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EUROPEAN COMMITTEE ON CRIME PROBLEMS
(CDPC)

EXISTING COUNCIL OF EUROPE INSTRUMENTS AND ACTIVITIES PERTAINING TO QUASI-COMPULSORY MEASURES (QCM)

Discussion paper prepared by the CDPC Secretariat
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During its 62nd Plenary Session (29 May – 1 June 2012), the European Committee on Crime Problems (CDPC) requested the Secretariat to prepare an overview of existing Council of Europe instruments and activities pertaining to quasi-compulsory measures (QCM). This decision followed the presentation of a document prepared by the Belgian delegation proposing this subject for possible future examination by the CDPC.

This report provides an overview of such measures including activities of the Council of Europe (CoE). An explanation will first be given regarding the distinction made between quasi-compulsory measures addressing drug offenders and those addressing sex offenders (I). A section is also dedicated to the ethical concerns regarding quasi-compulsory measures (II) in order to give an insight into these measures' real efficiency (III). Finally, the work carried out by the CoE and other international organisations will be discussed (IV) before a final conclusion (V).

I. QUASI-COMPULSORY MEASURES

A quasi-compulsory measure is mostly a particular alternative to imprisonment. It refers to the choice that is given to an offender to either undergo a treatment or face a penal sanction for crimes for which he or she has been (or may be) convicted.[1] Essentially, these measures may apply to two main types of offenders: on the one hand, drug offenders and, on the other hand, sex offenders.

In broad terms, a settlement (plea agreement), an instance of plea bargaining, an accepted probation measure to avoid imprisonment, accepting a voluntary search are all quasi-compulsory measures and require a framework of protective measures. In countries where the "opportunity principle" exists, the possibility can also be to accept a treatment in exchange for closing the case.

This raises obvious and unavoidable questions including: What if it appears that the context has changed? What if the offender has miscalculated by underestimation the accepted charge? Are there mandatory rules to reconsider the "agreement"?

1. Drug offenders

As far as drug offenders are concerned, it is important to highlight that quasi-compulsory treatment is generally used for a particular group: drug dependent offenders. This group is made up of dependent drug users who have committed crimes, other than drug possession, that would engender penal sanctions.[2] Consequently, it excludes non-problematic drug users and dependent drug users who have not committed any other crime than drug possession. The use of QCM for drug offenders is clearly restricted to minor offences and excludes serious crimes.

In the case of drug dependent offenders, the treatment is regarded as more effective than a prison sentence. The most important aim should be to treat the addiction. In other words, the offences committed by this group of offenders are related to their drug use

[1] The ethics and effectiveness of coerced treatment of drug users, Alex Stevens, PhD, Professor in Criminal Justice, University of Kent, September 2011.
[2] The ethics and effectiveness of coerced treatment of drug users, Alex Stevens, PhD, Professor in Criminal Justice, University of Kent, September 2011.

directly. Therefore, a prison sentence would not have a deterring effect on them since the vital need is to deal with the origin of the problem which is the addiction itself.

There are two types of coercive treatment. The first occurs when people who use drugs are ordered into treatment with no opportunity to provide informed consent to such treatment. This is called compulsory treatment. The second type occurs when drug users are given a choice of having treatment or facing a penal sanction that is justified on the basis of the crimes for which they have been (or may be) convicted. This is called quasi-compulsory treatment (QCT)"[3]. According to the Belgian paper presented at the CDPC, "a slight difference exists between both notions". Furthermore "the wording 'quasi-compulsory measures' is often used as a hybrid concept which lies between voluntary and compulsory treatment"[4].

According to UNODC's discussion paper (2009) 'Treatment as an alternative to criminal justice sanctions is specifically encouraged in the international drug control conventions and it has been found to be more effective than imprisonment in encouraging recovery from drug dependence and reducing drug related crime. It can be provided in ways that do not violate the rights of the patients, provided that the decision to refuse treatment remains in the hands of the drug user and the patient's autonomy and human rights are respected.'[5]

2. Sex offenders

In the case of sex offenders, the treatment is often compulsory or is used in addition to imprisonment. Since the offence committed is obviously more serious with strong potential consequences for the victims, giving perpetrators of such crimes a choice between treatment and imprisonment might reduce the deterring effect of punishment for these crimes and might also victimise the victims once more as they might feel that "justice has not been done". It is true that the effectiveness of the measure could rapidly be questioned.

One of the methods often used to deal with high risk sex offenders is chemical castration. Chemical castration is "the use of drugs to reduce libido".[6] For instance in November 2009, in response to a high number of sex offences committed against children, Poland amended its Criminal Code and introduced legal ground allowing courts to apply pharmacological treatment or psychotherapy to sex offenders in order to prevent the society from reoffending (Article 95a of the Criminal Code).

In 2009, a pilot scheme was launched in the United Kingdom at HMP Whatton which, by using drugs 'intervention', aims to reduce the sex drive of sex offenders in a bid to cut offending. This scheme includes chemical castration but mostly involves anti-

[3] Human Rights and Drugs, Volume 2, No. 1, The ethics and effectiveness of coerced treatment of people who use drugs, Alex Stevens, PhD, 2012
[4] European Committee on Crime Problems (CDPC), Alternative measures to imprisonment, Explicative paper by Belgium
[5] United Nations Office on Drugs and Crime (UNODC) 'From coercion to cohesion: Treating drug dependence
through health care, not punishment – Discussion Paper (2009)
[6] Chemical castration, Collins English dictionary, online

depressants. The prisoners are all volunteers and the initial evaluation appears to show that the scheme is working.[7]

There is also another type of castration, in this case irreversible, the surgical method, which is done, with the offender's consent, in the Czech Republic and in Germany. German law provides extremely strict requirements for the permissibility of surgical castration. In particular, adequate and comprehensive information must be provided to the person concerned previous to the required voluntary consent and milder measures than surgical castration must first be considered. A group of experts has to examine and confirm conformity with the legal requirements. In fact, surgical castration is performed only in very few exceptional cases in Germany. As in Germany, in the Czech Republic also several requirements have to be met, namely: adequate and comprehensive information provided to the offender. Surgical castration is proposed and considered if the offender requests it himself and only if other measures are non-applicable (e.g. state of health prevents use of chemical castration), the offender's consent is given and after an examination and a recommendation by a group of experts.

There is currently much debate between the European states about this invasive option of castration. Indeed, some consider surgical castration as being a treatment and not a punishment but most countries believe the contrary. In addition, several specialists have taken part in this debate. For example, the psychologist W.L. Baker considers that "the key question for practitioners to ask is whether the treatment exceeds the cure. As surgical castration prevents all sexual activity, it can only be classified as punishment and never treatment"[8].

In conclusion, although most European states seem to be against the use of surgical castration, we can observe that over the years more and more of them have passed legislation which allows for chemical castration of sex offenders. The most recent example is Moldova, in March 2012. The Parliament of Estonia adopted in January 2011 new amendments to different relevant laws that enable to partially replace imprisonment with combined treatment for sex offenders. Combined treatment includes: (1) psychiatric help (therapy sessions etc) and (2) when needed, pharmacotherapy (so-called chemical castration; if needed antidepressants etc). According to the new law, if a court imposes a prison term from 6 months up to two years and the offender is at least 18 years old (so the combined treatment is only for adult sex offenders), the court with informed written consent of the convicted offender, may partially substitute imprisonment by combined treatment for sex offenders. The term of the combined treatment for sex offenders is from 18 months to 3 years, so it can exceed the term of sentenced imprisonment. The new law will enter into force on 1 June 2013.

II. ETHICAL CONCERNS REGARDING QUASI-COMPULSORY MEASURES

1. Quasi-compulsory measures and human rights

[7] http://www.bbc.co.uk/news/uk-18402203

[8] Legal and Ethical issues when using Antiandrogenic Parmacotherapy with Sex Offenders, Karen Harrison, PhD, University of the West of England – Bristol, 2008

With regard to the European Convention on Human Rights (ECHR), there does not appear to be any case law which directly concerns the issue of quasi-compulsory measures. However in the *Toomey v the United Kingdom*[9] case, which was declared inadmissible for, *inter alia*, time-limit reasons, the ECHR did recognise that a Penile Polygraph (PPG) test was used and that this raises complex issues of fact and law under Article 3 the Convention. Moreover, in this case, the applicant claimed that his consideration for parole was conditional on his participation in the PPG tests. At the same time he also argued that the use of this text amounted to cruel, inhuman and degrading treatment.

Additionally in the case *Bizzoto v. Greece*[10] the ECHR recognised "the humanitarian nature" of the provisions of Greek Law nº 1729 which provides a support programme to habitual users of drugs. Also in the case of *Gardel v. France*[11] the ECHR stipulates that the sex offenders' register is designed to prevent persons who have committed sexual offences or violent crimes from reoffending as it serves a "preventive and deterrent purpose". Furthermore, the ECHR stipulates that it is unnecessary to have the authorisation of the sex offender to be included on the register as it is a public order measure.

Nevertheless it is important that the use of QCM should be in accordance with Article 3, Article 5 and Article 6 of the Convention. Furthermore, the treatment must not be inhuman or degrading and must avoid the infliction of harm on the person being treated. The right to liberty can be restricted both when in prison or undergoing treatment and in order to avoid a violation of Article 5 of the ECHR, this deprivation of liberty must be the least restrictive from the point of view of the objectives of treatment (*not* the objectives of punishment) and the period of any judicial order to remain in treatment should be limited, be subject to review and be of a duration which is not longer than the usual punishment for the offence.

Regarding the right to fair trial, ethical concerns arise. The informed consent by the offender must be guaranteed and no arbitrary detention should be executed. Moreover, the presumption of innocence should not be violated. Offering a QCM at the pre-trial stage could be a violation of this principle unless the evidence is irrefutable that the person has committed the offence, i.e. when there is a confession or when he or she was caught in the act without a contradiction of the evidence. Furthermore, the person should not be punished for failing in the treatment.

2. Issues concerning the use of quasi-compulsory treatment

The most ethical concerns relate to the treatment of sex offenders.

One of the main ethical issues concerning quasi-compulsory treatment is the importance of the negative side effects. These side effects include fatigue, hypersomnia, lethargy, depression, and a decrease in body hair, an increase in scalp hair and weight gain.[12]

[9] Toomey v. the United Kingdom (1998), Application no. 37231/97
[10] Bizzoto v. Greece (1996), Application no. 22126/93
[11] Gardel v. France (2010), Application no. 16428/05
[12] Legal and Ethical issues when using Antiandrogenic Pharmacotherapy with Sex Offenders, Karen Harrison, Sexual Offender Treatment, Volume 3 (2008), Issue 2.

Avoidance of the infliction of harm on the person being treated has been guaranteed in all codes of medical ethics since the Hippocratic oath.

Furthermore the concept of proportionality in sentencing should be taken into account. Classically, proportionality has been taken to mean that the harm caused by the punishment must be no greater than the harm that the offender has caused to other people. This principle is not yet included in UN instruments, but it is included in the European Charter of Fundamental Rights, Article 49, 3 of which states that '[t]he severity of penalties must not be disproportionate to the criminal offence'.

Another ethical concern relates to the availability of treatments: the question of knowing whether pharmacotherapy, in other words treatment through the administration of drugs, should be available to all those who need or request it or only available to those who have been convicted of a sexual offence.

The author J.M. Money (1979) argues that medical treatment of this type should be available for all. Indeed, it could be used to prevent offences. Someone who has sexually deviant thoughts should be allowed to undertake such a programme.

A 1986 World Health Organization consensus view was that legally coerced drug treatment (Porter, Arif, & Curran, 1986) was legally and ethically justified if: (1) the rights of the individuals were protected by "due process", and (2) if effective and humane treatment was provided.[13]

III. EFFICIENCY OF QUASI-COMPULSORY TREATMENTS

1. Efficient treatment

a. Quasi-compulsory treatments are more likely to work because the offenders are given a choice

People who want to do something are more likely to achieve it than people who are forced to do it. Bearing this in mind, offenders could be advised on the best way to achieve their own goals instead of being reminded on the potential threat of negative consequences that will occur if they do not change[14]. Most of the time, quasi-compulsory treatments are accepted by the offender because they include a lot of advantages:

- those who agree to the treatment as an alternative to incarceration can stay with their family and have more liberty than in prison;
- those who agree to change their behaviour are more motivated to do so of their own accord than when they are forced to do so. Alternatively they may be encouraged to do so by their families, which is a more effective motivator than legal coercion.

Only serious drug dependent offenders who are aware of their problems and who consent to treatment are more likely to succeed because they are highly motivated than

[13] CRIME AND JUSTICE Bulletin No. 144, September 2010, NSW Bureau of Crime Statistics and Research: Legally coerced treatment for drug using offenders: ethical and policy issues by Wayne Hall and Jayne Lucke

[14] Prevention for recidivism : the French delay, "Good Lives Model" : cutting-edge of the condemned monitoring, Sarah Dindo and Barbara Liaras

those who do not acknowledge their drug-related deviant behaviour. Indeed, the 'hitting rock bottom' theory presumes that people who have the more serious drug problems are more likely to have other severe personal problems and thus seek help and change their drug or alcohol behaviour.

However it should be borne in mind that all voluntary or quasi-compulsory treatments can be said to have some elements of pressure or persuasion such as informal social pressure or threat of negative consequences from family and friends. At the same time this may be another reason why quasi-compulsory treatments are more likely to work.

b) Low costs which enable a higher efficiency

Treatment is generally cheaper than incarceration. For example, a study of the Maryland State Commission on Criminal Justice Sentencing shows that Maryland's use of alternative sanctions has reduced the annual cost of housing an offender, from 20 000$ to 4 000$.[15]

c) Convincing results

The rate of recidivism for sexual offenders is very high: 18.9%[16] which can lead us to think that it is quite important that offenders undertake treatment in order to make sure that our streets are safe.

Another reason for supporting the use of quasi-compulsory treatments may be found in the comments of those who have undertaken such programmes: "I realised walk down the streets, see boys I found sexually attractive, and not be possessed by thoughts about having sex with them … It took that edge off" (Russel, 1997: 431)[17]

2. The efficiency of compulsory treatments can be severely questioned

There are many reasons why compulsory treatment cannot be efficient.

Firstly, these treatments do not require the consent of the offender. Thus because they do not pre-suppose the will of the offender, their efficacy can be disputed. For example, in Australia, the police may make an offer of release to drug dependent offenders where the bail conditions include an obligation to attend a treatment programme.[18] In this case, the treatment would be obligatory and therefore less efficient. In the same way, California employs pharmacotherapy as a condition of parole release and this is obligatory for all sexual offenders where the victim is under 12.

Secondly, there are problems concerning the way of administrating the treatment to the sexual offenders. If the treatment involves taking pills, then the offender can fail to take

[15] Treatment or Incarceration? National and State Findings on the Efficacy and cost savings of Drugs Treatment versus Imprisonment by Doug McVay, Vincent Schiraldi and Jason Ziedenberg, January 2004.
[16] About Recidivism, A meta-analysis, by Frans Gieles.
[17] Legal and Ethical issues when using Antiandrogenic Pharmacotherapy with Sex Offenders, Karen Harrison, Sexual Offender Treatment, Volume 3 (2008), Issue 2.
[18] Mandatory Treatment and perception of treatment effectiveness, Crime and Misconduct Commission, Research and Issues.

them. Even if the treatment is administrated through injections, the effects can be counteracted by obtaining testosterone illegally.

Thirdly, even if the offender has consented to the treatment, one can still question whether the offender is not just simply consenting to the lesser evil. Moreover, the motivation of the offender can be questioned because he could be motivated by self-hate or desire to punish himself/herself[19]

IV. WORK CARRIED OUT BY THE COUNCIL OF EUROPE AND INTERNATIONAL ORGANISATIONS IN THIS AREA

1. Activities of the Council of Europe

The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) has mentioned compulsory treatment in several of its country reports.

From 2007 to 2010 the Pompidou group was active in the field of quasi-compulsory treatment and other alternative measures to imprisonment, with different activities and meetings of the Criminal Justice Platform (PGCJP). The PGCJP, in close co-operation with European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), developed guidelines[20] on the application of quasi coerced treatments on drug-dependent offenders (P-PG-CJ (2007) 21).

The activities of the Platform not only included the preparation of a survey on the quasi-compulsory treatments of drug-dependent offenders and the setting up of an open-ended working party on a quasi-compulsory treatment communication strategy (P-PG-CJ (2008) 15), but also the publication of an overview of national experiences with quasi-coerced treatments of drug-dependent offenders (P-PG-CJ (2010) 3). Furthermore, a Conference on quasi-coerced treatment and other alternatives to imprisonment was organised in Bucarest on 11-12 October 2007 and a thematic meeting on monitoring and evaluating national experience with quasi-coerced treatment took place in Strasbourg on 27 May 2010.

Recently this issue was also raised in the context of the Parliamentary Assembly of the CoE with a motion for a resolution (Doc. 12659) presented by Mr Gardetto and others on 22 June 2011. Emphasis was put on the use of alternatives to custodial sentences in this regard in order to address the legitimate security concerns of society and promote the rehabilitation of the offender. There has not (yet) been a follow-up of this motion.

2. Work of other International Organisations

Alternative measures to imprisonment, have been developed over the years by other international organisations. Article 36, 1(b) of the United Nations Single Convention on

[19] Legal and Ethical issues when using Antiandrogenic Pharmacotherapy with Sex Offenders, Karen Harrison, Sexual Offender Treatment, Volume 3 (2008), Issue 2.

[20] Guidelines on the 'quasi-compulsory' treatment of adult drug-dependent offenders, results from a survey of Council of Europe Member States, Tim McSweeney, Institute for Criminal Policy Research, School of Law, King's College London, United Kingdom, December 2008.

Narcotic Drugs of 1961 refers to the possible use of alternatives to conviction or punishment, such as measures of treatment, education, after-care, rehabilitation and social integration. The Office on Drugs and Crime of the United Nations (UNODC) published a report on custodial and non-custodial measures - alternatives to incarceration (2006) and a discussion paper entitled 'from coercion to cohesion: Treating drug dependence through health care, not punishment' in 2009.

Furthermore, the United Nations distributed a Handbook of basic principles and promising practices on Alternatives to Imprisonment[21] (2007) in order to support countries in the implementation of the rule of law and the development of criminal justice reform. The handbook provides information about alternatives to imprisonment at every stage of the criminal justice process; important considerations for the implementation of alternatives, including what various actors must do to ensure its success; and examples of systems that have reduced imprisonment. No specific mention is made of quasi-compulsory measures.

In this field the work of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) of the European Union should be mentioned. Objective 13 of the EU Action Plan (2005-2008) foresees further development of alternatives to imprisonment for drug abusers and drug services.[22] Along with this, multiple comparative studies have been carried out by the EMCDDA to map the different legal systems of EU Member States in this regard.

The National Institute on Drug Abuse (NIDA) produced a paper entitled Drug Facts: Treatment for Drug Abusers in the Criminal Justice System in 2006. Here it discusses how drug abuse treatment can be incorporated into the criminal justice system. This may include treatment as a condition of probation, drug courts that blend judicial monitoring and sanctions with treatment, treatment in prison followed by community-based treatment after discharge, and treatment under parole or probation supervision. Once again no specific mention is made of quasi-compulsory treatment or measures.

V. CONCLUSIONS

It may be concluded that despite scarce data and research regarding the efficiency of the quasi-compulsory measures, as well as the ethical issues which arise in relation to their use and more specifically regarding consent, they remain a plausible alternative to imprisonment.

Treating certain groups of offenders and dealing with the causes of their addiction problems is a more efficient way of reducing recidivism than prison. It should nevertheless be noted that while for some types of offenders quasi-compulsory treatment is successfully used in prison which provides a controlled setting allowing better screening, supervision and maintenance of the treatment, for the majority treatment will be successfully used in the community. Whatever the setting for quasi-compulsory treatment, informed consent needs to be sought as far as possible and ethical issues need to be addressed as the motivation for undergoing such treatment plays an important role in its success in the long run. Another important issue is the need

[21] From the Criminal Justice Handbook Series, United Nations, New York, 2007.
[22] EMCDDA, 2005, Belgium, Alternatives to imprisonment – targeting offending problem drug users in the EU.

to ensure continuity of treatment after release from prison for those offenders who have started quasi-compulsory treatment while in detention. The question of introduction of such a treatment at the pre-trial stage of the criminal proceedings needs to be carefully regulated by law especially regarding issues related to the presumption of innocence and to whether or not there should be negative consequences from dropping out of such treatment.

Other issues to be borne in mind are professional secrecy and how to deal with this in the context of quasi-compulsory treatment. Also the ways in which the treatment is administered and whether any kinds of treatment should be excluded should also be considered.