Pharmacotherapy and Human Rights in Sexual Offenders: best of friends or unlikely bedfellows?

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Abstract

The use of pharmacotherapy is gaining ground as a risk treatment and/or risk management option with sex offenders, around the world. Whilst several articles have recently been published which look at the efficacy of this option, this is not the focus here. Rather it assesses the human rights implications of its use and importantly, questions whether the use of sexual suppressants with or without consent is a viable option in light of obligations under International Human Rights Law. With particular reference to the European Convention on Human Rights and the concept of human dignity, it examines whether pharmacotherapy is being administered in line with human rights protection.

Key words: pharmacotherapy, human rights protection, inhuman/degrading treatment, right to private life, right to procreate.

Introduction

Whilst there are several academic articles and research papers on the use of pharmacotherapy with sex offenders, especially regarding whether it works, there is far less literature concerning its legality. In an attempt to address this, this article will explore whether the use of anti-libidinal drugs with sex offenders is compatible with human rights principles[1]. Whilst there are references to the United States of America (US) Constitution and also to the African Charter on Human and Peoples Rights (ACHPR), due to space constraints the majority of this article examines the legality of using pharmacotherapy under the European Convention on Human Rights (ECHR). In particular, the paper examines whether the use of pharmacotherapy with sex offenders could be considered to breach Article 3 on the right not to be ill treated, Article 8 on the right to family and private life and Article 12 on the right to marry and found a family.

Human Rights Law: Protecting Dignity and Consent

The protection of human rights can be premised on the concept of human dignity; a concept enshrined in numerous international human rights instruments and in the constitutions of many states. Documents including the Universal Declaration of Human Rights provide the basis for many of the global and regional human rights instruments including the International Covenant on Civil and Political Rights (ICCPR) and the ACHPR. Despite this recognition of dignity elsewhere, the ECHR does not refer explicitly in its text to respect for dignity. However, the jurisprudence of the European Court of Human Rights (ECtHR) has used the concept to illustrate its reasoning, especially in reference to the right not to be tortured under Article 3 and the right to a private and family life under Article 8.

Whilst respect for human dignity can be said to be at the core of liberal human rights discourse, the

concept is difficult to define and its application is often disputed (Feldman, 1999). Respect for human dignity is thus open to different cultural interpretations and can even change in definition over time (Donnelly, 2003). Nevertheless, we must still attempt to reach a consensus, with Feldman describing it as,

> an expression of an attitude to life which we humans should value when we see it in others as an expression of something which gives particular point and poignancy to the human condition. (Feldman, 1999).

The role of the law is therefore to provide a framework to help preserve the opportunity for a dignified life (Feldman, 1999); with the ECHR providing such a framework. A dignified life consequently includes the right to autonomy and protection of physical and moral integrity. However, the concept can also encapsulate society, as well as the individual. The idea of the subjective dignity of the individual can clash with the concept of dignity as an objective value with the emphasis placed on the dignity of humanity as a whole. It may be justifiable for the state to interfere with an individual if that measure is shown to protect the dignity of humanity in general (Feldman, 1999).

Consent is also an issue with regard the use of pharmacotherapy. This relates respect for dignity as fully informed, non-coerced consent recognises the autonomy of the offender to make his own decisions; in most cases this would be accepted by courts where treatment is at issue. Various Council of Europe bodies have noted the importance of fully informed and non-coerced consent with regard to prisoners and treatment (see Council of Europe, European Committee for the Prevention of Torture and Inhuman or Degrading Treatment Report, 2007). If treatment is coercive then a court would have to decide if it is permissible under human rights legislation.

Torture, inhuman or degrading treatment

The right not to be tortured or made subject to inhuman or degrading treatment is a universally recognised right. Examples include Article 7 of the ICCPR; Article 5 of the ACHPR; and Amendment 8 of the US Constitution. The right is recognised by states as fundamental and has become part of international customary law, no longer needing legislation for it to be protected. Whilst the wording in each provision is slightly different, the essence remains the same, with the right being absolute and non-derogable in nature. By this it is meant that a state cannot interfere with the right in any way; nor can they justify any such interference, even if the person involved is regarded as highly dangerous and a threat to society. Article 3 of ECHR is premised directly on the idea of an attack on the subjective dignity of a human being. Despite what some popular discourse may state, every person including sex offenders and paedophiles have the right to have their dignity protected, irrespective of the crime which they have committed. Human beings never give up the right not to be torture or treated in an inhuman or degrading way. The fundamental question is whether the use of pharmacotherapy can be said to undermine subjective dignity and involve torture, inhuman or degrading treatment To conform with the Article, member states are obliged to ensure not only that any person within its jurisdiction is not subjected to torture or treated in a degrading or inhuman way; but also that there are adequate safeguards in place to prevent such behaviour occurring. This includes the duty to investigate all allegations (*Assenov v Bulgaria* (1999) 28 EHRR 651) and to protect those at risk of torture even if that person s conduct is a threat to the security of the investigating country (*Chahal v UK* (1997) 23 EHRR 413). In this way the Article places both negative and positive obligations on the participating states (Ovey and White, 2006).

In order to delineate between permissible suffering imposed by a state and torture, inhuman or degrading punishment or treatment, the ECtHR has defined the terms using a hierarchical scale, with the most flagrant acts of affliction being torture; although it is worth pointing out that in reality there may not necessarily be a clear demarcation between them. In the *Greek case* ((1969) 12 Yearbook 186 510) for example, inhuman treatment was stated to be treatment that deliberately causes severe suffering, mental or physical , whilst torture was described as an aggravated form of this. In the same case, it was held that treatment and/or punishment is considered to be degrading if it grossly humiliates him before others or drives him to act against his will or conscience . Furthermore, the ECtHR has held that degrading treatment is treatment which arouses in the victim feelings of fear, anguish and inferiority, capable of humiliation and debasement and possibly breaking physical or moral resistance (*Ireland V UK* (1979-1980) 2 EHRR 25 para 197). In making its decision, the court will take into account a number of factors including the nature and duration of the punishment or treatment, the age, sex, health of the victim and his/her physical and mental wellbeing (*Ireland v UK* (1979-1980)2 EHRR 25 para 162, *Tyrer v UK* (1979-1980) 2 EHRR 1 para 30). For the treatment or punishment to be classified as either torture, inhuman or degrading under the Article, it must thus reach a minimum level of severity. With regard to the threshold for degrading treatment, causing embarrassment is insufficient; although it is enough if the victim s treatment amounts to humiliation only in his eyes (*Tyrer v UK* (1979-1980) 2 EHRR 1 para 23).

Whilst it is unlikely that the primary intention of a member state is to humiliate or degrade a sex offender through the use of pharmacotherapy, the threshold may still be met even if, following *Tyrer*, the drugs used and effects which they cause, only amount to humiliation or debasement in the eyes of the victim. As discussed above, for pharmacotherapy to meet the threshold, the individual would need to demonstrate how either the coercive nature of the medication was such as to degrade or humiliate him or that the side effects were such that he was humiliated or debased by them.

As noted above, compatibility with Article 3 may depend on whether the treatment is being given on a voluntary or mandatory basis. For example, the US states of Florida, California and Montana use anti-libidinals on sex offenders as part of a mandatory programme; often as a condition of parole or prison release. If the offender is given the choice between a course of testosterone-reducing medication and a period of incarceration, it is likely that the offender will be coerced into choosing the treatment, on the basis that it is the lesser of two evils. Coerced consent may also occur if the offender is led to believe that participation in a pharmaceutical programme will enhance his chances of parole.

Furthermore, the length and appropriateness of treatment may also need to be taken into account. Whilst treatment duration will depend of the offender and his individual needs, it should be noted that pharmacotherapy can never offer an actual cure (Bowden, 1991; Gys and Gooren 1996). For long-term effectiveness, an offender may need to be on the medication for life. If any form of coerced medication has no temporal limitation it could be found to be akin to surgical castration and thus possibly fall foul of Article 3 (In the US States that have mandatory pharmacotherapy schemes for paedophiles, offenders will receive treatment for as long as they are considered to pose a risk of re-offending and in Florida the court can order treatment for any period of time, up to and including the life of the defendant (Stinneford, 2006)). Indeed in *State v Brown* (326 S.E.2d 410), the US Supreme Court found that surgical castration was a form of mutilation and thus prohibited it as a sentencing option. Likewise in 1970, surgical castration was also held to be inhuman in Denmark and its use discontinued. (Olsen, 1996).

The side effects of using pharmacotherapy with sex offenders also need to be taken into consideration, as treatment with both anti-libidinal and anti-psychotic drugs involve a myriad of

potential negative effects, with some academics arguing that the true extent is simply unknown. Serious problems include osteoporosis, hypoglycaemia, pulmonary embolism, diabetes, bone mineral density and, especially with Medroxyprogesterone Acetate (MPA), gynaecomastia (Bradford, 1983; Spalding, 1998; Craissati, 2004). Whilst the pain and suffering involved with such conditions may not pass the threshold for torture, the effects could be described as inhuman and/or degrading. With regard to gynaecomastia (the growth of breasts) this can easily be seen as degrading and humiliating for the offender involved, especially considering the fact that any growth is irreversible even when treatment is withdrawn. Even if an offender can hide such growths it could still be humiliating. As noted above, the case law of the ECtHR has found that degrading treatment can occur even if the humiliation is only apparent to him. It is also imperative that the offender s suitability for such medication is assessed and that the practitioners involved have knowledge of the offender s full medical history. If pharmacotherapy is given to an offender whose pre-existing medical condition is worsened or whose quality of life is seriously curtailed by taking part in such a programme, Article 3 may be engaged.

When deciding whether the threshold for torture, degrading or inhuman treatment has been met, the ECtHR will obviously take all of these factors into consideration. However, recent case law has limited the number of cases where a breach of Article 3 will be found. One example is the case of *Grare v France*, (Application Number 18835/91 (1993) 15 EHRR CD 100), where the Court found that even distressing side effects of coercive drug therapy for mental disorders did not reach the severity needed to breach Article 3. Furthermore, in *Herczegfalvy v Austria* (1992) 15 EHRR 437, a case involving force feeding, the ECtHR held that as a general rule, a measure which is a therapeutic necessity cannot be regarded as inhuman or degrading (Ibid: para 82). Therefore, it may be the case that only treatment which is not medically necessary will be considered by the Court. Thus, it makes it even more important to ensure that the offender is medically suitable and also that the medication used is working effectively; arguably if this is not the case then it is not therapeutically necessary. Consequently, any excessive use of force or treatment beyond that which is necessary may violate Article 3, with more recent case law providing such examples. For instance, in *Jalloh v Germany* (2006) ECHR 721 the ECtHR held that the use of medication to remove drugs from a suspect s stomach was in breach of Article 3. Furthermore, in *Nevmerzhitsky v Ukraine* (2005) ECHR 21, it was held that the primary purpose of force feeding a prisoner was not for medical reasons but as a means of preventing legitimate protest.

It may thus be important to consider whether the purpose of Pharmacotherapy is to prevent re-offending or to treat a medical condition. With many member states developing their sex offender strategies to coincide with and support the new risk penology , the use of anti-libidinal treatment could be seen to be primarily offering public protection, with the medical needs of the offender as a secondary aim. Whether the ECtHR would consider the use of pharmacotherapy as medically necessary is yet to be tested, but it is assumed that the Court would have to take into account the seriousness of the side effects and the *Herczegfalvy* test. This might suggest that it would be difficult to find a state in violation of Article 3 unless the side effects were severe and long term (possibly akin to surgical castration); and where the treatment went beyond what was considered to be therapeutically necessary.

Respect for family and private life

Article 8 of the ECHR refers to a private and family life. It states,

1. Everyone has the right to respect for his private and family life, his home and his correspondence.

2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of rights and freedoms of others.

As can be seen by subsection(2), the rights protected under Article 8 are not absolute, meaning that the state can justify interference as long as it is first, in accordance with the law; secondly, it is necessary in a democratic society and finally, it is for one of the stated aims.

The terms used in Article 8(1) are not explicitly defined; leaving it to the ECtHR to determine what should and should not be protected. Whilst the term family life could be interpreted to include the mandatory use of pharmacotherapy, as it would arguably affect family relationships, it is clear that anti-libidinal treatment affects the offender s private life. In *Botta v Italy* (1998) 26 EHRR 241, private life was defined to include a person s physical and psychological integrity . Protection under Article 8 may therefore be sought to ensure the development, without outside interference, of the personality of each individual in his relations with other human beings . Additionally the right may also encompass not just physical relations, but also moral integrity and sexual relationships. In *Dudgeon v UK* (1983) 5 E.H.R.R, the ECtHR held that there had been a breach of Article 8 where Northern Irish legislation made certain homosexual acts committed in private between consenting adults, criminal. The Court held that the Article extended to sexual choice and sexual relations and that it was in breach of the ECHR to inhibit such choice or relations. Furthermore, it may be important to look at whether there has been any interference with the offender s bodily integrity. Under Article 8 individuals have the right to be free from unwarranted physical harm being inflicted upon them. This has been recognised by the ECtHR in *Storck v Germany* (2005) ECHR 406, where it held that,

> even a minor interference with the physical integrity of an individual must be regarded as an interference with the right to respect for private life under Article 8 if it is carried out against the individual s will (para 143).

The use of pharmacotherapy may therefore be relevant to Article 8 of the ECHR as it interferes with family and private life by interfering with the offender s ability to develop his personality as well as affecting his sexual relations with others. Furthermore, if paedophilia is a sexual preference rather than a mental disorder, the use of pharmacotherapy to suppress paedophilic feelings arguably interferes with the offender s sexual choice (although it is accepted that this choice is unlawful under most international legislation). Additionally, through the risk of a plethora of negative side effects, pharmacotherapy could also affect bodily integrity, which if the programme is mandatory or consent is arguably coerced and therefore invalid, such use would be considered to be an interference with Article 8(1).

As stated above, Article 8 is not however an absolute right. Even where some interference with Article 8(1) has been found, the state can still justify some limitations on the right under article 8(2). To do this the state has to demonstrate three things: that the measures taken are in accordance with law, that the state has a legitimate aim for taking these measures and that any measure is necessary in a democratic society.

The first step for any member state when justifying an interference with rights protected under Article 8 is to demonstrate treatment is in accordance with the law. The provisions for treatment

should be regulated by law, which is accessible, predictable and its application foreseeable (*Malone v UK* (1985) 7 E.H.H.R 14). Procedural safeguards must be put in place and these must also be available to the offender. (See US examples such as the California Penal Code § 645, (Norman-Eady, 2006)).

Secondly, the state needs to prove that the interference is for a legitimate purpose. Under Article 8(2) a member state can lawfully intervene if, for example, it is in the interest of public safety, crime prevention and/or the protection of others. With reference to the use of pharmacotherapy with sex offenders, it is likely that this stage of the process will not be difficult to demonstrate. Taking into account the risk to public safety which high-risk sex offenders pose, it may be argued that the offender s rights are limited to some extent so that the legitimate aim of public protection can be achieved. The Court has rarely challenged the legitimacy of the aim put forward by the state. However limitations can only be accepted if the third step is demonstrated successfully by the state. It should also be noted than when examining the state s justifications for interferences with Article 8 it will give the state a margin of appreciation . The Court gives states an amount of discretion when making decisions on the balance between the individual and the state interest. In some areas such as crime prevention, the Court is willing to accept that the state may be better placed to make decisions on public protection grounds as it is in direct and continuous contact with the vital forces within the state (Handyside *v UK* (1979-80) 1 E.H.H.R 737). However the Court will still examine the issue and the amount of discretion will vary depending upon the nature of the right and measure and is bound up with the balancing exercise described below.

Thirdly, the signatory state must prove that the interference was necessary in a democratic society. For a measure to be necessary it has to be proportionate and thus strike a fair balance between the needs of society and the rights of the individual, between subjective and objective dignity. In *Hatton v UK* (2003) 7 E.H.H.R. 14, the Court held that in deciding whether this balance had been struck it was necessary to decide whether there was a link between the measure and the legitimate aim. The Court will then consider whether the interference is the least intrusive measure that could have been taken to achieve the legitimate aim. If it is not then it may be disproportionate. The Court may also consider if the very essence of the right has been interfered with. The state may limit protection under Article 8 but not undermine it completely. For pharmacotherapy to be considered proportionate, the Court will thus need to balance the rights of the sex offender against the public interest and the need to protect society from high-risk offenders.

Cases where mandatory castration has been found to be lawful in the UK, (although it is worth noting that these were prior to the implementation of the Human Rights Act 1998 which made the ECHR directly enforceable in the UK), involve the forcible sterilisation of learning or mentally disabled women. Such invasion has been justified in the Courts, for example in *Re F. (Mental Patient: Sterilisation)* [1990] 2 A.C. 1, on the basis that the interference was in the best interests of the patient. Whilst this may be assumed to be mean best medical interests, this is not the case *(Re M.B. (Medical Treatment)* [1997] 2 F.L.R. 426 at 439) and can additionally include medical, emotional and other welfare issues *(Re A (Medical Treatment: Male Sterilisation)*, (1999) [2000] 1 F.L.R. 548 at 556). The phrase other welfare issues is not well defined and it is unclear whether it may also cover the protection of the public from sex offenders. Some of the perceived benefits of forced sterilisation may also apply to sex offenders such as permitting patients to return to their homes, who would otherwise be confined to institutions for years. (Savell, 2004: 1119).

The use of pharmacotherapy may be seen as necessary in a democratic society and also in the best interest of the offender, especially if it allows him to be released from prison and re-integrated back into the community. Pharmacotherapy is less intrusive than surgical castration and as long as the side effects are reversible and short term, and not akin to surgical castration as discussed

above, member states may be able to demonstrate necessary interference under Article 8(2).

The Right to Found a Family

Article 12 of the ECHR provides the right to marry and found a family,

> Men and women of marriageable age have the right to marry and to found a family, according to the national laws governing the exercise of this right.

Similar to Article 8, the right can be limited by national laws. This means that if the national legislation, for example, does not permit homosexual marriage then the Article cannot be used to invoke such a right on its own.. In addition to marriage the right also involves the right to procreate.

Whilst the aim of pharmacotherapy is to reduce testosterone, sexual desire and thus sexual functioning; such effects can affect the offender s ability to perform sexually. Whilst some men are still able to achieve erections, ejaculate and therefore impregnate women, this is not the case for all. If an offender is in this latter category and is additionally subject to the drugs for a long period of time then the use of pharmacotherapy may interfere with his ability to have children. In this sense anti-libidinal medication could be seen as having the same effect as forced sterilisation or abortion; and as noted above, whilst national laws can regulate and limit rights if justified, they cannot erode their actual essence (Fenwick, 2002).

Concerning the specific issue of pharmacotherapy, there would appear to be no ECtHR cases. However case law in England and Wales on forced sterilisation may inform our discussion. As noted, there have been a number of cases where forced sterilisation and abortion have been found to be justified. However, even in these circumstances the right to procreate has been acknowledged *(Re D. (a Minor) (Wardship: Sterilisation)* (1975), [1976] 1 All E.R. 326). Moreover, Lord Hailsham in *Re B ((a Minor) (Wardship: Sterilisation)* (1987) [1988] 1 A.C. 199) approved the refusal to allow forced sterilisation because of the:

> irreversible nature of such an operation and the deprivation, which it involves, of a basic human right, namely the right of a woman to reproduce (203).

Whether this also applies to the right of a man to reproduce is not as clear; but there is no reason why this should not be the case.

Pharmacotherapy is however different. Whilst participation in an anti-libidinal programme can eradicate the ability to reproduce, such effects are reversed once treatment has been withdrawn, allowing the offender to have a family once treatment has been completed. Even where the medication is given on a longer basis, the offender could be given the opportunity to freeze sperm before commencement of the programme and then this used through In Vitro Fertilisation (IVF) to enable reproduction at a later time. The only problem however is that this would need to be arranged prior to treatment beginning, with the offender deciding whether this is something which he may later wish to rely on. It would also require prior knowledge that treatment could be potentially lengthy. Both of these issues may not however be known preceding treatment initiation. Whilst it would appear sensible to thus give every offender the option of freezing sperm there are nevertheless medical and financial considerations involved in this.

Whilst the legality of using pharmacotherapy with sex offenders is still to be tested by the ECtHR it may still be permissible under national laws to temporarily remove the ability to found a family, as long as the length of the treatment does not completely undermine the essence of the right. Thus proportionality would again be of primary importance. In *Dickson v UK* (2007) 44 EHRR 21, the Grand Chamber of the ECtHR found that there had been a violation of both Articles 8 and 12 where a prison had refused to facilitate the passing of sperm from a male prisoner to allow his wife to have IVF treatment; holding that such a refusal was disproportionate. Interestingly, the Court also commented that when considering whether Article 12 had been breached, it was equally important to consider not just the rights of the complainant, but also the rights of his partner or spouse. This may mean that it is not just the sex offender s rights which we need to consider when discussing the use of pharmacotherapy; but also his partner as well, as effectively her rights are being interfered with. Proportionality would thus appear to be key and so if an offender could prove that the use of pharmacotherapy was disproportionate to either his or his partner s rights, Article 12 may be applicable.

Conclusion

The use of pharmacotherapy with sex offenders is increasingly being used as a method of controlling deviant sexual urges, desires and resulting behaviour. Whilst most articles look at the efficacy of the method, this paper has considered its legality under the ECHR, and in particular whether it is likely to breach the rights contained within Article 3, 8 and 12. All three rights are there to protect human dignity and it would appear that one of the key factors as to whether pharmacotherapy would violate the essence of the rights is whether or not participation is mandatory or voluntary. As long as the medication is being given on a consensual basis and that consent is not coerced or invalid for any other reason, then it is unlikely that pharmacotherapy will breach the ECHR; as long as the treatment is not for such a period of time where the effects virtually amount to those of surgical castration. The question of when it would meet this threshold would be one for the court to decide, considering the evidence of medical experts. If, however, the programme is mandatory, this may raise issues under the ECHR, particularly under the rights not to be ill treated, privacy and the right to procreate. Whilst the protection of the public is important and individual rights can be interfered with to support such ends, pharmacotherapy with sex offenders would still need to be in accordance with the law and therapeutically necessary.

A detailed set of criteria is beyond the scope of this article which concerns general arguments on rights issues and provides a platform for further debate. However, to ensure that pharmacotherapy is delivered in line with rights protection, it is suggested that the following measures could provide a general framework for treatment. States should consider making all programmes voluntary, should have published protocols and procedures which are available to all including the offender, should ensure that the offender is medically suitable, should monitor the health of the offender throughout the programme so as to check on potential negative side effects, should allow for independent reviews of individual treatment and treatment programmes, should ensure that the treatment is medically necessary and should permit the offender to freeze sperm before programme commencement. If such provisions are considered then states may protect the public whilst at the same time ensuring the dignity of the offender is recognised and protected.

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Note

[1]For a more detailed evaluation of these issues see Harrison, K and Rainey, B (2009) Suppressing Human Rights? A Rights Based Approach to the use of Pharmacotherapy on Sex Offenders , Legal Studies, forthcoming.

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