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The Chemical Castration of Recidivist Sex Offenders in Canada: A Matter of Faith

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The Chemical Castration of Recidivist Sex Offenders in Canada: A Matter of Faith

Chemical castration refers to the use of medication to reduce male testosterone to pre-pubertal levels. Since the mid-20th century, reports have detailed this practice in attempts to control pathological sexual behaviour. In 2006, the Canadian Federal Court of Appeal ruled it constitutional for the National Parole Board to require that recidivist sex offenders, if found to be long-term offenders, be chemically castrated under their conditions of release. This paper examines the chemical castration of recidivist sex offenders in Canada through a review of long-term offender hearings reported between 1997 and 2009. The practice is analyzed from ethical, medical and legal perspectives. It is concluded that chemical castration of sex offenders is ethically problematic, that evidence for its effectiveness in preventing recidivism is limited and of poor quality, and that judges should avoid excessive reliance on chemical castration when deciding to grant conditional release to recidivist sex offenders.

On appelle castration chimique l'utilisation de médicaments pour réduire le niveau de testostérone chez les hommes à des niveaux prépubères. Depuis le milieu du XXe siècle, des rapports ont décrit en détail cette pratique dont l'objectif est de contrôler les comportements sexuels pathologiques. En 2006, la Cour fédérale d'appel a déclaré que la Commission nationale des libérations conditionnelles peut constitutionnellement imposer, comme condition de mise en liberté des récidivistes sexuels déclarés «délinquants sexuels à contrôler», qu'ils soient castrés chimiquement. L'auteur, pour examiner la castration chimique de récidivistes sexuels au Canada, a passé en revue les audiences des délinquants sexuels ayant été déclarés à contrôler rapportées entre 1997 et 2009. La pratique est analysée de perspectives éthique, médicale et juridique. Il conclut que la castration chimique des délinquants sexuels est problématique sur le plan éthique, que les preuves de son efficacité pour empêcher les récidives sont limitées et de piètre qualité et que les juges devraient éviter d'accorder trop d'importance à la castration chimique lorsqu'ils décident d'accorder la mise en liberté sous condition aux délinquants sexuels qui ont récidivé.

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Introduction

> Every human being of adult years and sound mind has a right to determine what shall be done with his own body.[1]
>
> —Justice Cardozo (1914)

> And if your eye causes you to sin, pluck it out. [Mark 9:47]

In Canada, forced medical treatment under the law is subject to strict controls because it invites egregious violations of fundamental human rights.[2] Law in this area is rooted in long-standing common law concepts[3]

1. *Schloendorff v Society of New York Hospital*, [1914] 211 NY 125 at 5, 105 NE 92.
2. See Patricia Peppin, "Informed Consent" in Jocelyn Downie, Timothy Caulfield & Colleen Flood, eds, *Canadian Health Law and Policy* (Ontario: LexisNexis Canada, 2007) at 189.
3. See *Malette v Shulman* (1990), 72 OR (2d) 417 at para 17, 67 DLR (4th) 321. See also Allen M Linden, Lewis N Klar & Bruce Feldthusen, eds, *Canadian Tort Law*, 12th ed (Ontario: LexisNexis Canada, 2004) at 35; Peppin, *supra* note 2 at 190.

but is now also grounded in the Canadian Constitution through the *Charter of Rights and Freedoms*.[4]

Canadian legal controls on compulsory medical treatment (regardless of their origin in statute, the common law or the *Charter*) attempt to balance individual rights with competing social interests.[5] The laws tend to limit the contexts in which medical treatments can be made legally compulsory by mandating procedural protections to prevent possible abuse of state power. Process-based protections typically introduce legal requirements for independent oversight and review of compulsory treatment orders,[6] together with provisions that enable those subject to compulsory treatment to contest the legal basis on which their treatment has been authorized.[7] In Canada, legal issues surrounding compulsory medical treatment arise most often in the context of public health and mental health.

This paper discusses a third area in which Canadian law authorizes compulsory medical treatment: the legally mandated use of medications to chemically castrate recidivist sex offenders.[8] This area has yet to receive much attention from Canadian legal scholars,[9] but its discussion

4. See *Fleming v Reid* (1991), 4 OR (3d) 74 at para 39, 82 DLR (4th) 298 (CA), Robins JA ("The common law right to bodily integrity and personal autonomy is so entrenched in the traditions of our law as to be ranked as fundamental and deserving of the highest order of protection. This right forms an essential part of an individual's security of the person and must be included in the liberty interests protected by s 7 [of the *Charter*]. Indeed, in my view, the common law right to determine what shall be done with one's own body and the constitutional right to security of the person, both of which are founded on the belief in the dignity and autonomy of each individual, can be treated as coextensive.") But see *Deacon v Canada (Attorney General)*, 2006 FCA 265 at para 73, [2007] 2 FCR 607, Linden JA ("It is thus apparent that *Fleming v. Reid* was dealing with a particular fact situation and did not suggest that an unqualified or absolute right to refuse medication in all situations is a principle of fundamental justice under section 7.").

5. See e.g. Peter J Carver, "Mental Health Law in Canada" in Jocelyn Downie, Timothy Caulfield & Colleen Flood, eds, *Canadian Health Law and Policy* (Ontario: LexisNexis Canada, 2007) at 405. See also Nola M Ries, "Legal Foundations of Public Health in Canada" in Tracey M Bailey, Timothy Caulfield & Nola Ries, eds, *Public Health Law & Policy in Canada* (Ontario: LexisNexis Canada, 2005) at 9.

6. See e.g. *Involuntary Psychiatric Treatment Act*, SNS 2005, c 42, s 26. Also see *Health Protection Act*, SNS 2004, c 4, s 47.

7. *Ibid.*

8. See generally Peer Briken & Martin P Kafka, "Pharmacological treatments for paraphilic patients and sexual offenders" (2007) 20 Curr Opin Psych 609.

9. This issue has however received attention in the US legal literature. See e.g. Kris W Druhm, "A Welcome Return to Draconia: California Penal Law 645, The Castration of Sex Offenders and the Constitution" (1997) 61 Alb L Rev 285; Raymond A Lombardo, "California's Unconstitutional Punishment for Heinous Crimes: Chemical Castration of Sex Offenders" (1997) 65 Fordham L Rev 2611; Matthew V Daley, "A Flawed Solution to the Sex Offender Situation in the United States: The Legality of Chemical Castration for Sex Offenders" (2008) 5 Ind Health L Rev 87.

is important because of the likelihood that severe harm will result should the law go the least bit astray.[10]

The purpose of this paper is to identify and discuss medico-legal and ethical issues that emerge from the legally mandated use of medications to chemically castrate recidivist sex offenders in Canada. The issues are presented in the context of a review of reported dangerous and long-term offender hearings (since 1997)[11] that included judicial evaluation of the utility of chemical castration for preventing recidivism in chronically offending pedophiles.[12] This examination offers a contextually embedded opportunity to explore legal and ethical issues surrounding compulsory chemical castration.

The first section of this paper introduces chemical castration by explaining what it is and how it is achieved, and by exploring the history and science behind its use as a treatment for sexual deviancy. The second section describes the legal setting and processes through which the Canadian legal system encounters and engages with the idea of mandated chemical castration. This section describes the operation of Part XXIV of the *Criminal Code* (Dangerous Offenders) to explain how and why the contemplation of chemical castration takes place in Canadian courts. A discussion of the constitutionality of imposing forced medical treatment under long-term supervision orders is also included. The third section discusses the state of the medical evidence supporting the efficacy of chemical castration as a method for preventing recidivism among sex offenders. The fourth section discusses ethical issues flowing from the use of chemical castration in Canada and identifies a number of troubling issues that arise in this context. The final section summarizes the paper and makes recommendations regarding future use of chemical castration.

10. Here, the term 'harm' is used in a broad sense, referring to both physical and mental/psychological harms.

11. The choice of 1997 follows from the fact that the long-term offender regime did not come into force until August of 1997 with the proclamation of *An Act to amend the Criminal Code (high-risk offenders)*, SC 1997, c 17.

12. The cases where long-term offender status was granted are: *R v JSM*, 2003 BCSC 1813, [2003] BCJ no 2991; *R v Stoney*, 2004 ABPC 3, 32 Alta LR (4th) 282; *R v Lalo*, 2004 NSSC 154, 225 NSR (2d) 344; *R v SS*, [2005] OTC 267, [2005] OJ no 1391 (Sup Ct J); *R v Mumford*, [2007] OJ no 4267, 75 WCB (2d) 784 (Sup Ct J); *R v Smith*, [2008] OJ no 2196, 77 WCB (2d) 654 (Sup Ct J); and *R v RTM*, 2009 ABQB 594, [2009] AJ no 1145. The cases where a dangerous offender designation was given are: *R v Roby*, 2000 CarswellOnt 6281 (Sup Ct J); *R v AES*, [2004] OJ no 5192 (Sup Ct J); *R v RM* (2005), 68 WCB (2d) 78, [2005] OJ no 4977 (Sup Ct J); *R v JMH* (2005), 67 WCB (2d) 351, [2005] OJ no 4169 (Sup Ct J); *R v WGL* (2006), 71 WCB (2d) 125, [2006] OJ no 4029 (Sup Ct J); *R v L(W)*, 2006 CarswellOnt 6141 (Sup Ct J); *R v DGB*, 2008 ABQB 302, 77 WCB (2d) 725; and *R v Maxwell*, 2009 ONCJ 362, [2009] OJ no 3328.

I. *Chemical castration*

Chemical castration is the practice of administering to post-pubertal males medication that reduces their circulating testosterone to pre-pubertal levels.[13] It achieves, in effect, reversible drug-induced biochemical mimicry of surgical castration.[14]

In defining chemical castration it is important to note that although the term is popularly used in lay publications[15] and occasionally in specialist publications,[16] it often gives way to more specific, albeit less evocative, terminology in specialist literature. For example, in the medical literature reference is made to the use of 'antiandrogen medication', 'hormonal medication', 'sex drive reducing medication' and 'antilibidinal medications' in place of the term chemical castration.[17] However, the term chemical castration is still used in the Canadian judicial context[18] and therefore in this paper.

Several pharmacological agents can be used to achieve chemical castration. These include medroxyprogesterone acetate (MPA), cyproterone acetate (CPA), and luteinizing-hormone-releasing hormone (LHRH) agonists.

MPA is a progestational steroid that reduces levels of testosterone 5α reductase in the liver,[19] which increases testosterone clearance and leads to decreased testosterone levels in serum and tissues.[20] In addition, MPA decreases the secretion of gonadotropins via a mechanism that remains to be elucidated. MPA is perhaps most commonly known as the active ingredient in the long-acting reversible hormonal contraceptive birth control drug sold under the name Depo-Provera.

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13. Briken & Kafka, *supra* note 8 at 610.
14. The drugs used to achieve chemical castration effectively lower a man's testosterone level to an extent similar to that achieved via surgical castration. This treatment is apparently reversible because testosterone levels can often return to normal in the weeks after drug treatment has stopped.
15. See e.g. Canwest News Service, "Chemical castration of pedophile upheld by federal court" *CanWest Media Publications Inc* (9 August 2006), online: <http://www.canada.com/topics/news/national/story.html?id=3bea636f-3999-4b90-9997-6b5436f608ec&k=72044>.
16. See e.g. Editors, "Chemical castration for paedophiles approved" (1996) 313 BMJ 707.
17. See e.g. Fred S Berlin, "Commentary: Risk/Benefit Ratio of Androgen Deprivation Treatment for Sex Offenders" (2009) 37 JAAPL 59.
18. See e.g. *Steel v Mountain Institution* (1989), 72 CR (3d) 58 at 110, 8 WCB (2d) 7 (BCSC); *R v Stuckless* (1998), 41 OR (3d) 103 at 123, 17 CR (5th) 330 (CA); *Lalo*, *supra* note 12 at para 74; *WGL*, *supra* note 12 at para 102; and *Smith*, *supra* note 12 at para 89.
19. Testosterone 5α reductase is the enzyme that converts testosterone in vivo to its biologically active metabolite.
20. See generally John MW Bradford, "Organic Treatments for the Male Sexual Offender" (1985) 3 Behav Sci Law 355; Victoria L Codispoti, "Pharmacology of Sexually Compulsive Behavior" (2008) 31 Psychiatr Clin N Am 671; and David RP Guay, "Drug Treatment of Paraphilic and Nonparaphilic Sexual Disorders" (2009) 31 Clin Ther 1.

MPA is clinically indicated for use in the treatment of endometrial carcinoma or renal carcinoma; secondary amenorrhea or abnormal uterine bleeding due to hormonal imbalance; reduction of endometrial hyperplasia in non-hysterectomized postmenopausal women receiving conjugated estrogens; prevention of pregnancy; and management of endometriosis-associated pain.[21] MPA is not approved by Health Canada for the treatment of sexual disorders.

CPA is a steroid that has both antigonadotrophic and antiandrogenic properties. CPA acts as an antigonadotrophic agent by inhibiting the secretion of luteinizing-hormone, which leads to decreased production of testosterone in the testes. CPA is considered a true antiandrogen because it competitively inhibits the binding of dihydrotesterone (the biologically active metabolite of testosterone) at androgen receptors.[22] Therefore, CPA both reduces the production of testosterone and blocks its biological effects.

Approved clinical indications for CPA include use in the palliative treatment of patients with advanced prostatic carcinoma (under the brand name Androcur) and also in women requiring a dual-purpose acne therapy/ oral contraceptive (under the brand names CyEstra™-35 and DIANE®-35). CPA is not approved by Health Canada for the treatment of sexual disorders.

LHRH agonists cause a paradoxical reduction in circulating testosterone by overstimulating the hypothalamus. LHRH secretion stimulates cells in the anterior pituitary to release the gonadotrophic-releasing hormones, follicle-stimulating hormone (FSH) and luteinizing hormone (LH).[23] Although these hormones typically work to stimulate the production and release of testosterone, continuous application of long-acting LHRH agonists instead causes the pituitary-gonadal axis to become suppressed. As a result, the secretion of FSH and LH becomes inhibited and testosterone drops to castration levels.[24]

As a class, LHRH agonists (also known as gonadotropin-releasing hormone analogues) are clinically indicated in the management and treatment of endometriosis, central precocious puberty in children, and

21. Medroxyprogesterone, Drug Monographs (Access medicine, The McGraw-Hill Companies).
22. *Supra* note 20.
23. *Supra* note 20. See also Peer Briken, Andreas Hill & Wolfgang Berner, "Pharmacotherapy of Paraphilias with Long-Acting Agonists of Luteinizing Hormone-Releasing Hormone: A Systematic Review" (2003) 64 J Clin Psychiatry 890.
24. *Ibid.*

advanced prostatic carcinoma.[25] LHRH agonists are not approved by Health Canada for the treatment of sexual disorders.

II. *Chemical castration: an historical perspective*

It has been suggested that the contemporary use of antiandrogenic medications in the treatment of paraphilias[26] evolved from ancient practices employing surgical castration as a means of social control;[27] however, the practice is now promulgated largely under the banner of modern neurobiology and neuropharmacology.[28] Two evolutionary movements characterize the recent history of castration as a treatment for sex offenders. The first was the move away from viewing castration as punishment toward the conceptualization of castration as a therapy, which took place during the late 19th and early 20th centuries. The second was a move away from the surgical removal of the testes towards using chemicals to reduce testosterone levels (which took place during the first half of the 20th century).

The surgical castration of sexual offenders has been used as a punishment since ancient times, its prescription flowing clearly from the biblical dictum of 'an eye for an eye'.[29] In North America, the use of surgical castration as a putatively therapeutic method for preventing recidivism in sex offenders stems from the work of Dr. Harry Sharp.[30] Dr. Sharp was an Indiana physician who, during the late 1890s, promoted the 'castration as therapy' model after surgically castrating 176 male prisoners in an attempt to decrease their sexual urges.[31] Although the practice of compulsory surgical castration of sex offenders under the law continues in at least one European jurisdiction[32] and remains an option (i.e., as a voluntary alternative to chemical castration) for recidivist sex offenders

25. Gonadotrophin-Releasing Hormone Agonists, Drug Monographs (Access medicine, The McGraw-Hill Companies).

26. Paraphilia is a clinical psychiatric term used to describe sexual arousal to objects or situations that are not considered a part of normal behaviour, e.g. animals or young children. See Hy Bloom & Richard D Schneider, *Mental Disorder and the Law: A Primer for Legal and Mental Health Professionals* (Toronto, Ontario: Irwin Law, 2006) at 157-60.

27. Charles L Scott & Trent Holmberg, "Castration of Sex Offenders: Prisoner's Rights Versus Public Safety" (2003) 31 JAAPL 502.

28. John MW Bradford, "The Neurobiology, Neuropharmacology, and Pharmacological Treatment of Paraphilias and Compulsive Sexual Behaviour" (2001) 46 Can J Psychiatry 26.

29. Robert D Miller, "Forced Administration of Sex-Drive Reducing Medications to Sex Offenders: Treatment or Punishment" (1998) Psychol Public Policy Law 175 at 178.

30. Scott & Holmberg, *supra* note 27.

31. Harry Sharp, "Vasectomy as a Means of Preventing Procreation in Defectives" (1909) 23 Jour AMA 1897 at 1907.

32. Surgical castration of sex offenders is practiced in the Czech Republic. See Dan Bilefsky, "Europeans Debate Castration of Sex Offenders" *The New York Times* (11 March 2009), online: <http://www.nytimes.com/2009/03/11/world/europe/ 11castrate.html>.

under legislation in some American states,[33] the surgical castration of sex offenders has largely been replaced by chemical castration since the rise of modern hormonotherapy during the 1940s.[34]

The use of drugs to lower male testosterone levels began in the first half of the twentieth century. The novel ability to manipulate sex hormones using drugs quickly morphed into a putative treatment for pathological sexual behaviours. For example, by 1944, the first report on the use of a hormonal medication (diethylstilbestrol) as a method for reducing pathological sexual behaviour (i.e., sexual psychopathy and chronic masturbation) appeared in the North American medical literature.[35] In 1958, a physician at Johns Hopkins University, Dr. John Money, became the first to report the successful treatment of nonparaphilic hypersexuality and sex offenders using the drug MPA.[36]

During the 1970s, the first clinical studies of CPA as a treatment for pathological sexual behaviour appeared in Germany.[37] In 1985, LHRH agonists were proposed as potential therapeutic agents in the treatment of pathological sexual behaviour,[38] and clinical studies of their use in this capacity appeared in the medical literature during the early 1990s.[39]

Today, chemical castration of sex offenders is practiced in North America, Britain, Europe and parts of Asia, but the practice is not universally compulsory.[40] However, each jurisdiction has ostensibly adopted the practice of chemical castration based on the view that it is a rational medical treatment grounded in the modern scientific understanding of the human brain and behaviour.[41]

III. *Chemical castration: a scientific perspective*

The scientific model underlying the use of chemical castration as a treatment for sex offenders is based in complex biology but it can be reduced to the simple idea that testosterone is critical for the maintenance of male sexual behaviour. Evidence for this idea was originally obtained in animal

33. See Fred S Berlin, "Sex Offender Treatment and Legislation" (2003) 31 JAAPL 510.
34. Scott & Holmberg, *supra* note 27 at 502.
35. Robert M Foote, "Diethylstilbestrol in the Management of Psychopathological States in Males" (1944) J Nerv Ment Dis 928.
36. Codispoti, *supra* note 20 at 672.
37. Bradford, *supra* note 28 at 31.
38. Bradford, *supra* note 20.
39. Bradford, *supra* note 28 at 32.
40. See e.g. Alex Duval Smith, "France introduces chemical castration for sex offenders" *The Independent* (11 November 2004), online: <http://www.independent.co.uk/news/world/europe/france-introduces-chemical-castration-for-sex-offenders-532792.html>. See also Karen Harrison, "Legal and Ethical issues when using Antiandrogenic Pharmacotherapy with Sex Offenders" (2008) 3 Sex Offender Treatment 1 at 2.
41. See e.g. Bradford, *supra* note 28.

studies[42] but has since accumulated from human studies evaluating the effects of androgen replacement therapy in hypogonadal and eugonadal men.[43]

Results from these studies have shown that reductions in sexual interest and arousability occur after three to four weeks of testosterone withdrawal and that normal levels of sexual interest and arousability can be restored with testosterone administration.[44] They show also that masturbation frequency and erectile rigidity and duration appear closely tied to testosterone levels. On this evidence, there appears to be a reasonably sound scientific rationale to support the use of androgen deprivation treatment as a method for suppressing the sexual urges of sex offenders. Interestingly, however, the human studies have also shown that testosterone withdrawal does not impair the ability to achieve penile erection, nor does it necessarily lead to a reduction in the amount of sexual activity engaged in with partners.[45]

IV. *Chemical castration and the Canadian legal system: the dangerous offender and long-term offender regime*

In Part XXIV of the *Criminal Code*,[46] Canadian law recognizes the need for a special sentencing regime applicable to offenders who present a uniquely high risk of recidivism. The primary objective of the dangerous offender and long-term offender regime found there is "to protect the public from offenders who have committed serious sexual or violent offences (except murder) and continue to pose a threat to society."[47] In practice, statistics indicate that in eighty per cent of dangerous offender hearings the underlying offence was of a sexual nature,[48] so the regime is applied primarily to sex offenders.

1. *The process*

The Crown can make a dangerous offender application during the period between conviction and sentencing.[49] Consent of the attorney general of

42. Foote, *supra* note 35.

43. Hypogonadal men have low levels of testosterone due to inadequate secretion of gonadotrophins.

44. John Bancroft, "The endocrinology of sexual arousal" (2005) 186 J Endocrinol 411.

45. *Ibid* at 413. Moreover, it is important to note here that sexual offending is not limited by the ability to achieve an erection because sexual offences can encompass activities apart from forced sexual intercourse.

46. *Criminal Code*, RSC 1985, c C-46, ss 752-61 [*Code*].

47. Parliamentary Information and Research Service, *The Dangerous Offender and Long-Term Offender Regime* (Ottawa: Library of Parliament, 2008) at 1.

48. See Public Safety and Emergency Preparedness Canada, *Corrections and Conditional Release Statistical Overview*, December 2007 at 103-105. Cited in: *ibid* at 1.

49. *Supra* note 46 at s 753(2) gives the Crown an additional six months to make the application should new evidence arise.

the province within which the application is being made is required before the application can proceed. In addition, offenders must be given notice of the hearing at least one week before its scheduled date and the notice must contain the basis for the Crown's application.[50]

Under s. 752.1(1) of the *Code*, the Court (where it has reasonable grounds to believe that the offender may be found to be a dangerous offender under s. 753 or long-term offender under s. 753.1) must order the offender remanded for a sixty-day dangerousness assessment to be completed by a multidisciplinary team of experts in corrections and mental health. The purpose of the assessment is to determine the extent of the risk the offender represents to the public and whether there is a reasonable possibility of eventual control of that risk in the community.[51]

2. *The hearing*

Dangerous and long-term offender hearings proceed under relaxed evidentiary rules that allow for the admission of evidence concerning the offender's morality, reputation, prior convictions and previous bad behaviour (not resulting in charges).[52] The core evidentiary component of dangerous and long-term offender hearings comprises expert reports and testimony.

The *Code*, in s. 753(1), sets out the requirements for a dangerous offender designation. The Crown must prove beyond a reasonable doubt that the offender has committed a 'serious personal offence' and that he or she represents a danger to society because of the likelihood of causing significant harm by reoffending.[53]

Under s. 754(5), if the dangerous offender requirements are not met, the Court can treat the application as for long-term offender status. In such cases, the Court will consider whether the offender meets the statutory criteria for that status under s. 753.1(1) of the *Code*.

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50. *Code, supra* note 46 at s 754(1)(a) and (b).

51. This court-ordered assessment is intended to provide a neutral set of expert opinions for the court to consider during the hearing. The adversarial battle of the experts under the old DO regime is therefore largely done away with, however, although not expressly granted under the *Code* parties retain the option to supplement the court ordered assessment with additional expert opinion on condition that the court finds the evidence relevant. See David MacAlister, "Use of Risk Assessments by Canadian Judges in the Determination of Dangerous and Long-Term Offender Status, 1997-2002" in Law Commission of Canada *Law and Risk* (BC Canada: UBC Press, 2005) at 36. Readers who are interested more broadly in the content of the court ordered assessments are referred to: Bloom & Schneider *supra* note 26 at 249-56.

52. Regarding the admissibility of evidence concerning the offender's morality or reputation, see *Code* at s 757. Regarding the admissibility of evidence concerning evidence of behaviour that did not result in criminal charges, see *R v Neve*, 1999 ABCA 206, 137 CCC (3d) 97.

53. See generally Kirk Heilbrun, James RP Ogloff & Kim Picarello, "Dangerous Offender Statutes in the United States and Canada" (1999) 22 Int J Law Psychiatry 393.

As a result, dangerous offender applications generally proceed with the Crown arguing that an offender should be declared a dangerous offender and the defence arguing in favour of long-term offender status. It is an understatement to call the difference between the two designations significant. In practical terms (given that only approximately five per cent of dangerous offenders are ever released from prison whereas long-term offenders are given supervised release following a determinate sentence[54]), the difference can be whether the offender will ever see the outside of a correctional institution.

The judge has considerable discretion in determining whether to designate an offender as either a dangerous or a long-term offender. At its core, the decision rests on whether the judge is satisfied, based on his or her assessment of the expert evidence, that there is a reasonable possibility of eventual control of risk in the community. At the hearing, neither side has the onus of convincing the judge on this matter and neither the criminal nor civil standard of proof applies.[55] Rather, the law in this area holds that in determining whether a reasonable possibility of control of the offender's risk in the community exists, the "mere wishing or speculating that he [the offender] will want to succeed, and will succeed, in controlling that risk is insufficient"[56] and that, "[t]here must be evidence of treatability that is more than an expression of hope and that indicates that the specific offender can be treated within a definite period of time."[57] The judge therefore considers all the evidence and decides whether it is strong enough to satisfy him or her that the offender can, with appropriate treatment, be controlled in the community. The critical nature of the expert evidence on this subject is obvious and in many cases judges are left to side with one of several potentially conflicting expert opinions.

A review of dangerous and long-term offender hearings involving chronically recidivist pedophiles makes it quickly apparent that judges' decisions as to whether there exists a reasonable possibility of controlling the offenders' risk in the community is often influenced by expert testimony on the subject of chemical castration. Consider the following examples from recent cases:

> None of this suggests that Mr. Maxwell presents a reasonable possibility

54. Public Safety Canada reports that as of July 2006, there were 351 active offenders with the Dangerous Offender designation, and of these only 18 had received parole while the other 333 remained incarcerated. Online: < http://www.publicsafety.gc.ca/prg/cor/tls/dod-eng.aspx>.

55. See *R v FED*, 2007 ONCA 246 at para 50, 84 OR (3d) 721. The law in this area is also helpfully reviewed in *Maxwell, supra* note 12 at paras 25-33.

56. *Ibid* at para 30.

57. *Ibid.*

of eventual control of the risk in the community. With his history of deceit, I just do not trust him to do what he must. I must agree with Dr.Woodside that he only presents as a hope of control. With his history of letting his sexual interest in pubescent boys find expression, and especially if he fails to take or continue taking *anti-androgen drugs*, I would expect he will offend again.[58]

I am not convinced that the offender's sexual deviancy can be controlled because all five recommendations of Dr Woods must be followed, including and especially the prescription of an effective *anti-androgen drug, such as Androcur*, in sufficient doses. However, if the five requirements set out by Dr Woods are completely followed during the duration of the long-term offender supervision period, then there is a reasonable possibility of eventual control of the offender's risk in the community.[59]

In my opinion, he is unlikely to take the *anti-androgen drugs* in the future, and in any event, because of his overall attitude, he is unlikely to benefit from them even if he took them. Dr. Woodside's view, which I share, is that without this particular form of drug therapy, the risk of Mr. Clancy reoffending is extreme and not reasonably manageable in the community.[60]

Bearing in mind the nature of the offences committed by Mr. Smith and the role that substance abuse has played in his offending behaviour, as well as the expert evidence regarding the effectiveness of Antabuse and *antiandrogen drugs* in lowering risk, it seems more than probable that these drugs would be recommended by Mr. Smith's treating psychiatrist. Certainly both Dr. Gojer and Dr. Klassen would recommend their use in this case. A treatment plan incorporating the taking of Antabuse and *antiandrogen drugs* - a plan that Mr. Smith would have to follow or be charged with a breach of the long-term supervision order - would be an effective way of keeping Mr. Smith's risk of re-offence at a low or acceptable level.[61]

In my view, it is crucial that Mr. Stoney take medicine under the direction of a psychiatrist and participate in therapy while on parole supervision. The offender cannot be given an option as to these conditions. *Anti-androgen drugs* may have unpleasant side effects. Mr. Stoney has shown a propensity to avoid participation in programs of which he does not approve. This cannot be an option for him related to drug treatment. If his participation is dependent upon his continued agreement, then that agreement may change. This would defeat the management of Mr. Stoney within the community.[62]

58. *Supra* note 12 at para 127.
59. *Ibid* at para 103.
60. *R v Clancy* (2007), 74 WCB (2d) 655, [2007] OJ no 3145 at para 109 (Sup Ct J).
61. *Smith, supra* note 12 at para 148.
62. *Stoney, supra* note 12 at para 131.

V. *The legal imposition of chemical castration: understanding the process*

In order to explore the ethical dimensions of forced chemical castration under Canadian law, it is important to establish how this treatment can be imposed. Typically, the process of forcing an offender to be chemically castrated begins at the conclusion of sentencing, after the judge has decided to make a long-term offender designation.[63] In view of the offender eventually returning to the community under a long-term supervision order, the trial judge provides a set of conditions he or she believes ought to attach to the offender's supervision order. These recommendations are provided for the benefit of the National Parole Board (NPB), and although they are not binding on the NPB, it is unlikely they would be issued if judges were not confident that they would be followed. An example of such judicial recommendations is in *R. v. Stoney*, where having found Mr. Stoney to be a long-term offender, Allan PCJ made the following recommendations:

> I realize that the NPB will decide what conditions that are part of Mr. Stoney's supervision order at the time of his release from custody. However, I will make the following recommendations for consideration of the NPB:
>
> - When released in the community, Mr. Stoney should live in a controlled residential facility.
> - The parole officer should make random checks related to his place of residence.
> - It would be beneficial to Mr. Stoney to have support systems. Mr. Stoney should be ordered to cooperate with community programs such as "Circles of Support". This will assist Mr. Stoney while in the community.

63. It is possible that legally mandated chemical castration is occurring in another context that makes the process more common than is apparent in reported dangerous offender cases: plea agreements. Statistics showing the proportion of felony convictions obtained by guilty plea (95 per cent) cited by one US author (John Stinneford, 'Incapacitation Through Maiming: Chemical Castration, The Eighth Amendment And The Denial Of Human Dignity' (2005) 3 U St Thomas LJ 559 at 563) formed the basis for the conclusion that the majority of offenders chemically castrated in the US receive the treatment pursuant to the terms of their plea bargain agreements (see Debra Wilson, *The Legal Implications of Chemical Castration of Sex Offenders in Criminal Law*, in Michael Adams, David Barker & Katherine Poludniewski, eds, *Australasian Law Teachers Association – ALTA, 2007 Refereed Conference Papers* (Perth, Western Australia: 2007) at 13). Canadian data indicate that over 90 per cent of criminal cases are resolved without trial (see Department of Justice Canada, *Plea Bargaining* by Milica Potrebic Piccinato (Ottawa: Department of Justice Canada, 2004) at 6) and this suggests that there is ample opportunity for the legal imposition of chemical castration outside the dangerous and long-term offender regime. This is potentially problematic and requires further study.

- Upon his release, he should participate in continued therapy for sex offenders.
- He should be *required to take anti-androgen medication or other medication to control sexual fantasies as prescribed by a treating physician.*
- He should abstain absolutely from alcohol, solvents, narcotics, or other intoxicating substances. He is only to take medication pursuant to a medical prescription.
- In addition, he should be required to be subject to random testing to ensure compliance with the abstinence condition.[64]

These judicial recommendations represent only the beginning of the story because the legal power to impose medical treatment on long-term offenders ultimately lies with the NPB. The leading case in this area is *Deacon v. Canada (Attorney General)*.[65]

Deacon concerned an appeal to the Federal Court of Appeal from a National Parole Board (NPB) decision refusing to remove a condition from the long-term supervision order of convicted pedophile Shaun Deacon. The condition forced Mr. Deacon to "take medication as prescribed by a physician" (including the anti-androgen medication Lupron to suppress sexual appetite and control sexual fantasies).[66] Mr. Deacon argued that this condition violated his s. 7 *Charter* right to not be deprived of life, liberty or security of the person except in accordance with the principles of fundamental justice. In ruling there was no violation, the Federal Court of Appeal discussed the process and the legal basis for imposing compulsory medical treatment as part of an offender's long-term supervision order.

The Court described how upon expiration of the offender's warrant of committal he becomes subject to the statutory jurisdiction of the NPB. The Court then explained that the NPB's statutory jurisdiction to impose conditions on a long-term offender derived from s. 753.2(1) of the *Code* and s. 134.1(2) of the *Corrections and Conditional Release Act*[67] as follows:

753.2(1) Subject to subsection (2), an offender who is required to be

64. *Stoney*, *supra* note 12 at para 229.

65. *Deacon v Canada (Attorney General)*, 2006 FCA 265, [2007] 2 FCR 607, leave to appeal to SCC ref'd, 31596 (11 January 2007).

66. In addition to Lupron, Shaun Deacon was also required, as part of his LTSO, to take the following medications: the anticonvulsant drug Topiramate to treat post-traumatic stress disorder; the antidepressant drug Zoloft to treat anxiety disorder and lower libido; the cholesterol-lowering drug Lipitor and progesterone to treat side effects of the other medications; and Tums calcium tablets and multivitamins, also to help alleviate side effects of the other medications.

67. *Corrections and Conditional Release Act*, SC 1992, c 20 [*CCRA*].

> supervised by an order made under paragraph 753.1(3)(b) [long term supervision order] shall be supervised in accordance with the *Corrections and Conditional Release Act* when the offender has finished serving
>
> > (a) the sentence for the offence for which the offender has been convicted; and
> > (b) all other sentences for offences for which the offender is convicted and for which sentence of a term of imprisonment is imposed on the offender, either before or after the conviction for the offence referred to in paragraph (a).
>
> **134.1(2)** The Board may establish conditions for the long-term supervision of the offender that it considers reasonable and necessary in order to protect society and to facilitate the successful reintegration into society of the offender

The Federal Court of Appeal interpreted s. 134.1(2) of the *CCRA* using a broad and purposive approach that began with an exposition of the purpose of the statutory regime for long-term offenders. Writing for the Court, Linden J.A. made the following observations:

> An offender whose conduct or behaviour is not "pathologically intractable", in that there is a reasonable possibility that the offender can eventually reach a stage where, although not curable, his or her risk can be controlled in the community, will now qualify for long-term offender status. Under the former provisions, such an offender—for example, a repeat sexual offender—might have been found to be a dangerous offender. Long-term supervision orders thus pursue two main objects: first, protecting society, and second, enhancing the social reintegration of long-term offenders, wherever possible, by granting release under the least restrictive conditions consistent with the protection of society.[68]

The Court noted the absence of any express *CCRA* provision granting the NPB authority to order forced medical treatment; however, it concluded that:

> If the statutory purposes of protecting society and enabling social reintegration of long-term offenders through supervised release with the least restrictive conditions possible are to be achieved, the Board must possess the power to impose a medical treatment condition in appropriate circumstances.[69]

Having decided that the NPB was empowered to impose a condition for forced medical treatment, the Court—foreshadowing its position on the *Charter* argument—suggested that the NPB did not force Mr. Deacon

68. *Deacon, supra* note 65 at para 36.
69. *Ibid* at para 38.

to take the medication. Mr. Deacon, the Court opined, remained "at liberty to refuse to take the prescribed medication."[70] But, they continued, "if he does, there will be consequences for such a refusal: the appellant will be in breach of his long-term supervision order and therefore liable to commitment under section 135.1 of the *CCRA* or imprisonment pursuant to section 753.3 of the *Criminal Code*."[71] The option for Mr. Deacon was to take the drugs or go back to jail. This was an unpalatable option to be sure, but the Court was right in noting that Mr. Deacon did have some choice as to whether he would receive the medication.

On the *Charter* arguments, the Court agreed that the condition requiring Mr. Deacon to take medication was a violation of his rights to liberty and security of the person.[72] Nevertheless, the Court ruled that this violation was consistent with the principles of fundamental justice. First, the Court held that the requirement of express legislative authorization for forced medical treatment was not a principle of fundamental justice.[73] Second, the Court held that the right to refuse unwanted medical treatment was not an absolute unqualified right and could not therefore be elevated to the status of a principle of fundamental justice:

> Contrary to the appellant's assertion, I do not think the requisite broad societal consensus is present concerning an absolute right to refuse unwanted medical treatment in every situation for the latter to be recognized as a principle of fundamental justice. Rather, the right to refuse medical treatment, while perhaps accepted as a general rule, is also recognized as properly subject to limitations in certain contexts.[74]

Based on its analysis, the Court unanimously upheld the condition of Mr. Deacon's long-term supervision order and with it the constitutionality of the legal regime empowering the NPB to impose conditions of release that require a long-term offender to choose between chemical castration and prison.

VI. *Chemical castration to prevent recidivism in sex offenders: assessing the evidence*

In reviewing the medical evidence for the efficacy of chemical castration, two topics warrant preliminary discussion. The first is the high human cost of prognostic uncertainty, and the second concerns a set of issues that complicate studies of sex offender treatments.

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70. *Deacon, supra* note 65 at para 40.
71. *Ibid.*
72. *Ibid* at para 49.
73. *Ibid* at para 56.
74. *Ibid* at para 71.

1. *Prognostic uncertainty*

For conventional medical treatments, where the purpose is to help the individual who suffers from a particular illness or disease, a preventative drug therapy that works in six out of ten patients would generally be considered successful.[75] Consider that the number needed to treat (a statistical measurement based on absolute risk that tells us how many people need to receive a drug in order to prevent one incident)[76] for atorvastatin (Lipitor) and other cholesterol lowering statins is 16-23 to prevent one heart attack in populations that show signs of heart disease, and 70-250 to prevent one heart attack in populations with risk factors for, but no signs of heart disease.[77] This means that, in a population suffering from heart disease, Lipitor will prevent one heart attack for every 16 people who take the medication.

In the case of chemical castration (when imposed as a parole condition), the pharmacotherapy is unconventional because its primary purpose is to prevent harm to society rather than to the recipient. It follows that an assessment of this treatment's efficacy should differ from assessments of conventional treatments. The failure of chemical castration to achieve remission of sexual deviancy likely entails the commission of a sex crime. Accordingly, the level of success demanded (i.e., the threshold used for determining efficacy) from such a treatment should arguably be much higher than is required of conventional preventative pharmacotherapies. This level of prognostic certainty is currently not possible for chemical castration. At the very least, courts should attempt to take into account what level of uncertainty society is prepared to accept when considering the release of recidivist sex offenders treated using sex-drive-reducing medications.

2. *Sex-offender research: the challenges*

The second preliminary issue concerns problems with sex offender research relating to assessment, study design, sampling and follow-up.[78]

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75. It is important to note that in assessing the potential utility of a medical treatment one single metric, such as the NNT, is not a sufficient basis on which to form a reasoned and thorough clinical opinion as to whether that treatment should be used in certain circumstances. Additional knowledge is required to inform clinical judgement, including, for example, knowledge of the treatment's potential side effects and the natural course of the disease/illness that is the target of treatment.

76. Lonnie Wen, Robert Badgett & John Cornell, "Number needed to treat: a descriptor for weighing therapeutic options" (2005) 62 Am J Health Syst Pharm 2031.

77. See Therapeutics Initiative, *Business Week* (31 May 2010), online: < http://bp0.blogger.com/_ZiPiXEv_Q_g/R5DjN-M3c71/AAAAAAAABAc/toN_Cn0Z3Jo/s1600-h/BusWeek-NNT-Table.gif>.

78. Linda S Grossman, Brian Martis & Christopher G Fichtner, "Are Sex Offenders Treatable? A Research Overview" (1999) 50 Psych Serv 349.

Investigators face problems in assessment because there are no agreed-upon standardized measurement techniques that can reliably and validly measure the frequency of sex offences. They face problems with study design because of reluctance to randomize sex offenders to control groups, in part because of an erroneous belief that it would be unethical not to provide control groups with treatment.[79] They face problems with sampling because the heterogeneity and small size of the sex offender population makes it difficult to control potential clinically relevant variables (e.g., socioeconomic status, age, type of offence, etc.) within a study population. Finally, investigators face problems with measuring recidivism because of the long duration of the necessary follow-up periods (it has been suggested that to properly assess recidivism offenders have to be followed for at least five to seven years after treatment). These challenges have limited the reliability and validity of sex offender research and should be addressed.

VII. *Evidence for the use of chemical castration to prevent recidivism*

Statements supporting the use of chemical castration in the treatment of sex offenders are not uncommon in the medical literature. For example, a recent editorial in the *British Medical Journal* contained the following claim: "Antiandrogenic drugs and physical castration undoubtedly reduce sexual interest (libido) and sexual performance, and they reduce sexual offending."[80] Nevertheless, such assertions ignore the lack of a sufficiently reliable evidentiary basis for the efficacy of these treatments.

The effectiveness of sex offender treatment has been studied and reviewed fairly extensively over the past ten years.[81] In assessing the results, some authors have suggested that sex offender treatments are useful, on balance, because of figures purportedly showing that treated participants have absolute recidivism rates that are six and a half per cent to eight per cent lower than untreated participants.[82] Other authors have

79. This is an erroneous view for at least two reasons. First, it ignores the fact that the available treatment has not been proven effective and cannot therefore be considered an established treatment. Second, it ignores the fact that all other parole and treatment conditions would have to be consistent and therefore that those offenders in the control group would still be receiving non-pharmacological treatment alongside offenders in the treatment group and both groups would still be subject to other restrictive parole conditions.

80. Editors, "Chemical Castration for Sex Offenders" (2010) 340 BMJ c 74.

81. See generally Leigh Harkins & Anthony Beech, "Measurement of the effectiveness of sex offender treatment" (2007) 12 Aggress Violent Behav 36.

82. See Dennis M Doren & Pamela M Yates, "Effectiveness of Sex Offender Treatment for Psychopathic Sex Offenders" (2008) 52 Int J Offender Ther Comp Criminol 234; see also Friedrich Lösel & Martin Schmucker, "The effectiveness of treatment for sexual offenders: A comprehensive meta-analysis" (2005) 1 J Exp Criminol 117.

expressed concerns about design problems with the studies on which such positive assessments are based.[83]

In light of the ongoing debate in the medical literature, it would be prudent to conclude that the efficacy of sex offender treatments has yet to be conclusively established. Moreover, there has been insufficient consideration in the literature of harm related to prognostic uncertainty and therefore even if treatments reduce recidivism at statistically significant levels, this finding may not provide sufficient evidence to support their use in highly dangerous populations.

Given the risks associated with treatment failure in populations of recidivist sex offenders it seems reasonable to demand that evidence for treatment efficacy be derived only from studies employing the most scientifically rigorous methodology. Fortunately, the Cochrane Collaboration recently published a review on the topic of management for people with disorders of sexual preference and for convicted sexual offenders.[84] This review specifically assessed the existing evidence for the efficacy of pharmacotherapy (i.e., chemical castration) in sex offenders.

The Cochrane Collaboration produces what is widely considered to be the gold-standard review of the existing clinical evidence for medical treatments because the reviewers apply strict methodological criteria in selecting studies for review. These criteria lead to the exclusion of research studies that do not use randomized controlled designs to avoid the introduction of error and bias into conclusions concerning clinical efficacy.

Assessing the whole of the sex offender literature, the Cochrane Collaboration was able to identify only a single study using anti-androgen medication that met their inclusion criteria. After reviewing the study, the authors provided the following advice for physicians: "anti-libidinal drugs should be used with caution [because] there is no trial-derived data to support or refute their use."[85] They then suggested that use of such medication should be considered experimental and that its use could only be justified in the context of well-conducted randomized experimental trials.[86]

The Cochrane Collaboration reveals the negligible evidentiary base for the use of chemical castration to prevent recidivism in sex offenders. This is troubling in light of case law that reveals Canadian courts are relying

83. Doren & Yates, *supra* note 82 at 235.

84. Paul White et al, "Management for people with disorders of sexual preference and for convicted sexual offenders (Review)" (2009) The Cochrane Library 1.

85. *Ibid* at 9.

86. *Ibid.*

on expert testimony in support of chemical castration when deciding to grant recidivist sex offenders long-term offender status, thus ensuring the offenders will return to our communities.

VIII. *Chemical castration in Canadian caselaw*

Since 1997, when the *Criminal Code* was amended to include the long-term offender designation,[87] there have been at least fifteen reported cases of dangerous or long-term offender hearings that considered the possibility of legally mandating chemical castration for recidivist pedophiles. In eight cases, the court opted for the dangerous offender designation, while long-term offender status was granted in the other seven.[88]

A review of these cases makes it clear that expert opinion on whether chemical castration will provide an effective means for preventing recidivism is often central to the decision as to which designation the offender ultimately receives. This judicial focus on chemical castration continues in spite of the fact that both the British Columbia Court of Appeal[89] and the Ontario Court of Appeal[90] have openly criticized the use of chemical castration because of doubts concerning its utility. Given the limited clinical evidence supporting its use in the sex offender population, it is troubling, to say the least, that this treatment continues to hold sway on judicial decision-making. As the following section illustrates, chemical castration of sex offenders also raises troubling ethical issues that call Canadian practice into question.

IX. *Ethical issues surrounding legally mandated chemical castration*

1. *Validity of consent*

It is well-established law in Canada that no competent person shall receive medical treatment unless they have given their voluntary and informed consent.[91] Similarly, the Canadian Medical Association *Code of Ethics*

87. *Supra* note 11.

88. *Supra* note 12.

89. *JSM*, *supra* note 12. This case overturned a lower court decision granting JM long-term offender status (*R v JSM*, 2001 BCSC 763, 50 WCB (2d) 522) because the trial judge's reliance on JM's assurances that he would submit to chemical castration was held to amount to an error of law. However, in an interesting twist, the case was sent back to the trial level, and JM was eventually given the long-term offender status based largely on the trial judge's acceptance of the utility of chemical castration (see *R v JSM*, 2003 BCSC 1813, 60 WCB (2d) 202).

90. Although the case in the Ontario Court of Appeal was heard prior to the introduction of the long-term offender regime, Austin JA strongly disapproved of the evidence in support of the utility of chemical castration as a means for preventing recidivism, see *Stuckless*, *supra* note 17 at paras 81-82.

91. Peppin, *supra* note 2.

requires that physicians respect the right of a competent patient to accept or reject recommended medical care.[92]

In the context of treatment administered under conditions attached to long-term supervision orders, it is questionable whether the patient/offender is capable of giving legally- and ethically-adequate consent. The reason for this is straightforward. The patient/offender is placed in a situation where they must choose between remaining in prison, perhaps indefinitely, and receiving the treatment. Accordingly, any decision by the patient/offender to consent to the treatment may lack the requisite level of freedom for valid consent to be given. Longstanding legal and ethical doctrine holds that consent cannot be voluntary if it is given by a patient who is coerced or under duress.[93] Notwithstanding the decision of the Federal Court of Appeal in *Deacon*, the consent that can be achieved under such catch-22 conditions (i.e., jail versus medication) is inconsistent with that doctrine. In fact, even accepting that the consent in this situation is legally valid, it remains firmly inconsistent with ethical principles governing medical treatment. Thus, physicians who participate in legally mandated chemical castration would be acting outside the ethical norms of their profession.

It may be that in dilemmas like those presented by repeat sex offenders the legal and ethical rules governing consent should be relaxed. Mandating the chemical castration of repeat sex offenders might seem justifiable if the alternative is keeping the offender in prison, perhaps indefinitely (if the treatment is ever proved efficacious). In *Deacon*, however, that argument was not made. Rather, the practice was constructed to 'fit' within existing legal doctrine through the Court's suggestion that Mr. Deacon was able to give valid consent because he did, after all, have a choice. Constructing the law to fit the practice is ethically troubling.

2. *Criminal acts or manifestations of illness?*

A second ethical issue, which might be called the inconsistency problem, arises where the release of an offender is predicated on his acceptance of receiving medical treatment to control a pathological condition. The inconsistency problem exists because two competing and fundamentally inconsistent conceptualizations of the underlying problem are simultaneously at play with the offender/patient caught in the middle.

Consider that the offender is assumed to have committed a criminal act that is morally repugnant and born of his own free will; the minimum justification for penal sanctions is therefore met. At the same time,

92. Canadian Medical Association, *Code of Ethics*, online: <http://www.cma.ca/index.cfm?ci_id=46137&la_id=1&requiredfields=&q=code+of+ethics&x=0&y=0&proxycustom=> #24.

93. Peppin, *supra* note 2 at 191.

however, the offender is told that his pathological behaviour is amenable to hormone-reduction therapy and that he must receive medical treatment to help assuage his criminal impulses. Implicit in this is the suggestion that his criminality is traceable to biology and not acts born of free will. Thus arises the inconsistency problem.

The offender is caught between two conceptual worlds, and subjected to the worst of both. To resolve this ethical dilemma it appears that we should either (1) decide that recidivist sex offenders are criminals who freely choose to act and punish them with criminal sanction alone; or (2) decide that recidivist sex offenders suffer from an illness and treat them medically, perhaps following the civil committal model. Instead, Canadian law has adopted both conceptions and this is ethically, if not legally, problematic.

Clearly, any argument suggesting that criminals should not be offered behavioural modification therapy (either through psychotherapy or pharmacotherapy, or both) would be inconsistent with years of practice. Further, there may actually exist a clear responsibility, if we subscribe to the rehabilitative model of criminal sanctions, to offer treatment.

It is important to recognize that the inconsistency issue described above does not question whether treatment should be made available—if an effective treatment exists it would seem unethical not to offer it—but rather the fact that treatment aimed at alleviating a crime-inducing pathology is forced upon an individual supposedly being criminally punished for acting of his own free will. A possible solution is to recognize the use of chemical castration as preventive supervision as opposed to medical treatment. Unfortunately, as discussed in the following subsection, physician participation in such a practice could be unethical.

3. *Treatment or punishment? Physicians as agents of social control*

It may be inaccurate to cast the administration of sex-drive reducing drugs as a medical treatment for certain types of sexual disorders. In the case of a recidivist pedophile for example, the problematic characteristic is not that the pedophile's sex drive is overactive, but rather that it is misdirected (i.e., at children rather than adults). Chemical castration does nothing to alter that misdirection and therefore does not target the underlying pathology that motivates the pedophile to offend. Additionally, the drugs can cause serious and potentially life-threatening side effects, including depression, osteoporosis, thromboembolism and stroke.[94] Therefore, it

94. Erik J Giltay & Louis JG Gooren, "Potential Side Effects of Androgen Deprivation Treatment in Sex Offenders" (2009) 37 JAAPL 53.

may be ethically problematic to accept the view that chemical castration is a medical treatment. It may be better conceived of as an extension of criminal sanctions—as a punishment—whereby the long arm of the law reaches into the community.

The American Medical Association (AMA) has released an opinion paper on court-initiated medical treatments in criminal cases that addressed the treatment versus punishment issue. The AMA concluded that, "in order to consider a particular court-initiated treatment a treatment and not a punishment, it would have to effectively treat the disorder that motivates the patient to offend."[95] The AMA also held that physicians should not participate in court-ordered punishments which might make them agents of social control.[96] Given that the chemical castration of pedophiles does nothing to address the offender's misdirected sexual desires, the AMA position seems to preclude physician participation in court-ordered chemical castration of recidivist pedophiles.

In Canada, the arguments in the AMA position paper may not be quite as persuasive because under Canadian law neither the Court nor the NPB directly orders the chemical castration of repeat sex offenders. Rather, the NPB simply requires, as part of its conditional release, that the "offender take all medications as prescribed by a physician." However, whether this changes the assessment of physician participation is arguably unimportant, because regardless of whether the castration was ordered on the advice of a physician or by a court (and in Canada it is effectively ordered by both), it fails to treat the underlying pathology and therefore should not be properly conceived of as therapy.

To summarize, physician participation in chemical castration seems precluded for two reasons: first, because chemical castration is not a treatment, but rather a form of social control and, second, on the basis that providing the treatment falls outside the ethical norms of the profession with regard to the requirements for voluntary and informed patient consent.

Conclusion

This paper suggests that when implemented under the coercive power of law, the chemical castration of repeat sex offenders is inconsistent with established canons of medical ethics and poorly supported by clinical evidence. It follows that the employment of chemical castration in the

95. American Medical Association, Opinion 2.065 – Court Initiated Medical Treatment in Criminal Cases (31 May 2010), online: <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion2065.shtml>.

96. *Ibid.*

Canadian legal system represents a misguided, almost faith-based, use of an unproved and potentially dangerous medical treatment as a risk management tool. The use of this so-called treatment not only puts physicians and their patients in ethically troubling positions, but may also engender a sense of false security among judges and the general public concerning the likelihood that sex offenders will re-offend. Ultimately, any reliance on this practice in our criminal justice system as grounds for releasing recidivist pedophiles into our communities represents a clear threat to children and other potential victims of sexual predators.

It is possible that the use of anti-androgen medications may one day have an effective role in the Canadian justice system. However, at present, the clinical evidence does not support the use of chemical castration in criminal law. Should the day come when it does, other issues including the use of medication as a form of social control will remain to be confronted before chemical castration can be accepted as an ethical and socially acceptable component of the Canadian justice system.

For the time being, given how few options exist for managing recidivist sex offenders, it is seems unlikely that chemical castration will disappear from the Canadian legal landscape. Accordingly, judges should be mindful of the problems associated with it and avoid being swayed by impressively-credentialed witnesses and evocative language when they make decisions concerning whether chronically recidivist sex offenders should be eligible for conditional release.