plesó v Hungary* App no 41242/08 (ECtHR, 02 October 2012).

³⁸ Karen Harrison, 'Legal and Ethical Issues When Using Antiandrogenic Pharmacotherapy with Sex Offenders' (2008) 3(2) *Sexual Offender Treatment* <http://www.sexual-offender-treatment.org/2-2008_01.html> accessed 27 November 2014; Bernadette Rainey, 'Human Rights and Sexual Offenders' in Karen Harrison and Bernadette Rainey (eds), *The Wiley Blackwell Handbook of Legal and Ethical Aspects of Sex Offender Treatment and Management* (Wiley-Blackwell 2013) 32.

³⁹ *Dvořáček* (n 1).

pharmacotherapy. The Court also admitted that since the applicant was in a difficult position to make a decision between the acceptance of pharmacotherapy treatment and the prospect of a longer confinement, in such a situation it was controversial that one could speak of free and informed consent.⁴⁰ However, according to the Court, the treatment in question was justified by medical reasons because it was recommended by the medical experts as more effective than psychotherapy, which did not alleviate the symptoms of the disorder and prevent the applicant from re-offending. In addition, although the alternative options (surgical castration or indefinite confinement) may be a form of pressure, the applicant was informed about pharmacotherapy, its consequences, the right to withdraw his consent at any time and, given the medical record, a verbal consent was obtained.⁴¹ On that account, the Court held that the examination of the facts of this case did not give sufficient elements to the Court to establish beyond a reasonable doubt that the applicant had been subjected to involuntary pharmacotherapy and the treatment was severe enough to fall into the scope of Article 3.⁴² The Court also stressed that it would have been clearer, if the applicant's consent was documented on a specific form which included all the necessary information about pharmacotherapy, its benefits and side-effect.⁴³ It appears that free and informed consent will be a defence to an allegation of violation in the case of pharmacotherapy. However, the court's application of a 'beyond a reasonable doubt' standard should not be understood as it leaves excessive room for judicial discretion and arbitrariness. Although in this particular case, the Court considered the obtainment of verbal consent sufficient to decide that the consent was voluntary and valid, the reason of not finding any violation of Article 3 is

⁴⁰ Ibid para 102.

⁴¹ Ibid paras 97, 104.

⁴² Ibid para 104. The Strasbourg Court recalls that '[a]llegations of ill-treatment must be supported by appropriate evidence. To assess this evidence, the Court adopts the standard of proof "beyond reasonable doubt" but [...] such proof may follow from coexistence of sufficiently strong, clear and concordant interferences [...].'*Jalloh* (n 35) para 67.

⁴³ *Dvořáček* (n 1) para 104.

because the Court did not have sufficient evidence and information to engage in a detailed analysis of the case whether the applicant's consent was free and informed or coerced. For this reason, it should not be inferred automatically that verbal consent would be found sufficient for the imposition of pharmacotherapy. In fact, in order not to give rise to any abuse or arbitrariness, it should be ensured that informed consent is documented using a specific written consent form.

This decision also indicates that when it is difficult for the Court to establish whether the consent in question is obtained under pressure or not, the consideration will generally be on the procedural details and the basis of the facts, i.e. the quality of the legal basis, the circumstances and the terms of its application, and the reports (medical records) submitted by both parties.⁴⁴ However, in this case, it appears from the Court's decision that the very nature of pharmacotherapy is compatible with the Convention because it is a medically necessary procedure and the use of pharmacotherapy is not a violation of the Convention rights as long as free and informed consent is obtained.

It is also worthy noting that in *Dvořáček v Czech Republic*, the Court mostly relied on the CPT's visit to the Czech Republic and the Committee's reports/recommendations on pharmacotherapy treatment. In general, according to the CPT, special and proper safeguards must be provided to ensure that prisoners are not coerced to accept pharmacotherapy. Moreover,

'[e]very competent patient, whether voluntary or involuntary, should be fully informed about the treatment which it is intended to prescribe and given the opportunity to refuse the treatment or any other medical

⁴⁴ Ibid para 98. For instance, in *Naumenko v Ukraine*, the applicant was a sane prisoner and he was subjected to forced treatment, the Court found that the applicant had not produce sufficiently precise and credible evidence to show the abusive nature of the medication that he was forced for its administration. App no 42023/98 (ECtHR, 10 February 2004) para 114.

intervention. Any derogation from this fundamental principle should be based upon law and only relate to clearly and strictly defined exceptional circumstances.’⁴⁵

In this respect, although individuals must be placed in a position to give free and informed consent to pharmacotherapy treatment, it can be possible to derogate from this requirement. In a similar way, the PACE, Committee on Social Affairs, Health and Sustainable Development holds that the Member States of the Council of Europe ensure that no one is forced to undergo surgical castration in any way for any reason,⁴⁶ however, for the use of pharmacotherapy, there is not such an absolute decision.⁴⁷ Therefore, in the following parts, the discussion will revolve around the involuntary use of pharmacotherapy and the exceptional circumstances.

1. The Use of Pharmacotherapy for PSOs under Article 3: Is It Inhuman or Degrading Treatment or Punishment?

Under the protection of the Convention, individuals have the right not to be subjected to inhuman or degrading punishment. It is expressly indicated in Article 15 that the Member States are not allowed to derogate from Article 3. The Court also notes that ‘Article 3 enshrines one of the most fundamental values of democratic societies. Even in the most difficult circumstances, [...] the Convention prohibits in absolute terms torture and inhuman or degrading treatment or punishment.’⁴⁸ The reason for this absolute protection is that the Court considers human dignity as a significant element of

⁴⁵ Report to the Czech Government on the Visit to the Czech Republic Carried Out by the CPT from 25 March to 2 April 2008 (Strasbourg, 5 February 2009) para 19 <<http://www.cpt.coe.int/documents/cze/2009-08-inf-eng.pdf>> accessed 28 October 2013.

⁴⁶ See PACE, Committee on Social Affairs, Health and Sustainable Development, ‘Putting an End to Coerced Sterilisations and Castrations’ (28 May 2013) <<http://assembly.coe.int/nw/xml/XRef/X2H-Xref-ViewPDF.asp?FileID=19755&lang=en>> accessed 26 November 2013.

⁴⁷ Ibid 43.

⁴⁸ *Selmouni v France* App no 25803/94 (ECtHR, 28 July 1999) para 95. See also *Pretty v the United Kingdom* App no 2346/02 (ECtHR, 29 April 2002) para 49; *Yankov v Bulgaria* App no 39084/97 (ECtHR, 11 December 2003) para 103.

Article 3 and dignity plays a pivotal role in the interpretation of the right under Article 3. According to the Court, inhuman treatment is premeditated and leads to ‘actual bodily injury or intense physical and mental suffering.’⁴⁹ Whereas degrading treatment arouse in the victim ‘feelings of fear, anguish and inferiority capable of humiliating and debasing [...] and possibly breaking [...] physical and moral resistance [...]’⁵⁰ and ‘grossly humiliates [the person] before others and drives him to act against his will or conscience.’⁵¹ On that account, ‘[w]here treatment humiliates or debases an individual, showing a lack of respect for, or diminishing, his or her human dignity, [...] it *may be characterized* as degrading [...]’.⁵² In this respect, the general approach is that Article 3 cannot be subject to any balancing process,⁵³ which is described as a ‘balancing-free norm’.⁵⁴

Feldman argues that dignity is an ‘expression of an attitude of life which we as humans should value.’⁵⁵ Thus, ‘[b]eing subjected to treatment, especially invasive treatment, without one’s consent is calculated to threaten one’s sense of one’s own worth and the feeling of being valued by others.’⁵⁶ Also, Wicks argues that imposing a medical treatment without obtaining free and informed consent is not only a breach of individual autonomy and self-determination, but also ‘[t]he right, and ability, to make a free choice as regards what is done to one’s body is a fundamental aspect of the dignity of a human

⁴⁹ *Jalloh* (n 35) para 68.

⁵⁰ *Ibid.*

⁵¹ *Denmark, Norway, Sweden and Netherlands v Greece* (the *Greek case*) App nos 3321/67, 3322/67, 3323/67, 3344/67 186, Report of 18 November 1969, (1969) 12 Yearbook, 186.

⁵² *Pretty* (n 48) para 52 (emphasis added). In addition, in *Valasinas v Lithuania*, the Court notes that ‘show[ing] a clear lack of respect for the applicant, and diminishing in effect his dignity’ amounts to degrading treatment. App no 44558/98 (ECtHR, 24 July 2001) para 117.

⁵³ Stephanie Palmer, ‘A Wrong Turning: Article 3 ECHR and Proportionality’ (2006) 65 Cambridge Law Journal 438, 446.

⁵⁴ Kai Möller, ‘Balancing and the Structure of Constitutional Rights’ (2007) 5 International Journal of Constitutional Law 453, 466.

⁵⁵ David Feldman, ‘Human Dignity as a Legal Value, Part I’ [1999] Public Law 682, 687.

⁵⁶ David Feldman, ‘Human Dignity as a Legal Value, Part II’ [2000] Public Law 61, 67-68.

being [...]'.⁵⁷ According to Beyleveld and Brownsword, however, there are two conceptions of human dignity: 'human dignity as constraint', 'which acts as an umbrella for a number of duty-driven approaches' and 'human dignity as empowerment', 'which treats human rights as based on the intrinsic of humans, identified with individual autonomy'.⁵⁸ They argue that the former conception reflects the belief that medical practice

should be driven, not by the vagaries of individual choice, but by a shared vision of human dignity that reaches beyond individuals. [...] [I]f we think of respect for human dignity as one of the constitutive values of our society [...], then those individuals preferences and choices that are out of line with respect for human dignity are simply off limits.⁵⁹

Whereas, the latter conception, human dignity as empowerment 'is not universal in applying to *all* human beings; [...] it applies contingently only to those human who have the capacity for autonomy.'⁶⁰ In this respect, there are two spheres for the application of respect for human dignity; (i) individuals who have the relevant 'dignity-related capacity' have the right to be recognised and respected as such, and (ii) individuals have a right to the circumstances under which they can fully exercise their 'dignity-related capacities'.⁶¹ As Raz puts it, '[r]especting human dignity entails treating humans as persons capable of planning and plotting their future. Thus, respecting people's dignity

⁵⁷ Elizabeth Wicks, 'The Right to Refuse Medical Treatment under the European Convention on Human Rights' (2001) 9 Medical Law Review 17, 22.

⁵⁸ Deryck Beyleveld and Roger Brownsword, *Human Dignity in Bioethics and Biolaw* (Oxford University Press 2001) 1.

⁵⁹ Ibid 29.

⁶⁰ Ibid 23.

⁶¹ Ibid 14-15.

includes respecting their autonomy, their right to control their future.’⁶² A denial of one’s autonomous decision or the opportunity to choose and control one’s actions will offend his/her dignity because of denying his rights and responsibility.⁶³ However, a person’s control over his actions and future can be incomplete when he is not able to decide what to do or not capable of realising his options or preferences.⁶⁴ Given that autonomy can be considered as an element of human dignity, this argument can offer an insight into an important point that medical treatment for the enhancement of autonomy can also come into prominence for the enhancement of human dignity. Thus, relying on the concept of autonomy to provide justification for a paternalistic intervention can be a ground for human dignity. In this respect, it can be argued that making a change in PSOs’ sexual motivation and behaviours by the use of involuntary pharmacotherapy may not lead to an interference with respect for autonomy and hence human dignity. In fact, given that paedophilic disorder can be an impediment to PSOs’ decision-making ability which renders those offenders unable to make an autonomous decision, the use of pharmacotherapy can promote the right to respect for dignity and personal autonomy of those offenders. However, this could only be one aspect of dignity. Considering the fundamental aspect of dignity, the use of involuntary pharmacotherapy may constitute a violation of human dignity because rendering offenders impotent or incapable of performing sexual activity may objectively be regarded as undignified. Moreover, putting restriction on a person’s sexual liberty and rendering him incompetent to the extent that he would be unable to perform any sexual activity for a certain length of time is also a case where sexual autonomy becomes an issue of concern. Since sexual autonomy is derived from individual autonomy and an essential part of human dignity,

⁶² Joseph Raz, *The Authority of Law: Essays on Law and Morality* (2nd edn, Oxford University Press, 2009) 221.

⁶³ Beyleveld and Brownsword (n 58) 16.

⁶⁴ Raz (n 62) 221.

such a restriction on sexual autonomy may also result in a diminution of human dignity. Lastly, given the side-effects of the medications for pharmacotherapy discussed in Chapter Two, this raises another issue with regard to the respect for human dignity. On that account, the use pharmacotherapy may fall within the context of Article 3 as being incompatible with the right to respect for human dignity.

However, before coming to a conclusion that any interference with human dignity automatically results in an interference with Article 3, it must be subject to requirements laid down by the Court. For instance, according to the Court, medical necessity is a logical exception to the operation of Article 3.⁶⁵ Also, there must be an indication that the treatment reaches a certain degree of severity (severity threshold or minimum level of severity) to violate Article 3.⁶⁶ The Court makes this determination, whether the state policy/action meets the severity threshold or not, with respect to a number of factors such as the nature and duration of the treatment, the physical and mental effects of the treatment, the age, sex and health of the victim.⁶⁷ In this respect, even if a particular measure imposes an extra burden on an individual, this does not necessarily come to mean that it violates Article 3. For instance, if a punitive measure is proportional to the crime, in this situation the measure is likely compatible with the right not to be subject to inhuman or degrading punishment.⁶⁸ Also, if an individual is subject to a forced medication which leads to an interference with respect for human dignity, this treatment can still be justified on the ground of medical necessity, and it might not amount to Article 3 violation.⁶⁹ On this matter, in the *Greek* case, it was noted that '[t]he notion of inhuman treatment covers at least such treatment as deliberately causes severe suffering,

⁶⁵ *Jalloh* (n 35) para 69.

⁶⁶ For more information, see *Grare v France* App no 18835/91 (ECtHR, Admissibility Decision 2 December 1992).

⁶⁷ *Ireland v the United Kingdom* App no 5310/71 (ECtHR, 18 January 1978) para 162.

⁶⁸ For more information, see *Vinter and others v the United Kingdom* App nos 66069/09, 130/10, 3896/10 (ECtHR, 09 July 2013).

⁶⁹ For more information, see *Herczegfalvy v Austria* App no 10533/83 (ECtHR, 24 September 1992).

mental or physical, which, *in the particular situation, is unjustifiable*.⁷⁰ With respect to this statement, one can argue that not all ill-treatment triggers the application of Article 3 and, even if a state action is regarded as ill-treatment due to the mental and/or physical suffering that it causes, this does not denote that it is impossible to justify the imposition of this particular ill-treatment. In this respect, the distinctive feature concerning whether an ill-treatment is inhuman or degrading or not depends on its justifiability. Thus, in the following section, it will be assessed whether pharmacotherapy adversely affects a person's dignity and/or attains a certain degree of severity, which would make it inhuman or degrading, or it can be justified and, therefore, regarded as it is compatible with respect for human dignity and does not lead to a violation of Article 3.

1.1. The Use of Pharmacotherapy in the Treatment of PSOs

As discussed above, using pharmacotherapy interferes with the individuals' right to make decision about their own lives, their integrity and dignity, especially when the protection of public interest and safety, the interests of the person concerned or the prevention of disorder or crimes overrides individual autonomy.⁷¹ However, there is a fact that according to the Court, depending on conditions, a particular measure which imposes an extra burden on an individual can still be compatible with the right under Article 3. On this matter, the Court notes that

[i]n order for a punishment or treatment associated with it to be “inhuman” or “degrading”, the suffering or humiliation involved must in any event go

⁷⁰ The *Greek* case (n 51) 186 (emphasis added).

⁷¹ Runkel notes that ‘the state’s paramount interest in protecting the public from those offenders who repeatedly perform predatory and sexually violent acts will outweigh any restrictions on the child molester’s rights.’ Jason O Runckel, ‘Abuse It and Lose It: A Look at California’s Mandatory Chemical Castration Law’ (1997) 28 Pacific Law Journal 547, 570.

beyond that inevitable element of suffering or humiliation connected with a given form of legitimate treatment or punishment.⁷²

In addition, in *Jalloh v Germany*, the Court notes that the state is allowed to impose invasive treatment if there is a medical necessity and if the procedural guarantees for this medical intervention exist.⁷³ Thus, if a particular medical treatment is imposed on the grounds of ‘medical necessity from the point of view of established principles of medicine’⁷⁴ and if the effects of this treatment on the person concerned do not reach a minimum or sufficient level of severity,⁷⁵ it cannot be called inhuman or degrading. Also, in the case of coercive medical intervention, the material considerations focused by the Court are whether (i) ‘the person concerned experienced serious physical pain or suffering as a result of the forcible medical intervention’,⁷⁶ (ii) ‘the forcible medical procedure was ordered and administered by medical doctors’,⁷⁷ (iii) ‘the person concerned was placed under constant medical supervision’,⁷⁸ and (iv) ‘the forcible medical intervention resulted in any aggravation of his or her state of health and hold lasting consequences for his or her health.’⁷⁹ Given the Court’s case-law, a particular medical treatment should also be adequate in order to be compatible with Article 3, meaning that

⁷² *Jalloh* (n 35) para 68. Also see *Dvořáček* (n 1) para 86.

⁷³ *Jalloh* (n 35) para 69.

⁷⁴ *VC v Slovakia* App no 18968/07 (ECtHR, 08 November 2011) para 103. In *Jalloh v Germany*, the Court suggests that if the aim of force-feeding is for saving the life of a person who is a detainee and refuses to take food, it will not be regarded as inhuman or degrading. However, ‘medical necessity has been convincingly shown to exist and that procedural guarantees for the decision, for example to force feed, exist and are complied with. *Jalloh* (n 35) para 69.

⁷⁵ *Jalloh* (n 35) para 82.

⁷⁶ *Ibid* para 72.

⁷⁷ *Ibid* para 73.

⁷⁸ *Ibid*.

⁷⁹ *Ibid* para 74

authorities must ensure that diagnosis and care prompt and accurate, and that, where necessitated by the nature of a medical condition, supervision is regular and systematic and involves a comprehensive therapeutic strategy aimed at adequately treating the detainee's health problems or preventing their aggravation.⁸⁰

It is worthy noting that although these are the general principles taken into account by the Court when there is an alleged violation of Article 3 due to the imposition of an involuntary medical treatment, the Court reserves a certain degree of flexibility to itself in determining and specifying the health care standards, depending on the circumstances surrounding the case.⁸¹ For instance, in *I. G. and Others v Slovakia*, the applicants allege that they have been put through a sterilisation process, however, neither the applicants nor their representatives have given a full and informed consent concerning this medical procedure.⁸² Therefore, the procedure 'had been abusive and humiliating. It had violated their physical and psychological dignity and had had lasting consequences in terms of physical and mental suffering.'⁸³ On this matter, it is stated by the Chief Executive of the International Federation of Gynaecology and Obstetrics (FIGO) that in the case of sterilisation, the essential requirement which has to be satisfied is whether people concerned have the 'intellectual capacity or maturity to make decisions on their health for themselves fell to be determined by their individual capacity to understand the effects and implications of their choices.'⁸⁴ The Court's opinion on this issue is 'where sterilisation was carried out without the informed consent of a mentally competent adult, it was incompatible with the requirement of respect for human

⁸⁰ *Reshetnyak v Russia* App no 56027/10 (ECtHR, 08 January 2013) para 84.

⁸¹ *Ibid* para 85.

⁸² App no 15966/04 (ECtHR, 13 November 2012) para 112.

⁸³ *Ibid* para 113.

⁸⁴ *Ibid* para 115.

freedom and dignity.’⁸⁵ Referring to *VC v Slovakia* case, the Court concludes that ‘although there is no indication that the medical staff acted with the intention of ill-treating the applicant, they nevertheless displayed gross disregard for her right to autonomy and choice as a patient.’⁸⁶ In addition, it is stressed that ‘even where the refusal to accept a particular treatment might lead to a fatal outcome, the imposition of medical treatment without the consent of a mentally competent adult patient would interfere with his or her right to physical integrity.’⁸⁷

Concerning the compulsory treatment for individuals with mental capacity and the justifiability of the involuntary use of pharmacotherapy, Feldman’s subjective and objective aspects of human dignity might play an essential role to address this issue. According to him, the subjective human dignity is about

one’s sense of self-worth, which is usually associated with forms of behaviour which communicate that sense to others. Typically this is reflected in a readiness to confront the realities of one’s circumstances, including talents and physical and mental limitations, and make the best of them without losing hope and a sense that one’s life is worthwhile; to live according to a set of normative standards, whether accepted from outside or imposed from within, accepting both burdens and benefits in full measure; and readiness to accept responsibility for the consequences of one’s own actions and decisions.⁸⁸

⁸⁵ Ibid para 118.

⁸⁶ *VC* (n 74) para 119.

⁸⁷ Ibid para 105.

⁸⁸ Feldman, ‘Part 1’ (n 55) 685.

On the other hand, objective human dignity refers to ‘the state’s and other people’s attitudes to an individual group, usually in the light of social norms or expectations.’⁸⁹ With regard to subjective and objective aspects of human dignity, the law of human rights is for the protection of an individual’s ‘self-respect and physical and moral integrity’ due to the subjective aspect of dignity and is for the optimisation of the conditions for ‘social respect and dignity’ when it is about the objective aspect of dignity.⁹⁰ Assuming that there might be a clash between subjective and objective aspects of dignity, since dignified life includes both individuals and society as a whole and thus, it embraces the dignity of humanity, a state measure or policy which interferes with a person’s dignity can be justified on the grounds that it is for the protection of the dignity of humanity.⁹¹ Although the resolution of this clash might be possible by the use of a proportionality test and by balancing the competing interests, i.e., holding a balance between the dignity of the individual and the dignity of society,⁹² it should be borne in mind that dignity has a moral concept as well as a legal one,⁹³ meaning that its scope depends on cultural social and/or economic considerations and interpretations, and this gives rise to a difficulty in striking a balance between moral values. In this sense, given the fact that the Strasbourg Court essentially engages in ‘substantive considerations of the right in question’ rather than examining the domestic systems in detail and considering what the majority’s view is,⁹⁴ one can argue that this balancing method is too comprehensive and controversial (and even too complicated) and might go beyond

⁸⁹ Ibid 686.

⁹⁰ Ibid 687.

⁹¹ Karen Harrison and Bernadette Rainey, ‘Morality and Legality in the Use of Antiandrogenic Pharmacotherapy with Sexual Offenders’ in Douglas P. Boer and others (eds), *International Perspectives on the Assessment and Treatment of Sexual Offenders: Theory, Practice and Research* (Wiley-Blackwell 2011) 628.

⁹² Ibid.

⁹³ Regarding the cultural interpretations of dignity and its moral and legal concepts, see Jack Donnelly, *Universal Human Rights in Theory and Practice* (2nd edn, Cornell University Press 2003).

⁹⁴ John L Murray (Chief Justice of Ireland), ‘Consensus: Concordance, or Hegemony of the Majority?’ in *Dialogue between Judges, European Court of Human Rights, Council of Europe, 2008* (France 2008) 39 <http://echr.coe.int/Documents/Dialogue_2008_ENG.pdf> accessed 9 December 2014.

the scope of the Strasbourg Court's authority, as a human rights court. However, with respect to the objective common denominator determined by the Court, since consent to medical treatment requirement is mainly for the protection of a person's dignity, autonomy and integrity,⁹⁵ it will simply be argued that in the case of pharmacotherapy, imposing this medical intervention and depriving a person of his sexual liberty without obtaining his consent might give rise to a feeling of being humiliated and interfere with both autonomy and dignity due to the consent issue.⁹⁶ However, if there is a medical necessity for the imposition of medical treatment and this necessity is convincingly shown to exist, then the use of pharmacotherapy without consent will be compatible with Article 3. At this point, the state will be responsible to show that the diagnosis of individuals' condition and the prescription of medications for pharmacotherapy are decided by the medical authorities because it is medically necessary under the existing circumstances.

Concerning medical necessity and involuntary medical intervention, the Court's decision in the case of *Herczegfalvy v Austria* is also of vital importance:

The Court considers that the position of inferiority and powerlessness which is typical of patients confined in psychiatric hospitals calls for increased vigilance in reviewing whether the Convention has been complied with. While it is for the medical authorities to decide, on the basis of the recognised rules of medical science, on the therapeutic methods to be used, if necessary by force, to preserve the physical and mental health of patients who are entirely incapable of deciding for themselves and for whom they are therefore

⁹⁵ Feldman, 'Part II' (n 56) 67-68.

⁹⁶ Wicks (n 57) 22.

responsible, such patients nevertheless remain under the protection of Article 3, whose requirements permit no derogation.

The established principles of medicine are admittedly in principle decisive in such cases; as a general rule, a measure which is a therapeutic necessity cannot be regarded as inhuman or degrading. The Court must nevertheless satisfy itself that the medical necessity has been convincingly shown to exist.⁹⁷

In light of this statement of the Court, it can be concluded that impaired autonomy and diminished decision-making ability can provide a justification for the states to take a paternalistic stance and to impose involuntary treatment. However, this paternalistic stance becomes a matter of concern when therapeutic necessity is at issue, which, according to Bartlett, is a difficult matter to address. He argues that the scope of the ‘medical necessity’ phrase or the conditions which are required that the medical necessity is ‘convincingly shown to exist’ are not clearly defined by the Court.⁹⁸ According to Bartlett, medical necessity

must be a higher standard than merely “medically appropriate”: the fact that an appropriate treatment is available should not mean that a State should be able to force people to have it. “Medical necessity” as intended by the Court

⁹⁷ *Herczegfalvy* (n 69) para 82.

⁹⁸ Peter Bartlett, “‘The Necessity Must Be Convincingly Shown to Exist’: Standards for Compulsory Treatment for Mental Disorder Under the Mental Health Act 1983” (2011) 19 *Medical Law Review* 514, 525.

presumably does not mean that without such treatment the patient will suffer death or serious physical injury.⁹⁹

He also discusses that some treatments can be appropriate but this does not mean that they are therapeutically necessary. For instance, a particular treatment which alleviates the symptoms of a disorder can be insufficient to treat the underlying disease. It may be completely appropriate to impose that treatment because of making the patients feel better; ‘but patients refusing such medication will not necessarily get better any slower than those taking it. Such medication cannot be seen as therapeutically necessary, if what is meant by that is treating the underlying disorder or improving outcomes.’¹⁰⁰ In addition, Bartlett suggests that the severity of disorder can also be a distinctive feature between ‘an appropriate treatment’ and ‘therapeutically necessary treatment’: ‘treatment of minor or unthreatening conditions may certainly be appropriate; it is less obvious that it is therapeutically necessary to a degree that warrants compulsion, at least in the absence of incapacity.’¹⁰¹

As discussed in Chapter Two, pharmacotherapy certainly alleviates the symptoms of paedophilic disorder and improves the conditions of PSOs. In fact, it is more effective than the other treatment or counselling options and it is considerably successful for PSOs, if it is imposed in conjunction with behavioural treatments or psychological counselling.¹⁰² Also, regarding the severity of disorder, it can be argued that PSOs have a threatening condition because if the symptoms of paedophilic disorder are not brought under control, they are highly likely to present a continuing serious threat to themselves

⁹⁹ Peter Bartlett, ‘Rethinking Herczegfalvy: the Convention and the Control of Psychiatric Treatment’ in Eva Brems (ed), *Diversity and European Human Rights: Rewriting Judgments of the ECHR* (Cambridge University Press 2013) 366.

¹⁰⁰ Bartlett, ‘The Necessity’ (n 98) 530-31.

¹⁰¹ Bartlett, ‘The Necessity’ (n 98) 531.

¹⁰² See, Friedrich Lösel and Martin Schmucker, ‘The Effectiveness of Treatment for Sexual Offenders: A Comprehensive Meta-Analysis’ (2005) 1 *Journal of Experimental Criminology* 117.

and society, especially to children. Having regard to Bartlett's arguments on medical necessity, it can be claimed that there is a medical necessity that warrants the involuntary imposition of pharmacotherapy because offenders who receive it will be more autonomous, gain the ability to control their deviant sexual urges and definitely get better, whereas those who do not receive pharmacotherapy may continue to suffer from the symptoms of paedophilic disorder, i.e. not being able to refrain from acting on paedophilic interests and being at risk of self-harm or harm to others. The Court is also of the opinion that if the use of pharmacotherapy is justified by medical reasons and is recommended as more effective than other treatment methods in terms of alleviating the conditions of the person,¹⁰³ the Court will be satisfied that the medical necessity convincingly shown to exist for the imposition of pharmacotherapy. In this respect, even if pharmacotherapy does not treat the underlying condition, since it alleviates the symptoms of paedophilic disorder which drive offenders to commit crime, it will be regarded as medically necessary.

Given that a clear definition of 'medical necessity' phrase is of the essence for the right under Article 3, Bartlett supports the idea that 'this is appropriately an area where a margin of appreciation should apply and domestic legislation should take the lead [...]: domestic legislation must establish real criteria, and those criteria must be defensible in human rights terms.'¹⁰⁴ To this respect, medical necessity can be described as 'the directing of care toward the least restrictive therapeutic treatment deemed appropriate by various means of clinical care and, where available, acceptable standards of empirical support [...]'¹⁰⁵ which 'is needed by virtue of the presence of symptoms, functional

¹⁰³ *Dvořáček* (n 1) para 102.

¹⁰⁴ Bartlett, 'Rethinking Herczegfalvy' (n 99) 367.

¹⁰⁵ Thomas R Giles, *Managed Health Care: A Guide for Practitioners, Employers, and Hospital Administrators* (Boston: Allyn and Bacon 1993) 28.

impairment, or both.’¹⁰⁶ Therefore, given that paedophilic disorder causes distress or impairment or entails personal harm or risk of harm to others, the imposition of pharmacotherapy is medically necessary to alleviate these symptoms and help PSOs control their paedophilic sexual urges. In fact, the objective of pharmacotherapy is to diminish the compulsive sexual imagery and irresistible sexual interest of the PSOs by simply decreasing their testosterone levels which results in a reduction in erection or ejaculation. By this means, offenders will not suffer from the distress of having deviant sexual arousal or of experiencing spontaneous erections and/or ejaculations, significant impairment in social, occupational, or other important areas of functioning because of paedophilic disorder.¹⁰⁷ On this matter, Scott and Holmberg argue that PSOs ‘have committed sex crime and as a result have demonstrated a lack of mastery over their fantasies. [...] [Thus, pharmacotherapy] is justified to help control their behaviour or to assist the offender in desisting from [sexually deviant] behaviors.’¹⁰⁸ In this respect, if the medical experts are of the opinion that the offender is medically suitable (medical appropriateness) for pharmacotherapy and the medication used is more effective than other alternative methods, it will likely be held by the Court that the use of pharmacotherapy is for medical reasons and is medically necessary. However, if the primary purpose of imposing pharmacotherapy on an offender is not for medical reasons¹⁰⁹ or if the use of medication goes beyond what is considered to be medically necessary,¹¹⁰ the Court might find that there is a violation of Article 3. On this matter, Rainey and Harrison state that ‘[w]ith many member states developing their sex offender strategies to coincide with and support the new risk penology, the use of anti-

¹⁰⁶ Francis R Kush, ‘Primary Care and Clinical Psychology: Assessment Strategies in Medical Settings’ (2001) 8 *Journal of Clinical Psychology in Medical Settings* 219, 226.

¹⁰⁷ Edward A Fitzgerald, ‘Chemical Castration: MPA Treatment of the Sexual Offenders’ (1990) 18 *American Journal of Criminal Law* 1, 6-7.

¹⁰⁸ Charles L Scott and Trent Holmberg, ‘Castration of Sex Offenders: Prisoners’ Rights versus Public Safety’ (2003) 31 *The Journal of the American Academy of Psychiatry and the Law* 502, 507.

¹⁰⁹ See *Nevmerzhitsky v Ukraine* App no 5425/00 (ECtHR, 05 April 2005).

¹¹⁰ See *Jalloh* (n 35).

libidinal treatment could be seen to be primarily offering public protection, with the medical needs of the offender as a secondary aim.’¹¹¹ Rainey also notes that ‘[t]he state has a duty to protect all within its jurisdiction and high risk sexual offenders may require treatment and management that may lead to some limitations on individual rights. However, public protection should not allow the objectification of offenders within the system [...]’.¹¹² If public protection takes precedence over the medical needs of the offenders, the ECtHR may find that the use of pharmacotherapy is not medically necessary for the treatment of the offenders’ condition.¹¹³ However, even if pharmacotherapy treatment provides public protection, it can still be considered as medically necessary in the case of PSOs because it can alleviate their deviant sexual desires and remove the impediments to autonomy, and without such treatment, the offenders may not benefit from developing ability to overcome internal and external constraints to their autonomy or their psychiatric condition may cause personal harm or risk of harm to others. Thus, the purposes such as protection of public safety and/or prevention of the harmfulness of the offenders’ behaviours and their dangerousness to society do not come to mean that the use of pharmacotherapy cannot be justified by medical reasons or it is not medically necessary. However, it should be convincingly shown that pharmacotherapy treatment is more effective than the alternative methods in terms of suppressing the offenders’ sexual libidinal pressure, preventing them from having compulsive and violent sexual desires and repeating undesirable sexual activities. The Strasbourg Court is also of the opinion that as a protective sexological treatment, if the intention behind the use of pharmacotherapy is to protect offenders, which, in this case, does not constitute punishment within the meaning of Article 3, and

¹¹¹ Bernadette Rainey and Karen Harrison, ‘Pharmacotherapy and Human Rights in Sexual Offenders: Best of Friends or Unlikely Bedfellows?’ (2008) 3 Sex Offender Treatment 1, 4-5 < http://www.sexual-offender-treatment.org/2-2008_02.html > accessed 11 December 2014.

¹¹² Rainey (n 38) 34-35.

¹¹³ Ibid 33.

if its application is justified by the offenders' state of health and their conduct, then it will be found that there is no violation of Article 3.¹¹⁴ On that account, it can be argued that the use of pharmacotherapy can be primarily for the satisfaction of the offenders' medical needs (protection of the health and safety of PSOs) and public protection or the safety of others can be considered as a side benefit or secondary aim achieved with the application of this medical intervention. From a human rights perspective, the protection of public and the prevention of reoffending by providing sanctions against PSOs can be central to justifying the punitive element of pharmacotherapy, which is DoSL. In this respect, when pharmacotherapy is used within the criminal justice system, since this medical intervention can keep PSOs from acting on paedophilic interests, while its imposition is medically necessary for the protection of PSOs and the enhancement of their autonomy, public protection and prevention of reoffending are carried out by treating/alleviating those offenders' medical condition and also by depriving them of their sexual liberty which can be considered as the objectives of their punishment.

Although the medical necessity criterion is the central concept within the context of Article 3, it is only the part of the picture. Given the Court's case-law, if pharmacotherapy is applied to PSOs, the state must also adduce that its involuntary application is necessary due to the facts that (i) it is the only appropriate, suitable and available means to manage those offenders effectively, (ii) its use is exceptional, meaning that it is applied to PSOs as a last resort, and (iii) it is a proportionate means of achieving the state's objective which is to treat their condition.¹¹⁵ On this matter, the algorithm for pharmacotherapy treatment discussed in Chapter Two can help to address the concerns over the appropriateness, suitability and availability of pharmacotherapy

¹¹⁴ *Dvořáček* (n 1). It can be argued that according to the Court, protective sexological treatment is for sex offenders with deviant sexual thoughts and motivations, such as PSOs, including psychotherapy and pharmacotherapy, and medical intervention in the form of protective sexological treatment is justified only in the case of offenders suffering from disorder of sexual preference. See *Dvořáček* (n 1).

¹¹⁵ *Bureš v the Czech Republic* App no 37679/08 (ECtHR, 18 October 2012) paras 91-104.

treatment, its exceptionality as a last resort and its proportionality. As noted above, a hierarchical order of treatment and of medication can be useful to provide a reasonable starting place for the treatment of paedophilic disorder, to establish the treatment process and the requirements, and to select an appropriate and effective treatment including pharmacological interventions. Depending on the needs of PSOs, this suggested hierarchy of treatment in which the different types of medications should be used can show that involuntary pharmacotherapy treatment is imposed on the offenders following a structured and consistent treatment plan and it is necessary under the circumstances and by their own health and condition in terms of being appropriate, proportionate and exceptional.

In addition, it is worth noting that regarding the integration of pharmacotherapy within the criminal justice system, as discussed in Chapter Three, it is the DoSL that is the punishment element and, as is the case with using pharmacotherapy in the treatment of PSOs, DoSL by pharmacotherapy should not be imposed as punishment on every sex offender. Rather it should be applied to PSOs as the preferred form of punishment as long as the aforementioned necessary conditions for the use of pharmacotherapy exist. If and to the extent that pharmacotherapy is the only appropriate, suitable and available means and its use is exceptional, then, DoSL with the imposition of pharmacotherapy can be considered as punishment for PSOs to effectively manage those offenders. Moreover, given the argument that DoSL via pharmacotherapy by its very nature involves a loss of sexual freedom and it should be imposed in return for a reduction in the length of prison sentence, and to a certain degree, this punitive measure can make the public safer by limiting the offenders' sexual liberty and alleviating their deviant sexual desires (incapacitating and rehabilitative effects), it can be considered as an

appropriate and proportionate means to achieve the states' objectives and response to the crime committed.

Also, the state must be cautious about the procedural safeguards because any procedural deficiency or any failure in the process of the administration of pharmacotherapy might lead to Article 3 violation. For these reasons, the state must be careful and strict on directing personal supervisions, carrying out periodic checks and recording the procedure, and the regulations on the procedure must be clear including the type of medication and the duration of pharmacotherapy treatment.¹¹⁶ For instance, according to the Court, if pharmacotherapy is used in conjunction with occupational therapy and psychotherapy, it cannot be concluded that the state authorities failed in their duty to protect offenders' well-being.¹¹⁷ Therefore, if the state provides all these essential requirements, then the interference which results from the involuntary imposition of pharmacotherapy can be justified because its use is needed (and also medically necessary) due to the presence of the symptoms of paedophilic disorder and the functional (and mental) impairment of PSOs, it is the only appropriate, suitable and available means to deal with PSOs and it is a proportionate means of treating their condition in terms of effectiveness and intrusiveness.

Having regard to the fact that pharmacotherapy causes negative side-effects to the participants; if a person is forced to undergo a treatment programme for therapeutic reasons and there is no alternative method which is less intrusive and more effective than the one imposed on this person,¹¹⁸ the Court notes that 'distressing' side effects of this particular treatment does not illustrate that the treatment reaches the severity threshold and thus, it does not fall within the scope of Article 3.¹¹⁹ As is discussed in

¹¹⁶ Ibid paras 86, 101-104.

¹¹⁷ *Dvořáček* (n 1) para 103.

¹¹⁸ *Jalloh* (n 35) para 82.

¹¹⁹ *Grare* (n 66) Law Section.

Chapter Two, the side-effects experienced due to the use of pharmacotherapy are reversible and not long-lasting. In fact, the side-effects of the drugs depend on the period of its administration and under constant medical supervision, these side-effects can be minimised and even stopped by adjusting the amount of the intake of medications. By this means, offenders will not experience any serious pain as a result of pharmacotherapy and any side-effects results from the medications can be lessened and thus, can be tolerated. However, the side-effects of medications for pharmacotherapy may be considered as serious enough to humiliate an offender and be degrading. For instance, pharmacotherapy can cause gynaecomastia (breast growth) and for this reason, it can be considered as inhuman or degrading because the offender may be humiliated in his own eyes, even if not in the eyes of others.¹²⁰ On that account, if pharmacotherapy worsens the pre-existing medical condition of the offender or curtails the quality of his life, Article 3 may be engaged. In response to this concern, if the offenders are monitored carefully and periodically, drug-induced gynaecomastia can be diagnosed in the early stage before it develops and becomes a major problem, including psychological embarrassment, and be addressed by switching to an alternative agent, discontinuing the offending agent or using other modalities.¹²¹ It may thus be argued that it would be difficult to find a state in violation of Article 3 because the side effects of pharmacotherapy may not be severe and long term or they can be treated or avoided by taking precautions. However, if these side effects are not treated and the necessary precautions are not taken, the Court may find that the State has failed in its obligations in terms of providing reasonable protection and there is a violation of Article 3.

In light of these arguments, pharmacotherapy can be used in the treatment of PSOs because it removes the impediments to their autonomy, enhances their ability to make

¹²⁰ *Tyrer v the United Kingdom*, App no 5856/72 (ECtHR, 25 April 1978) para 32.

¹²¹ For more information about treatment of drug-induced gynaecomastia, see John D Bowman, Hyunah Kim and Juan J Bustamante, 'Drug-Induced Gynecomastia' (2012) 32 *Pharmacotherapy* 1123.

autonomous decisions and treats the symptoms of paedophilic disorder, meaning that its use can be justified on the therapeutic reasons (medical necessity) ground. However, it should be convincingly shown that pharmacotherapy is used as a last resort for PSOs who do not respond well to other treatment methods and still pose a danger. In addition to the therapeutic reasons for the use of pharmacotherapy, as is discussed in Chapter Three, there can be other reasons for applying pharmacotherapy to PSOs which are: to minimise the danger that those offenders pose, to diminish recidivism, to increase the safety of society and to rehabilitate and incapacitate those offenders rather than solely incarcerate them. Given the arguments that pharmacotherapy can be integrated into the criminal justice systems as a component of punishment and utilised as a means to punish PSOs, the following part will attempt to assess its permissibility within the context of inhuman and degrading punishment and address whether it can be inflicted on PSOs as a punitive measure compatible with Article 3.

1.2. The Use of Pharmacotherapy in the Punishment of PSOs

The Court's general approach to punishment is that punishment 'shall be managed so as to facilitate the reintegration into free society of persons who have been deprived of their liberty [...] shall be designed to enable [prisoners] to lead a responsible and crime free life.'¹²² The Court also stresses the importance of the margin of appreciation when there is an issue regarding the criminal justice and sentencing. In this sense, the matters concerning criminal justice and sentencing do not fall within the scope of Court's determination, rather the Court can only assess the process of the imposition of punishment whether the rights of the offenders are protected in this process or not. For instance, the legal conditions attached to the punishment process should comply with the requirements of Article 3, but this assessment is about how the offenders are treated,

¹²² *Vinter* (n 68) para 113.

whether the legal conditions constitute an ill-treatment or not, rather than the punishment itself.¹²³ Regarding the imposition of pharmacotherapy on PSOs as a means of punishment, Clarke notes that offenders do not

manifest an expectation that future sexual fantasies will be within the protected zone of [the human rights] because they implicitly invited the state[s] to intrude into such activity by committing sexual [crimes]. Knowledge that the commission of a crime gives rise to a governmental duty to punish and prevent the crime involved should be imputed. The state needs to intrude into a[n] [offender's] sex life to prevent an offen[c]e from occurring again, because sex is the offender's weapon of choice. [Offenders] constructively forfeit an expectation of [rights] with respect to sexual activity when they commit a sexual [crime], knowing that criminal activity mandates governmental intrusion to the extent that it is necessary to punish and prevent future offen[c]es.¹²⁴

As is also noted above, the state can intrude offenders' sexual life and deprive them of their liberty to engage in a sexual intercourse in order to punish those offenders and prevent further crimes. On this matter, one of the remarkable points that must be taken into consideration is whether the punishment or the measure used by the state is 'grossly disproportionate' or not. According to the Court, 'any disproportionate sentence would amount to ill-treatment contrary to Article 3.'¹²⁵ However, if there is a concern over 'just and proportionate punishment', this issue is subject to 'rational debate and civilised

¹²³ Ibid paras 120, 122.

¹²⁴ Mary E Clarke, 'Florida's Hormonal Control Statute: Arguments for Constitutionality under Florida's Right of Privacy' (1999) 23 Nova Law Review 501, 516.

¹²⁵ *Vinter* (n 68) para 83.

disagreement’¹²⁶ and a margin of appreciation must be conceded to the member states in the matter of appropriate punishments for particular crimes. In this respect, the Court’s suggestion is that

it is not [...] [the Court’s] role to decide what is the appropriate term of detention applicable to a particular offence or to pronounce on the appropriate length of detention or other sentence [...].

For the same reasons, Contracting States must also remain free to impose life sentences on adult offenders for especially serious crimes such as murder: the imposition of such sentence on an adult offender is not in itself prohibited by or incompatible with Article 3 or any other Article of the Convention.¹²⁷

Moreover, in *Vinter and Others v UK*, the Court stresses that, an Article 3 issue would arise if (i) ‘the applicant’s continued imprisonment could no longer be justified on any legitimate penological grounds’ and (ii) ‘the sentence was irreducible *de facto* and *de jure*.’¹²⁸ It is also noted that one of the ‘essential functions’ of punishment is to prevent an offender from committing further crimes.¹²⁹ However, ‘a State’s choice of a specific criminal justice system [...] is in principle outside the scope of the supervision the Court carries out at the European level, provided that the system does not contravene the principles set forth in the Convention.’¹³⁰ Although in *Vinter and Others v UK*, the assessment of the severity of the punishment and its compatibility with Article 3 is

¹²⁶ Ibid para 105.

¹²⁷ Ibid paras 105, 106.

¹²⁸ Ibid para 87.

¹²⁹ Ibid para 108.

¹³⁰ Ibid para 104. Although these principles are not specified, it should be assumed that the Court refers to the rights guaranteed in the Convention and the principles which are required for the protection of the Convention rights. See also *Kafkaris v Cyprus* App no 21906/04 (ECtHR, 12 February 2008) para 99.

made concerning life imprisonment punishment, the crucial points touched upon by the Court can provide a general concept for the examination of pharmacotherapy which are: legitimate penological grounds and reducibility of punishment. In *Harkins and Edwards v UK*, the Court also enumerates certain factors which would be decisive for the Court's decision that there was a violation of Article 3. Those factors are 'the absence of any specific justification for the measure imposed', 'the arbitrary punitive nature of the measure' and 'the length of time for which the measure was imposed'.¹³¹

As discussed in Chapter Three, if pharmacotherapy is not considered as an option for reducing the danger posed by PSOs, the prediction of dangerousness and the protection of others rights and interest might lead to an increase in the probability of continued imprisonment or indefinite prison sentence. However, the use of pharmacotherapy can provide the potential for reducibility of the sentence if it is integrated within the criminal justice system in return for at least some reduction in the length of imprisonment with respect to the upper and lower limits of deserved punishment. The Court notes that member States must have a review mechanism that 'allows the domestic authorities to consider whether any changes in the life [and behaviour of the offenders] are so significant, and such progress [...] has been made in the course of the sentence, as to mean that continued detention can no longer be justified on legitimate penological grounds.'¹³² On that account, within the upper and lower limits of deserved punishment, PSOs' sentence can be reducible *de facto* and *de jure*, when pharmacotherapy is considered as a component of their punishment. Regarding the legitimate penological grounds, which are, according to the Court, 'deterrence, public protection and rehabilitation',¹³³ pharmacotherapy as a component of punishment serves the aims of punishment (both utilitarian and retributive), to wit, it fits the crime, it protects members

¹³¹ App nos 9146/07, 32650/07 (ECtHR, 17 January 2012) para 130.

¹³² *Vinter* (n 68) para 119.

¹³³ *Ibid* para 111.

of the public, especially children who are at risk of being abused, it includes rehabilitation and incapacitation components, meaning that the therapeutic aspect of pharmacotherapy helps to manage uncontrollable sexual urges and impedes those offenders from committing further crimes.¹³⁴ Thus, it can be justified on the ground that it serves legitimate penological grounds. Also, as is mentioned above, in the matter of appropriate, just and proportionate punishment, a certain degree of margin of appreciation is left to the member States. Therefore, considering the deprivation results from the imposition of pharmacotherapy (DoSL), one can argue that the imposition of DoSL with the use of pharmacotherapy and the amount of reduction in the length of imprisonment will probably remain within the states' discretion.

On that account, it can be claimed that the use of pharmacotherapy in the punishment of PSOs can show conformity with the standards indicated by the Court under Article 3. Given that the Member States' choice of criminal justice systems and of means for punishment is considered within the margin of appreciation, if pharmacotherapy is used in lieu of or in return for a reduction of continuing imprisonment with respect to upper and lower limits, and if its use is justified on rehabilitation and incapacitation grounds (also, protection and safety), it will be regarded as compatible with Article 3. However, it should be noted that since pharmacotherapy is a medical procedure, even if it is used for the purpose of punishment, its application must be in conformity with the standards indicated for its treatment concept.

1.3. Does Article 3 Impose a Positive Obligation on States to provide Pharmacotherapy for PSOs?

As discussed above, the use of involuntary pharmacotherapy can be a permissible state measure under Article 3. However, it is worth briefly noting that not providing

¹³⁴ For the Court, undergoing a rehabilitation programme indicates that the offender atones for his offence and thus, if the offender achieves the rehabilitation program, then following this, the prospect of release must be provided. Ibid para 114.

pharmacotherapy to PSOs might amount to a violation of Article 3. According to the Court,

the State must ensure that the health and well-being of detainees are adequately secured by, among other things, providing them with the requisite medical assistance. [...] [A] detainee was seen by a doctor and prescribed a certain form of treatment cannot automatically lead to a conclusion that the medical assistance was adequate. The authorities must also ensure that a comprehensive record is kept concerning the detainee's state of health and the treatment he underwent [...] where necessitated by the nature of a medical condition supervision is regular and systematic and involves a comprehensive therapeutic strategy aimed at curing the detainee's illnesses or preventing their aggravation, rather than addressing them on a symptomatic basis.¹³⁵

In this respect, 'a lack of access to medical treatment', 'an absence of health care', 'failing to prescribe adequate treatment', 'a lack of medical treatment and assistance' or 'failure to provide timely medical assistance' might amount to a violation of Article 3, especially if these situations cause the person's health to deteriorate.¹³⁶ In *Dybeku v Albania*, the Court stressed that 'a lack of resources cannot in principle justify detention conditions so poor as to reach the threshold of severity for Article 3 to apply.'¹³⁷ Also, when prisoners with mental disorder come into question, if the condition of the

¹³⁵ *Kharchenko v Ukraine* App no 40107/02 (ECtHR, 10 February 2011) paras 58-59.

¹³⁶ See *Nevmerzhitsky* (n 109); *Pilcic v Croatia* App no 33138/06 (ECtHR, 17 April 2008); *Ciorap v Moldova* (No. 3) App no 7481/06 (ECtHR, 20 July 2010). See also Martin Curtice, 'The European Convention on Human rights: An Update on Article 3 Case Law' (2010) 16 *Advances in Psychiatric Treatment* 199.

¹³⁷ App no 41153/06 (ECtHR, 18 December 2007) para 50.

detention is not appropriate for those offenders, this can cause acute hardship and distress or adversity of an intensity exceeding the unavoidable level of suffering inherent in detention, and thus lead to a violation of Article 3. According to the Court, some offenders may require special measures, regardless of the seriousness of the crime committed, and the lack of medical supervision and/or the continued detention in prison would be a breach of Article 3.¹³⁸

In addition, in *E and others v the United Kingdom*, which is about the state authorities' failure to take adequate measures to prevent continued sexual abuse of children by their mothers cohabitee, the Court holds that if a person has a criminal record of sexual or physical abuse and has close contact with children, the state authorities should be aware that those children remain at potential risk of sexual assault and should take adequate steps to prevent further abuse taking place. It is stressed that if the risk of sexual abuse or the damage suffered can be avoided or minimised by taking proper and effective measures, the states' failure to take reasonable available measure will be regarded as having a significant impact on the course of event (sexual abuse) and a violation of Article 3 will be found.¹³⁹ At this stage, it is worth noting that in this research it has been argued that paedophilia is a clinical term which refers to adults who are sexually attracted to prepubertal children (atypical sexual interest) and not all paedophiles abuse or harass children, including exploitation and non-physical sexual abuse. Some paedophiles may have fantasies about having sex with children but they do not act out those fantasies with a child. Therefore, paedophilia in itself is not deemed a medical or psychiatric condition that needs to be treated or a criminal offence which should be dealt with in the criminal justice system because it does not need to involve criminal sexual acts against children. Yet, for the purpose of this study, the main focus is centred on

¹³⁸ See *Rivière v. France* App no 33834/03 (ECtHR, Chamber Judgment 11 July 2006).

¹³⁹ *E and others* (n 22) para 96-97.

PSOs arguing that when paedophilia is associated with sexual crimes against children, this requires the punishment of the offender but also refers to the offender's psychiatric condition (paedophilic disorder). In this respect, this study does not argue whether paedophilia is a sexual preference or not, rather it discusses the positioning of paedophilia within the context of mental disorder stating that there is a distinction between paedophilia and paedophilic disorder and the latter one is about acting on paedophilic desires and/or feeling distress or impairment caused by recurring, intense sexual urges, fantasies or behaviours. While paedophilia is about the sexual attraction to children but does not cause personal harm or risk of harm to others, paedophilic disorder is a condition in which one has a paedophilia and the condition causes self harm or harm to others. Therefore, given the nature and implications of paedophilic disorder, the argument is that the states can be required to prescribe adequate treatment and, in certain cases, to provide pharmacotherapy to PSOs in order to keep those offenders from acting on their paedophilic urges, to promote their well-being/health and to protect their safety and that of others.

Under the Lanzarote Convention, it is also recognised that the use of pharmacotherapy is an effective measure and thus, it should be available and made accessible to sex offenders. The Lanzarote Convention, Article 7 (Preventive Intervention Programmes or Measures) provides as follows:

Each Party shall ensure that persons who fear that they might commit any of the offences established in accordance with this Convention may have access, where appropriate, to effective intervention programmes or measures designed to evaluate and prevent the risk of offences being committed.

In addition, Article 15 spells the general principles for the intervention programmes and measures out including ‘the prevention and minimisation of the risks of repeated offences of a sexual nature against children’, ‘the accessibility of such programmes and measures for everyone’, ‘the procedural protection against arbitrary interference by public authorities, such as health-care or the social services’, ‘the examination or the assessment of the offenders and the identification of the appropriate programme for those offenders’ and ‘the assessment of the effectiveness of the programmes and measures imposed’. Articles 16 and 17 of the Lanzarote Convention also provide guarantees for the access to the preventive intervention programmes or measures for individuals independent from whether they are convicted or not.¹⁴⁰ In this respect, apparently, the Lanzarote Convention requires the states to provide preventive programmes and measure for sex offenders and not providing such programmes and measures might be considered by the Court as a violation of the Convention rights, in particular, Article 3. It is also stressed that ‘the treatment offers [the offender] the possibility of acquiring control over his dangerous behaviour and consequently, the possibility of being released. [...] [Not providing] such treatment would interfere with the [offender’s] right to health and condemn him to years of further confinement, hardly a dignified outcome.’¹⁴¹

On that account, the involuntary use of pharmacotherapy with PSOs might not amount to a violation of Article 3 due to the medical necessity, the effectiveness of pharmacotherapy and the conditions of PSOs. However, if it is not provided, the Court might find that offenders are subjected to inhuman or degrading treatment by reason of their continued detention in such conditions or of indefinite detention, or the state

¹⁴⁰ Lanzarote Convention, CETS No. 201 (opened for signature 25 October 2007, entered into force 1 July 2010). For the preventive intervention programmes or measures, see Explanatory Report to the Lanzarote Convention (12 July 2007) para 102 <<http://conventions.coe.int/Treaty/EN/Reports/Html/201.htm>> accessed 12 December 2014.

¹⁴¹ Dissenting opinion by Ms Kateřina Konečná, in PACE, ‘Putting an End’ (n 46) 17-18.

authorities are failed to perform their duties under Article 3 by not providing adequate protective and preventive measures to avoid jeopardising the welfare of individuals, especially, children, or to minimize the risk or damage. Thus, it can be claimed that the public authorities have the responsibility to make efforts to provide pharmacotherapy because Article 3 imposes on the member states a positive obligation to ensure that prisoners are cared for in a way that their human dignity is protected and/or efficient and effective measures are in place to ensure that individuals are not subjected to inhuman or degrading treatment by private individuals.

2. The Use of Pharmacotherapy under Articles 8 and 12

2.1. Right to Respect for Private Life and Family Life

As far as autonomy and integrity are concerned, Article 8 also provides an immense protection for these notions. According to the Court, a particular treatment which does not fall within the scope of Article 3 may nonetheless interfere with Article 8 in its private life aspect.¹⁴² The scope of the right to respect for private life is defined by the Court as a

broad term not susceptible to exhaustive definition. It covers the physical and psychological integrity of a person. It can sometimes embrace aspects of an individual's physical and social identity. Elements such as, for example, gender identification, name and sexual orientation and sexual life fall within the personal sphere protected by Article 8. Article 8 also protects a right to personal development, and the right to establish and develop relationships with other human beings and the outside world. Although no previous case has established as such any right to self-determination as being contained in

¹⁴² *Bensaid* (n 35) para 46.

Article 8 of the Convention, the Court considers that the notion of personal autonomy is an important principle underlying the interpretation of its guarantees.¹⁴³

In this respect, within the scope of private life, some of the basic interests protected under Article 8 are, ‘moral and physical integrity’, ‘private space’, ‘sexual activities’ and ‘social life or the enjoyment of personal relationships’.¹⁴⁴

In the case of pharmacotherapy, even if its administration is carried out as a voluntary treatment, the use of pharmacotherapy can still give rise to concerns over those offenders’ rights.¹⁴⁵ However, as discussed in Chapter Two, this study suggests that if pharmacotherapy is offered as a genuine and appropriate treatment, if it alleviates the offenders’ condition or the symptoms of paedophilic disorder, if its refusal is not linked to any additional punishment and if it is clearly indicated that undergoing pharmacotherapy will not automatically provide offenders with an opportunity for early release, the Court will very likely be satisfied that the offenders’ consent is not coerced, that it is an voluntary and valid consent. Also, as discussed above by referring to the Court’s decision in *Dvořáček v Czech Republic* that since the Strasbourg Court does not make an in-depth analysis concerning the validity and voluntariness of consent and evaluates this issue in light of the material facts and since pharmacotherapy is not regarded as degrading treatment by its very nature, in this part, the discussion will be on the involuntary use of pharmacotherapy.

¹⁴³*Pretty* (n 48) para 61. In addition, the Court holds that ‘[m]ental health must also be regarded as a crucial part of private life associated with the aspect of moral integrity. (...) The preservation of mental stability is in that context an indispensable precondition to effective enjoyment of the rights to respect for private life.’ *Bensaid* (n 35) para 47.

¹⁴⁴ David John Harris, Michael O’Boyle and Colin Warbrick, *Law of the European Convention on Human Rights* (2nd edn, Oxford University Press 2009) 363-81.

¹⁴⁵ *Rainey* (n 38) 32.

Since autonomy and integrity comes within the protection of right to respect for private life, involuntary pharmacotherapy will certainly fall within the scope of Article 8. In addition to this, referring to the ‘offender’s ability to develop his personality (...) [and] his sexual relations with others’,¹⁴⁶ Harrison and Rainey stress that the application of involuntary pharmacotherapy to sex offenders would interfere with family and private life of the offenders. In fact, in *Botta v Italy*, the Court describes the protection afforded by Article 8 and holds that ‘Article 8 of the Convention is primarily intended to ensure the development, without outside interference, of the personality of each individual in his relations with other human beings.’¹⁴⁷ In light of this description, it can be asserted that the use of pharmacotherapy also interferes with the offenders’ ability to develop their personality. Moreover, since pharmacotherapy affects the offender’s sexual performance or ability to engage in a sexual activity, Rainey argues that ‘the concomitant right of the partner of the claimant to a private life’¹⁴⁸ might become an issue of concern as well. Although Rainey’s argument over the partner’s right is pivotal, one can argue that the partners’ rights can be a matter of discussion not only in the case of pharmacotherapy but also in the case of imprisonment sentence that both DoL and DoSL raise an issue over the right to respect for private and family life, the right to engage in sexual intercourse and the right to procreate. For instance, in *Dickson v UK*, the Court stresses the importance of the States’ positive and negative obligations and of holding a fair balance between the competing public and private interests and notes that any restriction on conjugal visits in prisons or right to beget a child is justifiable but it should not amount to a blanket ban.¹⁴⁹ Winick also argues that

¹⁴⁶ Karen Harrison and Bernadette Rainey, ‘Suppressing Human Rights? A Rights-Based Approach to the Use of Pharmacotherapy with Sex Offenders’ (2009) 29 Legal Studies 47, 68-69.

¹⁴⁷ *Botta v Italy* App no 21439/93 (ECtHR, 24 February 1998) para 32.

¹⁴⁸ Rainey (n 38) 34.

¹⁴⁹ App no 44362/04 (ECtHR, 04 December 2007) para 84.

[a]lthough the government's legitimate interest in protecting public health may justify some regulation of sexual practices [...], a total ban on certain sexual practices cannot be justified based only on such health concerns. Those individuals who may be harmed by these practices are primarily the sexual partners themselves, and as long as they are competent, consenting adults, protecting them from harm would appear to be an insufficient justification for banning such practices altogether.¹⁵⁰

From this point of view, for the Court, the rights of the offender's partner might not be a matter of discussion when the use of pharmacotherapy and DoSL come into question. However, from the offender's point of view, his sexual relations with others would definitely be affected and this gives rise to an interference with his bodily and functional integrity, including the ability to conceive a child, as well as his psychological integrity.¹⁵¹

Another controversial point on pharmacotherapy is that the medications used have several side-effects and this might cause an interference with the offenders' bodily integrity and personal autonomy.¹⁵² In addition, given that the implication of pharmacotherapy within the punitive context comprises the security, economic and social policy considerations, its imposition may interfere with Article 8 due to the extra burden imposed on those offenders. The reason is that the use of pharmacotherapy within this context takes part in the domain of conflict of interest. In other words, there

¹⁵⁰ Bruce J Winick, 'On Autonomy: Legal and Psychological Perspectives' (1992) 37 Villanova Law Review 1705, 1741-42.

¹⁵¹ In the dissenting opinion, it is stated that the Court failed to notice the fact that requesting artificial insemination facility for prisoners includes all sorts of couple such as 'a man in prison and a woman outside, a woman in prison and a man outside, a homosexual couple with one of the partners in prison and the other outside'. The dissenting judges hold the view that on this matter 'States should enjoy an important margin of appreciation.' (Joint Dissenting opinion of Judges Wildhaber, Zupančič, Jungwiert, Gyulumyan and Myjer) in *Dickson* (n 149).

¹⁵² Harrison and Rainey, 'Suppressing Human Rights?' (n 146) 68-69.

is a conflict between offenders' rights and the rights/interest of others, in particular, promotion of social welfare and safety and protection of individuals from danger, harm and abuse, and the state uses pharmacotherapy with the aim of protecting the others' interests/rights by restricting offenders' certain rights and putting extra burden on them. In this situation, the extra burden put on offenders or the restriction imposed on their rights with the use of pharmacotherapy will give rise to an interference with Article 8. Thus, due to the restrictions imposed on the rights of offenders, it seems that the use of pharmacotherapy with PSOs leads to an infringement of Convention rights, or simply, it precludes the enjoyment of rights recognised and protected by the Convention.

However, as regards the Convention, Article 8 rights are qualified and derogation is permitted in a number of circumstances as listed under Article 8(2). In this sense, if the imposition of pharmacotherapy as treatment is carried out in the absence of free and informed consent, the interference complained of must

- (i) 'have a legal basis, the law in question must be sufficiently clear and precise, and it must contain a measure of protection against arbitrariness by public authorities',¹⁵³
- (ii) have a legitimate aim, meaning that the measure should have an objective of sufficient importance and it is for the state to indicate an objective and reasonable justification for interfering with the right under Article 8, and
- (iii) correspond to a 'pressing social need and, in particular, that it is proportionate to the legitimate aim pursued',¹⁵⁴ meaning that the measure must be necessary in a democratic society in the interests of public safety, for the protection of public order, health or morals, or for the protection of the rights and freedoms of others.

¹⁵³ Harris, O'Boyle and Warbrick (n 144) 400.

¹⁵⁴ *Olsson v Sweden* App no 10465/83 (ECtHR, 24 March 1988) para 67. In *Handyside v the UK*, the Court holds the view that 'necessary' comes to mean that there must be a 'pressing social need' for the interference. App no 5493/72 (ECtHR, 07 December 1976) para 48.

2.1.1. In accordance with law

One can simply argue that if the interference that results from the involuntary imposition of pharmacotherapy is based on domestic law and is carried out through a judicial decision given by competent domestic authorities, including the decisions of medical authorities, it might be held by the Strasbourg Court that the application of pharmacotherapy is in accordance with law. However, according to the Court, this requirement does not only come to mean that the measure taken by the public authorities must be in compliance with the relevant national law, but it should also be pursuant to the Convention, ‘including the general principles expressed or implied in it, particularly the principle of the rule of law, which is expressly mentioned in the Preamble to the Convention.’¹⁵⁵ In *Malone v UK*¹⁵⁶, the Court delves into the expression ‘in accordance with law’ and set some standards. According to the Court,

the interference in question must have some basis in domestic law. [H]owever, over and above compliance with the domestic law ... [the domestic law has to be] compatible with the rule of law ... [meaning that] there must be a measure of legal protection in domestic law against arbitrary interferences by public authorities with the rights safeguarded by paragraph 1.¹⁵⁷

In light of this decision, the application of pharmacotherapy to PSOs must be compatible with the rule of law. This means that all necessary safeguards must be placed into the states’ law in order to put a constraint upon the states’ arbitrary administration of

¹⁵⁵ *Plesó* (n 37) para 59.

¹⁵⁶ *Malone v The United Kingdom* App no 8691/79 (ECtHR, 02 August 1984).

¹⁵⁷ *Ibid* paras 66-67.

pharmacotherapy. In addition, the Court stresses the importance of the accessibility, predictability and foreseeability of the legislation and notes that

the law must be sufficiently clear in its terms to give citizens an adequate indication as to the circumstances in which and the conditions on which authorities are empowered to resort to this secret and potentially dangerous interference with the right to respect for private life.¹⁵⁸

In *X v Finland*, according to the Court, the quality of law requires that the law in question has to be accessible to the person affected and its outcomes have to be foreseeable. Moreover, the term ‘law’ not only points out a formal context but also refers to a substantive concept. In fact, the law at issue has to be in accordance with the rule of law and thus the ‘quality of the legal rules’ applied to an individual has to be scrutinised. On these grounds, if the content of a law in question does not include any ‘proper safeguards against arbitrariness’ or it lacks sufficient safeguards against any arbitrary intervention concerning pharmacotherapy, the imposition of pharmacotherapy on PSOs would violate the right to private life, even if the measure taken has a legal basis.¹⁵⁹

In addition, in the event of granting a legal discretion to the executive body, the Court holds that legislation which gives discretion to the competent authorities should clearly specify and illustrate the extent of this discretion and the manner of its implication with respect to the legitimate aim of the policy at issue in order to protect the individuals

¹⁵⁸Ibid para 67. It is noted that this is a ‘threefold test for determining whether an interference is in accordance with law.’ In this sense, the interference must have ‘some basis in national law’, the law must be ‘accessible’ and ‘the law must be formulated in such a way that a person can foresee to a degree that is reasonable in the circumstances, the consequences which a given action will entail.’ Bernadette Rainey, Elizabeth Wicks and Clare Ovey, *Jacobs, White and Ovey, the European Convention on Human Rights* (6th edn, Oxford University Press 2014) 310.

¹⁵⁹App no 34806/04 (ECtHR, 03 July 2012) paras 215-17, 220-21.

adequately from any arbitrary interference.¹⁶⁰ The importance of this requirement results from the administration process of pharmacotherapy. In this respect, the scope of the state authorities task and discretion must be expressly defined and described, especially the ones who take place in the process of the application of pharmacotherapy. In the light of these principles, (i) if pharmacotherapy is regulated under domestic law and if the essential elements/requirements concerning its administration process are indicated with reasonable certainty and clarity (including the informed consent requirement), (ii) if the provisions are accessible and their outcomes are foreseeable (including the duration of pharmacotherapy and the prospect of release), and (iii) in case of granting discretion to the relevant authorities, if the scope and manner of this discretion is clearly and directly enunciated, then the Court would be satisfied that the administration of pharmacotherapy will be in accordance with the law. For instance, in the Slovak Republic, the CPT observed that the application of pharmacotherapy appeared not to be subject to any legal provision and important procedural safeguards were not sufficiently regulated. Thus, it was recommended that a comprehensive and detailed procedure including proper safeguards against arbitrariness such as ‘inclusion and exclusion criteria for such treatment’, ‘medical examinations before, during and after treatment’ and ‘access to outside consultation, including an independent second opinion’ had to be elaborated and fully and properly implemented in the national law.¹⁶¹

2.1.2. Legitimate aim

Once it is established that the interference is in accordance with the law and has a legal basis, the next consideration will be whether it also has a legitimate aim.¹⁶² According to

¹⁶⁰ *Malone* (n 156) para 68.

¹⁶¹ Report to the Government of the Slovak Republic on the Visit to the Slovak Republic Carried Out by the CPT from 24 March to 2 April 2009 (Strasbourg, 11 February 2010) para 126 <<http://www.cpt.coe.int/documents/svk/2010-01-inf-eng.htm>> accessed 06 April 2013.

¹⁶² Möller argues that legitimate aim issue gives rise to two significant questions as follows: (i) ‘What does it mean to speak of the “goal” of a policy?’ and (ii) ‘What goals are and which are not legitimate?’

the Court's case-law, any restriction on an individual's rights under Article 8 must pursue one or more of the legitimate aims as enumerated in Article 8(2)¹⁶³ and the states should clarify the objectives of interfering with a person's right protected under the Convention.¹⁶⁴ As is indicated in Article 8(2), there is a narrow 'end-setting discretion' endowed to the States by giving an exhaustive list of legitimate aims. In this sense, any legitimate aim chosen from the list falls within the end-setting discretion of the Member States.¹⁶⁵ Under Article 8(2), there are six legitimate aims that the states should pursue which are: 'in the interests of national security', 'public safety', 'the economic well-being of the country', 'for the prevention of disorder or crime', 'the protection of health or morals' and 'for the protection of the rights and freedoms of others'.¹⁶⁶ However, it should be noted that sometimes the Court holds a legitimate aim which is not expressly indicated in Article 8(2). For instance, in *Dickson v UK*, the indicated legitimate aims are 'the maintenance of public confidence in the penal system and the welfare of any child conceived and, therefore, the general interests of society [...]' and the Court is persuaded that such a ground falls within the legitimate aims listed in Article 8(2).¹⁶⁷

Speaking of the goals, according to Möller, a goal or an aim has two different aspects either having a goal is an issue of a 'state of mind' which would be misleading or, in some cases, it would be hard to be identified or having a goal refers to the rationality of the interests which is connected to the policy. He suggests that the idea of goal of a policy should be understood in the second way. Kai Möller, 'Proportionality: Challenging the Critics' (2012) 10 International Journal of Constitutional Law 709, 711-712.

¹⁶³ *SH and Others v Austria* App no 57813/00 (ECtHR, 03 November 2011) para 89.

¹⁶⁴ Harris, O'Boyle and Warbrick (n 144) 348.

¹⁶⁵ Matthias Klatt and Moritz Meister, *The Constitutional Structure of Proportionality* (Oxford University Press 2012) 153. It has to be made clear that what is referred with the expression of end-setting is a 'discretion whenever the constitutional right contains an authorization to limit its enjoyment which either leaves the reasons for the limitation open or which while identifying the possible reasons for limiting the right, merely permits limitations for these reasons without requiring them.' Robert Alexy, *A Theory of Constitutional Rights* (Julian Rivers tr, Oxford University Press 2002) 395. Article 8(2) points out the second case, meaning that the legislature is left with the decision that the means, ends, aims or principles are in conformity with what is authorized under Article 8 in order to justify the restriction of the right.

¹⁶⁶ On legitimate aim and the Court's case-law, see P Kempees, "'Legitimate aims'" in the Case-Law of the European Court of Human Rights' in Paul Mahoney and others (eds), *Protecting Human Rights: The European Perspective. Studies in Memory of Rolv Ryssdal* (Köln: Carl-Heymanns Verlag 2000) 659.

¹⁶⁷ *Dickson* (n 149) paras 42, 76. Also, in *SAS v France*, which is about the ban on wearing clothing designed to conceal the face in public places, one of the legitimate aims indicated by the government is 'respect for the minimum set of values of an open and democratic society'. The Court finds that under

However, this does not come to mean that the states can invent new legitimate aims and there is a possibility that the Court might approve them. Rather, it will be approved by the Court only if the indicated legitimate aims fall within one of those identified in Article 8(2) even if it is not expressed with the same words used in Article 8(2). In this sense, the state can allege another reason which is not listed under Article 8(2) and if the Court assents to the state's allegation that such a ground falls within the legitimate aims given in Article 8(2), it can be regarded as the policy pursues a legitimate aim which is in compliance with the aims listed under Article 8(2).

The primary purposes behind the use of pharmacotherapy can briefly be summarised as follows: (i) prevention of PSOs from committing further crimes and inflicting harm on others, (ii) treatment of their uncontrollable sexual motivations and urges and (iii) improvement or prevention of deterioration on their mental health and enhancement of their autonomy. With respect to the words of Article 8(2), ECHR, pharmacotherapy can be imposed on certain sex offenders with the aim of maintaining 'public safety', 'preventing disorder or crime', 'protecting health or morals', 'protecting the rights and freedoms of others'. As noted in previous chapters, pharmacotherapy is an effective and efficient way of decreasing offenders' sexual urges and enhancing their autonomy and ability to gain control over their sexual motivations. By this means, they will not pose a risk to society or be a threat to society and there will be a reduction in recidivism rates of sex offences. In addition, it has been stressed that other psychological treatment programmes play a key role in promoting the effectiveness of pharmacotherapy and these additional therapy programmes might facilitate the reintegration of this person into the society. On that account, pharmacotherapy can pave the way for the states to

certain conditions this aim 'can be linked to the legitimate aim of the "protection of the rights and freedoms of others".' App no 43835/11 (ECtHR, 01 July 2014) paras 114, 121.

maintain public safety, protect others' interests/rights and prevent further sexual crimes and the states can rely on these aims to use pharmacotherapy with PSOs.

It is noteworthy to stress that the importance of the legitimate aim(s) indicated by the states comes into play when there is a need to hold a balance between the rights of individuals concerned and the interests of the member States. The Strasbourg Court resorts 'the principle of proportionality' or 'fair balance' to determine whether a reasonable relationship between a particular objective indicated and the means used to achieve this objective exists or not. For instance, it will be considered by the Court as disproportionate, if the legitimate aim indicated by the state to justify the interference cannot be proved.¹⁶⁸ However, the use of principle of proportionality essentially comes up after the evaluation of whether the interference is necessary in a democratic society or whether the interference corresponds to a pressing social need because it is essential for the determination of the reasonableness of the restriction. Also, the evaluation regarding the existence of a 'pressing social need' requires the consideration of the margin of appreciation doctrine. On this matter, the Court notes that

[when] there is no consensus within the member States of the council of Europe either as to the relative importance of the interest at stake or as to how best to protect it, the margin will be wider. [...] There will also usually be a wide margin accorded if the State is required to strike a balance between competing private and public interests or Convention rights.¹⁶⁹

Since the principle of proportionality and the margin of appreciation doctrines are essential to determine how far the states can go to regulate an area or an issue which

¹⁶⁸ *Vereinigung Demokratischer Soldaten Österreichs and Gubi v Austria* App no 15153/89 (ECtHR, 19 December 1994)

¹⁶⁹ *Dickson* (n 149) para 78.

imposes certain restrictions on individuals rights guaranteed in the Convention, both concepts will be assessed more thoroughly after the examination of the ‘necessary in a democratic society’ criterion.

Given the legitimate aims of the use of pharmacotherapy within the context of Article 8(2), the use of pharmacotherapy can also be justified on the ground of the protection of children, their health and security and moral values of a society. As is noted by the Court,

one of the purposes of the legislation is to afford safeguards for vulnerable members of society, such as the young (...). [Especially, the protection of morals] may imply safeguarding the moral ethos or moral standards of a society as a whole, but may also, as the Government pointed out, cover protection of the moral interests and welfare of a particular section of society, for example [children]. Thus, “protection of the rights and freedoms of others”, when meaning the safeguarding of the moral interests and welfare of certain individuals or classes of individuals who are in need of special protection for reasons (...) amounts to one aspect of “protection of morals”.¹⁷⁰

In this respect, some degree of regulation concerning individuals’ behaviours, in particular sexual behaviours, can be made by the states for the preservation of public order and decency and for the protection of vulnerable members of society from what is dangerous, injurious and offensive to them. Thus, regulations sought to boost the

¹⁷⁰ *Dudgeon* (n 17) para 47.

protection of children and to promote their well-being can be regarded by the Court as a persuasive legitimate aim listed under Article 8(2).

2.1.3. Necessary in a democratic society

Since being lawful and serving a legitimate aim are not enough for an interference to be justified, it must also be necessary given the circumstances, meaning that the measure which interferes with the rights must be necessary¹⁷¹ and, arguably, be the least restrictive way of achieving the indicated objective or for serving that objective.¹⁷² In the words of the Court, there must be a ‘reasonable relationship of proportionality between the means employed and the aim sought to be achieved.’¹⁷³ In this sense, the reason(s) to put restriction on an individual’s right must rely on a pressing social need and this restriction must be no more or greater than what is necessary to address this pressing social need.¹⁷⁴ It should be noted at this stage that the determination of ‘no greater than what is necessary’ requires the application of the proportionality test. According to the Court, ‘necessary in a democratic society’ clause comprises several principles that a state policy has to be included and ‘necessary’ indicates the presence of a ‘pressing social need’ for the breach at issue which has to be initially evaluated by the national authorities within the context of a margin of appreciation.¹⁷⁵ In this respect, ‘a restriction on a Convention right cannot be regarded as “necessary in a democratic society” – two

¹⁷¹ In *Stubing v Germany*, the applicant was criminally convicted due to the incestuous relationship and under the German Criminal Code, having sexual intercourse between siblings is a punishable offence. The ECtHR takes the stance that convicting the applicant because of having incest relationship ‘corresponded to a pressing social need, as required by Article 8 § 2 of the Convention.’ App no 43547/08 (ECtHR, 12 April 2012) para 62 (emphasis added).

¹⁷² According to Möller, sometimes the states have more than one option so as to accomplish the legitimate aim indicated, i.e. the alternative measure which is less intrusive but with some disadvantages, and the resolution of this issue can be carried out either under the necessity assessment or the proportionality assessment. Kai Möller, ‘Proportionality’ (n 154) 713-715.

¹⁷³ *Francesco Sessa v Italy* App no 28790/08 (ECtHR, 03 April 2012) para 38.

¹⁷⁴ *Rainey, Wicks and Ovey* (n 158) 325.

¹⁷⁵ *Dudgeon* (n 17) paras 50-51.

hallmarks of which are tolerance and broadmindedness - unless, amongst other things, it is proportionate to the legitimate aim pursued.’¹⁷⁶

In *Silver and Others v UK*, the Court analysed the ‘necessary in a democratic society’ phrase and indicated certain principles concerning this phrase which can also be regarded as the classic formulation of the Court’s proportionality test:

- (a) the adjective ‘necessary’ is not synonymous with ‘indispensable’, neither has it the flexibility of such expressions as ‘admissible’, ‘ordinary’, ‘useful’, ‘reasonable’ or ‘desirable’;
- (b) the Contracting States enjoy a certain but not unlimited margin of appreciation in the matter of the imposition of restrictions, but it is for the Court to give the final ruling on whether they are compatible with the Convention;
- (c) the phrase ‘necessary in a democratic society’ means that, to be compatible with the Convention, the interference must, *inter alia*, correspond to a ‘pressing social need’ and be ‘proportionate to the legitimate aim pursued’;
- (d) those paragraphs of Article of the Convention which provide for an exception to a right guaranteed are to be narrowly interpreted.¹⁷⁷

With respect to this formulation, it can be argued that addressing the following questions might give the answer to the case in point, which is, whether the severity of the

¹⁷⁶Ibid para 53.

¹⁷⁷ App nos. 5947/72, 6205/73, 7052/75, 7061/75, 7107/75, 7113/75 and 7136/75 (ECtHR, 25 March 1983) para 97.

interference with an individual's right is proportionate to the importance of the state or public interest:

1. Is there a pressing social need for the limitation of the Convention Right(s)?
2. If there is, does this particular limitation or the interference correspond this pressing social need?
3. If it does, is the response to the pressing social need proportional?
4. Are the objectives indicated by the state, relevant, sufficient and suitable?

As discussed in Chapter Two, pharmacotherapy can remove internal impediments to offenders' autonomy by treating their condition and helping them control their sexual urges, and can enhance their (future) autonomy. It can also remove the external barriers to the enjoyment of fundamental rights when it is used as an alternative to further incarceration. In addition, in Chapter Three, it is argued that since PSOs damage the lives of their victims and cause irreparable harm to society as a whole, DoSL with the use of pharmacotherapy (as a component of punishment) can deal with those offenders better than imprisonment (DoL) by rehabilitating and incapacitating PSOs and protecting society from actual/potential harm. On that account, given the needs of PSOs and the concerns of the members of public on these offenders, pharmacotherapy has benefits both for PSOs and society as a whole. Thus, it can be claimed by the state that there is an existence of a pressing social need for the interference caused by the application of pharmacotherapy and this medical intervention responds to this pressing social need in an effective and efficient way. It can also be argued that there is a proportionate balance between this medical intervention and the aims pursued because pharmacotherapy serves not only society's interests in ensuring the safety and welfare of

individuals but also PSOs' benefits by aiming to overcome the internal and external constraints on their autonomy.

Regarding the relevance, sufficiency and suitability of the means requirement, when the effects of pharmacotherapy on PSOs' deviant sexual motivations and behaviours are considered, the use of pharmacotherapy can be regarded as a relevant, sufficient and suitable means of accomplishing the objectives of the states. On this matter, Young argues that in the case of certain sex offenders, if a particular treatment may result in a decrease in future sexual misconduct, their fundamental rights can be diminished or any interference with their rights can be justified by concerns of prevention of crime or disorder, reduction of recidivism rates and the maintenance of public safety.¹⁷⁸ Given the effectiveness of incarceration, it is argued that this traditional method refers to the removal of an offender's opportunity to give further damages or to commit further crimes but does not work for impulsive offences because it does not impede offenders from committing crimes completely. The reason is that incarceration or DoL does not render prisoners completely 'unable to commit crime, it fails to achieve complete offense-specific incapacitation (...) it merely substitutes one set of potential victims for another, imprisonment fails on the total victim-specific incapacitation front as well.'¹⁷⁹ Rather, DoL as punishment has 'partial offen[c]e-specific' and 'partial victim-specific' effects and these are merely achieved by excluding offenders from society and preventing them from committing further crimes for a certain length of time.¹⁸⁰ Whereas, DoSL with the use of pharmacotherapy can render PSOs unable to commit crime by rehabilitating/incapacitating them, achieve complete offence-specific incapacitation and help offenders to reintegrate to society after their release from prison.

¹⁷⁸ Laura J Young, 'Chemically Castrating the American Civil Commitment Remedy for Sexual Offenders' (2001) 1 Digital Commons at Michigan State University College of Law 1, 4, 36.

¹⁷⁹ Kevin Bennardo, 'Incarceration's Incapacitative Shortcomings' (2014) 54 Santa Clara Law Review 1, 1.

¹⁸⁰ See *ibid.*

In this respect, the use of involuntary pharmacotherapy aimed at diminishing uncontrollable or abnormal sexual desires of PSOs and reducing or even bringing an end to the further crimes of those offenders can be considered as relevant, sufficient and suitable for pursuing the amelioration of their abnormal sexual motivations, enhancement of their self-control and promotion of public safety including the protection of the rights and freedoms of others and health or morals. Therefore, as an adequate remedy for PSOs, the use of pharmacotherapy can be perceived to be a justifiable method to remedy the deficiencies of incarceration and to a safer society.¹⁸¹ Regarding the proportionality between the measure taken and the reason(s) indicated, Clarke argues that when an involuntary medical treatment is in question,

issues such as effectiveness and [...] side effects are important to determine whether the treatment is the least intrusive means of accomplishing the statute's goal. For example, if the drug does not accomplish the desired effects, it fails the least intrusive method requirement because the least intrusive means of achieving nothing is nothing. [...] In essence, if the drug does not accomplish the purported goal of the law, it is not necessarily related to the state interest involved.¹⁸²

Clarke's argument on effectiveness of the treatment and its adverse side-effects is worthy of consideration to determine the reasonable relationship of proportionality between the means used and the aim sought to be achieved. Striking a balance between the rights and interests of individuals concerned and the rights and interests of others,

¹⁸¹ It is worth noting that according to the Court, the member States are not under an obligation to use the least restrictive (burdensome) measure. See *McCann and others v the United Kingdom* App no 18984/91 (ECtHR, 27 September 1995); (Partly concurring, partly dissenting opinion of Judge Jungwiert) in *Andronicou and Constantinou v Cyprus* App no 25052/94 (ECtHR, 09 October 1997).

¹⁸² Clarke (n 124) 508.

including the needs/interests of the states, is also one of the determinant factors that should be considered. In this respect, given that the use of pharmacotherapy is more effective and less restrictive alternative than incarceration (DoL), the effects of medications are reversible after discontinuation and the side-effects can be kept under control and minimised, the restriction on offenders' rights can be regarded as proportionate to the furtherance of the aim(s).

2.1.4. The margin of appreciation and the proportionality test: Is the use of pharmacotherapy proportionate to the legitimate aim considering the margin of appreciation granted to the Member States?

The margin of appreciation is a core principle which generates a controlling effect over the Convention and the Court's decision making process. This principle is 'a degree of discretion' granted to the States that is mostly applied to the cases when a 'difficulty in identifying uniform European conceptions of the extent of rights or restrictions' is gone through.¹⁸³ As the Court puts it, '[t]he scope of the margin of appreciation will vary according to the circumstances, the subject-matter and its background; in this respect, one of the relevant factors may be the existence or non-existence of common ground between the laws of the Contracting States.'¹⁸⁴ Also according to the Court, 'not only the nature of the aim of the restriction but also the nature of the activities involved will affect the scope of the margin of appreciation.'¹⁸⁵ Therefore, if there is a lack of consensus among the States or a 'room for manoeuvre' of the state authorities, especially in terms of highly sensitive issues, the resolution of the matter is left to the

¹⁸³ Iain A Cameron and Maja Kirilova Eriksson, *An Introduction to the Convention on Human Rights* (Iustus Förlag 1993) 72.

¹⁸⁴ *Rasmussen v Denmark* App no 8777/79 (ECtHR, 28 November 1984) para. 40.

¹⁸⁵ *Dudgeon* (n 17) para 52. Also it is noted that the *Dudgeon* case embraces the most intimate aspect of private life and for this reason, the state's margin of appreciation is narrow and it should be demonstrated that 'particularly serious reasons before interferences on the part of the public authorities can be legitimate for the purposes of paragraph 2 of Article 8.' Ibid para 52.

Contracting States.¹⁸⁶ It is worthy stressing that the Court considers the standards set by the Council of Europe and its Member States as the common policy. Thus, a large extent of agreement on a particular issue among the Member States will be regarded by the Court as a sign of what a democratic society requires.

Before the assessment of the margin of appreciation doctrine within the context of the Court's case-law, it is crucial to point out that although this doctrine derives its force from the ECtHR's authoritative interpretation, 'Protocol No. 15 amending the Convention on the Protection of Human Rights and Fundamental Freedoms' includes a new recital, which shall be added at the end of the preamble to the Convention, concerning the recognition of the margin of appreciation doctrine within the context of the Convention.¹⁸⁷ In this regard, the wording of Article 1 of the Protocol 15, ECHR, is as follows:

Affirming that the High Contracting Parties, in accordance with the principle of subsidiarity, have the primary responsibility to secure the rights and freedoms defined in this Convention and the Protocols thereto, and that in doing so they enjoy a margin of appreciation, subject to the supervisory jurisdiction of the European Court of Human Rights established by this Convention [...].

It is noted in the explanatory report that the aim of this new recital is to promote

¹⁸⁶ Cameron and Eriksson (n 183) 72.

¹⁸⁷ (Strasbourg, 24 June 2013).

the transparency and accessibility of these characteristics of the Convention system and to be consistent with the doctrine of margin of appreciation as developed by the Court in its case-law. [...]

[t]he Convention system is subsidiary to the safeguarding of human rights at national level and that national authorities are in principle better placed than an international court to evaluate local needs and conditions. The margin of appreciation goes hand in hand with supervision under the Convention system. In this respect, the role of the Court is to review whether decisions taken by national authorities are compatible with the Convention, having due regard to the State's margin of appreciation.¹⁸⁸

In general terms, the margin of appreciation doctrine 'refers to the latitude a government enjoys in evaluating factual situations and in applying the provision enumerated in international human rights treaties.'¹⁸⁹ This doctrine is also described as 'breathing space',¹⁹⁰ or 'elbow room',¹⁹¹ which is granted to the national authorities by the international ones. Especially, if the protection of morals is a matter of discussion, the Court stresses that 'State authorities are in principle in a better position than the international judge to give an opinion on the exact content of those requirements as well as on the "necessity" of a "restriction" or "penalty" intended to meet them.'¹⁹² In this respect, the margin of appreciation doctrine plays a key role in the negotiation between

¹⁸⁸ Explanatory Report to the Protocol 15 ECHR (Strasbourg, 16 May 2013) paras 7, 9 <<http://conventions.coe.int/Treaty/EN/Reports/Html/213.htm>> accessed 12 December 2014.

¹⁸⁹ Yutaka Arai-Takahashi, *The Margin of Appreciation Doctrine and the Principle of Proportionality in the Jurisprudence of the ECHR* (Intersentia 2001) 2.

¹⁹⁰ Howard Charles Yourow, 'The Margin of Appreciation Doctrine in the Dynamics of European Human Rights Jurisprudence' (1987) 3 Connecticut Journal of International Law 111, 118.

¹⁹¹ Bert B Lockwood, Janet Finn and Grace Jubinsky, 'Working Paper for the Committee of Experts on Limitation Provisions' (1985) 7 Human Rights Quarterly 35, 67.

¹⁹² *Handyside* (n 154) para 48.

‘the interests concerned with national and supranational decision-making’¹⁹³ and the width of this doctrine refers to the degree of protection required by the Contracting States.

While the margin of appreciation is at the heart of the Court’s investigation into the necessity of the restriction in a democratic society, the proportionality test is at the heart of the examination of the reasonableness of the restriction. On this matter, it is argued that ‘the margin of appreciation goes to the legitimacy of the aim of the interference in meeting a pressing social need, whereas the doctrine of proportionality concerns the means used to achieve that aim.’¹⁹⁴ Also, Yutaka notes that the margin of appreciation doctrine refers to ‘the measure of discretion allowed the Member States (...) [whereas] the principle of proportionality has been conceived to restrain the power of state authorities to interfere with the rights of individual persons, and hence it should be regarded as a device for the protection of individual autonomy.’¹⁹⁵ In this respect, it can be argued that the margin of appreciation doctrine and the principle of proportionality have an overlapped sphere, especially, when there is a concern over a member State’s margin of appreciation whether it has been exceeded or not.

According to Lester and Pannick, ‘a greater latitude is appropriate in relation to [the] rights which expressly require a balancing of competing interests (...)’,¹⁹⁶ meaning that the extent of the margin of appreciation varies depending on the right, i.e., to what extent it requires a balancing exercise. On that account, it has been argued that the margin of appreciation doctrine is relevant to some Convention rights, not all, which allows limitations to be imposed on rights and requires positive obligations to be carried

¹⁹³ Janneke Gerards, ‘Pluralism, Deference and the Margin of Appreciation Doctrine’ (2011) 17 *European Law Journal* 80, 107.

¹⁹⁴ Rainey, Wicks and Ovey (n 158) 333.

¹⁹⁵ Arai-Takahashi (n 189) 2.

¹⁹⁶ Anthony Paul Lester and David Pannick (eds), *Human Rights Law and Practice* (2nd edn, London: LexisNexis 2004) 94.

out by a state to accomplish its obligations.¹⁹⁷ The reason is because balancing essentially is applied to the conflicts between fundamental rights and the interests of the state (or public interests) and thus, it can only be used when a qualified right is a matter of discussion. From this point of view, it is claimed that the significance of the right, the objectivity of the restriction and the uniform conception in Europe on a particular matter (the European standards or the European Consensus standard) determine the breadth of the margin of appreciation.¹⁹⁸

Considering the rapid progress of medical and scientific developments and since there is ‘no uniform conception of morals’¹⁹⁹ among the Contracting States, one can claim that the scope of the margin of appreciation granted to the member States is likely to be wide over the matters regarding the imposition of new medical methods. Although the uncertainties derived from the administration of these new techniques raise concerns over moral and ethical matters and also over human rights issues and thus, a justification of these techniques would be required, the Court might grant a margin of appreciation to the States to regulate the areas surrounding the development over the medical and scientific matters,²⁰⁰ and also to choose the method to be used.

Concerning pharmacotherapy and the margin of appreciation principle, it is worth noting that the Council of Europe Parliamentary Assembly, which has a significant role in the European political context regarding recommendations on human rights issues, discussed the states’ position in support of the use pharmacotherapy for convicted sex

¹⁹⁷ Harris, O’Boyle and Warbrick (n 144) 13.

¹⁹⁸ Rainey, Wicks and Ovey (n 158) 325-332. Also see *Handyside* (n 154); *Otto-Preminger Institute v Austria* App no 13470/87 (ECtHR, 20 September 1994); *Monory v Romania and Hungary* App no 71099/01 (ECtHR, 5 April 2005).

¹⁹⁹ Rainey, Wicks and Ovey (n 158) 327.

²⁰⁰ See *Mata Estevez v Spain* App no 56501/00 (ECtHR, 10 May 2001); *Frette v France* App no 36515/97 (ECtHR, 26 February 2002); *Vo v France* App no 53924/00 (ECtHR, 08 July 2004); *A, B and C v Ireland* App no 25579/05 (ECtHR, 16 December 2010).

offenders due to the belief that it is an effective way of dealing with such offenders.²⁰¹ However, the Assembly mostly focused on forced sterilisation and surgical castration and it briefly noted that pharmacotherapy could be an option for alleviating the condition of PSOs.²⁰² Given that the Assembly mostly refers to the CPT standards and findings concerning pharmacotherapy, the CPT reports can be considered as it erects a scaffold to create a uniform concept regarding the use of pharmacotherapy. As is noted above, according to the Committee any derogation from free and informed consent to treatment is reasonable, only if it is ‘based upon law and only relate to clearly and strictly defined exceptional circumstances.’²⁰³ In this sense, the CPT holds the view that under certain circumstances, imposing pharmacotherapy on certain sex offenders without obtaining their consent is possible and permissible. Also, given the report on surgical castration for the treatment of sex offenders, the Committee stresses that ‘surgical castration is a mutilating, irreversible intervention and cannot be considered as medical necessity in the context of the treatment of sexual offenders ... [and] could easily be considered as amounting to degrading treatment.’²⁰⁴ Whereas, the imposition of pharmacotherapy is a less invasive intervention compared with surgical castration and ‘when a medical intervention on a human being is carried out, the least invasive option shall be chosen. In this context, the importance of physical integrity as guaranteed by Article 2, 3 and 8 of the European Convention on Human rights cannot be overemphasised.’²⁰⁵ In light of this assessment, it appears that regarding the involuntary

²⁰¹ PACE, Committee on Legal Affairs and Human Rights, ‘Promoting Alternatives to Imprisonment’ (19 April 2013) <<http://assembly.coe.int/nw/xml/XRef/X2H-Xref-ViewPDF.asp?FileID=19557&lang=en>> accessed 3 December 2014; PACE, ‘Putting an End’ (n 46).

²⁰² PACE, ‘Putting an End’ (n 46) para 31.

²⁰³ Report to the Czech Government (n 45) para 19.

²⁰⁴ Report to the German Government on the Visit to Germany Carried Out by the CPT from 25 November to 7 December 2010 (Strasbourg, 22 February 2012) para 145 <<http://www.cpt.coe.int/documents/deu/2012-06-inf-eng.htm>> accessed 10 December 2014.

²⁰⁵ Report to the Czech Government on the Visit to the Czech Republic Carried Out by the CPT from 21 to 23 October 2009 (Strasbourg, 21 July 2010) para 9 <<http://www.cpt.coe.int/documents/cze/2010-22-inf-eng.pdf>> accessed 10 December 2014.

use of pharmacotherapy, the states can act within their margin of appreciation and apply this medical intervention to PSOs. However, according to the CPT, the involuntary use of pharmacotherapy must be limited to exceptional circumstances. Also, although the objective reasons for limiting the right under Article 8 are considerably reasonable and justifiable, since the right to respect for private life has been characterised as fundamental, and the use of pharmacotherapy impacts on an intimate area of offenders' sexual life, autonomy and integrity which fall within the inner core of the right to private life, the width of margin of appreciation will probably be narrow.²⁰⁶

In general terms, pharmacotherapy is an effective means to achieve the states' aims of treating PSOs' conditions, rehabilitating and incapacitating them, protecting health and welfare of children; there is a proportionate balance between all rights and interests at issue, and between the use of pharmacotherapy and the aim(s) pursued in terms of its effectiveness and appropriateness; and, to a certain extent, its administration falls within the states' margin of appreciation. For these reasons, it can be asserted that the interference with the right to respect for private life can be permissible under Article 8.

2.2. Right to Marry and Found a Family

Article 12 essentially protects individuals' right to marry and to found a family according to domestic laws governing the exercise of this right. To this respect, it is granted to the states to provide the detail and substance that enables individuals to enjoy the right under Article 12. In addition, this right provides a protection for the right to intimate association and the right to procreate. Since pharmacotherapy has impact upon individuals' ability to engage in a sexual relation and to conceive a child, its application also requires justification under Article 12.

²⁰⁶ See *Odievre v France* App no 42326/98 (ECtHR, 13 February 2003).

Considering the *IG and others v Slovakia* case mentioned above (involuntary sterilisation of individuals), it was claimed that the State failed to carry out its obligation under Article 12 by not providing appropriate safeguards for the protection of the right to found a family. However, the Court abstains from going in further detail and examining the sterilisation case under Article 12 due to the reason that

the sterilisation performed (...) was in breach of Article 8 of the Convention.

In view of that finding, and also in regard of all the circumstances, the Court considers that a further examination of whether the facts of the case also give rise to a breach of their right to marry and to found a family is not called for. It is therefore not necessary to examine the (...) complaint separately under Article 12 of the Convention.²⁰⁷

In general, the Court's approach to the limitations on the exercise of the right under Article 12 is that the states are granted a narrow margin of appreciation and thus, the limitations on Article 12 should not 'restrict or reduce the right in such a way or to such an extent that the very essence of the right is impaired.'²⁰⁸ In addition, the Court enumerates the grounds for the states to regulate or to put limitations on the exercise of the right under Article 12, including, 'publicity and the solemnisation of marriage', 'public interest, in particular concerning capacity, consent, prohibited degrees of affinity or the prevention of bigamy (...)' and 'security, in particular the prevention of crime and

²⁰⁷ *IG and others* (n 82) paras 150-51. Also see, *VC v Slovakia* (n 74) paras 160-61.

²⁰⁸ *Fransik v Poland* App no 22933/02 (ECtHR, 05 January 2010) para 88.

disorder’.²⁰⁹ According to the Court, apart from these given reasons, the state law may not include any restriction on the exercise of the right protected under Article 12.²¹⁰

In *Frasik v Poland*, it was noted by the third party, Helsinki Foundation for Human Rights, that ‘concerning the rights of prisoners, any measure depriving a person of liberty inevitably entailed limitations on the exercise of Convention rights, including a measure of control on prisoners’ contacts with the outside world.’²¹¹ However, if the right under Article 12 is a matter of concern, the states’ discretion is limited and the state authorities should hold a balance between ‘the demands of security in prison and the prisoner’s right’ while they exercise their power on this issue.²¹² In this respect, the Court stresses that being in prison is not an obstacle to exercise the rights under Article 12 and thus, ‘a prisoner continues to enjoy fundamental human rights and freedoms that are not contrary to the sense of deprivation of liberty, and every additional limitation should be justified by the authorities.’²¹³ In other words, individuals should not forfeit their right to marry and to found a family just because of being imprisoned, and if the exercise of this right is subject to restriction, the states must justify why the limitation of this right is operated. On this matter, Foster argues that in addition to the loss of liberty and freedom of movement, imprisonment might put a certain level of restriction on a number of rights of offenders, however, ‘this should not (...) detract from the fact that prisoners enjoy the *prima facie* rights’ protected under the Convention. He notes that

[a]ll these restrictions are a necessary and incidental part of maintaining the regime [in prison] (...) and proportionate measure to ensure prison discipline

²⁰⁹ Ibid paras 89, 93. The Court notes that the last justification reason, prevention of disorder or crime, results from the conditions of imprisonment, not the prisoners’ status. Ibid para 93.

²¹⁰ Ibid para 89.

²¹¹ Ibid para 84.

²¹² Ibid.

²¹³ Ibid para 91.

or the prevention of crime, they are not in violation of the prisoners' human rights. (...) [A]ny interference with those rights has to be justified within the established principles of *legality and proportionality*, subject, of course, to a *margin of discretion to accommodate the nature and effectiveness of the regime*.²¹⁴

In addition, according to the Court, the Convention does not include any 'automatic interference with the prisoners' (...) right to establish a marital relationship with the person of their choice' on the ground that it 'might be acceptable to or what might offend public opinion.'²¹⁵ This indicates that the Court does not consider the right to marry and to found a family as a tool for the maintenance of social order or public confidence and thus, the right to marry and found a family should not be sidelined in the interests of public opinion.²¹⁶ Rather, the 'what would offend public opinion' argument is an indication that the right under Article 12 is a fundamental right and must be protected independent from what offends public opinion because it is about 'the choice of a partner' and 'the decision to marry him or her, whether at liberty or in detention'. This choice should not be overridden on the grounds that the relationship 'is not acceptable' to the public authorities or it 'may offend public opinion'.²¹⁷ Although the enjoyment of the right under Article 12 might be subject to certain regulations set by the state authorities due to the security or the prevention of crime and disorder,²¹⁸ any interference this right should not be arbitrary or disproportionate.²¹⁹ On that account, it can be contended that if a restriction on the exercise of the right to marry and to found a

²¹⁴ Steve Foster, 'Automatic Forfeiture of Fundamental Rights: Prisoners, Freedom of Expression and the Right to Vote' (2007) 16 Nottingham Law Journal 1, 21-22 (emphasis added).

²¹⁵ *Fransik* (n 208) para 93.

²¹⁶ Alice Diver, 'The "Earned privilege" of Family Contact in Northern Ireland: Judicial Justification of Prisoners' Loss of Family' (2008) 47 The Howard Journal of Criminal Justice 486, 496.

²¹⁷ *Fransik* (n 208) para 95.

²¹⁸ *Ibid.*

²¹⁹ *Ibid* para 96.

family, including the right to intimate association and to procreate, is based upon public opinion (the exercise of the right might be offensive for the public), this state policy or action might be regarded as arbitrary or disproportionate by the Court. For instance, in *Dickson v UK*, the UK Government argued that the allowance for prisoners to procreate while they are in prison conflicts with the retributive element of penal policy. However, according to the Court, the justification of the restriction must be based upon either the ‘necessary and inevitable consequences of imprisonment’ or ‘an adequate link between the restriction and the circumstance of the prisoner in question’ rather than solely based ‘what would offend public opinion’ or ‘public concern’.²²⁰

As is mentioned in Chapter Two, the use of pharmacotherapy might affect the very essence of the right under Article 12, in particular, the right to engage in a sexual intercourse and to procreate.²²¹ The reason is that according to the opponents of pharmacotherapy, the medications deprive individuals of testosterone, decrease or eliminate the ability to have sexual fantasies and to perform sexual activity, override the organ’s function (sexual organ) and thus, destroy the ability of individuals’ to procreate.²²² As a response to this argument, the conjugal visits in prison (intimate visits) case can shed light on this matter. The right to conjugal visits is one of the ways for the prisoners to exercise their right to procreate; however, denial of conjugal visits does not give rise to a breach of the right to procreate under Article 12.²²³ Although prisoners can still exercise the right to procreate through In Vitro Fertilisation (IVF) treatment, there is no absolute protection as such for IVF treatment request as well.²²⁴ In

²²⁰ *Dickson* (n 149) para 68.

²²¹ William Green, ‘Depo-Provera, Castration and the Probation of Rape Offenders: Statutory and Constitutional Issues’ (1986) 12 *University of Dayton Law Review* 1, 24-25.

²²² John F Stinneford, ‘Incapacitation Through Maiming: Chemical Castration, the Eighth Amendment, and the Denial of Human Dignity’ (2005-2006) 3 *University of St. Thomas Law Journal* 559, 596.

²²³ *Dickson* (n 149) para 31.

²²⁴ The IVF treatment is a procedure for conceiving a child outside the body by removing the eggs from the ovaries and fertilising them with sperm outside the body and the fertilised egg is later placed in the

fact, according to the Court, the right to procreate via natural or artificial insemination are the matters that the Member States enjoy a wide margin of appreciation in determining the steps or the measure to be taken to ensure compliance with the Convention.²²⁵ This refers to the fact that the right to procreate can be subject to a restriction such as on the ground of prison security. Also, the proponents of pharmacotherapy assert that its use does not impinge upon individuals' right to procreate because 'the offender, even though producing an increased number of abnormal sperm, can still [...] beget a child.'²²⁶ It is also stated that the use of pharmacotherapy is 'much less intrusive on [offenders] procreative liberty than [...] incarceration.'²²⁷ Rainey and Harrison argue that pharmacotherapy does not cause permanent damage to the ability to reproduce. Even if it is imposed on a longer basis, 'the offender could be given the opportunity to freeze sperm before commencement of the programme and then this used through IVF to enable reproduction at a later time.'²²⁸ However, the decision on IVF treatment should be made and carried out before the imposition of pharmacotherapy and the offender should be informed that IVF could be a long process. They also discuss that '[w]hilst it would appear sensible to thus give every offender the option of freezing sperm there are nevertheless medical and financial considerations involved in this.'²²⁹ However, it is noteworthy to stress that IVF programme can be a matter of discussion for any offender and the medical and financial considerations apply not only to PSOs but also to other offenders.

In this respect, it can be claimed that the effects of pharmacotherapy on the rights under Article 12 are less intrusive than the effects of incarceration in terms of exercising an

woman's womb. See Human Fertilisation Embryology Authority, 'IVF-What is In Vitro Fertilisation (IVF) and How Does It Work?' <<http://www.hfea.gov.uk/IVF.html>> accessed 22 August 2014.

²²⁵ *Dickson* (n 149) para 31.

²²⁶ *Fitzgerald* (n 107) 44.

²²⁷ *Ibid.*

²²⁸ *Rainey and Harrison* (n 111).

²²⁹ *Ibid.*

intimate relationship with another person and conceiving a child either in nature or artificial way. Especially, given that conjugal visit in prison is the only way to promote the rights of prisoners to engage in a sexual activity and to procreate, and any restriction on conjugal visit would be an enormous obstacle to exercise these rights, the Strasbourg Court's position on this issue is that a limitation imposed by the state can be justified on certain grounds. On that account, a similar decision can be applied to the use of pharmacotherapy that even if it deprives PSOs of their liberty to perform sexual intercourse and their ability to procreate and thus, leads to an interference with Article 12, the effects of this medical intervention might be considered within the context of sentencing process and might well be possible to justify.

Conclusion

This chapter argues that the right to sexual autonomy or enjoyment of sexual relations protected under the Convention can be subject to limitations and PSOs, therefore, can be deprived of their sexual liberty with the aim of protecting health and morals, the rights/interests of others and/or preventing crime. However, when this DoSL is carried out through the use of medication, this medical intervention requires scrutiny as to whether it is permissible in light of the Convention.

According to the Court, personal autonomy and integrity provide an immense protection against any involuntary medical treatment. However, there are certain occasions where autonomy can be restricted and involuntary treatment can be permissible and be compatible with the Convention rights such as if there is a medical necessity. Regarding the use of pharmacotherapy with PSOs, an effective treatment for PSOs is medically necessary because if paedophilic urges are not treated, this might lead to mental dysfunction or exacerbate mental health problems of those offenders. Also, PSOs might have impaired or decision-making ability with regard to their sexual desires and the

treatment of their condition, because paedophilic disorder affects, in one way or another, their present autonomy. For this reason, involuntary pharmacotherapy can be used with PSOs to treat their disorder, which is, arguably, a threatening condition, to enhance their ability to make autonomous decisions (to advance their future autonomy) and to help them manage their conditions effectively. However, in order to prevent the arbitrary use of pharmacotherapy, ‘being medically appropriate’ and ‘being medically necessary’ issues must be determined and clarified by the medical authorities and the use of pharmacotherapy must produce the expected or desired effects when it is applied, which is the alleviation of the symptoms of paedophilic disorder and the enhancement of autonomy to be able to manage uncontrollable or irresistible sexual urges.. Given that not all sex offenders suffer from paedophilic disorder, the medical necessity requirement can account for ‘this discrepancy in effectiveness by allowing administration of the drug to only those defendant deemed medically appropriate for treatment by a medical expert.’²³⁰ This requirement can also provide a protection to ensure that the offenders do not ‘indiscriminately’ receive pharmacotherapy.²³¹ In addition, any offender considered as an appropriate candidate for the pharmacotherapy treatment should be observed throughout the course of the administration of pharmacotherapy to ensure that the imposition of pharmacotherapy is still required and the person concerned is still eligible for this treatment programme.

If pharmacotherapy is used as a means of punishment, there are two essential points that the states should consider: it should be proportionate and there must be legitimate penological grounds for its use. According to the Court, although any additional suffering, such as indeterminate sanction, can be justified by the need to protect society, punishment must be *de jure* and *de facto* reducible which entails that a reduction in the

²³⁰ Clarke (n 124) 510.

²³¹ Ibid.

length of prison sentence should be allowed and this can be achieved by setting upper and lower limits of deserved punishment. Given the rehabilitation and incapacitation functions of pharmacotherapy and given that this medical intervention can be used as a component of punishment in return for at least some reduction in the length of further imprisonment, this punitive measure will be held compatible with Article 3.

Having determined that the use of pharmacotherapy interferes with PSOs rights under Article 8, it is worth repeating that this interference can be justified, simply, if it is in accordance with law, if it is in furtherance of a legitimate aim listed in Article 8(2), and if it is necessary in a democratic society. In particular, if pharmacotherapy is regulated by domestic law and the essential requirements, concerning its involuntary application to PSOs and the assessment of those offenders' ability to make autonomous decision, are indicated with reasonable certainty and clarity; if the provisions are accessible and are formulated in such a way that PSOs can foresee their consequences, including the medical procedures followed, the type and the amount of medications used and the duration of treatment; and if the scope and the manner of the state authorities' discretion is clearly and directly enunciated, it can be confirmed that it is in accordance with law. Since it is established in Chapters Two and Three that pharmacotherapy can be used as a means for the purpose of punishment and treatment, it clearly serves certain aims listed in Article 8(2) and necessary to achieve these aims. Given the Court's evolutive interpretative principles, margin of appreciation and principle of proportionality, pharmacotherapy is a relatively new medical intervention for PSOs and thus, arguably, its use for DoSL can be considered within the states' discretion. However, this discretion is limited due to the fundamental aspect of the right to private life, due to the general requirements set by the advisory international organisation, such as the Council of Europe and the CPT, for the use of pharmacotherapy and due to the proportionality

principle which is of the essence for the limitation of the power of state authorities and for the protection of human rights.

On that account, it can be claimed that the use of pharmacotherapy shows conformity with the standards indicated by the Court under Article 3, and the interference with Articles 8 and 12 is justifiable and proportionate, having regard to the legitimate aims of protecting the rights and interests of others, health and morals, public order, public safety, and preventing crime. However, its use demands stringent procedural protections to guard against the possibility of human rights violation and should never be applied to offenders with the aim of effecting a quick and easy fix.

CHAPTER FIVE

TOWARDS A NEW APPROACH TO DEALING WITH PAEDOPHILIC SEX OFFENDERS: THE PRACTICE OF PHARMACOTHERAPY UNDER THE EUROPEAN CONVENTION ON HUMAN RIGHTS

Introduction

The aim of this thesis was to address the concerns over the use of pharmacotherapy for PSOs, and to stipulate conditions under which the use of pharmacotherapy is justified and takes place in the treatment/punishment of PSOs. It has been discussed throughout this study that PSOs' probability of continuing their criminal behaviours and of re-offending is mainly driven by sexual deviant motivations which can be alleviated, or even terminated, and the risk of re-offending in paedophiles can be reduced through the imposition of pharmacotherapy. However, as a medical practice, pharmacotherapy is concerned with personal autonomy and integrity, it imposes a restriction on individuals' sexual liberty by limiting the ability to perform sexual intercourse and significant side-effects are observed with this anti-androgenic drug treatment. Therefore, the use of pharmacotherapy for PSOs, in all its aspects, remains controversial in that while it helps those offenders control their abnormal, deviant sexual motivations and, in a sense, enhances their future autonomy (even if this enhancement amounts to a certain extent of decrease in present autonomy), it engages with fundamental human rights because of the nature and the extent of the interference with dignity and autonomy and of the pain/deprivation experienced with the imposition of pharmacotherapy.

Despite the substantial number of publications, the current literature is not comprehensive enough to settle these controversies, to give decisive answers to the long-standing arguments and not very helpful in identifying what requirements are truly necessary and what standards and regulations the states must implement as a matter of

legal and medical ethics and of human rights protection concerning pharmacotherapy for PSOs. For instance, the most controversial matters pertaining to the use of pharmacotherapy for PSOs have been on which basis pharmacotherapy should be given, i.e., voluntary or involuntary, and whether it can be used as a means of punishment for PSOs. On these issues, the prevailing view seems to be that pharmacotherapy may be used for PSOs as long as free and informed consent is obtained, and using pharmacotherapy in the punishment of PSOs has been contended as constituting an assault on offenders' dignity and as being grossly disproportionate to the severity of the crime. However, the involuntary use of pharmacotherapy with PSOs or its coerced administration has never been discussed within the justifiable limits of paternalism and autonomy in terms of whether the use of involuntary pharmacotherapy can be considered as one of the justifications for informed consent and whether it can be rendered proportionate punishment to the crime committed. For these reasons, this research project has attempted to delve into the crucial aspects of using pharmacotherapy for PSOs by combining theoretical and practical knowledge and discussions in order to fill the gaps in the literature on the use of pharmacotherapy, to provide a better understanding of its application and potential impacts, and to offer solutions and make contributions to addressing the problems and needs regarding its use with offenders. In this respect, from both theoretical and practical standpoints, this study has provided an analysis of pharmacotherapy as an alleviating treatment for paedophilia and a recidivism reducing strategy for paedophilic sexual crimes which refers to the consideration of two essential forms of this medical intervention: (i) treatment form of pharmacotherapy, and (ii) punishment form of pharmacotherapy. By discussing treatment and punishment forms, this research project has set out to explore the ethical and legal justifications for the use of both forms of pharmacotherapy and has identified

the requirements for its administration to PSOs. Also, this thesis has been designed to provide a basis for the permissibility of pharmacotherapy in light of the Convention in order to address the following question: What would a state wishing to impose pharmacotherapy on PSOs need to do in order to be acting within the scope of the Convention? For this reason, this study has been conducted by adopting a normative, doctrinal and critical approach and taking into account the most relevant rights protected under the Convention and case-law of the Court for the use of pharmacotherapy. It has been established that if the administration of pharmacotherapy complies with the requirements and standards discussed in this research project, it may not be regarded as inhuman or degrading treatment or punishment and the interference results from its use will, in all likelihood, fall within the justification defence.

A. An Alternative Approach in Dealing with PSOs: DoSL

While establishing the principal aim of my research project, which is questioning the permissibility of pharmacotherapy in light of the Convention, I also attempted to develop an argument here supporting the idea of DoSL via pharmacotherapy: DoSL can be used for PSOs as an alternative to DoL (further incarceration), if there is a necessity for the deprivation of certain offenders' sexual liberty rather than extensive DoL by means of incarceration.

As discussed throughout this thesis, punishment is often described in terms of suffering or unpleasantness, but, in this section, I will conceptualise it as DoL in order to understand DoSL more clearly and to illustrate that DoSL can be considered as an appropriate and proportionate punishment for serving the intended aims of punishment for certain crimes. DoL via imprisonment consists of the loss of liberty and autonomy, but it also involves the loss of many material comforts and the interruption of an important portion of the offenders' life, including the loss of basic experiences, which

are taken for granted for most people, and of opportunities for self-actualisation.¹ On this matter, it is stated that the pain of imprisonment is not 'limited to the loss of physical liberty. The significant hurts lie in the frustrations and deprivations which attend the withdrawal of freedom, such as the lack of sexual relationships, isolation from the free community, the withholding of goods and services and so on.'² According to Sykes, these frustrations and deprivations also 'carry a more profound hurt as a set of threats or attacks which are directed against the very foundations of the prisoner's being.'³ In addition to these concerns, DoL is also criticised on the ground that it can be an inadequate response to certain crimes in terms of grasping the offenders' inner world or it can lead to an increase in the recidivism rates of imprisoned offenders because of the relative depreciation of legitimate knowledge and skills.⁴ Arguing that certain crimes against persons may be committed as a result of personal issues under unique personal conditions and circumstances, it would be optimal for the authorities to consider different punishments for different groups of offenders whose probability of recidivism is high due to the internal factors. However, I do not mean to suggest that DoL via imprisonment should be abolished and the alternative methods should be considered in place of prison sentence. Rather, I argue that alternative methods are worth being considered for specific types of offences or offenders, especially where the motivation to commit crime results from the irresistible or uncontrollable urges which can be regarded as an impediment to autonomy (due to the conflict between first- and second-order desires). In this respect, by including alternative methods/measures into the criminal justice systems (in lieu of imprisonment or in return for a reduction in the

¹ Derride Golash, *The Case against Punishment: Retribution, Crime Prevention, and the Law* (New York University Press 2005) 2-3.

² Gresham M Sykes, *The Society of Captives: A Study of a Maximum Security Prison* (Princeton University Press 2007) 78-79.

³ Ibid 79.

⁴ Isaac Ehrlich, 'On the Usefulness of Controlling Individuals: An Economic Analysis of Rehabilitation, Incapacitation and Deterrence' (1981) 71 *The American Economic Review* 307, 315.

length of incarceration), the concerns over DoL via imprisonment can be overcome and the purpose of punishment can be achieved in the sense that the measure is effective, appropriate and proportionate to the crime committed.

Given the discussions in this thesis regarding the motivations of PSOs to commit a sexual crime against children, I believe that an effective approach in dealing with PSOs needs a new understanding and more focused punishment for these offenders concerning their behaviours and motivations rather than more restrictive or severe punishments. For this reason, in this research, by stressing exactly why paedophilic sex crimes are committed and how PSOs effectively are impeded from committing further crimes, I have intended to draw attention to the administration of pharmacotherapy aiming at revoking the right (or the liberty) of PSOs to perform sexual activity by imposing a restriction on their ability to engage in a sexual relationship and on their sex drive. It has been discussed that sexual liberty is one of the significant points to take into consideration concerning the application of pharmacotherapy because some of the ancillary consequences of the experience of pharmacotherapy are directly associated with the loss/deprivation of sexual liberty and this deprivation can be, to some extent, considered as an appropriate response to sexual crimes against children committed by PSOs. In this respect, the underlying premise of DoSL via pharmacotherapy is to terminate PSOs' erectile capabilities and sexual desires so they no longer pose a threat to society, especially to potential child victims, and to help them control their deviant or abnormal sexual motivations so they become more autonomous in time. At this point, it is noteworthy to stress that the use of pharmacotherapy is better classified as a temporary restriction, as is the case with incarceration, on individuals' ability to perform sexual activity, rather than a permanent restriction. It has been argued that this temporary loss of sexual liberty via pharmacotherapy can be an appropriate response to

offenders with paedophilic disorder because it has two main dimensions, namely, treatment and punishment, and these dimensions are related as form and content. While its punishment aspect refers to the deprivation of something valued, i.e. the loss of sexual liberty, its treatment aspect refers to the alleviation of the symptoms of paedophilic disorder and the enhancement of the condition. On that account, the concept of DoSL via pharmacotherapy for PSOs can be described as integrating punishment and treatment and this integration can prevent crime by reducing the factors that could lead to reoffending, incapacitate offenders by terminating their ability to perform sexual activity and depriving them of the opportunity for committing crime, and can contribute to public safety by effectively managing the risk posed by the offenders. In addition, given that paedophilic sexual urges might be autonomy-undermining, DoSL via pharmacotherapy can be considered as an effective means of enhancing autonomy by removing the impediments to the offenders' autonomy (reducing uncontrollable/irresistible deviant sexual urges) and helping them to gain the ability to critically assess their first-order-desires and volitionally endorse or repudiate their first-order-desires with second-order-desires. By these means, offenders may be said to have enhanced autonomy and to govern their lives more autonomously since they will possess certain volitional skills and attributes, and be able to employ a certain set of cognitive skills.

In addition to being an effective and appropriate punishment in terms of meeting the needs of the offenders and society, it has also been argued that DoSL can be conceived as a proportionate response to PSOs convicted of sexual crimes against children. In general, the essence of proportional punishment is that the severity of punishment should be reasonable and proportional to the severity of the crime in order to serve to exclude excessive punishment or unfair inconsistency in punishment. Given the

importance of maintaining proportionality between crime and punishment, imposing DoSL via pharmacotherapy in return for a reduction in the length of prison term can address the concerns over the proportionality of crime and the severity of DoSL via pharmacotherapy. Moreover, as discussed above, punishment is a way for the unfair advantage which is taken by the offender to be annulled. In the case of PSOs, those offenders have failed to respect limits on conduct that others (law-abiding citizens) accept because of exercising excessive sexual liberty and has taken unfair advantage. On that account, DoSL via pharmacotherapy can be considered as a deserved deprivation of sexual freedom proportional to the violation of sexual freedom constituted by sexual crime by removing that unfair advantage and restoring the equilibrium of benefits and burdens and the balance of the standing of the offenders and the others.

It is worth noting that due to the scope of this research, I do not attempt to engage in an examination of the seriousness of paedophilic crimes, the severity of DoSL via pharmacotherapy as a punishment strategy and the considerations that are necessary for the administration of DoSL in practice concerning how it works. Rather, I argue that providing a transition between the upper and lower limits of deserved punishment and tailoring the length of imprisonment with respect to the severity of DoSL via pharmacotherapy can address the concerns of determining the proportionality of punishment in relation to crime. Although every individual has a different threshold of pain that makes it hard to measure the severity of punishment, including imprisonment, the notion of the severity of punishment can generally be interpreted as involving the amount of infliction and the sorts of deprivation or loss. On that account, it can be claimed that the imposition of DoSL via pharmacotherapy in return for a reduction in the length of prison term can be a proportionate (not an excessive) punishment for

sexual crime against children committed by PSOs, however, as long as this reduction is in accordance with the upper and lower limits of punishment.

Given the principal objective of this study, the claim on DoSL is that it must be brought into force and applied to paedophiles with the use of pharmacotherapy because compared to other methods –imprisonment/incarceration and surgical castration- DoSL via pharmacotherapy is the most effective and appropriate way of depriving PSOs of their right to engage in a sexual relationship. Since it has been established that pharmacotherapy does not constitute inhuman or degrading treatment or punishment, and the interference resulting from pharmacotherapy is justifiable, if its imposition is carried out in accordance with the criteria and conditions established in this thesis, the concept of DoSL can be meted out to PSOs. At this point, the case-law of the Court concerning conjugal visits in prisons has been considered important to enlighten the Court's possible approach in relation to the deprivation of offenders' right to sexual liberty. Although the Court mostly grapples with conjugal visits in prisons from the point of view of a right to procreate and the right to family life rather than the right to engage in sexual activity, the case-law on this issue can still provide an insight concerning DoSL. To be more precise, it is important to start with a brief criticism concerning the Court's approach to conjugal visits in prisons. Fundamentally, the Convention is for the protection of individual rights and for this reason, the scope of conjugal visits in prisons should not be limited to procreation or to family life; rather it should be recognised as sexual relations between two people. Although the Strasbourg Court does not limit the scope of family life to marriage and notes that there are other factors to determine that a relationship amounts to family life such as 'whether the couple live together, the length of relationship and whether they have demonstrated

their commitment to each other by having children together or by any other means'⁵ including a cohabiting same-sex couple,⁶ such approach is still narrow-sighted, ignoring the fact that having sex or taking part in a sexual relationship is more than a desire that should be exercised only within family life. Even if the main aim behind these visits is the maintenance of the relationship, this issue must be taken into consideration more than just a matter of family life. Otherwise, it would be considerably difficult for the Court to address the concerns over couples who do not meet the determined standards, and their rights to receive conjugal visits. Moreover, in *Varnas v Lithuania*, the Court holds that conjugal visits are 'an area in which the Contracting States enjoy a wide margin of appreciation in determining the steps to be taken to ensure compliance with the Convention due regard to the needs and sources of the community and of individuals.'⁷ Although it is not an easy matter to establish who shares a family life and who does not, and also, as a matter of fact, the determination of the existence of family life does not fall within the jurisdiction of the Court, it would be better if the Court granted a narrow margin of appreciation to the Member States and considered the issue of conjugal visits within the context of personal and sexual autonomy under Article 8. By this way, any states' regulation which excludes couples from receiving conjugal visits on the ground that their relationship does not qualify as family life in the Article 8 sense will still be subject to the Court's assessment because it might interfere with the right to respect for private life, Article 8 and the prohibition of discrimination, Article 14, ECHR.

However, this criticism of the Court's approach to conjugal visits should not be understood in a way that individual rights should not be balanced against collective rights or interests indicated by the state authorities, dismissing whether the Court is in a

⁵ *Van Der Heijden v the Netherlands* App no 42857/05 (ECtHR, 03 April 2012) para 50.

⁶ *Schalk and Kopf v Austria* App no 30141/04 (ECtHR, 24 June 2010) para 94.

⁷ *Varnas v Lithuania* App no 42615/06 (ECtHR, 09 July 2013) para 109.

position of holding such a balance, because after all, '[t]he decisive consideration (...) must be that the overriding function of [the] Convention is to protect the rights of individuals (...) the role of the Convention and the function of its interpretation is to make the protection of the individual effective.'⁸ The Court stresses that any limitation on offenders' rights must be justified in each individual case and '[t]his justification can flow, *inter alia*, from the necessary and inevitable consequences of imprisonment from an adequate link between the restriction and the circumstances of the prisoner in question. However, it cannot be based solely on what would offend public opinion.'⁹ In this respect, although PSOs are not well-received due to the nature of their crimes, they should be treated as other criminals and any interference with their rights must be justified on the grounds that the measures taken by the states do not go beyond what is necessary and proportional.

Therefore, it can be advocated that DoSL via pharmacotherapy can be considered as an alternative measure by the member States to address offenders' criminal desires and break criminal inclinations on the grounds that particular criminal conducts intrinsically merit specific punishments. However, concerning the application of this measure, the member States should be cautious and thoughtful in terms of providing full protection of the rights offenders, i.e. not all sex offenders should be considered as potentially suitable to undergo DoSL and the necessary safeguards must be put and kept in place for its application to ensure that offenders' rights are not unnecessarily or disproportionately breached. Given that this research also supports the idea that pharmacotherapy must be used as a means of depriving PSOs of their sexual liberty, the

⁸ *Golder v the United Kingdom* App no 4451/70, (Report of the Commission, 1 June 1973) para 57.

⁹ *Dickson v the United Kingdom* App no 44362/04 (ECtHR, 04 December 2007) para 68. The Chamber decision, however, accepted that 'the maintaining of public confidence in the penal system has a legitimate role to play in the development of penal policy within prisons', meaning that the prison authorities could pay attention to public confidence in the penal system and interfere with the rights of offenders as part of their punishment. *ibid* para 34.

following section will summarise the key points discussed in this thesis concerning the conditions, requirements and procedures under which the use of pharmacotherapy can be justifiable option for PSOs and takes place in their treatment/punishment.

B. Treatment Aspect of Pharmacotherapy

1. Voluntary Use of Pharmacotherapy

Concerning the treatment form of pharmacotherapy, this project has focused on its voluntary and involuntary applications. For the voluntary use of pharmacotherapy, the components of informed consent with respect to pharmacotherapy have been identified in accordance with the international human rights and national and international medical standards. In Chapter Two, it has been suggested that the objections regarding the imposition of pharmacotherapy on PSOs might be overcome if; (i) the informed consent requirement is fully satisfied and the offender is given objective and comprehensive information about the contemplated treatment (the purpose, nature, possible benefits, alternative treatments or medications, risks and side-effects, especially those which are related to the offender's specific condition, and the solutions which are needed to overcome the risks or to reduce them in order to enable the offender to take precautions such as the risk of pharmacotherapy for his reproductive ability and the possibility of taking IVF treatment) and (ii) offenders agree to undergo pharmacotherapy and give the consent by their free will, without coercion or pressure.

Regarding the voluntary use of pharmacotherapy and the informed consent requirement, first of all, this study has concerned itself with the question of how much information must be provided in order for the consent to be valid. On this matter, the viewpoint taken in this thesis has been in line with the Court of Appeal decision in *Pearce*. I have advocated that information about any significant risk to an offender's health which will result from the imposition of pharmacotherapy and will affect the judgement of a

(reasonable) offender ought to be provided.¹⁰ However, the offender also ought to be informed about small (like 1-2%) but unavoidable risks and side-effects of pharmacotherapy.¹¹ Thus, regarding the disclosure of the facts relating to pharmacotherapy, which is necessary for informed consent, this thesis has supported the recognition of the conflation of reasonable doctor and reasonable patient standards,¹² meaning that the offenders' interests must be given considerable weight and the reasonable doctor has a duty to give information that the reasonable patient would want to be told of.¹³

Moreover, this study has been concerned with the prison environment, namely the coercion inherent in imprisonment and the mental and emotional state of the offenders in prison, and discussed whether it could be regarded as a strong incentive for offenders to give consent to pharmacotherapy. In response to the arguments that offering pharmacotherapy to imprisoned offenders might underpin concerns over the validity of consent, firstly, I believe that withholding pharmacotherapy from offenders on the ground that the consent is not valid due to the presence of coercion has paradoxical results: the informed consent principle is for the protection of autonomy and pharmacotherapy provides a unique opportunity for offenders to overcome the internal (uncontrollable sexual motivations) and external (deprivations or restrictions resulting from imprisonment) impediments to their autonomy and make them more autonomous.¹⁴ Secondly, I also submit that if the treatment offer is a genuine one and does not contain a threat of additional punishment or a promise of benefit, and if it

¹⁰ *Pearce v United Bristol Healthcare NHS Trust* [1999] 48 BMLR 118 [21].

¹¹ *Chester v Afshar* [2004] UKHL 41 [5].

¹² José Miola, 'On the Materiality of Risk: Paper Tigers and Panaceas' (2009) 17 Medical Law Review 76, 97.

¹³ *Ibid* 98.

¹⁴ Thomas Douglas and others, 'Coercion, Incarceration, and Chemical Castration: An Argument from Autonomy' (2013) 10 Bioethical Inquiry 393, 399.

alleviates the offenders' conditions which drive them to commit crime, the use of pharmacotherapy will likely stand up to scrutiny in terms of the validity of consent.

2. Involuntary Use of Pharmacotherapy

The involuntary use of pharmacotherapy has generally been objected to on the principle of autonomy and informed consent grounds. But contrary to this general view, in Chapter Two, this research project has offered an insight into how involuntary pharmacotherapy could be put into place for the treatment of PSOs. I have based my support for involuntary pharmacotherapy on Dworkin's autonomy and behaviour control based argument. This argument implies that an autonomous decision becomes an issue when first and second-order motivations or preferences line up. This hierarchical conception of autonomy is considered 'as a second-order capacity of persons to reflect critically upon their first-order preferences [...] and the capacity to accept or attempt to change these in light of higher-order preferences and values.'¹⁵ As an example, supposedly, the urge/motive for a paedophile to engage in sexual intimacy with a child is a *first-order desire* and the urge/motive to be free from the urge/motive to engage in a sexual intimacy with a child is a *second-order desire* and a paedophile desires that his first-order motive not be effective, or not overpower second-order desire, otherwise the first-order motive will drive him to commit a crime. Dworkin argues that if a person does not have a certain capacity to reflect upon his first-order desires, he will be regarded as non-autonomous and '[i]t is possible that promotion of autonomy in the long run requires sacrificing autonomy in the short run.'¹⁶ To be more precise, since paedophilia constitutes an impediment to PSOs autonomy, a decrease in the present autonomy due to the application of involuntary pharmacotherapy can be justified on the ground that it is for the enhancement of future autonomy. It has been

¹⁵ Gerald Dworkin, *The Theory and Practice of Autonomy* (Cambridge University Press, 1988) 20.

¹⁶ Ibid 114.

established in Chapter Two that pharmacotherapy removes both internal and external barriers (abnormal and irresistible sexual interests, desires, urges and restriction on the right to liberty, right to private life, freedom of movement, freedom of association) faced by PSOs and they certainly are in need of being free from these impediments to be more autonomous. In this case, withholding pharmacotherapy by reason of not giving rise to any interference with the informed consent requirement would be counterproductive. The reason is that this requirement is for the protection of autonomy and taking away the option which is conducive to the enhancement of (future) autonomy is, to some extent, in contradiction with the purpose of this requirement. In this regard, the justification for involuntary pharmacotherapy depends on whether the future increase in autonomy overrides the decrease in present autonomy and, in the case of paedophilia, the present autonomy can be regarded as impaired or disturbed because of not having a certain ability to exercise higher-order reflections. However, this autonomy-enhancing treatment might lead to other issues related to the side-effects of pharmacotherapy and the impacts of those side-effects upon personal autonomy. These can also be called autonomy-undermining side-effects or autonomy-restricting side effects. However, due to the breadth and depth of this issue and due to the scope of this study, the focus has been on the autonomy-enhancing treatment modality of pharmacotherapy. The autonomy-undermining side-effects issue might be subject to further research arguing that the side-effects of medications for pharmacotherapy would have detrimental effects on the autonomy of the person concerned, especially, on *de facto* autonomy even if it could be consistent with *de jure* autonomy.

So far, the arguments presented in Chapter Two have addressed one of the key hypotheses of this thesis that pharmacotherapy can be used on both a voluntary and involuntary basis depending on the ability of offenders to make an autonomous decision

when there is a conflict between first-order-desires and second or higher-order-desires. It has been suggested that any reliance on the practice of pharmacotherapy in the treatment of PSOs is based on autonomy interests in controlling certain sexual desires/motivations and in making decisions about certain issues, and when it is implemented under the coercive power of the state, it is still consistent with established canons of medical and legal ethics on autonomy-enhancing-paternalism grounds.

C. Punishment Aspect of Pharmacotherapy

In Chapter Three, this research project has argued and provided theoretical justifications for using pharmacotherapy in the punishment of PSOs and supported the idea of integrating pharmacotherapy into the criminal justice process for those offenders. Given the discussions in this study about the potential impacts and gains of pharmacotherapy, I advocate that this integration can promote a new understanding in the punishment of paedophilic sex crimes; can facilitate to address the concerns, challenges and arguments regarding PSOs, the recidivism rates, public reaction to paedophilic acts and criminal justice approaches to PSOs; and can improve consistent sentencing in the punishment of PSOs. With respect to two very general aims of punishment, namely, utilitarian and retributive, the aims behind this new understanding are mainly to alleviate those offenders' criminal motivations or desires and to impede them directly and speedily from committing further crimes by imposing punishment within upper and lower limits of deserved punishment.

It has been discussed that the responsiveness of PSOs to traditional incentives is low and their recidivism rate is high because those offenders are impulsive, ritualistic,¹⁷ repetitive and/or socially deviant offenders¹⁸. The principal claim which this project has

¹⁷ Robert R Hazelwood and Ann Wolbert Burgess (eds), *Practical Aspects of Rape Investigation* (3rd edn, CRC Press 2001) 105-106.

¹⁸ Michael H Miner and others, 'The Compulsive Sexual Behavior Inventory: Psychometric Properties' (2007) 36 Archives of Sexual Behavior 579, 580.

attempted to defend is that pharmacotherapy is a more effective/efficient and less intrusive means to rehabilitate and incapacitate PSOs and the alteration of their motivations than the traditional sentencing. Traditional sentencing, which usually means imprisonment, attempts to manipulate offenders' motivations by only changing their environment or depriving them of certain rights and liberties and it falls short of altering the offender himself which is crucial in the case of PSOs. Thus, I have suggested that the criminal justice system should include a unique alternative to incarceration; the repetition of the cycle of crime and incarceration can be prevented by a well-established administration of pharmacotherapy and the likelihood that PSOs will commit crimes again can be reduced by its more effective and efficient rehabilitative power and incapacitation function.

Also, I have argued that such a medical intervention serves the aim of the proportional punishment principle and incapacitates/rehabilitates offenders more narrowly than traditional sentencing policy. On this issue, in the last part of Chapter Three, this thesis has proposed a model designed to explain the use of pharmacotherapy as an alternative to further (or continued) incarceration or in return for a reduction in the length of imprisonment called the 'action-reaction model'. Under this model, it has been suggested that punishment, as an equal and opposite reaction, is supposed to promote good consequences and the happiness by meeting the needs of society and solving the problems complained of, but it is also supposed to be reasonable and proportionate to the gravity of the crime. In the case of PSOs, pharmacotherapy, as a means of punishment,

- (i) corresponds closely to what is expected from its imposition,
- (ii) covers the underlying reasons for the necessity of using it, including society's reaction toward these offenders, and,

(iii) given all aspects and impacts of this medical procedure including the extra pain/suffering derived from the use of a medical intervention and also the deprivation of performing sexual intercourse as the result of pharmacotherapy, it also meets the demand of proportionate punishment by paving the way for striking a fair balance between the harm caused by paedophilic sexual crime of crime and the pain/deprivation that stems from the imposition of pharmacotherapy.

This thesis supports the argument that pharmacotherapy must be considered as an alternative to incarceration because this medical intervention deprives offenders of the right to engage in a sexual relationship and this deprivation will lead to unjust treatment only if the state fails to relieve the additional pain imposed on offenders. For this reason, a certain reduction in the length of imprisonment has been suggested as a solution for the achievement of the proportionality of punishment, meaning that the additional pain/deprivation resulting from DoSL can be recovered by a reduction in the prison term within upper and lower limits of punishment. By doing so, it is possible to compensate for DoSL, which amounts to an additional punishment, by reducing the time that the offenders are deprived of their liberty. Therefore, I contend that pharmacotherapy is an effective tool in the punishment of PSOs by addressing the wide range of problems of those offenders which constrains their autonomy and fulfils punishment purposes by holding offenders responsible for their criminal acts, by rehabilitating/incapacitating and by imposing proportionate deprivation/pain on those offenders.

This thesis mainly suggests that for PSOs, criminal justice and treatment can be combined but the decision regarding which form of pharmacotherapy is the most appropriate and convenient means for dealing with PSOs is better left to states. Pharmacotherapy is like a pendulum swinging between treatment and punishment and

the treatment and punishment concepts of pharmacotherapy can be used for PSOs both in the form of treatment and punishment. I have argued that the distinction between treatment and punishment depends on the procedures that are being pursued to apply pharmacotherapy and the intentions of those applying it. This distinction is of the essence for doing what is needed to be done to offenders in terms of their conditions and circumstances and for the justification of using pharmacotherapy with PSOs regarding in which form it is imposed. Because each form is *sui generis*, to wit, requires specific clarifications, elaborations, requirement and justifications that have been presented above. However, either as a means of punishment or as a method of treatment, the conflict between the coercive power of the state with the use of pharmacotherapy and the deprivation and limitation of rights and liberty has moved the discussion into the human rights context because resolving the conflicts that emerge as a result of pharmacotherapy for PSOs requires consideration of the states' interests and also the offenders' rights. For this reason, further significance of this thesis has been established by providing a chapter on the ECHR and ECtHR's case-law regarding the permissibility and justifiability of pharmacotherapy as a means of dealing with PSOs.

D. Compatibility of Pharmacotherapy with the ECHR: An Alternative for Responding to PSOs?

As noted throughout this thesis, using pharmacotherapy, either in the treatment or in the punishment of PSOs is associated with those offenders' sexual liberty, in particular, the right to perform sexual intercourse. It has been recognised that within the context of the ECHR, the right to sexual liberty has generally been discussed as part of sexual autonomy and the right to respect for private life under Article 8. On that account, if the limitation on this right serves the aims indicated under Article 8(2), is proportional to

the legitimate aims pursued, does not have a broad character,¹⁹ and is for the prevention of serious injuries or of potential danger,²⁰ it will be considered as a justifiable limitation. Especially, when there is a need to protect a particular section of society, such as children, and the moral values of society against an actual or a potential danger, the states have a degree of discretion to determine how to solve this problem. In this respect, the Member States can deprive PSOs of their sexual liberty with the aim of achieving certain objectives. However, this study has been concerned with the use of pharmacotherapy to deprive PSOs of their right to sexual liberty. Therefore, a further consideration has been given to the question of whether using pharmacotherapy with PSOs is justifiable and permissible under the Convention.

In my analysis of the protection of autonomy and integrity and the use of pharmacotherapy, the most relevant provisions of the ECHR are Article 3, right to be free from inhuman or degrading treatment or punishment, Article 8, right to respect for private and family life and Article 12, right to marry and found a family. It has been identified that if pharmacotherapy is a justified means of dealing with PSOs under Articles 8 and 12 and is in conformity with the standards under Article 3, then it can be used in treating/punishing PSOs and depriving those offenders of their sexual liberty within the jurisdiction of the member States.

Under Article 3, the Strasbourg Court attaches great importance to the obtainment of free and informed consent for the use of pharmacotherapy but it appears from the Court's decision that the very nature of pharmacotherapy itself is not degrading.²¹ In this respect, although the involuntary use of pharmacotherapy could be characterised as ill-treatment because it compromises PSOs' self-determination and dignity, it has been

¹⁹ *Dudgeon v United Kingdom* App no 7525/76 (ECtHR, 22 October 198) paras 42-62.

²⁰ *Laskey, Jaggard and Brown v United Kingdom* App nos 21627/93, 21826/93, 21974/93 (ECtHR, 19 February 1997) para 40.

²¹ See *Dvořáček v Czech Republic* App no 12927/13 (ECtHR, 06 November 2014) (translated from French by the author).

acknowledged that it may not fall within the scope of Article 3. According to the Court, to be considered a breach of Article 3, ill-treatment must attain a minimum level of severity which is a relative assessment and depends on all the circumstances of the case.²² On that account, the practice of involuntary pharmacotherapy in the treatment of PSOs will not be regarded as inhuman or degrading, if

- i. the offenders' consent is not obtained because their capacity to make a decision about the imposition of pharmacotherapy is disturbed or impaired by paedophilia; and
- ii. its use is deemed medically necessary to treat PSOs, meaning that pharmacotherapy is the only appropriate, suitable and available means to manage those offenders; its use is exceptional (the last resort) in terms of effectively treating the paedophilia, because they suffer from uncontrollable deviant paedophilic sexual motivations/desires and pose a danger.

This thesis also suggests that the state must be careful and strict on directing personal supervisions, carrying out periodic checks, recording the procedure; the medical authorities should not fail in their duty to protect offenders' health such as if necessary, using pharmacotherapy in conjunction with psychotherapy, cognitive behavioural therapy or other rehabilitation measures; and the regulations on the procedure must be clear including the length of the administration of pharmacotherapy.

Moreover, I have argued that the states have an obligation to ensure that appropriate and effective measures are provided to offenders who appear to be in need of such measures, their health and well-being are adequately secured, requisite medical assistance is provided and, depending on the nature of a medical condition, the

²² *Ireland v the United Kingdom* App no 5310/71 (ECtHR, 18 January 1978) para 162.

treatment of prisoners' illness or the prevention of their aggravation is carried out.²³ Otherwise, the lack of treatment or insufficient health care will be considered as a violation of Article 3.²⁴ The message is clear. Therefore, my argument is that considering paedophilic disorder as a serious mental health condition (mental impairment or psychiatric disorder) of high public concern which requires periodic medical treatment, visits and monitoring,²⁵ pharmacotherapy must be provided to the offenders, if it is shown to be necessary.

Regarding the use of pharmacotherapy in the punishment of PSOs and the prohibition of inhuman or degrading punishment, it has been established that the use of pharmacotherapy must not constitute a grossly disproportionate punishment when imposed on PSOs, its imposition should be justified on legitimate penological grounds and this punishment should be reducible *de facto* and *de jure*. However, the question of what just and proportionate punishment is or whether a particular measure is inhuman or degrading (or grossly disproportionate) does not have a single answer and it is possible to receive different answers in different countries or, even different answers at different times in the same country. Because the gravity of the offence, the personal characteristics of the offender and the particular circumstances of the case are some of the basic principles while considering what range of punishment would be appropriate and proportionate to the crime. Thus, a margin of appreciation is granted to the states in deciding on the appropriate punishment for a particular crime. In response to the concern over proportionate punishment and the use of pharmacotherapy, this study has recommended that not all sex offenders but only PSOs should be considered as potentially suitable for the infliction of pharmacotherapy and a reduction in their jail

²³ *Kharchenko v Ukraine* App no 40107/02 (ECtHR, 10 February 2011) paras 58-59.

²⁴ See *Khudobin v Russia* App no 59696/00 (ECtHR, 26 October 2006).

²⁵ Boris Schiffer and others, 'Functional Brain Correlates of Heterosexual Paedophilia' (2008) 41 *NeuroImage* 80, 80-81.

term is required in return for the additional pain/deprivation that PSOs suffers from pharmacotherapy. On that account, if the member States benefit from pharmacotherapy in the punishment of PSOs, I contend that its use as punishment complies with the requirements of Article 3 because

- (i) it is not so excessive or grossly disproportionate in its severity and reducibility as to constitute inhuman or degrading punishment for PSOs, and
- (ii) it clearly serves penological goals because as an appropriate punishment, it rehabilitates, incapacitates and, to some extent, deters offenders and protects the public from those offenders.

Also, given the Court's case-law, the pain or suffering resulting from pharmacotherapy must not reach the threshold level of inhuman or degrading punishment²⁶ but there is no established standard(s) for this assessment because this requirement depends on the facts of the case, in particular, 'on the nature and context of the punishment itself and the manner and method of its execution.'²⁷ According to the Court, publicity and humiliation or debasement level can be considered as relevant factors for this assessment.²⁸ On this matter, I suggest that the factors to be taken into account in measuring the minimum level of severity for pharmacotherapy treatment (the duration of pharmacotherapy, its physical and mental effects and state of health of the offender) can be used for this determination. For this reason, pharmacotherapy as a means of punishment should also be administered in accordance with the requirements and procedural safeguards established for the treatment concept of pharmacotherapy.

Within the context of Article 8, the justifiability of the use of pharmacotherapy has been conducted under the headings, as follows: (i) In accordance with law; (ii) Legitimate

²⁶ *Tyrer v the United Kingdom* App no 5856/72 (ECtHR, 25 April 1978).

²⁷ *Ibid* para 30.

²⁸ *Ibid* para 32.

aim; (iii) Necessary in a democratic society; and (iv) The margin of appreciation and the proportionality test. It may be necessary here again to indicate briefly the general findings of this justifiability assessment. Under the heading of ‘in accordance with law’ it has been suggested that, if pharmacotherapy is regulated under domestic law and if the essential elements of its administration procedure are indicated with reasonable certainty and clarity; if the accessibility of the rules is sufficiently eased for citizens; in case of granting discretion to the relevant authorities, if the scope and manner of this discretion is clearly and directly enunciated, the ECtHR will probably hold that the administration of pharmacotherapy is in accordance with the law. Given that some degree of regulation concerning PSOs criminal behaviours can be made by the states with the aim of maintaining public order, protecting vulnerable members of society, especially children, from what is dangerous, injurious and offensive, policies sought to prevent crime, maintain public order and boost the protection of children and to promote their well-being will be regarded as persuasive legitimate aims by the Court.

As the principle of necessary in a democratic society requires, the justification of the use of pharmacotherapy depends on whether there is a proportionate relationship between the aims sought to be realised and the imposition of pharmacotherapy to PSOs to achieve such aims. On this issue, the medical and social benefits gained through the use of pharmacotherapy, which have been discussed throughout this research, make the application of this medical procedure to PSOs relevant, sufficient and suitable for pursuing the protection of the rights and freedoms of others, and/or health or morals, the prevention of disorder or crime and the maintenance of public safety.

Moreover, to determine the scope of the Convention rights and compatibility of a state measure with the Convention or the justifiability of the interference with the Convention rights, the significance of the rights limited, the objectivity of the

restriction, the uniform conception in Europe on a particular matter and the proportionate balance between the rights/interests of the person concerned and the rights/interests of others should be taken into consideration. Although there is no common European standard on the use of pharmacotherapy that could be enforced uniformly, I advocate that the CPT reports on pharmacotherapy and to the reports of the Committee on Social Affairs, Health and Sustainable Development of the Parliamentary Assembly of the Council of Europe will quite likely tie the member States' hands in using pharmacotherapy with PSOs. Also, since autonomy, sexual life and integrity are within the inner core of the right to respect for private life, even if there are significant benefits for the offender and society from the use of pharmacotherapy, I believe that the use of pharmacotherapy will fall within the margin of appreciation but the margin of appreciation accorded in such a case will probably be narrow.

In addition, it has been discussed that due to the impact of pharmacotherapy on offenders' ability to engage in a sexual relation and to conceive a child, its use also requires justification under Article 12. On this matter, I have relied on the Court's decisions on conjugal visits in prison and the right to procreate via natural and artificial insemination. It has been acknowledged that since denial of conjugal visits does not give rise to a breach of the right to engage in a sexual relation and to procreate,²⁹ since prisoners can exercise the right to procreate through IVF treatment and since the member States enjoy a wide margin of appreciation on these matters, the interference resulting from the use of pharmacotherapy can be considered within the context of sentencing process and be possible to justify.

Consequently, the goal of this study has been to question the applicability and permissibility of the use of pharmacotherapy for PSOs in light of the rights protected

²⁹ *Dickson v the United Kingdom* (n 9) para 31.

under the Convention. It has been supported that the use of pharmacotherapy is crucial in terms of (i) strengthening or enhancing the abilities of PSOs to gain control over their behaviour and thoughts motivated by paedophilic urges and to be more autonomous; (ii) making those offenders more law-abiding individuals; (iii) helping them become reintegrated back into the community; (iv) preserving the security and public safety; protecting the rights/interests of others; (v) preventing further paedophilic sexual crimes; and protecting the health and morals. Thus, the principal contribution of this thesis is that pharmacotherapy can be used for PSOs; it does not amount to inhuman or degrading treatment or punishment; and any interference with the Convention rights is justifiable.

Conclusion

There is no doubt that pharmacotherapy is a severe and serious medical intervention and its coerced administration, either in the form of treatment or punishment, directly implicates the rights and liberty interests of offenders. The justification for its use has mostly been defended by comparing it with surgical castration or by referring to the US Supreme Court's decisions on forced administration of antipsychotic drugs, surgical castration and sterilisation.³⁰ In this thesis, I have made an attempt to select the most relevant theoretical discussions and judgements to highlight some of the problems on the use pharmacotherapy with PSOs and address them. Also, a particular focus has been the establishment of the requirements, in particular, under the Convention and the Court's case law for the justifiable use of pharmacotherapy in dealing with PSOs.

Given the central research questions of this study, which were, in which form should pharmacotherapy be imposed on PSOs, i.e. punishment or treatment or both; and is the use of pharmacotherapy for those offenders compatible with the rights protected under

³⁰ It is worthy noting that the US Supreme Court has never directly examined the constitutionality of pharmacotherapy.

the ECHR?, I have argued that consent to pharmacotherapy treatment can be truly voluntary, the philosophical and practical justifications for informed consent can also be applied to the involuntary pharmacotherapy treatment and this medical intervention can be integrated into the criminal justice systems as a means of punishment. Therefore, pharmacotherapy can be used either in the treatment or punishment of PSOs. Regarding its compatibility with the rights protected under the Convention, given the medical and social benefits of pharmacotherapy, state of mental health of PSOs and the necessity of using such medical intervention, the use of pharmacotherapy for PSOs can be considered as being in conformity with the standards under Article 3 and being justifiable under Articles 8 and 12.

In addition, having regard to the discussions on the permissibility of pharmacotherapy for PSOs in light of the European Convention, this thesis can be considered as a kind of guideline for Member States wishing to impose pharmacotherapy on PSOs concerning what they should do and should not do in order to be acting within the scope of the Convention. I have also contended that with the use of pharmacotherapy, it is possible to deprive PSOs of their sexual liberty and this deprivation is compatible with the rights protected under the Convention. There may be, however, residual concerns and issues over the use of DoSL via pharmacotherapy, especially, regarding the procedural requirements and human rights. For this reason, further research is needed to address the following issues more thoroughly: How can DoSL be integrated in the criminal sentencing process? What could the procedural requirements and safeguards be for the infliction of DoSL? Are there any possible human rights concerns due to the use of DoSL? How can the states make the use of DoSL proportionate to the gravity of crime? The use of pharmacotherapy has recently been challenged in the Court under Article 3 and it has been decided that voluntary pharmacotherapy does not amount to inhuman or

degrading treatment. I advocate that if the involuntary use of pharmacotherapy is brought to the Court's attention that such medical intervention interferes with the Convention rights, as long as its practice is carried out within a human rights framework and necessary safeguards are provided under the national law, the Court will most likely rule that the states have a duty to provide protection for all individuals within their jurisdictions and some offenders may require unique measures that may lead to some restrictions on their rights, and thus, the use of pharmacotherapy with PSOs in both forms is compatible with the Convention rights.

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