PERFORMANCE UNDER PRESSURE: THE IMPACT OF COERCIVE AUTHORITY UPON CONSENT TO TREATMENT FOR SEX OFFENDERS

by

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B.Sc./LL.B. (Hons), The University of Western Australia, 1994

A THESIS SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF

MASTER OF LAWS

in

THE FACULTY OF GRADUATE STUDIES

(Faculty of Law)

We accept this thesis as conforming to the required standard

THE UNIVERSITY OF BRITISH COLUMBIA

September 1998

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Date  December 1, 1998

DE-6 (2/88)
ABSTRACT

This thesis is concerned with the correctional treatment process for sex offenders, and the problems that criminal justice system authority poses for treatment settings. A particular focus is whether inmate participation in treatment programs is voluntary or coerced, given the link between programs and prospects of release.

In examining this question, the author considers the results of an empirical project in which a group of inmates were interviewed about their perceptions of the correctional treatment process. Background to this project includes discussion of the doctrine of informed consent and respect for autonomy as its underlying rationale, discussion of the concepts of coercion and voluntariness, and examination of the development of rehabilitative ideals. A conclusion drawn from the discussion is that the presence of coercive authority may impact adversely upon correctional treatment efforts. Coercive authority creates difficulties in relation to the voluntariness of inmates' consent, the confidentiality of the treatment relationship, and the professional autonomy of the clinician. These problems in turn raise questions as to whether correctional programs retain the character of treatment, or are more properly considered as part of punishment, or as tools of social control. However, coercive authority is a necessary presence if correctional services are to work towards the goal of protection of society.
The central question to be addressed therefore is whether the prospects of release can be used to motivate inmates for treatment in a way that is consistent with the requirement of voluntary consent to treatment. The results of the empirical project suggest that for the majority of inmates, the link between treatment and release is not coercive. However, a number of inmates did indicate they felt coerced into treatment programs. Reforms may thus be necessary to avoid coercive authority resulting in coerced treatment. In discussing these results, the author considers a number of directions for reform, including the introduction of an operational presumption of coerced referrals to treatment, which would place greater emphasis on clinicians' obligations to secure voluntary consent.
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First and foremost, I would like to thank Professor Isabel Grant and Dr. James Ogloff, who have been very supportive in supervising my work. Without their guidance, this project would not have been possible. I would also like to thank the inmates and staff of both Mountain Institution and the Regional Health Centre (Pacific) for their insight and co-operation. Finally, thanks to the staff and fellow students involved in the Graduate Program at the Faculty of Law, University of British Columbia, who provided support throughout the year.
1. Introduction

1.1 Background

The range of complex issues encountered at the interface of criminal justice and health systems is exemplified within correctional services. If a particular crime is perceived as being related to a mental health problem, an offender's involvement with the criminal justice system may be seen as an opportunity for treatment, either instead of or as part of punishment. In many jurisdictions, court referrals to treatment have become a common way of dealing with offenders perceived to have a problem with alcohol or illicit drugs.\(^1\) The presence of the criminal justice system's coercive authority creates potential conflicts for clinicians operating in such a treatment setting.\(^2\) In particular, there may be questions regarding the ability to obtain a client's voluntary, informed consent to the treatment concerned, the confidentiality of the clinician-client relationship, and the professional autonomy of the clinician. The developing field of treatment for incarcerated sex offenders brings these ethical and legal dilemmas into focus, in the context of the ongoing tension between enhancing community safety and preserving individual liberties.

The general public views sex offenders with particular repugnance. A growing awareness of the social impact of sexual offending has lead to an increase in the reporting of such

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\(^1\) Particularly for repeat drink driving offenders, and drug or property offenders with an illicit drug habit; see e.g. W. Hall, "The role of legal coercion in the treatment of offenders with alcohol and heroin problems" (1997) 30 A.N.Z. J. of Crim. 103.

offences in the last decade.\(^3\) As a result, greater numbers of sex offenders have entered the criminal justice system and the assessment, treatment and management of sex offenders has become a major component of correctional services. Estimates of the proportion of sex offenders within the federally incarcerated population in Canada were at 10 per cent in 1987,\(^4\) and 24 per cent in 1996.\(^5\) Correspondingly, the number of places available within sex offender treatment programs offered by the Correctional Service of Canada (CSC) has increased from under 200 per year in 1987 to over 1700 per year in 1995.\(^6\) Over this period, treatment models and program content have continued to develop and be refined. It is against this background that this thesis will explore the proper limits upon the use of coercion in the therapeutic treatment of sex offenders.

1.2 Thesis statement

This thesis will consider the impact of the correctional setting upon the treatment aims and ethics of psychological therapy for offenders. “Psychological therapy” here is used to describe the contemporary treatment approach in sex offender programs: a mixture of cognitive behavioural and psychotherapeutic (also called psychodynamic) methods, used to address both “criminogenic risk factors” and psychological issues relating to behaviour surrounding sex offending. Except where otherwise expressly provided, the terms

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\(^6\) Blanchette, *supra* note 3, at 35.
“treatment” and “correctional treatment” will be referred to in this sense. The terms “inmate” and “client” will be used interchangeably to refer to treatment subjects as appropriate. The male pronoun will be used to refer to treatment subjects, reflecting the fact that the vast majority of sex offenders, and all of those interviewed for this thesis, are male.  

The aim of this thesis is to contribute to the wider debate about the potential for and the appropriateness of therapeutic environments within correctional settings. The discussion is focused upon the role coercive authority plays in the correctional treatment process and the relationship between coercion and voluntariness, and between punishment and treatment.

I will argue that reforms are required to ensure that the use of coercive authority is limited to the role of facilitating treatment that is ultimately attended on a voluntary basis. That is, while it is acceptable for coercive authority to be used to secure initial attendance at a treatment setting, it is not acceptable to deny an inmate the right to refuse any treatment offered. Coercive authority must not be so pervasive as to impact adversely upon the integrity of treatment efforts, or to work against values central to treatment aims, in particular self-determination and inviolability. I will also make recommendations as to the reforms necessary to provide practical limits on coercion and greater protection of these values and rights.

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7 99.7 per cent of sex offenders under CSC jurisdiction were male, as at the end of 1995; see Motiuk & Belcourt, supra note 5, at 4.
1.2.1 Empirical component of the thesis

In examining the question of whether the presence of coercion in the correctional treatment process effectively denies inmates a right to refuse treatment, there is a need to define both what is meant by "coercion" and how its presence is to be determined. In the mental health field, there has been growing recognition of the relevance of clients' perceptions of treatment processes to discussions of coercion. In particular, it has been noted that even where treatment is predicated upon the use of coercive authority, it may be implemented without a significant perception of coercion by the client. It is suggested, in turn, that lower levels of perceived coercion can assist treatment effectiveness, improving the working relationship between clinician and client, and increasing the likelihood that clients will adhere to treatment regimens. Thus, how and in what circumstances potentially coercive treatment processes are perceived to be coercive by the client has become an area of research interest.

Part of this thesis is, therefore, an empirical project comprised of interviews with inmates about subjective experiences of coercion in being referred to and participating in sex offender treatment programs offered by CSC. A particular focus of the discussion is upon

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9 "Impact of Coercion", Ibid., at 318; see also Hiday et al., Ibid., at 238
the interplay between CSC's policy of "active encouragement" of inmates to participate in treatment programs and its obligations to secure voluntary consent to treatment. Whether the presence of coercive authority is considered to be actually coercive in effect is a matter of how the term "coercion" is defined. By its very nature, it is not possible to measure coercion, other than by direct observation, or available accounts of the treatment process. It has been shown that although there are inevitably some discrepancies, clients' accounts of coercion in treatment processes are at least as reliable as both clinicians' accounts and written records. With these limits in mind, the empirical project in this thesis measures levels of perceived coercion amongst a sample of inmates to reflect upon the question of whether the potentially coercive correctional treatment process is actually coercive in effect. The results of this project will be used to illuminate some of the arguments outlined above.

1.2.2 Thesis structure

The final section of this introductory chapter will briefly outline the problem to be addressed, namely the potential for conflict between the mandate of correctional services to offer treatment programs to inmates, and the obligations to preserve clinical ethics in a coercive environment. Having set the context, the second chapter will provide a more detailed background as to the issues raised. The doctrine of informed consent will be briefly outlined, to put the present legal and ethical obligations with respect to treatment

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relationships in correctional settings into context. Emphasis will be placed upon the underlying rationale, “respect for autonomy”, as one of the definitive principles of treatment settings. The meaning of “autonomy”, and of other terms integral to this thesis, such as “voluntariness” and “coercion” will also be examined.

An argument will then be developed that the role of coercion in correctional treatment settings must be limited to facilitating treatment on a voluntary basis. I will argue that, despite their imprisonment, inmates retain significant rights regarding treatment, regardless of the seriousness of the offence committed or the risk to society they present. It will be acknowledged that any right of inmates to autonomy with respect to treatment decisions must be balanced against the interest society has in reducing reoffending. The role of programming in addressing this broader social interest will be considered in the context of the ongoing tension between the punitive and rehabilitative aims of corrections.

I will argue that, despite lingering questions over the efficacy of rehabilitative efforts, the treatment and rehabilitation of offenders remain legitimate goals of the correctional system. The development of the rehabilitative ideal will be reviewed to highlight the dilemmas created by the ill-defined boundaries between punishment and treatment. The role of punishment and treatment in working towards correctional aims will be considered, along with evidence of treatment effectiveness. Such evidence is crucial to the legitimacy of treatment as a correctional goal. Without some evidence to suggest correctional programs can be effective in meeting their aims, they cannot be considered truly to be treatment measures, and the argument as to the role of coercion breaks
down. It will be concluded that if correctional programs are to pursue treatment aims, they must be clearly separated and distinguished from the punitive aspects of corrections. Failure to maintain clear boundaries detracts from treatment efforts to the point where programs may become little more than mechanisms of social control.

Although effective social control may meet the interests of society in reducing reoffending, it fails to give sufficient weight to inmate autonomy. Inherent in social control aims is the suggestion that the right of inmates to refuse treatment is not relevant, and this poses a threat to the value of individual autonomy in a wider social sense. A further conclusion to be drawn, therefore, is that while the interests of society and the unique circumstances of imprisonment may justify the use of correctional authority to refer inmates to treatment, they do not justify coercing treatment. This limited role for the use of coercion is an appropriate balance between the interests of society and the rights of inmates. In sum, if rehabilitation is to be pursued as ethically and humanely as possible, treatment must proceed on a voluntary basis, as well as being separated from the punitive aspects of corrections.

The third chapter will consider the implications of these conclusions in the context of CSC treatment practices and relevant law. The results of the empirical project will be used to consider the question of whether current CSC practices result in coerced treatment, and whether there are any particular factors that may be associated with inmate perceptions of coercion (such as age, or length of time served). This discussion will be used to reflect upon issues raised by the argument developed in the second chapter, and to consider what
reforms are necessary if correctional law and practice is to adhere to the position argued.

1.3 The correctional context

CSC is an administrative arm of the Canadian federal government that operates in co-operation with and as part of the criminal justice system. Its primary task as a correctional body is to administer sentences imposed upon offenders by the court system, with the ultimate aim of reintegrating offenders into the community. The role of CSC cannot be properly considered in isolation from the other components of the criminal justice system, particularly because CSC is not directly in control of the flow of inmates through its institutions.

At one end of the process, the courts pass sentences directing offenders into correctional institutions, and at the other the National Parole Board (NPB) makes decisions as to the release of inmates in the course of a sentence. Although CSC retains responsibility for monitoring and supervising offenders on conditional release until the end of their sentence (referred to as the “warrant expiry date”), the focus in this thesis is upon time spent by inmates in correctional institutions and CSC’s role in decisions regarding the release of inmates.

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11 For an overview of CSC’s structure and organisation, see J.W. Ekstedt & M.A. Jackson, The Keepers and the Kept (Scarborough: ITP Nelson, 1996) at 2-23; see also the policies and principles guiding CSC as outlined in Correctional Service of Canada, Mission of the Correctional Service of Canada, 3rd ed. (Ottawa: Supply & Services Canada, 1991) [hereinafter “Mission”]; Note that there is a split in correctional jurisdiction in Canada, with provincial governments responsible for all offenders serving sentences of less than two years. Those sex offenders serving less than two years fall outside of CSC’s jurisdiction, and therefore outside of the scope of this study.
12 See the Corrections and Conditional Release Act, S.C. 1992, c. 20, s. 3.
It is important to emphasise that release decisions are not made by CSC itself, but by an independent government agency, the NPB. There is some degree of co-operation, with "case management" information provided by CSC staff to assist the NPB in its decision making. Of particular relevance to the consideration of correctional treatment relationships is the extent to which information arising in the course of treatment should be disclosed by treatment providers to CSC case management and to the NPB.

As an issue related to the impact of coercion in correctional treatment, it will be argued in this thesis that the nature of treatment is such that the relationship between inmates and treatment providers should be afforded a similar degree of confidentiality as would be found in the community. However, before considering the specific concerns raised by correctional treatment relationships, there is a need to briefly outline correctional aims and the process of correctional treatment.

1.3.1 Correctional aims

If sentencing is to be directed at prevention of future offending, it must serve a wider social purpose than simply the disposition of the offender at hand. For this reason,

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13 See J.W. Ekstedt & C.T. Griffiths, Corrections in Canada, 2nd ed. (Toronto: Butterworths, 1988) at 287; see also the discussion of the case management process under Chapter 2, section 2.3.1, below.
14 That is, the main exception to confidentiality being immediate threats to a person's safety; this "duty to warn" is discussed in Tarasoff v. Regents of University of California, 551 P. (2d) 334 (Sup. Ct. of Cal. 1976); see T.E. Gammon & J.K. Hulston, "The Duty of Mental Health Care Providers to Restrain Their Patients Or Warn Third Parties" (1995) Mo. L. Rev. 749. See the discussion of this issue in more detail below under Chapter 2, section 2.3, and Chapter 3, section 3.6.
administration of sentences by correctional services is a matter of public policy. Given that contemporary correctional practice and the administration of punishments are informed by a range of theoretical bases, discerning an agreed upon purpose is not an easy task. Because corrections is a part of the criminal justice system, the law of sentencing, and the underlying philosophies of punishment define its purposes. The field of criminology has also added considerably to the debate over the roles of punishment, incarceration, and correctional programming in terms of achieving socially desirable goals. The discussion of corrections in this thesis is centred upon the federal correctional service in Canada, as a means of providing a focus to the issues raised, and to relate them to the empirical project conducted. The principles discussed should however be considered as readily applicable to correctional systems in other jurisdictions.

In Canada, CSC has articulated the objectives and policies of federal corrections in the form of a “mission statement”\(^\text{15}\) The purposes of the correctional system and its guiding principles are also enunciated in governing legislation, specifically the *Corrections and Conditional Release Act*.\(^\text{16}\) The paramount consideration in the correctional process is stated to be “the protection of society”. CSC perceives itself as contributing to this goal through “actively encouraging and assisting offenders to become law abiding citizens while exercising reasonable, safe, secure and humane control”.\(^\text{17}\) This statement reflects the dual strategies of corrections: incapacitation and reformation. Since the establishment

\(^{15}\) See *Mission*, supra note 11.

\(^{16}\) *Supra* note 12 [hereinafter “the Act”].

\(^{17}\) See *Mission*, supra note 11 at 4.
of correctional institutions, a large body of empirical research, theoretical models and program evaluation has been built around attempts to provide treatment that will effectively prevent reoffending.\textsuperscript{18} However, while it is evident that imprisonment can maintain the goal of offender incapacitation, the idea that treatment in custody can successfully reform offenders has remained a controversial aspect of corrections.

\subsection*{1.3.2 Legal and procedural aspects of correctional treatment}

The Act provides that one of the purposes of the correctional system is to assist the rehabilitation and reintegration of offenders into the community “through the provision of programs” and, to this end, places an obligation upon CSC to “provide a range of programs designed to address the needs of offenders”.\textsuperscript{19} There is an “expectation” upon inmates to “actively participate in programs”.\textsuperscript{20} Despite this suggestion of an obligation, the Act unequivocally provides that inmates retain a right to refuse any treatment that may be offered, and obliges CSC to ensure that participation in treatment is on a “voluntary” basis.\textsuperscript{21} These provisions clearly prohibit the coercing of inmates into treatment programs. However, CSC practices in referring inmates to programs raise questions as to whether a


\textsuperscript{19} See s. 3(b) and s. 76 of the Act, \textit{supra} note 12. This statement does not create an obligation to provide a specific program; see \textit{William Head Institution Inmate Committee v. Canada (CSC)} (1993), 24 C.R. (4th) 399 (F.C.T.D.). Under the previous legislative scheme, an obligation to provide “appropriate training programs” was interpreted as not providing an inmate with a right to rehabilitative programs; see \textit{Beaulieu v. Canada (Director of Leclerc Institution)} (1987) 4 W.C.B. (2d) 211 (F.C.T.D.).

\textsuperscript{20} See s. 4(i) of the Act, \textit{supra} note 12.

\textsuperscript{21} \textit{Ibid.}, s. 88.
meaningful right to refuse treatment exists.

In operational terms, the “active encouragement” of inmates to participate in treatment means that various pressures are placed upon inmates to enter programs. In particular, participation in treatment is linked to the prospects of release, or of transfer to a lower security institution. In such circumstances, it could be argued that there is sufficient psychological pressure upon inmates to bring into question the voluntariness of any consent to treatment given. Whether this approach to treatment in correctional settings presents legal, ethical or moral difficulties is the central concern in this thesis. The next chapter will consider the appropriate limits upon the use of coercive authority that are necessary to ensure the obligation to secure voluntary consent to treatment can be met.

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22 See Corrections and Conditional Release Act Regulations, SOR/92-620, reg. 102. The correctional treatment process is described in more detail below in Chapter 2, section 2.3.1.
2. Treatment and coercion

The purpose of this chapter is to establish a framework for analysing the proper role of coercive authority in correctional treatment. It will be argued that it is justifiable for correctional services to use coercive authority to achieve an inmate’s attendance at a treatment setting, but that, ultimately, the right of inmates to refuse treatment must be respected. As background, consideration will be given to the nature of informed consent generally and the meaning of concepts such as “autonomy”, “voluntariness”, “coercion” and “authority”. It will be concluded that the underlying rationale for informed consent, respect for autonomy, is a defining characteristic of treatment settings. That is, unless programs are implemented in a way that is consistent with restoring inmate autonomy, they cannot be considered to be truly treatment measures. These issues will then be considered in the context of correctional treatment.

The first step in this argument is to establish that, although incarceration necessarily entails some constraints upon inmates, it does not limit inmates’ right to refuse treatment. In the context of correctional settings, there is a need to balance this inmate autonomy against the interest of society in preventing further sex offending. In large part, it is this broad social interest that lies behind the push for correctional programming to address sex offending. Any consideration of the appropriate balance of these interests requires that treatment efforts be located in the broader context of corrections. Of particular concern here is the tension between administering punishment and working towards rehabilitation.
This chapter will therefore include a brief consideration of the history and development of the rehabilitative ideal. Discussion of the rehabilitative ideal will be used to illustrate the dilemmas and difficulties that may arise if the lines between treatment and punishment become blurred in the pursuit of rehabilitation. It will be argued that, in light of the evidence as to the lack of effect of imprisonment alone upon rates of reoffending, and evidence of the detrimental effects of incarceration, the role of imprisonment is best considered as a punishment deserved by the offender in return for the harms inflicted by his actions. Treatment, on the other hand, is characterised by an assessed need for treatment, an intention to act for the offender's benefit by reducing his risk of reoffending, and the existence of evidence that the treatment means can achieve this aim. As this last element, evidence of effectiveness, is essential to the legitimacy of treatment efforts aimed at rehabilitation, the literature on the effectiveness of sex offender treatment will be reviewed. I conclude that treatment and rehabilitation remain legitimate goals of correctional programming, and must be clearly separated and distinguished from the punitive aspects of corrections.

Returning to the issue of informed consent, the need to limit the use of coercive authority in the correctional treatment process will be considered in light of the conclusions drawn.

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23 While this characteristic corresponds with the correctional aim of protecting society, the emphasis in this thesis is that, in a treatment setting, the clinical focus is upon the individual. That is, acting for the benefit of an individual is a defining characteristic of treatment. Although there may be wider concerns in the correctional setting, to allow these to dominate to the point where the interests of the individual are ignored is to allow programs to lose the character of treatment. See supra notes 53 and 131 and accompanying text.
It will be argued that the appropriate balance between the interests of society and the rights of inmates is to allow coercive authority only to extend so far as referring inmates to treatment settings. Because the aim is to reintegrate offenders into the community at the end of the correctional treatment process, it is essential that programs accord with fundamental social values. The right to refuse treatment is a safeguard for one of the essential characteristics of treatment: that treatment is directed at restoring autonomy. To suggest that denying inmates a right to refuse treatment is justified by the interests of society in ensuring risks of reoffending are reduced is to allow the ends of social control to replace this characteristic of treatment. Ignoring the right to refuse treatment therefore blurs the line between treatment and punishment in correctional programs.

While social control may be a valid goal of correctional efforts, treatment programs are not an appropriate setting for this role. The suggestion that coerced participation of competent inmates in programs is treatment masks both an ulterior motive of maintaining public order and a lack of regard for inmates’ interests. Even if no active part is taken in coercing of inmates, by allowing treatment to be coerced clinicians effectively assume correctional power. In such circumstances, program facilitators would be engaging in social, moral and political decision making under the guise of clinical expertise. As well as masking social control as treatment, coerced participation in programs also has wider

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25 See R.V. Ericson, “Penal Psychiatry in Canada: The Method of our Madness” (1976) 26 U.T.L.J. 17 at 18. This criticism of programs even if we reject Ericson’s contention that treatment is ineffective in meeting therapeutic goals.
ramifications as a threat to the value of individual autonomy in society.

While there is a need to account for a public interest in correctional treatment, the practice of coercing participation in programs privileges this interest to the exclusion of the inmate’s interest in treatment. The notion that behavioural changes can be brought about without concern for inmate autonomy presents an attack on individual freedom and dignity in a wider sense. For these reasons, it is important that a meaningful right for inmates to refuse treatment be retained.

2.1 Treatment issues and the correctional setting

This section will consider the doctrine of informed consent and its underlying rationale, and explore the meaning of several of the terms integral to this thesis. In locating the role of informed consent in correctional treatment, it will be argued that the constraints upon autonomy that are a necessary function of imprisonment do not extend to denying inmates the right to refuse treatment. However, in working towards the goal of “protection of society”, correctional treatment processes manipulate the circumstances of imprisonment to create pressures for inmates to enter treatment and potentially deny inmates a meaningful right to refuse treatment.

2.1.1 Informed consent

As noted in the introductory chapter, the presence of coercive authority creates potential conflicts for clinicians operating in correctional treatment settings, particularly in relation to obtaining voluntary, informed consent to the treatment concerned. In order to discuss the implications of coercive authority in this regard, there is a need first to examine the doctrine of informed consent.

The term “informed consent” has both legal and ethical dimensions. As a legal doctrine, informed consent describes a set of rules that regulate the way in which clinicians interact with clients prior to providing treatment and allow redress for injury to the client in certain circumstances. The common law notion of consent as a

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27 See e.g. Weinberger, supra note 2.
prerequisite for medical treatment dates back at least to the mid 18th century.\textsuperscript{28} The doctrine requires that “a degree of explanation by the [clinician] about the anticipated treatment” precede the decision of the client to accept or refuse treatment, in order for consent to treatment to be valid.\textsuperscript{29} Rather than the rules governing liability in treatment relationships, it is the right to refuse treatment that is the focus in this thesis.

The right of refusal embedded in the law of informed consent protects clients’ interests. Such protection is required because clinicians are acting from a position of power, given their greater knowledge with respect to treatment matters and their potential authority over clients’ liberty. It is generally accepted that at common law all competent adults, outside of emergency settings or involuntary detention based on mental illness, have an absolute right to refuse treatment.\textsuperscript{30} This right of competent

\textsuperscript{28} Slater v. Baker (1767), 95 E.R. 860 (K.B.).

\textsuperscript{29} A. Meisel, “Expansion of Liability for Medical Accidents: from Negligence to Strict Liability by way of Informed Consent” (1977) 56 Neb. L. Rev. 51 at 75. For background on the development of the doctrines, see P.S. Applebaum, C.W. Lidz & A. Meisel, Informed Consent: Legal Theory and Clinical Practice (New York: Oxford University Press, 1987) [hereinafter “Informed Consent”] at 35-43; The development of “informed consent” as a legal doctrine in its own right was, in its origin, peculiar to the American common law, commencing in the mid 1950’s, and generally recognised as culminating in the 1972 decision Canterbury v. Spence, 464 F. (2d) 772 (D.C. Cir. 1972) [hereinafter “Canterbury”]; see also G. Robertson, “Informed Consent to Medical Treatment” (1981) 97 Law Q. Rev. 102. The doctrine has met with mixed reception and modification in various common law jurisdictions; Canterbury appeared to construe the doctrine as grounding actions in either battery or negligence (at 783, 793-794). The Supreme Court of Canada in Reibl v. Hughes, [1980] 2 S.C.R. 880 suggested abandoning the term informed consent where it confuses battery with negligence, recognising the action in negligence is founded upon the duty to disclose, but otherwise tacitly accepted the reasons in Canterbury; The High Court of Australia in Rogers v. Whitaker (1992), 175 C.L.R. 479 was similarly critical of the use of the term informed consent for discussing actions based on a duty to disclose; the House of Lords rejected the suggestion that English law should adopt the Canterbury doctrine in its decision in Sidaway v. Governor of Bethlem Royal Hospital, [1985] A.C. 871 at 894, 899, holding that the duty to disclose is to be construed as part of the duty to take reasonable care.

individuals to refuse treatment is afforded further protection under section 7 of the
*Canadian Charter of Rights and Freedoms*.31

The existence of a right to refuse treatment takes on enhanced significance in the
correctional setting, as the clients under consideration are in a captive setting, and
potentially more vulnerable to abuses of power. This function of informed consent,
protecting a vulnerable client group, is more closely related to the ethical aspects of
informed consent than are the rules governing liability. It is therefore of assistance
here to consider the ethical basis for the doctrine to understand its intended operation as
a legal rule.

As an ethical principle of clinical practice, informed consent is based upon the value of
autonomy (in the sense of both self-determination and inviolability).32 Respect for
autonomy provides protection for both bodily and physical integrity, and dictates that if
a client is competent, it should ultimately be his or her decision to accept or refuse
treatment. This ideal is borne out in the clinical process of obtaining informed consent
prior to treatment.

The guiding principles for decision making by clinicians are generally embodied in

31 Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11
[hereinafter “Charter”]; See Fleming, *supra* note 28 at 85, 88. This holding by the court was in the
context of a decision regarding the constitutionality of limits imposed upon this right on the basis of
patient incompetency.

32 See Law Reform Commission of Canada, *Consent to Medical Care* by M.A. Somerville (Ottawa:
Supply & Services Canada, 1979) [hereinafter “Consent to Medical Care”] at 3-10.
ethical codes of practice. These documents provide some insight into how clinicians view the ideals and essential aspects of the practice of their profession. As the focus here is upon programs facilitated by clinical psychologists, the *Canadian Code of Ethics for Psychologists* is of some relevance.\(^33\)

The Code of Ethics provides an illustrative discussion of the major issues raised by the requirement to obtain informed consent under a section expounding the principle of "Respect for the Dignity of Persons". It emphasises, amongst other issues, the need to seek "as full and active participation as possible from others in decisions which affect them"; to recognise "that informed consent is the result of a process of reaching an agreement to work collaboratively, rather than of simply having a consent form signed"; to ensure the client understands the "purpose and nature of the activity; mutual responsibilities; likely benefits and risks; alternatives; the likely consequences of non-action; the option to refuse or withdraw at any time, without prejudice; over what period of time the consent applies; and how to rescind consent if desired"; and to take all reasonable steps to ensure "consent is not given under conditions of coercion or undue pressure [or] to confirm or re-establish freedom of consent if ... given under conditions of duress".\(^34\) This list of issues captures some of the concerns the correctional setting raises for informed consent. Consent is more than a legal

\(^{33}\) *Canadian Code of Ethics for Psychologists* (Canadian Psychological Association, 1991) [hereinafter "Code of Ethics"]. See the Preamble to the Code of Ethics at (i), which provides that the Code of Ethics is intended to "articulate ethical principles, values and standards to guide all members ... each psychologists commitment to behave as ethically as possible ... is essential to the fulfilment of [the] discipline's contract with society".

\(^{34}\) *Ibid.*, at 3-5.
requirement evidenced by the signing of a form; it is based upon adequate provision of information, and requires awareness of the effect of any pressures placed upon clients and a continuing right to withdraw from treatment.

As well as having its foundation in common law, and being a standard of practice in relevant codes of ethics, informed consent has been adopted as a requirement by the laws that govern the correctional setting. Specifically, section 88 of the *Corrections and Conditional Release Act* (the “Act”) provides that treatment shall not be given to an inmate unless the inmate “voluntarily gives informed consent thereto”. Subsection (1)(b) goes on to protect expressly the right of an inmate to refuse treatment. Further the Commissioner's Directive on *Consent to Health Service Assessment, Treatment and Release of Information* notes that consent that is “voluntary, informed, and specific to the ... treatment” must be obtained from offenders for all psychiatric and psychological treatment. These requirements effectively codify or supplement existing common law rights. But what does the requirement of obtaining informed consent actually involve?

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35 *Supra* note 12.
37 *See Reibl v. Hughes*, *supra* note 29; and *Fleming*, *supra* note 30.
For the purposes of discussion here, the elements of informed consent may be summarised as follows: (1) provision of information to the client (about what the treatment entails, and the risks and benefits involved) presented in a form appropriate to the client's level of understanding; (2) competency of the client to understand this information, and a capacity to make a decision based upon it; and (3) circumstances in which the decision can be made in a voluntary manner (freedom from any pressures, coercion or duress).\(^{38}\)

It is this third element, ensuring voluntary participation in treatment, that is the crux of the informed consent issue in correctional environments. For an apparently simple concept, the requirement of voluntariness presents analytical difficulties, given the inevitable presence of some pressures in any clinical setting. The nature and effect of such pressures may vary, depending on the nature of the particular clinical setting and the client’s circumstances. The importance of context must be recognised when considering the application of the doctrine of informed consent, as the focus of the doctrine may vary from one set of clinical circumstances to another.

In particular, the focus in general medical care is often upon the potential for liability to arise. The bulk of case law in the area of “informed consent to medical treatment” concerns physically invasive treatments (such as surgical or pharmaceutical interventions) and the liability that may arise from resulting physical harms. Emphasis

\(^{38}\) Consent to Medical Care, supra note 32, at 11, 46.
has been placed upon the duty to disclose "material risks". This emphasis is a reflection of the fact that risk of physical harm is a predominant consideration in relation to physically invasive treatment. It is the voluntary assumption of risk by the client that is therefore the key concern for the clinician in such circumstances.\textsuperscript{39}

In contrast, in correctional treatment settings, the concern is more with the ethical aspects of the requirement of informed consent. Specifically, given that inmates are involuntarily detained, concerns may arise over the voluntariness of the decision to accept any treatment offered, and the existence of a meaningful right to refuse treatment. Voluntary consent in these circumstances may be viewed as an ethical safeguard, setting guidelines to ensure competent patients are not subject to treatment against their wishes.

Although the disclosure of material risks is not much of a concern in the correctional setting (given the non-invasive nature of most treatment programs) it is important to note that there are other informational components that the clinician is under a duty to disclose. Relevant considerations include informing the client as to the nature, character and purpose of treatment (is it diagnostic, therapeutic, experimental?), the likely duration of the treatment process, what the alternatives to treatment are and what

\textsuperscript{39} Some commentators have argued (in light of the large body of damages claims) that the doctrine of informed consent has served primarily to address the concerns of the courts to compensate victims of medical accidents, and consequently to expand the liability of health care professionals. See e.g. Meisel, \textit{supra} note 29, at 77, and Robertson, \textit{supra} note 29, at 109.
benefits may be expected. It is essential for these issues to be communicated to an inmate for him to be in a position to make an informed decision to accept or refuse treatment.

The focus upon risks and liabilities in the general medical context has created an emphasis upon the legal imperative of obtaining consent (as a protection against liability or justification for a course of treatment), and diverted attention from the ethical principles underlying the requirement of consent. If informed consent were viewed in the correctional setting as merely an institutional or legal requirement, this would compound concerns about the voluntariness of consent to treatment. The concern is that informed consent would simply become the act of “having a consent form signed”, rather than working towards an informed, voluntary decision.

A final point that is not evident from the case law on informed consent in the general medical context is that psychological treatment is an ongoing therapeutic process, rather than a single physical event. If commencing a treatment process requires consent, then so does the continuance of the process. Consent has to persist, free from coercive pressures, throughout the treatment process. It needs to be made perfectly clear to a client that by providing their initial consent, they have not lost the right to withdraw consent.

In sum, the concerns regarding the doctrine of informed consent in the correctional treatment setting relate to the existence of a right to refuse treatment, the ability to voluntarily exercise that right in the face of pressures upon the decision maker, and ensuring that the right is a continuing right throughout the treatment process. The underlying rationale for each of these aspects of consent to treatment is the ethical principle of respect for autonomy. Discussion of this principle is a logical starting point for considering the relationship between voluntariness of consent and the potential for coercion in correctional treatment settings.

2.1.2 Respect for Autonomy as the underlying rationale

When informed consent was enunciated in *Canterbury*, the Court placed client autonomy and the right to self-determination at the forefront of its reasoning. The principle of respect for autonomy is now generally accepted as a fundamental part of bioethics. But what is meant by the concept of personal autonomy? Feinberg suggests that personal autonomy is a label for “the realm of inviolable sanctuary most of us sense in our beings”. At a basic level, personal autonomy can be defined as

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42 *Supra* note 29.
43 In particular, this was encapsulated in the following quote (adopted as the “root premise” for the doctrine by the Court in *Canterbury*, supra note 27, at 780) from Cardozo J in *Schloendorff v. Society of New York Hospital*, 211 N.Y. 125 (Ct. App. 1914): “every human being of adult years and of sound mind has a right to determine what shall be done with his own body”.
the "sovereign dominion" to rule oneself and one's life. It is essentially a political value, and is fundamental to the notion of citizenship in a liberal democratic society. In this sense it provides freedom of action, and prevention from unjustified state interference, as prescribed in documents such as the Charter.\textsuperscript{46}

In the context of informed consent, freedom of action and prevention from interference are reflected in the right of self-determination and the right of bodily integrity respectively.\textsuperscript{47} These rights manifest themselves in the right of competent clients to make their own decisions in terms of the treatment they are to receive, that is, the right to refuse treatment.

It is important to realise that autonomy is not an abstract bundle of rights to be viewed in a vacuum. As one amongst a range of ethical principles that can guide clinical practices, respect for autonomy is attached to and in tension with other values.\textsuperscript{48} There has been criticism of the current perspective towards issues at the interface of health and law as dominated by the view that personal autonomy is the single most important value in treatment decisions, as an absolute right in and of itself.\textsuperscript{49} This view ignores the ends to which autonomy is directed; not only should it be seen as a good thing in itself, but also because of the fulfilment it can bring the individual: values such as

\textsuperscript{46} Supra note 31.
\textsuperscript{47} See Consent to Medical Care, supra note 32, at 3-10.
\textsuperscript{48} Other principles referred to in contemporary bioethics include beneficence (acting for the good of the client); non-maleficence (ensuring no harm is done to a client), and justice (treating like cases alike). See e.g. Childress, supra note 44, at 14.
responsibility, self-esteem and personal dignity.\textsuperscript{50}

It has also been suggested, on the basis of psychological research and theory, that individual choice is an important part of goal setting and of achieving goals. Thus, enabling a client to exercise autonomy and self-determination in the clinical setting can assist the therapeutic process by improving attitudes towards, motivation for, and commitment to treatment goals.\textsuperscript{51} Autonomy is, therefore, an ideal to strive for, not just in terms of restoring rights, self-esteem and dignity but also in recognition of the fact that self-determination can be a valuable therapeutic tool in helping a client achieve psychological well-being.\textsuperscript{52}

In most clinical situations, the client will have a diminished degree of autonomy (in terms of self-determination), either due to the effect of the condition for which treatment is sought, or the apparent imbalance in knowledge. The goal of the clinician is therefore to attempt to restore the client’s autonomy as far as possible.\textsuperscript{53} Informed consent plays a role here, by ensuring that decisions made in the course of treatment are either made by the client, or in accordance with the client’s wishes. That is, the

\textsuperscript{51} See Winick, \textit{ibid.}, at 1757-1763
\textsuperscript{52} \textit{Ibid.} at 1765-1768.
\textsuperscript{53} See Little & Leeder, \textit{supra} note 40, at 6; See also E. Erwin, \textit{Behaviour Therapy: Scientific, philosophical and moral foundations} (New York: Cambridge University Press, 1978) at 40, who discusses this in terms of treatment being provided to “alleviate suffering and enhance functioning”; See also Winick, \textit{supra} note 50, on the value of autonomy generally. Discussion below under section 2.2.2 also considers this issue in relation to characteristics that distinguish treatment from punishment.
right of competent persons to refuse treatment protects the character of a clinical intervention as treatment, by respecting autonomy. If an intervention is directed at restoring autonomy, it can be properly considered as treatment. If an intervention takes place without regard to a person's autonomy, it loses the character of treatment, and becomes an infringement of rights.\textsuperscript{54}

Having established the central role respect for autonomy plays in treatment settings, it is important to move beyond the focus on the individual, and to emphasise that autonomy is not an absolute right. To consider autonomy as an absolute right ignores that fact that individuals are social animals and members of a wider community. Consideration of the interests of others and wider societal interests necessitates some limits upon autonomy. As will be discussed in a section to follow, whether society's interest in reducing the incidence of sex offending should limit inmate autonomy with respect to treatment is of particular relevance. Given that the concern here is upon the threat coercion poses to autonomy (as manifested by the right to refuse treatment), it is necessary to explore the meaning of the terms "coercion" and "voluntariness", before considering the possible justifications for limits upon autonomy.

2.1.3 The concepts of coercion and voluntariness

In exploring the meaning of these terms, it should be noted that searching for

\textsuperscript{54} Not only is such intervention unethical, but also illegal (in the absence of any statutory provisions modifying the common law position, \emph{e.g. infra} note 92) constituting an assault or battery. See \emph{e.g. Informed Consent, supra} note 29, at 114; and Verdun-Jones, \emph{supra} note 30, at 92.
universally operative definitions is likely to be counter-productive. As Wertheimer notes:

terms such as coercion, voluntariness, ... are best understood as terms of art that do not admit of tight specifications of necessary and sufficient conditions for all plausible or legitimate uses of the word.\textsuperscript{55}

In particular, our understanding of coercion may depend on the interest we have in its effect (e.g. considering whether coercion may relieve or mitigate a person's responsibility for their actions, as opposed to whether it invalidates the consensual nature of a decision). It is also necessary to consider the context of the relevant conduct: the nature of the pressure upon the inmate, and its source (e.g. from family members, clinicians, or correctional officers).

In this thesis, the context for considering coercion is determining whether the pressures placed upon inmates during the correctional treatment process invalidate any consent to treatment that may be given. The term coercion is, therefore, used in the sense of pressures sufficient to render a decision to enter treatment involuntary. Determining whether coercion is present involves both philosophical considerations, as to the nature of coercion, and empirical considerations, as to whether or not coercion can be seen to be present.

It is important to note here that the concept of coercion is in part a moral one.\textsuperscript{56} It is not merely assessing whether pressures are present, but whether those pressures “take an unfair advantage of some vulnerability in the subject”.\textsuperscript{57} In the case of involuntarily detained persons such as inmates, it is the deprivation of liberty itself that is that gives rise to the greatest vulnerability. Before giving thought to what sort of pressures unfairly take advantage of this circumstance, it needs to be considered what exactly is meant by the requirement of voluntariness.

The concern in this thesis is not with involuntariness in the sense of non-volition, whereby a person is subject to physical force to overcome their wishes. Rather, we are concerned with pressures that impinge upon the decisions of inmates to accept or refuse treatment, and present a constraint upon choice, or a pressure to choose. The question here is whether, in the presence of such constraints or pressures, a person can be considered to have made a voluntary choice; or whether those pressures are sufficient to have “overborne a person’s will”, rendering the decision to accept treatment involuntary, although volitional.

In considering whether or not a person’s decision or action is voluntary, it must be realised that voluntariness is not an all or nothing proposition but a question of degree.

\textsuperscript{56} See e.g. J.G. Murphy, “Total Institutions and the Possibility of Consent to Organic Therapies” in J.G. Murphy, 
\textsuperscript{57} “Consent to Organic Therapies”, \textit{ibid.}, at 193.
Considering the wide range of factors that may affect the degree of voluntariness of a decision for various moral or legal purposes (e.g. competency, duress, manipulation, ignorance, mistaken beliefs, emotional states, fatigue, intoxication), the concept of a perfectly voluntary decision is “an impossibly difficult ideal”. Feinberg suggests, therefore, that “we should treat voluntariness as a “variable concept” ... depending on the nature of the circumstances, the interests at stake and the moral or legal purposes served”.

It is generally recognised, therefore, that it is not possible to obtain a complete level of voluntariness in informed consent, even outside of the correctional context. Clients who present of their own accord do so because of a pressing or perceived “need for treatment”, are in a vulnerable position, and to this extent have lost some autonomy. Factors that may be of assistance in determining the degree of voluntariness a person has in relation to a decision to accept treatment include: (1) the severity of the consequences of refusing treatment; (2) the freedom in choosing the treatment provider; and (3) the degree to which treatment is controlled by external regulations, policies or resources.

Considered in the context of correctional treatment programs, these factors suggest that

58 Feinberg, supra note 45, at 116.
59 Ibid., at 117.
61 V. Slonim-Nevo, ibid., at 120.
inmates typify the “non-voluntary” client. The consequences of an inmate refusing to participate in a treatment program are severe; it is likely to result in prolonged incarceration and a greater likelihood of serving time at a higher security level.

Further, the range of treatment programs in prison settings is limited, and inmates are generally at the mercy of the selection process when it comes to gaining a place in a program. The treatment process is constrained by a lack of resources and is closely regulated by CSC. Inmates have virtually no control or freedom in choosing the type of treatment, or the treatment provider.\textsuperscript{62} For these reasons, and the fact that inmates are involuntarily detained, the correctional treatment process appears to frame inmates as “non-voluntary” clients. However, this in itself does not constitute coercion, nor denial of a right to refuse treatment.

Empirical studies in the context of civil commitment have noted that legal classifications as voluntary or involuntary may not accord with a client’s perception of the treatment process and, in particular, of any coercion.\textsuperscript{63} That is, although some clients have in theory been exposed to a coercive treatment process, the degree of respect afforded to them during that process may lead them to feel as if they had not been coerced. In the context of correctional treatment, this suggests that even though inmates may be exposed to a coercive treatment process, there is room for a distinction to be drawn by some inmates between their involuntary detention and the offers of

\textsuperscript{62} Although there is the possibility of inmates arranging their own treatment privately, very few would have the means to pay for such treatment.

\textsuperscript{63} See \textit{supra} note 8.
treatment, and to perceive themselves as voluntary participants in treatment.

At this point, it is important to recognise the possible differences between actual and perceived coercion resulting from the presence of potentially coercive pressures. Actual coercion refers to the presence of pressure resulting in a decision being involuntary, and essentially involves consideration of the nature of coercion and voluntariness. Perceived coercion is the expression by someone involved in the decision making process that, in his or her opinion, the decision was not voluntary.

In most instances, it is to be expected that where treatment has been coerced, an inmate will perceive some coercion, and vice versa. However, it is obvious that the perception of coercion cannot in itself be conclusive of whether treatment has been actually coerced. The presence of coercion must be more than the subjective “say so” of the client. While empirical consideration of client perceptions is not determinative of whether or not a decision was actually coerced, it may assist in reaching a conclusion. This deliberation involves more than simply determining whether pressure applied to a decision maker is an offer or a threat. Rather, it is a question of whether the conduct in applying pressure offends some applicable standards, and can therefore be concluded to be unfairly taking advantage of the decision maker’s circumstances. Apart from simply addressing the question of whether a person felt pressured to make a decision, we also need to consider where that pressure is coming from, the nature of the pressure, and, importantly, whether the placing of pressure upon inmates is considered to offend any relevant legal or moral standards.
Having considered all of these factors, it may be that perceived coercion does not correspond with actual coercion in a particular instance. It is possible that although pressure is present upon an inmate, and he feels coerced into treatment, the conclusion to be drawn is that the pressure applied does not render the decision to accept treatment involuntary, nor invalidate consent given. It may assist to illustrate this issue by considering some simple examples. It is important to emphasise that the examples discussed here are intended to show the possible disparities between perceived and actual coercion, and not to resolve the issue of what kinds of pressures are actually coercive in the correctional treatment context.

Consider an inmate who resents the fact that if he does not participate in a treatment program he will not receive a pay level increase, and indicates that he feels coerced as a result of this fact.\textsuperscript{64} It may be noted that, upon incarceration, an offender loses the ability to be employed in the community unless provided with permission to leave the prison setting for that purpose. The question of inmate employment and remuneration logically falls upon the correctional service as a consequence of imprisonment. The “financial pressure” of being denied a pay increase if not in treatment is therefore a pressure applied by CSC generally, and arises indirectly from the inmate’s deprivation

\textsuperscript{64} There are in fact 6 pay levels offered by CSC for work done by inmates, ranging (as at September 1998) from 0 to $3.65 per day. An inmate’s pay level is determined on the basis of “good behaviour”, including consideration of progress along the correctional treatment plan: see regulation 102, supra note 22; see also clause 7 of the Treatment Agreement in Appendix B and discussion of the correctional treatment process below, under section 2.2.5.
of liberty. Importantly, the pressure is not of the same degree as enhanced prospects of release. The clinician can appear distanced from this pressure, and is able to explain the available alternatives to the inmate and the consequences of choosing them. The inmate, therefore, can still be dealt with fairly by the treatment process. As this financial pressure arguably does not offend any legal or moral standards, it possible to conclude that it is not actually coercive, but a legitimate incentive for treatment.

There may be examples where the converse situation exists, in that although an inmate does not feel coerced into treatment, consideration of the other factors leads to a conclusion that the decision was actually coerced, and that consent to treatment should be considered invalid, and rendered involuntary. Let us consider an inmate detained indeterminately as a dangerous offender. A correctional psychiatrist says to the inmate: “if you commence this course of medication, you’ll be recommended for parole; if you choose not too, you’ll be staying here a lot longer”. Our inmate considers this, and agrees to commence treatment. Further, the inmate indicates that he feels he is making his own decision to accept treatment, despite the pressure placed upon him.65

The pressure here emanates directly from the clinician, and appears to exceed the

65 This example is adapted from “Consent to Organic Therapies”, supra note 56, at 188, in which the author critiques the case of Kaimowitz v. Michigan Department of Mental Health, 1 M.D.L.R. 147 (Mich. Cir. Ct., Wayne Cty. 1973). Although it may be suggested that an inmate in such a hypothetical situation would perceive coercion, this is not necessarily the case. In the case of Kaimowitz, discussed in A.D. Brooks, Law, Psychiatry and the Mental Health System (Toronto: Little, Brown & Co., 1974) the inmate gave the appearance of full consent and co-operation with treatment efforts (Brooks, at 914-915).
authority of a member of clinical staff. Not only is the clinician directly pressuring the inmate to accept treatment, but parole is also being predicated simply on a decision to accept treatment, without reference to the criteria of dangerousness that justified the indeterminate incarceration. The enhanced prospects of release creates an enormous pressure in circumstances of indeterminate detention, and is coupled here by a dereliction of the clinician’s duty to provide the inmate with a clear understanding of the alternatives open to him. On this basis, it may be concluded that the treatment process here unfairly takes advantage of the inmate’s deprivation of liberty, and is coercive in effect. Again, these hypotheticals are not intended to determine which pressures are coercive and which are not, but to illustrate that there may be disparities between an inmate’s perception, and the actual incidence of coercion.

The fact that in this last example, an apparently voluntary decision is determined to be involuntary may be clarified by reference to “weak” and “strong” notions of voluntariness. On a “weak” view of voluntariness, the mere appearance of the exercise of choice, even if constrained by various pressures, is sufficient to render a decision voluntary. Thus, voluntariness is equated with volition. On a “strong” view, voluntariness requires more

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66 Note that legitimacy is not necessarily determinative of the issue, unless coercion is defined as illegitimate pressure. It is possible that illegitimate pressures may not actually be coercive in a particular instance, but this does not make them any more acceptable. Morally or legally legitimate pressures may also be coercive in effect, but it is likely that the use of coercion will (on the basis of its legitimacy) be more easily justified.

67 Compare in “Consent to Organic Therapies”, supra note 56, at 188, 195, the author’s consideration of circumstances in which a clinician carefully explains the nature of treatment, and the likelihood of it reducing dangerousness etc. On this view, the unfairness isn’t inherent in the nature of the pressure, but in the approach taken by treatment providers in the face of that pressure.

68 See e.g. the discussion by Wertheimer, supra note 55, at 243-244.
than mere volition; it requires the absence of certain types of "coercive pressures", or the presence of a significant level of self-motivation despite pressure for treatment.

Because the general rule is that consent will not be legally effective if "coerced, or given under duress"; 69 it is apparent that the doctrine of informed consent is based on this "strong" view of voluntariness. It is obviously difficult to specify exhaustively the kinds of conduct which invalidate consent. Although in relation to any treatment decision pressures exerted by the clinician directly raise more obvious legal concerns, it is possible that structural or situational pressures, or pressures brought to bear by third parties may also affect the validity of a consent. 70

A difficulty in every treatment setting is that inevitably there is a range of pressures present upon a person making a decision whether to undertake treatment: social; familial; financial; and other factors that may severely constrain a person's choice. 71 The mere presence of pressure will not necessarily constitute coercion, nor render a decision involuntary for the purposes of informed consent. Given it is not practically possible to make treatment decisions in the absence of such pressures, the question becomes one of degree: "how much [pressure] must be present for a decision to be considered not to have been made autonomously?". 72 A further difficulty that arises is the need to

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70 See Informed Consent, supra note 29, at 62.
71 For example, as suggested by Wertheimer, supra note 55, at 244, the situation of a patient faced with a limb amputation or risking severe illness from infection and gangrene.
72 Informed Consent, supra note 29, at 24.
distinguish between those pressures that are considered coercive and those that are not. Given the moral dimension evident in the concept of coercion, making such a distinction requires balancing the competing rights and interests of the parties involved.

Some commentators suggest that the pressure of an offer of early release cannot be coercive, because the state has a right to imprison the offender. In my view, it is not that simple; the alternative to treatment (prolonged incarceration) is severe, and state authority weighs heavily upon inmates. Linking treatment to the prospects of release from a correctional setting necessarily compromises the right to voluntarily consent to treatment. Although undeniably correctional services have legitimate authority over inmates’ liberty interests, this is not unlimited, and potential remains for it to be used unfairly and hence coercively. It is in attempting to resolve this issue that the empirical project fits in this thesis: considering inmate’s views as to the fairness of the treatment process, and whether they have been provided with a meaningful right to refuse treatment, will assist in determining the extent to which the potential for coercion is realised.

In conclusion, the concern here is with coercion in the sense of pressures sufficient to render a decision involuntary, denying inmates a meaningful right to refuse treatment,

73 See e.g. Public Health Service, Legal aspects of the enforced treatment of offenders by R. Schwitzgebel, (Rockville: National Institute of Mental Health, 1979) [hereinafter “Enforced treatment”] at 55.
although consent may appear volitional. If an inmate indicates he feels unfairly pressured, this is not necessarily determinative of the issue, because consideration of the context and balancing of moral issues is also required. The nature of the pressure, the circumstances in which it is applied, its moral and legal legitimacy, and whether there are other significant factors motivating the person to seek treatment must be considered. Of particular relevance here is the deprivation of inmates’ liberty and the legitimacy of manipulating this deprivation to pressure inmates to enter treatment.

The next issue to be addressed is the extent to which correctional services have rights to constrain inmate autonomy and to place pressures upon inmates with respect to treatment decisions.

2.1.4 Constraints upon autonomy

As noted above, there is inevitably a range of pressures upon a person deciding either to accept or refuse treatment. This fact reflects another point made earlier, that autonomy is not an absolute right, but is necessarily limited to some degree. It is evident there will always be some constraints (both external and internal) upon the autonomy of all individuals.

Internal constraints upon autonomy relate to an individual’s feelings or perceptions of a situation. For example, a person may feel too weak or ill informed to make a decision; the resulting sense of powerlessness may lead to that person abdicating his or her decision making to another. Such situations may be prevalent in both clinical and
correctional settings, due to apparent imbalances in power and knowledge, leading a
client to be overly susceptible to influences that would not otherwise be considered
improper. Of greater relevance here, however, are external constraints upon
autonomy.

External constraints may be imposed as a result of consideration of wider societal
interests, and in some instances, by judgements made by others as to what may be in an
individual’s best interests. In both the correctional and clinical settings, these
constraints may be conceptualised as authoritarian and paternalistic practices. It is of
some assistance to briefly consider what “authority” and “paternalism” mean in this
context.

Authority can be defined as the power to issue mandatory orders or directions (most
commonly a delegation of state power, and limited by the scope of that delegation) and
as such infringes upon personal autonomy.\textsuperscript{75} By force of legislation, correctional
services have legitimate authority over inmates and their liberty interests, flowing from
both the fact of criminal conviction and the need to ensure the security and safe
administration of the prison institution.\textsuperscript{76} In contrast, although there is a clear power
imbalance due to the differing levels of knowledge in clinical settings, the clinician


does not usually have any authority in this sense over a client. The clinician generally acts in an advisory way, although it is possible that as alluded to above clients may simply yield to advice due to the imbalance in knowledge, on the basis that “doctor knows best”.

In contrast to mere exercises of authority, paternalist rationales provide that infringements upon personal autonomy may be justified on the basis the infringement is in the individual’s best interests, regardless of his or her wishes. Historically, the medical profession has been paternalistic in practice. The Hippocratic Oath provides an overriding obligation to act in the client’s best interests, without reference to the client’s wishes. On this basis, prior to the emergence of the doctrine of informed consent, consent to ordinary medical treatment was presumed, and information was only provided if asked for by the client. The rise of the doctrine of informed consent has corresponded with the downfall of paternalistic practices.

As clinicians operating in correctional settings are acting as agents of a coercive authority whose paramount concern is the protection of society, there is potential for both paternalistic and authoritarian practices to enter the treatment setting and conflict with inmate autonomy. Normally in clinical settings, a clinician will be acting in

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77 See Consent to Medical Care, supra note 32, at 14.
78 “Strong” paternalism, which argued that infringing the autonomy of a competent client could be justified on the basis of a judgement as to the client’s best interests, has given way to “weak” paternalism, which argues that intervention based on best interests judgements can only be allowed where a client is deemed incompetent. Feinberg, supra note 45, at 12-16, discusses these principles as “hard” and “soft” paternalism, arguing that “soft” or “weak” paternalism is very much a misnomer as it is not truly paternalism in any sense, if only non-voluntary decisions or incompetent persons are interfered with.
accordance with duties owed to the client, and as an agent of the client.\textsuperscript{79} In the
correctional setting, as it currently operates in Canada, the clinician is undeniably an agent
of CSC, and acting in accordance with CSC’s paramount goal of “protection of society”.\textsuperscript{80}
While treatment is ultimately also intended for the benefit of the inmate, his interests are
necessarily secondary to the goals of CSC.\textsuperscript{81}

This apparent conflict between the rights and interests of the inmate and the rights and
interests of the correctional service and society is not able to be resolved unless the
interests coincide. That is, a clinician can only be taken to be restoring inmate
autonomy if it is established that the inmate has voluntarily accepted that he has a
problem requiring treatment, and has therefore accepted the need for treatment. The
presence of the ulterior goal of protecting society suggests that in effect a paternalistic
approach to treatment may be adopted here. That is, the treatment “needs” of inmates
are dictated by decisions made by clinicians that what is in the interests of society is
essentially in the best interests of the inmate. Such an approach still presents problems
for meeting the requirement of informed consent based on the “strong” view of
voluntariness, if the substituted “best interests” judgement appears to be accepted in the
face of unfair pressures. Paternalistic rationales for treatment of competent individuals
are, therefore, a subset of coercive practices, distinguished by the appearance of “best
interests” decision making.

\textsuperscript{80} See the Act, \textit{supra} note 12, ss 3, 4; and Mission, \textit{supra} note 11 at 4.
\textsuperscript{81} This follows from the paramountcy of “protection of society”: see Kuipers v. Canada (1994), 74 F.T.R.
306 at 310.
There is also the added dilemma in the correctional context of how the authority that is at the clinician's disposal is to be used to work towards treatment goals, without adding to an inmate's sense of powerlessness regarding decision making, nor unjustifiably imposing treatment upon a resistant or unmotivated client. A question therefore arises as to whether treatment can in fact be justifiably imposed upon inmates, in pursuit of correctional aims. First, we need to consider the extent to which correctional authority flowing from a sentence from imprisonment justify infringements upon autonomy; and secondly whether from the aims of correctional treatment any infringements upon autonomy can be justified upon paternalistic grounds.

It is evident from the mere fact of imprisonment that inmates have been denied a significant portion of the personal autonomy enjoyed by ordinary members of society. Historically, inmates were considered to have undergone “civil death” upon imprisonment, effectively losing all rights they may have held. This view has given way to reform movements for more humane treatment of inmates, and a long history of litigation over inmates’ rights. It is now accepted that “an inmate in a prison institution retains all of his civil rights except those taken away expressly or by necessary implication”. The Act provides that inmates retain the rights and privileges of

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82 Piche, supra note 76, at 103. This decision considered the legality of the practice of “double bunking” (i.e. putting 2 inmates in each cell) – in rejecting the prisoner’s argument as to infringement of Charter rights, Nitkman D.J. held that “in a prison setting, a certain loss of privacy is an inherent incident of confinement in the institution” at 105. See also section 4(e) of the Act, supra note 12.
ordinary members of society, except those “necessarily removed or restricted as a consequence of sentence”.

These statements are, however, far from definitive on the scope of rights retained by offenders upon imprisonment.

Undeniably, the regimented routines and degree of restriction of movement associated with imprisonment severely limit inmate autonomy. The demands of administering a prison also necessitate some restrictions on freedom of movement and some loss of privacy. The degree to which these rights are seen to be justifiably restricted is evident from considering some of the provisions of the Act relating to the administration of correctional institutions. Rights of self-determination, and of bodily integrity are diminished in an authoritarian manner in aid of maintaining order and secure control within the prison. This curtailment of rights relates primarily to issues such as frisk searches, strip searches, searching of cells and urinalysis testing for drug use all being permissible on a routine basis, without the usual requirement of “reasonable grounds for suspicion”.

Infringements of autonomy as a consequence of imprisonment contemplated by the Act do not, however, appear to extend so far as to allow involuntary treatment of inmates.

The principles and purposes of the Act, and the provisions in relation to treatment do not

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83 Ibid., s. 4(e).
84 See in particular, see ss 47, 48, 54(b) and (c), ibid.
85 Ibid. An inmate is not entitled to hold an expectation of privacy with respect to practices such as surveillance, searching, frisking and random drug testing which are necessary for the security of the prison institution. See e.g. Weatherall v. Canada (Attorney-General), [1993] 2 S.C.R. 872, 83 C.C.C. (3d) 1; Fieldhouse v. Kent Institution (1995), 98 C.C.C. (3d) 207, 40 C.R. (4th) 263 (B.C.C.A.).
contemplate the imposition of treatment upon inmates. There is, amongst the guiding principles of the Act, mention of an expectation upon inmates to actively participate in programs.\textsuperscript{86} Participation in treatment programs, however, is not an issue that is essentially connected with the fact of imprisonment, nor the secure running of an institution. The Law Reform Commission has argued that to allow psychological treatment to be imposed as a consequence of sentence, regardless of consent, would be contrary to the basic values of a liberal, democratic society: suppressing autonomy, reducing persons to objects, and opening the door to abuses.\textsuperscript{87} Treatment constitutes an “additional interference” with bodily or psychological integrity, and in theory should only be provided upon obtaining the informed consent of the inmate concerned, to protect the right to refuse such interference.\textsuperscript{88}

The authoritarian curtailment of autonomy inherent in the correctional setting indeed suggests added protection of rights may be required in relation to treatment decisions. This provides the rationale for both the express requirement in the Act to obtain informed consent to any treatment offered to inmates, and the express protection of the inmates’ right to refuse treatment.\textsuperscript{89} It is clear from these provisions that the Act prohibits CSC from coercing inmates into treatment programs. To coerce treatment is not only contrary to the requirements of the Act, it would also arguably be an infringement of autonomy, in

\begin{flushright}
\textsuperscript{86} \textit{Ibid.}, s. 4(i).
\textsuperscript{88} \textit{Consent to Medical Care, supra} note 32, at 96.
\textsuperscript{89} See s. 88 of the Act, \textit{supra} note 12.
\end{flushright}
terms of a fundamental right applicable to all competent adults, including inmates: the right to psychological integrity.\textsuperscript{90} By providing a right to refuse treatment, the requirement of informed consent can in theory protect the psychological integrity of inmates.

The common law right to refuse treatment was noted previously under section 2.1.1.\textsuperscript{91} The limits upon this right are either based on an emergency need for treatment, incompetency to make a treatment decision, or statutory provisions expressly limiting the right.\textsuperscript{92} The rationale is that these infringements upon a patient's autonomy are justified on paternalistic grounds: the patient may not want the treatment, but they are deemed incompetent to make decisions by reason of their illness, and it is for the patient's own good they receive the treatment. However, there are no such limits upon inmates' rights under the Act. The exceptions as to emergency circumstances or incompetency do

\textsuperscript{90} This is a right with sources at common law, and under section 7 of the Charter. In Fleming \textsuperscript{supra note 30} the guarantee of a right to life, liberty and security of the person was interpreted as necessarily including and being coextensive with the existing common law right to bodily integrity and personal autonomy (at 85, 88). In other contexts, the Supreme Court of Canada has interpreted the concept of "security of the person" within section 7 of the Charter as including "personal autonomy, at least with respect to the right to make choices concerning one's own body, control over one's physical and psychological integrity" (assisted suicide, in Rodriguez \textit{v. B.C. (A.G.)}, [1993] 3 S.C.R. 519; access to services for abortion, Morgantaler \textit{v. R.}, [1988] 1 S.C.R. 30, per Dickson C.J., Lamer J. at 55; Wilson J. at 163, 173). This right that has been considered to be applicable in the correctional context, albeit in form reduced on the basis of security requirements (Jackson \textit{v. Joyceville Penitentiary} [1990] 3 F.C.R. 55 (T.D.), per Mackay J. (at 103)). Considering the combined effect of these cases points to the conclusion that there is prima facie a significant right to psychological integrity for inmates in correctional institutions, although some infringement may necessarily occur as a consequence of the fact of imprisonment and the requirements of maintaining security and order within the prison.

\textsuperscript{91} See \textit{supra} note 30.

\textsuperscript{92} For example, consider provincial mental health legislation allowing treatment of some involuntarily detained patients without obtaining their informed consent: Mental Health Act R.S.B.C. c. 288, s. 31; Also on the statute books since 1991 but not yet in force is a provision of similar effect under the Criminal Code R.S.C. 1985, c. C-46: s 672.58 remains inoperative until 672.64 to 66 come into force by order of the Governor in Council.
not generally arise in the treatment context under consideration here. It is apparent from case law that the fact a person is involuntarily detained does not in any way indicate they are not competent to make treatment decisions.93

On the basis that inmates are competent to make treatment decisions, and in the absence of any specific statutory provisions on the issue, the right to refuse treatment is not limited by the nature of correctional settings.94 As alluded to above, protection of the right to psychological integrity prohibits any express authoritarian imposition of treatment as part of the correctional process. A question that remains is whether the correctional process imposes treatment upon inmates in an indirect way, by effectively denying inmates a meaningful right to refuse treatment due to an overwhelming presence of coercive authority. Further, possible paternalistic justifications for such a result (based on assumptions that an inmate’s “best interests” corresponds with the state’s interest in treatment as contributing to the protection of society) also need to be considered.

93 See Fleming, supra note 30, at 86-87; and Freeman v. Home Office (No. 2), [1984] 2 W.L.R. 803 (C.A.), in which The English Court of Appeal rejected argument that prison inmates were incapable of giving a legally valid consent to treatment. See also Attorney-General (B.C.) v. Astaforoff (1983), 54 B.C.L.R. 309 (C.A.) which considered inmates’ right to refuse treatment of a general medical nature. Astaforoff was an inmate in a provincial institution, who had gone on a hunger strike, indicating a wish to not be fed by force or receive any treatment, whether conscious or not. The Attorney-General of Canada sought an order directed at provincial authorities to provide treatment under compulsion, but the Court declined to make such an order. Although the Court emphasised that it was concerned with duties and obligations upon the Attorney-General, and not the powers of correctional services, the decision is nonetheless consistent with a right of inmates to refuse treatment. It has been suggested the decision could be used to argue for an absolute right for competent inmates to refuse treatment (see M.A. Somerville, “Refusal of medical treatment in “captive” circumstances” (1985) 63 Can. Bar Rev. 59).

94 See Attorney-General (B.C.) v. Astaforoff, ibid.
The state's interest in the outcome of correctional treatment has lead one author to suggest that in correctional settings in the United States informed consent applies on a sliding scale: the more dangerous or intrusive treatment is, the more likely consent is to be considered a relevant issue. The cases considered suggest an "implicit hierarchy of the seriousness and potential consequences of particular treatment programs" such that inmates appear to have no legal right to refuse treatment in relation to "traditional forms of psychological and psychiatric therapy". In light of the statutory provisions and case law discussed to this point, it is unlikely Canadian courts would take such a view. While treatments involving risks of physical harm, or physically invasive techniques may suggest a need for extra safeguards to ensure voluntariness of consent, it does not follow that no safeguards are required where treatment involves no such risks or techniques. In the context of correctional treatment, the overriding concern of the presence of coercion from the nature of the setting needs to be taken into account regardless of the risk treatment poses. Although the consent given by an inmate may appear to satisfy the legal requirements, clinicians have an ethical responsibility to ensure it is adequately voluntary to the "strong" standard described earlier.

95 C.A. Veneziano, "Prison Inmates and Consent to Treatment: Problems and Issues" (1986) 10 Law & Psychol. Rev. 129 at 138; Feinberg, supra note 45, at 117, presents a similar analysis of consent that suggests less stringent standards for "voluntariness" can be applied where the risks of what is being consented to are low, and that stricter standards should be applied where a decision entails higher risks of harm, and particularly of irrevocable harm.

96 Veneziano, ibid., at 138.

97 See B. Dickens, "Legal and Ethical Considerations in Enforced Therapy" in Freedman & Verdun-Jones, eds., supra note 30, 23 at 52; Also, Veneziano, supra note 96, at 141-145, argues that correctional treatment personnel should have an ethical duty to ensure consent is genuine, given the punitive purposes of imprisonment, and the effects of linking treatment to the prospects of release.
However, it is apparent from the few Canadian decisions considering correctional treatment, that while the courts may emphasise the requirement for informed consent, little consideration is given to the role of coercive authority and pressure for treatment. In fact, it appears that implicitly the courts read down the requirement of voluntariness of consent from the "strong" standard, to accept the acquiescence to pressures to enter treatment, and the mere exercise of volition as a sufficient ethical safeguard to treatment practices.

*R. v. Rogers* was a decision which held that treatment could not be compelled as a condition of probation.98 The Court noted that to compel an accused to take treatment "is an unreasonable restraint upon the liberty and security of the accused person". The Court issued an amended order, requiring Rogers to attend for treatment, but noting that he was not required to submit to any treatment to which he did not consent. The original order also required Rogers to take reasonable steps to ensure his illness was not likely to cause him to behave in a dangerous manner or commit further offences. To address concerns regarding possible breaches of this requirement a proviso was added that, if he did not consent to recommended treatment, he must report to his probation officer for monitoring of his condition. Although the amended order expressly acknowledged a right to refuse treatment, there still remained the threat of breaching the order, and possibly facing imprisonment, as a pressure to accept treatment. This pressure plays upon a vulnerability arising from the offender's involvement in the criminal justice system (the threat of imprisonment), and potentially renders consent to treatment voluntary only to the standard

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98 (1990) 2 C.R. (4th) 192 (B.C.C.A.). The accused was a diagnosed paranoid schizophrenic, who had been convicted of "being in possession of a weapon for a purpose dangerous to the public".
of mere volition. Despite a lack of thorough judicial consideration of the role of the threat of possible imprisonment as a coercive pressure in such orders, power to order attendance at treatment remains.99

This decision illustrates how the criminal justice system may pay lip service to the right to refuse treatment, while using its authority over liberty interests to apply pressure for treatment. Little regard is paid to the potential impact of this pressure upon the integrity of the right to refuse treatment. Although it may be suggested that if probation with such conditions is not available as a sentencing option the alternative is imprisonment, this misses the point to be made in relation to this thesis. Whether a sentence is one of probation or of imprisonment, the issue here is how the sentence should relate to the need for treatment.

In circumstances where it is decided that treatment of an offender is warranted in the interest of public safety, there appears to be an implicit assumption that this interest is seen to justify reading down the requirement of voluntariness of consent to treatment to the “weak” standard. This concept, that public interest in the treatment of offenders implicitly lowers the standard of voluntariness to treatment, is as applicable to the prison setting as

99 See s 742.3 of the Criminal Code, supra note 92. Note that s. 732.1(g) of the Criminal Code was amended as a consequence of R v. Rogers, ibid., to require the offender’s agreement before ordering the offender “to participate actively in a treatment program”. This ignores the fact that the appropriate locus for obtaining informed consent is the clinic, and not the court room. A similar provision in the Young Offenders Act R.S.C. 1985, c Y-1 was eventually repealed, because of the problems presented in implementing orders. See e.g. A. Leschied & C. Hyatt, “Perspectives: Section 22(1), consent to treatment under the Young Offenders Act” (1986) 29 Can. J. Crim. 69; P. Platt & A. Rosenthal, eds., Young Offender Service (Toronto: Butterworths 1984-1997) at 33:2:2.
to orders for probation. Rather than pressuring offenders under threat of imprisonment, correctional treatment programs are offered as an opportunity to improve an inmate’s prospects of release. It is manipulating the same vulnerability resulting from involvement in the criminal justice system, simply after the threat of imprisonment has been realised. Again, there is potential for consent to treatment to only be reaching the “weak” standard of voluntariness. This point can be illustrated from consideration of the decision in *Kuipers v. Canada*.

Kuipers had been on the waiting list for a sex offender treatment program for some time, and in the interim, he had completed 9 out of 18 months of an apprenticeship program through CORCAN. With less than one year to go before his warrant expiry date there was concern that Kuipers would be released without having participated in a sex offender treatment program. When a placement in a program became available, CSC advised him that if he did not take part, he would be removed from his apprenticeship.

In rejecting Kuipers’ application for an injunction to prevent CSC carrying out this threat, Gibson J. noted that CSC’s paramount concern was “the protection of society”, and suggested it was open for CSC to conclude that this would be better served by completing treatment than by completing an apprenticeship. His Honour commented that Kuipers could either:

facilitate CSC’s priorities or frustrate them completely by reason of section 88(1) ... if

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100 *Supra* note 81.
he chooses to thwart CSC's priorities, CSC has indicated in turn, to thwart his desire to complete the apprenticeship. Whilst the [inmate] may not view this tactic on the part of CSC as entirely fair ... I find nothing that would preclude CSC's resort to this kind of "carrot & stick" approach.

From this passage, it can be seen that the Court emphasised the requirement of informed consent as a right the inmate could avail himself of (to refuse treatment), rather than placing any obligation upon CSC (not to use any undue pressure).

It is arguable that having completed a substantial portion of his apprenticeship, Kuipers should have had a legitimate expectation of not being removed for the program for reasons other than a breach of the program rules, or a breach of discipline. The threat of being removed from the apprenticeship if he did not leave to attend treatment fits neither of these descriptions, and in reality is a result of CSC's poor administration, rather than any lack of motivation on behalf of the inmate. It is suggestive of an authoritarian exercise of power, with the potential to render any decision to attend treatment an act of mere volition.

Kuipers' situation was not reflective of the intended correctional treatment process; having failed to place him in a treatment program until shortly before his release, CSC could not effectively use the prospect of early release as an inducement. Although this decision does not assist in assessing the fairness of linking treatment to release prospects, it indicates

101 An issue central to this thesis is whether the link between participation in treatment programs and prospects of release is unfair. Such a link need not be unfair, it will be argued, if the treatment setting is adequately protected from the impact of coercive authority. See the discussion below under section 2.3.1.
that the courts are willing to give CSC substantial leeway in the type of pressures that may be applied. An arguably coercive and unfair use of pressure in relation to an inmate’s decision to enter the treatment program was legitimated, without considering the issues of coercion or voluntariness of consent, on the basis of there being a greater interest at stake.

In conclusion, there is a danger in corrections of assuming that participation in treatment is voluntary, without truly investigating the matter, and to conclude that as a result, the ethical concerns that may flow from a lack of voluntary consent do not arise. There appears to be a gulf between the express requirements for consent to treatment in correctional settings, and the treatment process as envisaged by the criminal justice system. Specifically, the requirement of obtaining the voluntary consent of inmates does not appear to be entirely respected by correctional practices which potentially render consent to treatment a mere exercise of volition. The existence of this disparity appears to be a result of the state’s interest in working towards a goal of “protecting society” being considered ahead of the rights of inmates. The goal of protecting society from consequences of further offending is naturally a dominant priority for correctional services. Problems emerge for treatment efforts, as will be discussed in a section to follow, when this dominance is carried to its possible extreme of ignoring inmates’ interests altogether.

To fully consider the appropriate balance between these interests, the role of treatment and its effectiveness in meeting this goal need to be considered in the broader context of corrections. Specifically, both the concepts of treatment and punishment need to be
examined: the relationship between them, and the aims and effectiveness of each of them. A discussion of these issues is essential in determining the appropriate limits upon the use of coercive authority if treatment is to be pursued as a legitimate part of corrections.
2.2 The nature of correctional treatment

To understand the nature of the state’s interest in correctional treatment, there is a need to consider the goals of corrections in a broader sense, and the history of correctional treatment programs in working towards those goals. Throughout this history, there has been an ongoing tension between the punitive and treatment aspects of the correctional system. The development of the rehabilitative ideal will be reviewed to illustrate the difficulties the dual role of punishing and treating inmates has created for the correctional system’s efforts to rehabilitate offenders. The effectiveness both of treatment and of punishment in working towards correctional goals will also be considered. It will be concluded that rehabilitative treatment remains a legitimate goal of the correctional system, but that clear boundaries are required to distinguish between punishment and treatment in working towards that goal.

It is important to attempt first to elucidate what is meant by the use of the term “rehabilitative ideal” in this thesis. This term can encompass a range of conflicting social policies. A useful starting point is that, as a policy, the rehabilitative ideal holds change in the character, attitudes and behaviours of a convicted offender as a primary purpose of the correctional system. The ultimate objectives in effecting such changes are both to contribute to the protection of society through a reduction in offending and to contribute to the welfare of the offender. This broad starting point may be narrowed according to: (1) the theory as to the causes of crime underlying the treatment model; (2) whether treatment is considered to be the exclusive justification of penal sanction; (3) the treatment means that are adopted; and (4) the larger purposes of treatment.
As will be evident from the discussion of correctional treatment to follow, contemporary sex offender treatment programs are suggestive of a rehabilitative ideal defined by a mix of theories of criminal behaviour, as being a result of a mix of predisposing factors, learned behaviour, and the "rational choice" of the offender.\textsuperscript{102} It is also clear that, under contemporary correctional practices, the purpose of incarceration is primarily punitive, and therefore treatment is not considered as an exclusive justification of imprisonment.\textsuperscript{103} The larger purpose of treatment should be the protection of society in a manner that remains consistent with promoting and preserving the autonomy of inmates. Before considering in greater detail the essential principles and characteristics defining the modern rehabilitative ideal, the relationship between and punishment and rehabilitation needs to be examined.

\textit{2.2.1 The role of imprisonment in corrections}

What constitutes punishment, its purpose and justification are topics that have been widely considered.\textsuperscript{104} At the heart of the issue is the relationship between law and morality, and


\textsuperscript{103} See the discussion of imprisonment as a sanction of last resort in Ekstedt & Griffiths, supra note 13, at 79-80; See also “Imprisonment and Release” in Law Reform Commission of Canada, Studies on Imprisonment (Ottawa: Supply & Services Canada, 1976), note that the aims of incapacitation and denunciation can be included within this “punitive” purpose of imprisonment.

\textsuperscript{104} See Introduction in J.G. Murphy, ed., Punishment and Rehabilitation, 2nd ed. (Belmont, Ca.: Wadsworth, 1985) [hereinafter “Punishment and Rehabilitation"] 1 at 1.
the conflict between the rights of the individual and the state’s use of coercive powers.\textsuperscript{105} The decision to deprive an offender of his liberty through a sentence of imprisonment is one of the most extreme exercises of coercive authority by the state. The legal process of arriving at such a sentence necessarily incorporates consideration of a range of moral concepts: fundamentally the criminal law is concerned with notions of right and wrong, and attaching responsibility to or excusing persons for their actions. The justification of imprisonment and underlying moral philosophy have been debated since the beginning of correctional systems, and it is my intention here to provide only a brief overview of the historical relationship between punishment and rehabilitation. Of particular concern is whether the use of imprisonment can contribute to or, at the very least, not impede rehabilitative efforts in corrections.

As Foucault has identified, since the birth of the prison there has been an expectation upon correctional systems to demonstrate the utility of imprisonment, as having “a positive technical role, operating transformations on individuals” through the deprivation of liberty.\textsuperscript{106} Historically, within the correctional system, there has been an incongruent mix of “custodial-punitive” (revenge, incapacitation, deterrence, punishment) and “treatment-rehabilitative” (reform, reintegration, rehabilitation) goals.\textsuperscript{107} This ongoing tension has been referred to as the “split personality” of corrections, and has presented

\textsuperscript{105} Ibid.
problems in working towards rehabilitative goals. The fact that imprisonment is charged with both a retributive function of confining offenders as well as the task of effecting changes in attitude and behaviour of offenders has been a source of difficulty for establishing effective treatment initiatives. The role of imprisonment as an institution of punishment needs to be examined to allow consideration of the role treatment should play in corrections.

The principles behind current sentencing practices as set out in the Criminal Code provide a useful starting point for considering the punishment of imprisonment. The objectives set out include denunciation, deterrence (general and specific), incapacitation, and rehabilitation, to be considered within the overriding fundamental principle of proportionality. These objectives present a range of philosophies of punishment and allow sentencing courts to give greater weight to those principles that appear most appropriate in any given case. The concept of proportionality of sentence that the Criminal Code holds out as a fundamental principle is drawn from retributive and “just deserts” theories of sentencing. The courts have recognised that the concept of retribution has become integrated into the principle of proportionality.

Retributive justice provides that an individual is to be punished as a simple consequence of

108 See Ekstedt & Griffiths, supra note 13, at 235.
109 Supra note 92, ss. 718, 718.1.
110 See e.g. A. von Hirsch & A. Ashworth, eds., Principled Sentencing (Boston: Northeastern University Press, 1992), c. 4.
having broken the law.\textsuperscript{112} The offender is to be held responsible for his or her own actions, and justice demands that the offender suffer in return for any harm caused. As a justification for punishment, retribution is founded in a system of values theoretically adopted by society as a form of moral consensus. The argument runs that it is morally better for a guilty criminal to suffer for his or her crime than for no punishment to be administered, regardless of the consequences of punishment. At the heart of this reasoning must lie some consensus as to the acts to be considered "morally wrong" or "criminal", often theorised in terms of the law representing a social contract or the general will of society. Theories of punishment as a "just desert" for the offender limit the retributive element in punishment: sentences should be proportionate to the seriousness of the criminal conduct.\textsuperscript{113} It is worth noting that imprisonment is one of the most severe forms of punishment, and should only be considered after all the possible alternatives have been contemplated.\textsuperscript{114}

Much contemporary discussion of punishment theory is focused upon the consequences for individuals subjected to punishments. Proponents of "just deserts" justifications suggest that punishment of an offender must not be seen as a means to an end of achieving

\textsuperscript{112} For a discussion of retributivism in sentencing, and the points that follow here, see S.I. Benn, "Punishment" in Punishment and Rehabilitation, supra note 104, 8 and J. Rawls, "Punishment as Practice" in Punishment and Rehabilitation, supra note 104, 68; and also R.J. Gerber & P.D. McAnany, eds., Contemporary Punishment: Views, Explanations and Justifications (Notre Dame: University of Notre Dame, 1972), c. 2.

\textsuperscript{113} See e.g. von Hirsch, supra note 110, at 195.

\textsuperscript{114} The exception being of course those correctional systems that still use capital punishment; but see s 718.2 (e) of the Criminal Code supra note 92. See also "Imprisonment and Release", supra note 103, at 12.
However, it must be recognised that criminal justice is, in a broad sense, a matter of public policy and as such necessarily serves social goals. Ultimately, it is the protection of society through controlling or preventing crime that is the justification for punishment and the aim behind the evident mixing of correctional strategies. Imprisonment alone, however, has not generally been successful in efforts to prevent crime.

If a conclusive statement can be made about the effects of sentencing dispositions from considering the long history of corrections, it is that punishment by incarceration has not had any appreciable effects on rates of offending: there is a lack of demonstrated impact upon crime rates of specific deterrence, incapacitation, or punishment alone. Criticism of imprisonment goes even further than this as, throughout its history, it has been described as brutal, inhumane and possibly criminogenic. Early attempts to reform offenders were based on using the punishment of imprisonment as an opportunity for "penitence".

The deterrent and retributive models of punishment that prevailed at the time correctional services came into being (the early to mid 1800's in the context of Canadian corrections)

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were based upon the "classical" theory of criminality developed in the writings of the Enlightenment era. The theory suggested that criminals chose freely to break laws in a rational fashion, motivated by the self-interested pursuit of pleasure. Although the main emphasis stemming from this view of crime is upon swift, uniform punitive measures in aid of deterrence, attempts at reform in this early era of corrections through the concept of penitence also assumed this classical view of human nature and criminal activity. Because an offender's actions were seen to be of a deliberate nature, criminal behaviour was equated with sinful behaviour. Reform efforts were based, therefore, upon religious contemplation and reinforcing political and social order through the punishment of imprisonment.

Early prisons were designed to reflect themes of order and morality and operated upon principles of punishment, hard labour, silence, religious discipline and strict obedience. Inmates were required to be silent at all times, working during the day and confined to individual cells at night, as a means to contemplate their actions and do penitence. The correctional system in Canada was established in 1835, with the construction of Kingston penitentiary on the basis of such a model in then Upper Canada. From this early period through to the 1930's, the correctional system in Canada was the subject of much criticism for failing to meet its goals and as actually contributing to problems of crime.

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118 This "classical" school of criminology is represented most prominently by writers such as Beccaria and Bentham; see Cullen & Gilbert, *ibid.*, at 28ff; see also Gerber and McAnany, *supra* note 112, c. 2 and c. 3; Ekstedt & Griffiths, *supra* note 13 at 24-29; and The Rise of the Sparrow: A Paper on Corrections in Manitoba (Winnipeg: Department of Health & Social Development, 1972) [hereinafter "Rise of the Sparrow"] at 27.

and social disorder. The correctional setting typified the worst of the "total institution" that Goffman critiques as resulting in loss of individuality, dehumanisation, and depersonalisation for all inmates, to the detriment of any possible benevolent intentions. Some of these institutional characteristics of prison settings remain as a present day obstacle to rehabilitative efforts.

The conclusion to be drawn here is that imprisonment as punishment alone has very little to contribute to the goal of offender reform. Nevertheless, it plays an important role in the correctional system as being the most severe punishment and a punishment of last resort, serving goals of general deterrence, denunciation, retribution and incapacitation. Few people would disagree with the need to ensure offenders who have committed serious sex offences receive some form of punishment on the basis that it is simply deserved. But if "protection of society" is to remain the ultimate correctional goal, there is a moral obligation owed to society by correctional services to utilise the experience of imprisonment to facilitate treatment of offenders where treatment may assist in reaching this goal. The failure of imprisonment alone to achieve rehabilitative goals suggests treatment is a concept to be considered separately from notions of punishment. Questions are then raised as to what we mean by "treatment" in the correctional context, and how we work toward treatment goals in an essentially punitive setting such as prison, and

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120 See Ekstedt & Griffiths, supra note 13, at 39-50.
122 See Ekstedt & Griffiths, supra note 13, at 230.
123 See “Imprisonment and Release”, supra note 103, at 12.
124 See e.g. Allen, supra note 26, at 84, 85.
indeed, whether we can do so with any degree of effectiveness.

2.2.2 The role of treatment in corrections

Rehabilitative treatment, as it is understood today, has its foundations in the “medical model” of criminality. The abuses and brutalising conditions resulting from a system of stern discipline stimulated a trend from the early 1900’s onward for reform within the correctional system to ensure more humanitarian treatment of inmates. This era was also characterised by the development of theories of criminality that attributed offending behaviour to underlying causes within the individual and the community: personality defects, or intellectual and social inadequacies.\(^{125}\) The failure of escalating punishments to deter or reduce crime helped this move away from the classical view of criminality to “positivist” views: theories placing the causes of criminal behaviour as factors beyond the offender’s control, but within the scope of scientific methods and techniques.\(^{126}\)

These “positivist” theories as to causes of crime referred to above, and the growth of behavioural science, psychiatry and psychology provided the basis for developing this model, postulating crime as a problem capable of cure.\(^{127}\) In the context of Canadian correctional history, it was not until around the mid 20th century that the concept of

\(^{125}\) See e.g. *Rise of the Sparrow*, supra note 118, at 27; See also the summary of positivist and sociological theories of crime presented in Carlson, *supra* note 74, at 42-46.

\(^{126}\) See e.g. Carlson, *ibid.*, at 44.

correctional treatment (as distinct from punishment within the correctional experience) developed.\textsuperscript{128} If in our efforts to rehabilitate offenders the concept of treatment is to be considered as being distinct from punishment, we must consider what is meant by treatment and what characteristics distinguish it from punishment.

It is evident there is no universal definition of what comprises treatment in correctional settings and what does not.\textsuperscript{129} McGuire notes that although contemporary use of the term treatment in corrections refers to “an enormous variety” of measures, it “does not derive from the application of a medical model, imply that offenders are “ill”, or that they can be “cured” by the dispensing of medication or other ministrations which depend in part on power difference between practitioner and client”.\textsuperscript{130} This quote is revealing of the way in which contemporary psychology seeks to address criminal behaviour: modification and change is to be attempted in a way that distinguishes it from medicalised views of criminality which have fallen out of favour.

Although proponents of the new psychological models of criminal behaviour may seek to distinguish them from medical models, the characteristics of programs of psychological therapy and treatment are, in many ways, analogous to medical models. Two essential characteristics can assist in distinguishing treatment measures from

\textsuperscript{128} See Ekstedt & Griffiths, \textit{supra} note 13, at 51ff and c. 7.
\textsuperscript{129} See the reviews of the literature in McGuire & Priestley, \textit{supra} note 18; Gendreau & Ross, \textit{supra} note 18.
\textsuperscript{130} J. McGuire, “Preface”, in McGuire, ed., \textit{supra} note 18, xi at xiii.
The aim of treatment is to enhance functioning or to alleviate suffering (at least from the clinical point of view; ultimately the correctional service hopes this goal will coincide with reduced recidivism). This characteristic of treatment settings goes to the underlying ethic of treatment as discussed under section 2.1.2: clients generally present with diminished autonomy and the clinician’s efforts are directed at restoring autonomy.

Treatment is not provided unless there is some assessment or diagnosis of a problem, and there is some evidenced based reasoning to suggest that enhancement of functioning or alleviation of suffering is a probable outcome of the treatment. The evidence based approach is essential to define treatment as a clinical science: there must either be a theoretical basis for a treatment if it is new, or some empirical evidence demonstrating the effectiveness of existing treatments if a correctional program is to be considered truly a treatment measure.

In contrast, punishments can be justified without recourse to issues of evidence of effectiveness, or benevolent intentions, but on the basis of general deterrence, desert and retribution as noted above.

131 These characteristics (adapted from similar discussions by from L. Wilkins, “Putting treatment on trial” (1975) 5(1) Hastings Center Rep. 35 at 36; and from Erwin, supra note 53, at 40-41) assist in distinguishing treatment from punitive measures.
For the most part, treatment has been perceived as an adjunct to the punitive experience, although some advocate treatment as the only justification for incarceration.\textsuperscript{132} Given the evident promise of the original medical model of rehabilitation in making steps towards “curing” criminality and the apparent failure of punishment by imprisonment to achieve the goal of offender reform, why not base the correctional system purely on treatment philosophy? Arguments against such a system are based primarily on the fact that it would discard many of the important values of the justice system upon which justification for incarceration is based. To justify imprisonment for treatment purposes only as opposed to punishment requires accepting that either offenders are not responsible for their actions (blaming the apparent illness), or that the concept of responsibility for actions is not relevant to the question of what should be done with the offender.\textsuperscript{133} Such an approach ignores the retributive and general deterrent values of punishment and allows deprivation of liberty on the basis of arguable and relativistic notions such as “dangerousness” and “criminality”, rather than on the basis of a criminal conviction and the rights of due process this entails.\textsuperscript{134}

The decision to incarcerate a person has moral undertones and these are ignored if the decision is approached on a scientific basis. Such an approach runs the risk of being

\textsuperscript{132} K. Menninger, “Therapy, Not Punishment” in \textit{Punishment and Rehabilitation, supra} note 100, 172; and see also the discussion of Patuxent institution in Wilkins, \textit{ibid.}, and in J.S. Meister, “A visit to Patuxent: ‘Participation is voluntary...” (1975) 5(1) Hastings Center Rep. 37.

\textsuperscript{133} R. Wasserstrom, “Problems with the therapeutic approach to criminality” in \textit{Punishment and Rehabilitation, supra} note 106, 190

\textsuperscript{134} See e.g. J. G. Murphy, “Criminal Punishment and Psychiatric Fallacies” \textit{Retribution, Justice and Therapy, supra} note 56, 147 at 151, 152; see also Ericson & Burtch, \textit{supra} note 24, at 70.
unjust and indeed institutions endorsing a treatment approach as justification for incarceration have been criticised for leading to arbitrariness in sentence length.\textsuperscript{135} It has also been documented that in the prison setting, the lines between punishment and treatment have on occasion been blurred to extremes where treatment vocabulary is used to thinly veil what can only be described as brutal punishment.\textsuperscript{136} Thus, although the concept of correctional treatment arose in part from the failure of imprisonment to meet goals of offender reform, this did not immediately give rise to clear boundaries between means of treatment and means of punishment.

Generally, in the correctional setting, “custodial-punitive” goals have retained primacy over “treatment-rehabilitative” goals. Ultimately, the more concrete concerns of administering an institution, such as secure custody, will prevail where there is a conflict presented with treatment philosophies.\textsuperscript{137} Treatment goals have, however, remained an important priority in light of the lack of demonstrated impact upon crime rates of specific deterrence, incapacitation, or punishment alone.\textsuperscript{138} These conflicting goals and ideals provide the background of the correctional treatment process that is relevant to this thesis, in which various modes of treatment have fallen in and out of

\textsuperscript{135} See Rothman, \textit{supra} note 127, at 20.
\textsuperscript{136} See \textit{e.g.} the discussion of the case of \textit{Knecht v. Gillman}, 488 F. (2d) 1136 (8th Cir. 1973), a case which dealt with excessive use of emetic drugs in a behaviour modification program, in \textit{Enforced treatment}, \textit{supra} note 73, at 45; the account of high pressure hosing of juvenile delinquents referred to as “hydrotherapy” and use of cattle prods as “aversion therapy” in \textit{Allen}, \textit{supra} note 26, at 51; also \textit{Wilkins}, \textit{supra} note 131, at 36, and \textit{Ericson & Burtch}, \textit{supra} note 24, at 71.
\textsuperscript{137} Ekstedt & Griffiths, \textit{supra} note 13, at 235-238; compare the radical critique of this point in G. Klerman, “Behavior control and the limits of reform” (1975) 5(4) Hastings Center Rep. 40 at 42; the view taken that the nature of the prison as a total institution leads to social control issues being preferred ahead of rehabilitation.
\textsuperscript{138} See references \textit{supra} note 116.
favour. The next section will examine several critiques of the rehabilitative ideal and the medical model of treatment, to develop an argument that if treatment is to be a legitimate goal of corrections, it needs to be clearly separated from the punitive aspects of corrections.

2.2.3 *The medical model of correctional treatment*

As noted above, in the early part of the 20th century, the inquiry into the causes of criminal behaviour through the techniques of the social and behavioural sciences was in its infancy. The involvement of psychiatrists and psychologists in developing and operating correctional programs lent scientific credibility to this endeavour and presented the promise of discovering the true causes of criminal behaviour. Through the powers of social sciences, psychology and psychiatry, the "medical model" of correctional treatment presented itself as a promising basis to substantially reduce, if not entirely eliminate, the incidence of deviance in society. 139 Thus, the advent of the medical model of offending appeared to offer a means of developing highly effective treatment and provide a rationale for its imposition upon inmates: if we can eliminate recidivism, surely it is in the public interest to treat inmates with or without their consent. 140

However, proponents of this view failed to provide anything other than a very vague

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139 See e.g. Rothman, *supra* note 127, at 19; and Wilkins, *supra* note 131.
140 Such views were evident in Canadian corrections as recently as 1972; *Rise of the Sparrow, supra* note 118, suggested at 24 that "participation in correction programs and techniques should not necessarily be a matter of consent of the offender ... safeguards against abuse are best achieved through a methods other than allowing rehabilitation to be dependent upon the decision of the offender".
conception of the "illness" to be the focus of treatment, relying upon the commission of
the offence itself as an obvious indicator for a diagnosis of sexual deviancy. The
promise and expectations of the time were evident:

the problem of the sex offender ... is primarily a medical problem ... Medical science is
still uncertain as to the kind of treatment that may be effective, but it is obvious that
effective treatment can only be discovered if such persons are made the subject of special
study.

By the late 1960's, there was growing concern about the medical model of rehabilitation,
and particularly the effectiveness of treatment programs within prison settings. Numerous
research efforts through the 1950's and 1960's documented the limited effectiveness of
rehabilitative efforts at the time. In hindsight, many of the poor outcomes could be
attributed to problems such as poor funding, lack of support from non-treatment staff,
excessive expectations upon treatment to provide a panacea for criminal behaviour and a
failure to implement programs as intended. Nonetheless, such reports signalled the start
of a shift away from the medical model and a loss of public and academic faith in the
ability of the clinical professions to address crime problems.

141 See Ericson & Burtch, supra note 24, at 58; see also Ericson, supra note 25, at 19.
142 Report of a Committee Appointed to Inquire into the Principles and Procedures Followed in the
Remission Service of the Department of Justice Canada by G. Fauteux (Chairman) (Ottawa: Queen’s
offenders: Report of the working group sex offender treatment review (Ottawa: Supply & Services
Canada, 1990) at 4.
143 See R. Martinson, "What works? - Questions and answers about prison reform" (1974) 10 The
Public Interest 22; United Kingdom, The Effectiveness of Sentencing (Home Office Research Study No.
144 See McGuire & Priestley, supra note 18, at 14ff; Ekstedt & Griffiths, supra note 13, at 241-247; and
Gendreau & Ross, supra note 18 at 5-7. See also Ericson & Burtch, supra note 24 at 55.
145 This trend in Canada culminated in the 1977 report, The Role of Federal Corrections in Canada by
the Task Force on the Creation of an Integrated Canadian Corrections Service (Ottawa: Supply & Services
Canada, 1977) and followed similar shifts in the United States and United Kingdom.
The medical model of criminality was also criticised for its deterministic view of criminality, championing the powers of technologies of normalisation, and for treating the offender solely as an object, effectively devaluing moral and contextual issues in decisions made regarding their liberty interests.\textsuperscript{146} It has also been suggested that this treatment approach allows offenders to avoid accepting responsibility for their actions by blaming the “disease” suffered. The underlying psychological theories suggested it may be possible to condition a person’s behaviour without need for their consent, and incorporated unpleasant experiences as part of therapy. Such treatment efforts posed a threat to liberty interests and autonomy, and created difficulty in properly distinguishing punishment from treatment. By considering critiques of the rehabilitative ideal, it will be argued that the lesson emerging from the reign of the robust “medical model” throughout the post-war period, is that a sharp distinction must be maintained between punitive and treatment efforts if the correctional system is to legitimately work towards treatment aims.

One focus for criticism of rehabilitative efforts is the nature of the prison setting. Sociological and historical analyses of both prisons and mental hospitals provided the impetus for movements promoting decarceration.\textsuperscript{147} These critiques suggested that the division between staff and inmates, and the rituals and subcultures that result, are sufficient

\textsuperscript{146} See Retribution, Justice and Therapy, supra note 56, at 161; see also M.E. Wolfgang, “The Just Deserts vs. the Medical Model” in J. McCord & J.H. Laub, eds., Contemporary Masters in Criminology (New York: Plenum Press, 1990) 279; and Wasserstrom, supra note 133.

\textsuperscript{147} See the discussion of historical critiques such as those by Erving Goffman and David Rothman in Klerman, supra note 137, at 40.
to override any efforts at treatment and rehabilitation, and create instead “human warehouses that produce humiliation, degradation and rebellion.”¹⁴⁸ As the prison is an institution in which “a large number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life”, it is argued that an inevitable consequence is that inmates will suffer a loss of individuality, dehumanisation and depersonalisation.¹⁴⁹

The radical response to the evils of institutionalisation that emerges from these critiques is to abandon the prison as a treatment setting and to locate correctional efforts in the community. The essential argument is that treatment must be separated from the punitive and coercive environment of the prison if it is to be effective. While recent studies of effectiveness of treatment suggest that indeed treatment efforts can be more effective in the community,¹⁵⁰ the notion of returning all inmates to the community does not provide a realistic solution to the problem at hand.¹⁵¹

Although it is arguable that imprisonment may be overused as a punishment and that indeed some inmates could safely be returned to the community,¹⁵² there will nevertheless

¹⁵¹ See e.g. McGuire and Priestley, *ibid.*, at 15; Rothman, supra note 127, at 22.
¹⁵² This comment is not made with reference to sex offenders; but note the high percentage of fine defaulters and non-violent property offenders in prison; see “The September Study: a look at sentencing and recidivism” in *Studies on Imprisonment*, supra note 103, 5 at 18; also see N. Morris, *The Future of Imprisonment* (Chicago: University of Chicago Press, 1974) at 5ff, discussing the “Abatement of Imprisonment”.
remain a group of offenders whose offences are so serious or who present a significantly high risk of reoffending such that a community based sentence cannot meet the needs of justice or protection of society. Thus, there will always be some need for the use of secure custodial settings as correctional institutions. To deny treatment services to those offenders who are incarcerated would be to neglect many who are arguably in most need of treatment services, and would relegate prisons to the purpose of “warehousing” inmates until their release.\footnote{153} Indeed, given that treatment has been demonstrated to be effective in some settings,\footnote{154} and in light of the severe consequences sex offences cause victims and families, some commentators point to a moral obligation upon correctional services to ensure incarceration is used as an opportunity to facilitate inmate involvement in treatment.\footnote{155} On this basis, treatment providers have continued to grapple with the problem of providing effective treatment in a prison setting. The punitive and coercive nature of prison settings has, however, created problems for efforts to establish clinical environments in corrections. If it is accepted that the use of imprisonment as a punishment is an inevitable aspect of the criminal justice system, the focus then becomes the reform of the institutional setting as to make it more conducive to treatment of inmates.

\footnote{153} Blanchette, \textit{supra} note 3, at 38-39.  
\footnote{154} See McGuire & Priestley, \textit{supra} note 18; Losel, \textit{supra} note 150; and M. Lipsey, “What do we learn from 400 research studies on the effectiveness of treatment with juvenile delinquents?” in McGuire, ed., \textit{supra} note 18.  
An attempt at reform of the “total institutions” in this way can be seen in the development and implementation of the Living Unit Program introduced by CSC in 1973. The program involved abolishing the traditional role of correctional officers as uniformed guards and replacing them with Living Unit Officers who wore ordinary street clothes. In this way, it was hoped the gulf between inmates and staff would be bridged, creating an environment more amenable to open communication and treatment. Living Unit Officers had caseloads of 5 to 10 inmates and assumed the role of treatment facilitator as well as the responsibility for maintaining security. The inherent conflict in these duties tended to undermine treatment objectives, as officers viewed security issues as their most important priority. This overwhelming concern with custody and control of inmates diluted the emphasis upon the goals of treatment.\textsuperscript{156} Similar problems can be seen in efforts to establish therapeutic environments in correctional settings elsewhere.\textsuperscript{157}

Examples such as these highlight a need to delineate clearly between “custody-punitive” and “treatment-rehabilitative” roles within the correctional institution. The difficulty is with efforts made to transform the whole institutional environment into part of the entire therapeutic experience. Inevitably, the demands of secure administration of a custodial environment will conflict with such attempts.\textsuperscript{158} Rather than try to transform the institutional setting entirely, efforts are better directed at creating a

\textsuperscript{156} Ekstedt & Griffiths, supra note 13, at 239-240.
\textsuperscript{158} The possible exception here is treatment provided to low risk inmates in minimum security settings.
treatment setting separated from these concerns, in which an effort can be made to adhere as closely as possible to clinical ethics where there are conflicts with other correctional issues.

However, the influence of the correctional setting upon treatment goes further than conflicts with matters such as security of the institution. Attempts to implement treatment in the regimented prison system of discipline have led to what has been termed “the debasement of the rehabilitative ideal”; treatment has in practice been vulnerable to being subverted to serving unintended and unexpressed social ends. The zealous efforts of medical and behavioural science to classify, diagnose and treat sex offenders in the correctional setting during the 1950’s and 1960’s appeared to some to constitute additional punishment, and an unwarranted invasion of privacy. Reliance upon clinicians’ professionalism and apolitical dedication to science was not a sufficient guarantee against abuses of authority. There were revelations of particularly noxious “treatments” having been administered as “negative reinforcements” that in some instances were held to constitute cruel and unusual punishment. The misappropriation of the vocabulary of the clinic to disguise and justify continued excesses of stern discipline lead to criticism of rehabilitative efforts as nothing more than punishment clothed in therapeutic rationalisation. There was also a realisation that, in adopting rehabilitation as the primary purpose of incarceration, too much discretion had been afforded to treatment

159 Allen, supra note 26, at 33.
160 See discussion supra note 136.
providers, especially given that the target of treatment remained ill-defined. The granting of such discretion was perceived as leading to arbitrary and unjust practices in the administration of punishment.\textsuperscript{162}

This debasement of the rehabilitative ideal was not limited to treatment programs comprising an unintended form of "therapeutic despotism",\textsuperscript{163} but also had potential political implications. As Allen argued, the deterministic view of human nature and rigidly scientific approach to criminality allowed the rehabilitative ideal to become dangerously detached from moral and political concerns. That is, in striving to be an objective science, behaviour modification was susceptible to being co-opted for ulterior motives.

The concept of innate or inherited criminality was suggestive of biological inferiorities and enabled comparisons of rehabilitative efforts with such distasteful and anti-democratic movements as eugenics.\textsuperscript{164} The introduction of physically invasive treatment regimens such as aversive conditioning and drug therapies in the context of coercive prison environments raised the spectre of social control as a tool of state oppression along the lines of Orwell's \textit{1984} or Burgess's \textit{A Clockwork Orange}.\textsuperscript{165} However, any treatment that would enable conditioning of offenders as automatons would be reprehensible to the values central to the liberal, democratic society. By failing to truly enhance autonomy, such treatment techniques may act to protect society from the individual, but threaten

\begin{footnotes}
\item [162] See \textit{e.g.} Rothman, \textit{supra} note 127, at 20.
\item [163] See Ericson & Burtch, \textit{supra} note 24, at 70.
\item [164] Allen, \textit{supra} note 26, at 41-42.
\item [165] See Klerman, \textit{supra} note 137, at 45; also Rothman \textit{supra} note 127, at 22.
\end{footnotes}
autonomy as a general social value.\textsuperscript{166}

Hence, Allen’s argument that imposed or invasive treatments in correctional settings “constitute incursions by the state into areas of human freedom and autonomy ... outside the proper province of state action”.\textsuperscript{167} Voluntariness of consent needs to be adhered to as a central principle of the rehabilitative ideal to provide “at least a modicum of meaning to the [assertion] that penal treatment should result in benefit to the offender”.\textsuperscript{168} That is, there is a need to adhere as closely as possible to the ethics of treatment in correctional programs if it is to be truly considered as treatment, and not be debased by punitive and social control ends.

In conclusion, the nature of correctional institutions as a punitive and coercive setting has historically been an impediment to rehabilitative efforts, and played a role in the decline of the medical model of rehabilitation. This history suggests that if treatment efforts are to continue, there is a need to define clear boundaries between punitive and rehabilitative roles. This analogy of boundaries can be carried further, in the sense of being protective of a clinical space in the correctional setting within which efforts can be made to adhere to treatment ethics as closely as would be expected in any other clinical setting. The

\begin{verbatim}
\textsuperscript{166} Although this threat loomed large, it was only in isolated instances that techniques such as psychosurgery were performed. See the discussion of Kaimowitz in Brooks, supra note 65, at 902ff; and F.S. Berlin, “Sex Offenders: A Biomedical Perspective and a Status Report on Biomedical Treatment” in J.G. Greer & I.R. Stuart, eds., The Sexual Aggressor: Current perspectives on treatment (New York: Van Nostrand Reinhold, 1983) 83 at 111-114. More common and just as much of a threat to autonomy is the misuse of drug therapy as a means of maintaining order within the institutional setting. See Ericson & Burch, supra note 24, at 72.
\textsuperscript{167} Allen, supra note 26, at 45.
\textsuperscript{168} Ibid., at 46.
\end{verbatim}
practical implications of this conclusion will be considered in discussion of the results of the empirical project. In particular, if the rehabilitative ideal is to be legitimately based upon a treatment ethic, steps need to be taken to ensure inmates have a meaningful right to refuse treatment, as voluntariness of consent is an essential part of defining this clinical space. The question is then raised as to what reforms to the correctional treatment process are necessary to ensure the integrity of the clinical space for inmates, following the shift away from the medical models of rehabilitation.

2.2.4 Psychological models of treatment and the voluntariness of consent

Despite the shifts in correctional policy following the damning critiques of the medical model, psychological therapy and treatment have consistently remained an important feature of correctional services. Research subsequent to the decline of the medical model in the area of sexual offending and treatment has suggested that it is only in very isolated instances that offending can be truly attributable to physiological causes. The theories underlying the treatment of sex offenders have for the most part moved away from deterministic medical models, to models of psychological intervention. However, this did not immediately necessitate a clear role for voluntariness of consent in treatment.

Early psychological approaches were as deterministic as medical views of criminal behaviour, with sex offending perceived as stemming from purely sexual motivations, and arising from "deviancies" in the offender’s sexuality. Sexual deviancies were viewed as

169 Typically, offenders with raised testosterone levels: see W.L. Marshall & H.E. Barbaree, supra note 102, at 260; also Lanyon supra note 102, at 43.
responses learned from external stimuli, that could be effectively be altered through techniques of operant conditioning or aversive therapies.\textsuperscript{170} The tension between the rehabilitative ideal and the liberal political stance of preserving individual autonomy, as discussed above, is at its height when treatment techniques are based on the deterministic views of human behaviour and criminality. The unease created by the use of such treatment means is not a rejection of their scientific basis, rather it is due to the potential for the scientific, empirical approach to become divorced from moral, philosophical considerations. Accepted techniques such as aversive conditioning, surgery, or drug therapy are not good or bad in isolation: it is factors such as the imbalance between risks and benefits, the high degree of intrusiveness, and the potential for ulterior motives of providers that may make treatment unacceptable. Consequently, there is a need not only to consider the means of treatment, but the practices and processes in a more general sense, in examining the issue of treatment ethics.

While conditioning may still form part of treatment in some instances, contemporary programs are predominantly based upon theories taking a “soft” determinism view of

\textsuperscript{170} See e.g. N.J. Pallone, \textit{Rehabilitating Criminal Sexual Psychopaths: Legislative Mandates, Clinical Quandaries} (New Brunswick, NJ: Transaction Publishers, 1990) at 89-93; and Solicitor-General of Canada, \textit{A Survey of Treatment Programs for Sexual Offenders in Canada} (User Report No. 35) by J.S. Wormith & M. Borzecki (Ottawa: Solicitor-General of Canada, 1985) at 19-22. The notion of “deviance” is relative (one group’s definition of “morally wrong”, “deviant”, or “criminal” may not accord with another’s) and can be a source of criticism for the use of treatment particular instances. In the context of sexual offending as it is discussed in this thesis (instances of non-consensual sexual activities, possibly coupled with aggression or violence; specifically crimes such as incest, sexually interfering with children, rape, and sexually motivated murders), I would suggest there is currently little controversy in this regard. It has not always been the case: witness the criminalisation of consensual homosexual activities (and its listing as a psychiatric disorder) until the late 1960’s in Canada. Some advocates of “paraphilias” as legitimate sexual preferences rather than deviances warranting criminal justice system intervention have drawn analogies with the previous attitudes to homosexuality - but this tends to overlook the major stumbling block of consent as a prerequisite for legal sexual activity.
human nature. That is, treatment interventions still posit human behaviour as influenced by external factors, but ultimately call for the offender to accept responsibility for his actions. This emphasis upon offenders accepting responsibility for actions incorporates a role for voluntariness of consent other than as a treatment ethic, as an acknowledgement by the offender that they accept their actions were wrong. That is, voluntariness in correctional treatment emerged as an issue not as a result of concessions made to ethical imperatives, but as a consequence of the failure of treatment based upon generalised deterministic models of criminality.

As this medical model of rehabilitation fell out of favour, the focus of correctional policy shifted from the notion of objectively imposing treatment upon offenders to ensuring that offenders accepted responsibility for their behaviour. In this way, the inmates rather than CSC could be faulted for lack of success in rehabilitation. In 1977, the CSC adopted what it referred to as the “opportunities model”, aiming to provide the opportunity for inmates to voluntarily participate in available programs, placing responsibility for change squarely with the offender. The adoption of this model, and the shift in responsibility for change to the offender, was also a recognition that unrealistic expectations and goals had been placed upon the diagnosis, treatment and

171 See internal documents from CSC, Intensive Treatment Program for Sex Offenders, Regional Health Centre (Revised 15 November 1996) [hereinafter “ITPSO Manual”] at 6; and Intensive 20-week Program for the Personality Disordered Sex Offender at Mountain Institution (Revised 9 March 1993) [hereinafter “SOP Manual”] at 3; also A.N. Groth, “Treatment of the Sexual Offender in a Correctional Institution” in Greer & Stuart, eds., supra note 166, 160 at 166; Erwin, supra note 53, at 176; and Lanyon, supra note 102.
“cure” of offenders under the medical model.\textsuperscript{172} CSC reports into programming design and implementation in the 1980’s provided momentum for modifying this model to the position currently provided for in the CSC mission statement: “active encouragement” of participation in programs.\textsuperscript{173}

Thus, while the inmate still retains responsibility for change, CSC’s current policy dictates that it take an active role, supporting and encouraging this process by directing inmates into appropriate programs through correctional plans and the case management system. This policy of active encouragement to participate operates through placing various pressures upon inmates to enter programs. Pressures emanate mainly from the case management process, which commences for an inmate upon his reception into the correctional system. As noted under section 2.1.4, there is potential in these circumstances for inmates to be denied a meaningful right to refuse treatment.

As argued above, if, through such use of coercion, the state is allowed to determine what is for the offender’s benefit without regard to voluntariness of consent to treatment, the lines between therapy and repression will inevitably become blurred, and treatment becomes so in name only. Treatment without regard to the consent of competent inmates fails to work towards restoring autonomy and as such takes on a punitive or social control character. Voluntary consent suggests certain limits upon correctional treatment methods:

\textsuperscript{172} Ekstedt & Griffiths, \textit{supra} note 13, at 56-57.
\textsuperscript{173} See Ekstedt & Jackson, \textit{supra} note 11, at 99-112; \textit{Mission Statement, supra} note 11, at 4. See also reg. 102 of the regulations to the Act, \textit{supra} note 22.
not only consent to the commencement of a program of treatment, but continuing consent and effort by the inmate such that any progress made is also a personal achievement. Such limits assist in protecting the right of inmates to psychological integrity and, as noted above, should be central to the rehabilitative ideal if programs are to be considered truly treatment settings.\footnote{See \textsuperscript{174} supra note 90 on the right to psychological integrity; see also quotes from Allen, \textit{supra} notes 167, 168.}

Allen's conclusion as to how rehabilitative efforts should be pursued in a way that respects the principle of voluntariness of treatment concurs with earlier arguments made by Morris.\footnote{Morris, \textit{supra} note 150, at 13-14; Allen, \textit{supra} note 26, at 82.} This argument is founded on a premise that the main problem for effecting rehabilitation in the prison setting is the "corrupting link between time and treatment, which creates a further corrupting link between treatment and cure."\footnote{Morris, \textit{ibid.}, at 14; this argument carries more force in the context of indeterminate sentences, where release is not a certainty; See e.g. Meister, \textit{supra} note 132, at 38: "the real 'cure' is not the therapy, it is the indeterminate sentence".} The suggestion is that the linking of treatment to release means that no inmate is voluntarily entering treatment, and that therapy becomes a game of concocting appearances of rehabilitation.\footnote{Allen, \textit{supra} note 26, at 83.}

However, as argued in this thesis, to remove the connection between treatment and release does not make sense, if one of the aims of treatment is to reduce the risk an offender presents to society, and the system of parole and conditional release (based on assessments...
of risk) is to remain. The likely result of removing this connection is that inmates would lose any motivation for treatment, and prefer the option of “easy time”, again relegating time in prison to simple “warehousing”. To remove this incentive for treatment fails to give sufficient weight to the moral obligation to facilitate some reduction in sex offender recidivism. If we take into account the public interest in reducing recidivism, the issue then becomes whether we can utilise the prospects of release as a motivator for treatment in a way that is consistent with the requirement of voluntariness of consent.

This answer to the argument requires rejection of the central assertion that the “corrupting link” between treatment and release is necessarily coercive. The fact that the correctional treatment process is potentially coercive requires a heightened awareness of this need for voluntary consent to treatment, but it does not lead to the conclusion that treatment is necessarily coerced. It may be possible for this link to operate as a motivator for treatment without being coercive. That is, the mere presence of coercive authority in referring inmates to treatment (this referral process is described more fully under the section to follow) does not mean that each and every inmate is denied a meaningful right to refuse treatment.

Central to the concept of coercion explored under section 2.1.3 is an element of unfairness in the consequences of refusing treatment. To assist in investigating this question of unfairness in the correctional treatment process and whether the process is coercive in

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178 See comments made by inmates below, Chapter 3, section 3.5.1.
effect, inmates' views and perceptions of coercion will be taken into account under
Chapter 3. From a consideration of the lessons emerging from the history and critiques of
the rehabilitative ideal we turn to necessary background to this empirical project: the
present treatment paradigm for sex offenders.

2.2.5 Current treatment model and process

Sexual offending can be portrayed as having a wide range of potential causes:
physiological or hormonal, problems of childhood development or “abnormal”
psychology such as conditioned or learned “deviant” sexual preferences; or normal but
deficient psychological development, such as a deficiency of social skills, or cognitive
distortions.\textsuperscript{179} Offending conduct is not in and of itself a diagnosable condition or
entity, but a behaviour that cuts across a range of such categories.\textsuperscript{180} In this way,
sexual offending can be viewed as symptomatic of some form of psychological distress
and there is a need to address the internal psychological state of the offender if the risk
of reoffending is to be decreased.\textsuperscript{181}

The current treatment approach draws upon a range of psychological approaches, and is
based upon re-education, resocialisation and counselling.\textsuperscript{182} The treatment model is
primarily “cognitive-behavioural”, involving group counselling to redress errors in

\textsuperscript{179} Marshall & Barbarce, \textit{supra} note 102; and Lanyon, \textit{supra} note 102.
\textsuperscript{180} See Groth, \textit{supra} note 171, at 161; see also D. Perkins, “Clinical Work with Sex Offenders in Secure
Settings” in Hollin & Howells, \textit{supra} note 102, 151.
\textsuperscript{181} Groth, \textit{ibid.}, at 166.
\textsuperscript{182} See e.g. Groth, \textit{ibid.}, and Perkins, \textit{supra} note 180.
thinking patterns or attitudes towards sexual behaviours, and behavioural treatment to recondition sexual preferences in some cases if it is indicated. As psychological treatment assumes some underlying distress, although not necessarily pathological or physiological in origin, the current model has been characterised as a “weak” version of a medical model.¹⁸³

Underlying this treatment model is a broadly based theory on the causes of sexual offending. Sexual offences are not seen as attributable to simple causes, but rather as a complex interaction of internal and external factors underlying the behaviour. Offending is seen to be a result of the operation predisposing factors (such as needs, attitudes or fantasies) and triggering factors (such as intoxication, stress, or victim availability).¹⁸⁴ These factors may operate differently for different offenders, and lead to variation in the severity of the apparent problem. A central part of the treatment model is assessing the level of risk an offender presents in terms of reoffending and the treatment needs of an offender, to assist in determining the appropriate treatment elements and treatment intensity.¹⁸⁵ Assessment is therefore the first step in the CSC treatment process.¹⁸⁶

¹⁸³ Erwin, supra note 53, c. 4.
¹⁸⁴ Lanyon, supra note 102, at 49-51, also Marshall and Barbaree, supra note 102.
As part of every inmate's admission and reception into the federal correctional system, they undergo an intensive assessment process at the relevant Regional Reception and Assessment Centre. The process involves carrying out a battery of psychological tests and taking a detailed social history to identify an inmate's treatment needs. The stated objectives of assessment are:

(a) to obtain the most complete information regarding the offender’s criminal behaviour; (b) to assess the level of risk related to such behaviour factors; and (c) to assess possibilities for correctional planning aimed at reduction of risk.\(^{187}\)

CSC's interest in treatment is evident from this early stage: managing the risk of reoffending. A broad approach to assessment has been advocated as a means of improving validity and accuracy of the techniques used. As well as clinical interviews and psychological testing, assessment may involve physiological assessments of sexual preferences, behavioural observations, and detailed file reviews. It is apparent therefore that a large amount of sensitive and potentially prejudicial information may be gathered in treatment files for the purposes of assessing levels of risk and treatment needs.

Reception also provides an “orientation ... aimed at reinforcing the offender’s responsibility in addressing his criminal behaviour and encouraging participation in institutional programming”.\(^{188}\) The inmate is then transferred to an institution


\(^{188}\) Ibid.
appropriate to his assessed level of risk (maximum, medium or minimum) and an
Institutional Parole Officer (IPO) is assigned for “case management” purposes. CSC says of the case management process:

this process holds offenders responsible and accountable for their behaviour. Offenders are actively encouraged to participate in programs and/or treatment designed to address their individual needs and problems associated with their criminal behaviour ... in this way case management contributes to the protection of society ... through effective risk management.

This quote again reveals CSC’s interest in treatment as an aid to making release recommendations on the basis of assessed risks. IPO’s use the results of assessment and their interviews with inmates to attempt to develop interest in and motivation for treatment, and to formulate a “correctional plan”.

The correctional plan details which of the programs offered by CSC are recommended for the inmate, and the priority in which they should be taken. Adherence to the correctional plan and progress along it is used to determine an inmate’s pay level, and is influential in decisions regarding adjustments to an inmate’s security level (the objective being to have an inmate “cascade” from maximum to minimum security during the course of his sentence), and in decisions about granting parole or conditional release. The link between progress in treatment and prospects of either cascading or being released is also

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189 Risk is assessed along three dimensions, likelihood of escape, degree of institutional adjustment, and likelihood of serious reoffending upon release. Note also that there are in fact 7 security levels within the spectrum from maximum to minimum - see Ekstedt & Griffiths, supra note 13, at 191ff.
190 Programs and Facilities, supra note 187, at 13.
191 Ibid., at 15-16.
expressly acknowledged in the regulations to the Act.\textsuperscript{192} By offering the possibility of a lower security setting in which to serve time, or the possibility of early release, case management and correctional planning openly utilise coercive authority, in the form of the control over an inmate’s liberty interests that follows from a sentence of imprisonment, as a tool to motivate inmates for treatment.

Entry into treatment programs is, however, constrained by a lack of resources. Although the number of placements available in programs has been increasing, it is evident there are still problems regarding access to treatment. While IPO’s may refer inmates they deem suitable candidates to program facilitators, limited placements mean not all of these inmates will be immediately accepted into treatment. There may be over 100 inmates referred for a program in which there are 12 to 16 places. These candidates are ranked for selection using a system referred to as the Program Priority Referral System.\textsuperscript{193} This system takes into account the “needs” of the inmate, as indicated by the initial assessment, and progress along the correctional plan. Whether the need addressed by the program ranks highly amongst the inmate’s treatment needs, whether the inmate has taken any prerequisite programs, whether the inmate must take the program at the current security level or could be transferred, and whether any release or transfer decisions are approaching are all taken into account in ranking prospective referrals.

\textsuperscript{192} Regulation 102, \emph{supra} note 22.
\textsuperscript{193} From discussions with program facilitators. See the P.P.R.S. form in Appendix B.
Once the referrals are ranked, approximately 30 to 35 candidates are chosen for a selection interview to assess their suitability in terms of the program criteria. Criteria for programs typically include that inmates be:

- accepting of responsibility for sexual offending and demonstrate a willingness to openly discuss all aspects of their criminal behaviour cycle … requesting treatment and demonstrating a motivation to change [and] of average cognitive/intellectual ability.\(^{194}\)

The two psychologists who facilitate the program conduct the interview, and the inmate’s IPO may also be present. Interviews generally last for about 45 minutes, and are aimed at assessing inmates’ motivation levels, level of relationship skills, and insight in the nature of their problem. The inmate is advised that he may not be selected for the program, and of the consequences should he drop out after the first two weeks (namely placement on zero pay, lowering chances of favourable recommendations and denying other inmates an opportunity to participate in the program) and the content of the group therapy program is briefly explained. He is provided with a copy of a “treatment agreement”,\(^{195}\) and is asked to consider it, and sign it in his own time, between the interview and notification of whether he has been selected for the program.

The signing of this agreement is effectively the only overt reference to obtaining the informed consent of inmates in the correctional treatment process. Although the consequences of withdrawing from the program are explained, the treatment agreement

\(^{194}\) See the *SOP Manual, supra* note 171, at 3.
\(^{195}\) See the forms in Appendix B. These forms effectively acts as a record of informed consent.
falls far short of including sufficient content to meet the requirements of evidence of informed consent. Little information is provided as to the content of the program, or the rights of the inmate with respect to the program; rather the focus is upon the obligations of and concessions to be made by inmates upon entering treatment.

The content of the cognitive-behavioural programs for sex offenders operated by CSC are outlined in manuals provided for program facilitators. The program manual states under the heading “treatment goals”, that by:

becoming a member of the “therapeutic culture” and participating in the program,

offenders will have the opportunity to develop insight/understanding into their deviant/dysfunctional behaviours, and to learn “self help” skills to prevent abusive behaviours towards others or self in the future.196

The first step in treatment is then to examine and re-evaluate attitudes towards sexuality and aggression by having the inmate recognise the inappropriateness and the serious consequences of his offending conduct. The offender may then be armed with “tools” to help him control his behaviour on a day to day basis. Characteristic thought patterns and behaviour cycles are identified to assist the offender in recognising high risk situations and taking steps at these points to prevent reoffending.

Key components of this process include presenting to the group a “verbal autobiography”, as well as the detail of “thoughts, feelings and behaviours that were

196 See the SOP Manual, supra note 171, at 2; and the ITPSO Manual, supra note 171, at 4.
present prior to, during and following" the offending behaviour. These enable the
inmate to recognise their own “criminal behaviour cycle”, by identifying the key
thoughts, feelings and behaviours that are involved in building up to, acting out, and
justifying offending. The aim is to then teach appropriate deterrents and interventions
to “break the deviant cycle”. Although not physically invasive, the therapy sessions
are emotionally intense and potentially traumatic, as inmates are asked to discuss in
detail past actions, thoughts and emotions in a group setting.

Having briefly outlined the process of referring inmates to treatment, and the treatment
techniques inmates are subject to in programs, I now turn to consider the most
important characteristic of treatment if its use is to be justified in prison settings: evidence
of treatment effectiveness. There remains considerable controversy over which
treatment model works best, and for which offenders it is most effective. The question
of treatment effectiveness is one that is central to the legitimacy of treatment as a
correctional undertaking and has been a controversial issue throughout the history of
the rehabilitative ideal.

2.2.6 Treatment effectiveness

Evaluation of treatment effectiveness has been an area of heated debate over several
decades. However, greater rigour and improved methodology in the design,
implementation and evaluation of treatment programs has given greater certainty to

197 See e.g. Gendreau & Ross, supra note 18; McGuire & Priestley, supra note 18.
claims that treatment can reduce levels of recidivism and, in particular, levels of sexual recidivism.

The wave of anti-rehabilitation arguments arising from the prominence of the medical model reached a peak in the mid 1970's following a declaration in the treatment evaluation literature that “nothing works”. This peak of anti-rehabilitation sentiment corresponded with the shift in correctional policy discussed above. Subsequent reflection upon the question of treatment effectiveness in prison settings suggested that this pessimism as to the future of rehabilitation was unwarranted. It can not seriously be contended that research which has continued since that time has exhausted the limits of knowledge in the area of correctional treatment, or reached a definitive conclusion that treatment could never be effective in a prison setting. Further, it has been acknowledged that many of the factors working against treatment effectiveness and measurements of effects are not necessarily related to the treatment itself, but to problems such as failing to implement programs as they were intended, or to design appropriate evaluations. Adequate resources and support are essential for programs

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198 See Martinson, supra note 143. The actual conclusion drawn (at 49): “It is just possible that some of our treatment programs are working to some extent, but that our research is so bad that it is incapable of telling. Having entered this very serious caveat, I am bound to say that these data ... give us very little reason to hope that we have in fact found a sure way of reducing recidivism through rehabilitation”. 199 Imprisonment was considered to no longer be the appropriate location for rehabilitative efforts; recommendations were made that treatment would be better focused within community settings, as part of probation and conditional release schemes. See Ekstedt & Griffiths, supra note 13, at 210; and “Imprisonment and Release”, supra note 103. 200 See Gendreau & Ross, supra note 18; and McGuire & Priestley, supra note 18. 201 See Gendreau & Ross, ibid., at 5-7; also V.L. Quinsey, G.T. Harris, M.E. Rice & M.L. Lalumiere, “Assessing treatment efficacy in outcome studies of sex offenders” (1993) 8 J. of Interpersonal Violence 512, as cited in Blanchette, supra note 3, at 38: “virtually all sex offender treatment outcome studies are plagued by serious methodological flaws”. 

to be implemented in accordance with original aims and intentions: a factor referred to as program integrity. Recent studies suggest that programs of high integrity are more likely to be effective if they utilise a range of available treatment approaches, are targeted at specifically identifiable risks and needs, and are provided at a level of intensity appropriate to the degree of risk. Progress in relation to program design and implementation has lead to measurable improvements in the quality of evidence of sex offender treatment effectiveness.

These advances, however, have only been fully realised in the past decade. As recently as 1989, a tentative conclusion was drawn by Furby et al. from a comprehensive review of 42 studies conducted between 1952 and 1988 that “there is as yet no evidence that clinical treatment reduces rates of sex reoffenses in general”. The authors noted that the statistical technique of meta-analysis (combining studies to obtain an overall measure of treatment effect) was inappropriate due to the methodological problems inherent in many of the studies. On this basis, it was argued that until sufficient time and resources are devoted to methodologically rigorous studies, progress in understanding sex offender recidivism would continue to be elusive. In contrast, an

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203 See e.g. McGuire & Priestley, supra note 18, at 14-15.
205 Ibid., at 27. The quality of an experimental design impacts upon the strength of the evidence and confidence with which conclusions can be made; the major issues to be considered in ensuring rigour of evaluation methodology are sample selection and size, design of comparison groups and definitions of successful treatment outcomes; see discussion ibid., at 4-9, and in Marques et al., supra note 3, at 30-34.
informal review of the literature carried out by the Solicitor General of Canada's office in 1990 adopted a more optimistic view. 18 studies conducted between 1961 and 1988 (including 8 considered in the earlier review) were considered and it was suggested that "a reasonable conclusion from the available literature ... is that treatment can be effective in deducing sexual recidivism from about 25% to 10-15%".\(^{206}\)

A more recent and rigorous study by Hall indicating positive effects of sex offender treatment resolves much of the doubt over the question of effectiveness.\(^{207}\) This study considered 12 studies published since the review by Furby that were methodologically adequate for inclusion in a meta-analysis.\(^{208}\) Recidivism across the studies was defined in terms of "additional sexually aggressive behaviour ... which resulted in additional official legal charges". The meta-analysis revealed a statistically significant difference in recidivism rates between the non-treatment (27%) and treatment (19%) groups. This difference was more pronounced in community treatment settings (from 30% to 19%) than in institutional settings (25% to 19%). Another trend that was evident was that cognitive-behavioural and hormonal treatment approaches were seen to be of a greater effect than purely behavioural approaches. Importantly, the observed difference overall was robust: that is, if the observed difference was to be rendered statistically insignificant, it would require an additional 88 evaluations of sufficient rigour that

\(^{208}\) Of the 92 studies located that were published in 1988-89, 32 were eliminated due to small sample sizes, and 48 were eliminated due to inadequate experimental design.
averaged a zero treatment effect to be included in the meta-analysis.

The conclusion to be drawn is that improved research methodology now lends greater confidence to assertions that treatment can produce reductions in sexual recidivism. The reductions may be small, but the differences are statistically significant, and the costs saved in terms of harm to potential victims (on Hall’s figures for incarcerated offenders, 6 fewer victims in every 100 people) is of immeasurable importance. Lipsey’s conclusion (in the context of efficacy of treatment for juvenile offenders) seems appropriate here: that as rehabilitative treatment has been shown to be effective generally, effort should be directed towards developing and identifying the treatment models that will be most effective.\textsuperscript{209}

As the methodology of research continues to improve, we will be able to conclude with increasing confidence which treatments produce greater effects and in which circumstances. In particular, it is hoped that improved techniques for assessing treatment needs will assist focusing treatment efforts upon those who need it most (noting that over 70\% of those in the effectiveness studies did not reoffend with or without treatment). Further, improved assessment may also assist in matching appropriate treatment means to offenders to improve successful outcome rates. It should be remembered that offending is a result of a complex interaction of many factors, and it is unrealistic to expect a treatment program to be able to eliminate

\textsuperscript{209} See Lipsey, \textit{supra} note 154, at 78.
recidivism altogether. Treatment programs should be seen in the context of a co-ordinated approach of community support and follow-up to help prevent reoffending, and indeed to reduce the incidence of first offences.\textsuperscript{210} In light of the evidence as to effectiveness of treatment in institutional settings, it appears that working towards clinical treatment goals is indeed a legitimate and justifiable aim for correctional services.

In sum, it has been argued to this point that treatment and rehabilitation remain justifiable and legitimate goals for correctional services. Punishment, and particularly punishment by imprisonment, has little to contribute to this goal and has historically been shown to have no positive effects upon recidivism rates. In efforts to rehabilitate offenders, the prison setting is in many ways counter-productive. Although treatment has been shown to be effective in the community, the punitive and coercive nature of the setting has in effect been an obstacle to implementing effective treatment programs in prisons. Treatment providers have persevered nevertheless, in light of the continued need to imprison serious offenders, and the failure of punishment alone to show any positive effects. The history of these rehabilitative efforts suggests that both ethical concerns and protecting the integrity of treatment programs are best addressed by ensuring there are clearly defined boundaries between treatment efforts and the punitive experience of imprisonment. This requires finding the appropriate balance between the

public interest in reducing recidivism and the autonomy of inmates, to assist treatment programs to adhere to the traditional ethics of clinical treatment.

Recent evaluations confirm that treatment programs can in fact reduce recidivism for imprisoned sex offenders. On the basis that treatment can be effective in reducing recidivism, there arises a moral obligation upon correctional services to facilitate treatment of sex offenders where possible, to reduce the levels of harm caused to members of the public by sex offending. The potential for coercion in correctional treatment processes to conflict with clinical values, notably the voluntariness of consent, was discussed under section 2.1. The next section will consider in greater detail arguments as to the appropriate balance between the moral obligation to facilitate treatment and the need to adhere to the traditional ethics of treatment to ensure the legitimacy of rehabilitative efforts: that is the limits to be imposed upon coercive authority in the correctional treatment process.
2.3 Limiting the presence of coercive authority

As the correctional treatment process currently operates, there is potential for the link between treatment and prospects of release to be coercive in effect, and this potential is largely ignored by the justice system and CSC. The prospect is thus raised that, rather than working towards a common goal with inmates, correctional programs are attempts to impose conformity through coercion. This prospect crystallises the dilemma of correctional treatment: given the public interest in reducing reoffending and the mandate of corrections to work towards this goal, there is a need to consider whether the use of coercion in this way can be justified or should be avoided altogether. The treatment oriented aspects of corrections thus bring into focus the conflict between society's rights and the rights of offenders. Drawing limits upon the use of coercive authority is a question of balancing these rights. This section will briefly review the impact of coercion in treatment settings before considering the appropriate limits upon the use of coercive authority in the context of the correctional treatment process previously outlined.

2.3.1 The impact of coercion in correctional treatment

In considering the impact of coercion in correctional treatment settings, some analogies can be drawn from the use of coercion in psychiatric facilities, and recent empirical work into patient perceptions of coercion in such settings. Both civil commitment and involuntary psychiatric treatment provide useful comparisons for correctional treatment settings, as they all involve considering the guiding principles for treatment of persons under detention. It is important, however, to acknowledge some important differences
between them.

As noted earlier, mental health legislation allows for treatment of some involuntarily detained patients without obtaining their informed consent, on the basis of a paternalistic rationale.\textsuperscript{211} That is, the justification for such infringements upon a patient’s autonomy is that although the patient may not want the treatment, it is for his or her own benefit that treatment is given. In the context of treatment in such psychiatric facilities, the principle of informed consent operates as an ethical safeguard to treatment practices. Only a clear clinical judgement of a mental illness of such severity as requiring treatment for the protection of the client, or for the protection of others allows a lawful infringement of consent to treatment.\textsuperscript{212}

In considering ethical justifications for involuntary treatment in mental health facilities, it is important to note that functional or decision making incompetence may mean a client is rendered substantially non-autonomous. The moral dilemma of justifying paternalistic interventions only arises when a client retains a degree of autonomy and refuses treatment. Much of the debate in this area is focused on the proper assessment of client competence. As this thesis is concerned with treatment of competent persons in correctional settings, this focus is not directly relevant here. In the correctional setting, any justification of coerced treatment must rely on the nature of the inmate’s offending conduct, and the expected benefits of treatment (primarily to society, but also importantly to the offender as

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{211} \textit{Mental Health Act, supra} note 92, ss. 31.
\item \textsuperscript{212} \textit{Ibid.}, ss. 1, 22.
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\end{footnotesize}
well) that follow if it is effective in preventing further conduct of the same nature.

Further, both the process of civil commitment and the use of involuntary treatment are governed by legal procedures and restrictions as a "super added protection" of patient autonomy.213 Those patients who are voluntarily admitted for treatment are not afforded these procedural protections, it is assumed there is no infringement of autonomy as they are making a voluntary decision to accept treatment. As admission to these facilities is predicated upon a need for treatment, treatment will usually follow within a short time period after admission. Empirical studies suggest that the labels "voluntary" or "involuntary" may not accord with perceptions of coercion in the admission and treatment processes and, further, that perceptions of coercion may be linked to poorer treatment outcomes.214

In contrast, in correctional settings, inmates are involuntarily detained, primarily as punishment for a conviction rather than treatment for any mental disorder. Within that framework, it is then suggested that inmates voluntarily participate in treatment, as a means of enhancing prospects of release, and promoting law abiding behaviour upon release. Entry into a treatment program may be a number of years after the initial detention in the correctional institution. The coercive nature of the setting (involuntary detention) is not openly acknowledged by CSC as a factor in decisions to enter treatment. It may be possible that not all inmates perceive they are coerced into treatment, and it is

213 Ibid., see also Hoge et al., supra note 8, at 169.
214 See references listed supra note 8.
certainly possible that any perception of coercion may lead to poorer treatment outcomes.

One of the major difficulties in considering the impact of coercion in correctional treatment settings is that treatment in such settings most often proceeds on the assumption by correctional services and treatment providers that it is voluntary. Therefore, the topic is not openly raised by many advocates of treatment and is generally only discussed in critiques against the rehabilitative ideal. Some commentators take a strict view that the effect of coercion is to render correctional treatment programs “scientifically unfeasible and morally objectionable”.215 Inmates are forced into program of behaviour modification and, it is argued, this can only work against treatment aims by creating resentment amongst inmates.216 Opponents of this view would argue that inmates are ultimately given a choice, albeit a constrained one, to participate (this may contradict, however, the “strong” view of voluntariness required for informed consent, as explained in section 2.1.3).217 Further, it may be countered, that society expects these efforts to be made as part of the duty of the correctional service to protect society. Considering how this duty can fit within the ethics of treatment which, as has been argued, is an essential part of the rehabilitative ideal, may assist in reaching a middle ground in this debate.

That the aim of correctional programs is to reduce recidivism in an effort to meet CSC’s

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215 See e.g. Ekstedt & Griffiths, supra note 13, at 248.
216 See e.g. Morris supra note 152, at 17-29; and , Carlson supra note 74, at 110-111.
217 See e.g. Enforced treatment, supra note 73, at 55; and Fox, supra note 56.
goal of “protection of society” suggests treatment is intended to operate to some extent as a means of social control. Allen has observed regarding correctional settings for treatment that “the ends of therapy inevitably become matters of social concern and definition, however dedicated the individual therapist may be to the proposition that the goals of treatment are ultimately matters of choice for the patient”. The problem is finding the appropriate balance between meeting correctional aims, and concern for the rights of inmates, given that some concern for inmates’ interests is necessary for a program to be truly a treatment setting. To allow the public interest to dominate correctional programs allows social control objectives to take the place of treatment objectives.

Formerly popular treatment regimens such as aversion therapy and operant conditioning raise more obvious ethical concerns in this regard. Administering noxious stimuli, withdrawing privileges, or administering penalties under the rubric of treatment causes difficulty in drawing distinctions between punitive-control and rehabilitative-treatment intentions. The failures of these techniques during the reign of the robust medical model of rehabilitation, and particularly the evident abuses in this period, suggest a need to separate treatment from punishment as clearly as possible in the correctional setting. Again, this emphasises the need for rehabilitative efforts to respect the requirement of voluntary consent to treatment.

\[218\] Supra note 26, at 28.
To observe that cognitive therapies are not as invasive or intrusive as behavioural techniques is not to say that they are without ethical concerns. Indeed, as Perkins has noted, inmates may approach the prospect of cognitive therapies with greater apprehension, internal conflict and distress than the prospect of aversion therapies.\textsuperscript{219} The process of cognitive therapy depends upon participation and co-operation to develop a working relationship between inmate and clinician, and this relationship is the central component of treatment.\textsuperscript{220} The presence of coercive authority may hinder the development of such a relationship and, therefore, run counter to the effectiveness of treatment. However, the prime concern regarding correctional treatment programs is whether we can justify, either as treatment or punishment, an attempt to impose conformity upon a resistant client through a coercive treatment mechanism. To impose treatment and treatment goals upon competent inmates can not be justified purely on the basis of imprisonment or conviction for an offence. Coerced treatment is contrary to the ethics of clinical practice, and necessarily infringes inmates' rights to psychological integrity.\textsuperscript{221}

Not only does the presence of coercive authority present an immediate threat to autonomy, but a threat is also posed on an ongoing basis from the collection of information which in the traditional clinical setting would be held in confidence. Treatment models have historically been vague and varied in their conception of

\textsuperscript{219} See Perkins, supra note 180, at 167.
\textsuperscript{220} See e.g. Winick, supra note 50; see also a similar argument in Pallone, supra note 170, at 97 for behavioural treatment using conditioning techniques.
\textsuperscript{221} See supra note 90.
criminality as an illness or disorder, and the continued development of the rehabilitative ideal has seen the state’s interest grow beyond merely the offending of the inmate, to include the whole of the life history and social environment that characterises the inmate. Much of the contemporary approach to correctional treatment is built on compiling a wealth of information upon inmates from which to make assessments of risk, and decisions regarding the inmate’s release or transfer.

As noted earlier, the nature of imprisonment entails some restrictions upon privacy.222 Surveillance of inmates, however, goes beyond the matter of institutional security (the usual justification offered for the infringement), and is part of a system of recording information upon which decisions about an inmate’s transfer or release can be based. Treatment programs potentially provide a wealth of information for use in such records. Ongoing assessments and reports serve the interests of CSC ahead of the inmate; both as a database from which to make release and transfer decisions on a “risk management” basis,223 and as a means of examining program effectiveness. Any information about an inmate, arising in the course of a program, will be disclosed by the clinician if it is relevant to release decision making, to the supervision or surveillance of offenders in the institution or community, to dangerousness or risk assessments, or to case management.224 These provisos demonstrate that a much looser approach is taken

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222 Supra notes 82-85 and accompanying text.
223 See supra note 190 and accompanying text.
224 See Commissioner’s Directive No. 803, supra note 5, clauses 12-15. These criteria are also drawn from an internal memorandum of the Correctional Service Canada, entitled Pacific Region – Confidentiality Obligations for Program Therapists 1996, from the Director of Psychology, Regional Health Centre, dated December 14th, 1995.
towards obligations of confidentiality within correctional settings.\textsuperscript{225}

The duty of confidentiality is an important aspect of clinical settings, as a means of promoting an open and honest treatment relationship. To erode the confidentiality of treatment in correctional settings is to allow the rehabilitative ideal to be debased to a modern tool of social control, as a program of risk management. The approach of risk management is based on a thoroughly utilitarian philosophy of reduction in levels of harm,\textsuperscript{226} and as such has little concern for the questions of individual autonomy that are central to treatment ethics. Contemporary treatment programs are in danger of becoming preoccupied with using information as a tool of risk management in the wider social interest, to the detriment of progressing through treatment in the inmate’s interest. Rather than addressing treatment priorities, programs may be viewed as tools for surveillance and observation, to compile information for release decision making. By devaluing inmates’ interests in treatment outcomes, correctional programs begin to lose the characteristics of treatment. If clinicians in correctional settings are legitimately aiming to help inmates reach treatment goals, a stronger commitment to the ethical value of client-clinician confidentiality may be warranted.

A further area of concern in relation to the use of coercive authority in correctional treatment is the overcoming of “denial” exhibited by treatment resistant clients. It is

\textsuperscript{225} The main exception to confidentiality in clinical settings is the presence of immediate threats to a person’s safety; see \textit{supra} note 14.

\textsuperscript{226} See \textit{e.g.} R.V. Ericson & K.D. Haggerty, \textit{Policing the Risk Society} (Toronto: University of Toronto Press, 1997) at 124.
evident that, although program selection criteria specifically require that inmates accept responsibility for their offending, treatment efforts are commonly directed at those inmates who are in denial or who are minimising the gravity of their conduct. Greer has observed that “therapists often work for long periods of time to reach a point at which the offender admits that a ... crime took place. The therapist has to help the client acknowledge his behaviour ... before he can be helped to inhibit it”.

Overcoming this sort of initial resistance to treatment is an area in which the therapist encounters the thin divide between influence over a client in capacity as a clinician, and authority over an inmate as an agent of the correctional service. It may be difficult to distinguish between legitimate discussion or persuasion as to treatment goals, and the use of coercion to ensure goals with which an inmate disagrees are adopted. This is an additional reason that correctional treatment programs may be susceptible to criticism as being manipulative in approach and unilaterally imposing treatment goals upon inmates.

Techniques that are successful for overcoming denial and resistance tend not to involve confrontation, but rather emphasise co-operative aspects of treatment, and the provision of information to the inmate regarding treatment aims and methods. Emphasising

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227 See supra note 194 and accompanying text.
228 J.G. Greer, “Introduction” in Greer & Stuart, eds., supra note 166, vii at xi.
229 See Perkins, supra note 180, at 168ff; see also W.L. Marshall, “Treatment effects on denial and minimization in incarcerated sex offenders” (1994) 32 Behav. Res. & Ther. 559.
the current circumstances, and the possibility of returning to prison, may also assist in motivating inmates for treatment; in this way the crisis of imprisonment is used as leverage. As dealing with denial is in effect a precursor to treatment, it is an issue that should be dealt with separately from the treatment programs being considered in this thesis.

Behaviour therapists have acknowledged that although it is inevitable some influence will be wielded over a client, it is fundamental to such therapy that the client have input in setting treatment goals. Agras, Kazdin and Wilson have suggested that in all treatment settings, clinicians will influence a client’s behaviour to some degree; the critical ethical question is therefore not about the influence per se, but whether the therapist is aware of this influence and its appropriate boundaries.  

It is apparent from discussion above that, not only is protection of inmates’ rights required for the more obviously invasive treatment means, but it is also warranted even where treatment requires considerable co-operative effort on the part of the inmate for its success (such as psychological counselling). If the presence of coercive authority in a treatment process is allowed to extend into the treatment setting, this can impact adversely upon the integrity of a program. It is possible that coerced treatment may result in poorer treatment outcomes, or in programs pursuing other interests and goals ahead of those that are truly

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treatment oriented. History has shown that the rehabilitative ideal in its implementation in prison settings has been liable to be debased and subverted to other purposes. In light of such a record, the need for continued safeguards to ethical treatment practices should not be underestimated. The difficulties discussed above do not warrant eliminating treatment from the correctional context, nor do they warrant eliminating the link between treatment and prospect of release; rather they highlight the need to develop a series of ethical guidelines to strike the appropriate balance between the interest of society and the rights of inmates to ensure that consent to treatment is informed and voluntary, and that therapy is undertaken on as confidential a basis as possible.

2.3.2 Balancing public and individual interests

Given the ultimate aim of the correctional treatment process is to reintegrate inmates into the community, an essential part of this process would seem to be restoring autonomy, self-esteem and dignity. To administer treatment without regard to the consent of inmates is to fail to give sufficient weight to the requirement that treatment be for the benefit of the offender. Thus, coerced treatment in the correctional setting loses the character of treatment, and by failing to respect autonomy may become a mechanism of social control or an instrument of punishment. Such use of coercion threatens the effectiveness of treatment by failing to operate according to the value system upon which treatment is based, as well as threatening the social value of

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231 See Allen, supra note 26; and Ericson & Burtch, supra note 24.
232 See Mission, supra note 11, at 10; and the Act, supra note 12, s. 3.
autonomy in a wider sense. In effect, this threat coercion poses means that its presence works against the aim of reintegration.\textsuperscript{233}

However, there is to some extent a moral obligation upon correctional services, arising from the goal of protecting society, to make efforts to reduce the risk of reoffending. If CSC is to respect this obligation, the experience of imprisonment must be seen as an opportunity to facilitate treatment. If no effort to were made to facilitate treatment, imprisonment would in effect be far more likely to be “warehousing” a majority of inmates. To fail to address treatment and then to release an inmate is to neglect the public’s interest in rehabilitation of offenders,\textsuperscript{234} to fail to address treatment and thereby prolong incarceration is to neglect the inmate’s interest in rehabilitation.\textsuperscript{235} The correctional treatment process draws a middle ground, linking treatment to the prospects of release to use the pressures inherent in the circumstance of imprisonment as motivation for treatment.

As discussed earlier under section 2.2.5, this link is effectively manipulates the coercive authority correctional services hold over inmates. The coercive authority that is present in the treatment process creates a pressure for treatment. A distinction can be drawn here between the presence of coercive authority as creating a potential for coerced treatment,

\textsuperscript{233} See Carlson, supra note 74, at 110: “proponents of reintegration ... seek to create a therapeutic climate with a minimum of coercion ... inmates must make real choices in prison if they are to make real choices after their release”.
\textsuperscript{235} See e.g. R. v. Forster (1995), 82 O.A.C. 78.
and as resulting in treatment actually being coerced. The presence of the coercive authority does not necessarily mean treatment has been coerced.

Does the nature of an inmate’s offence directly attack social values in a way that justifies this pressure? Serious sexual and violent offending may, if considered in such a light, in themselves go some way to justifying the use of coercive authority to refer inmates to treatment in working towards the goal of the “protection of society”. However, for the reasons discussed above, the use of coercive authority must be within a framework that ultimately respects the rights of inmates to refuse treatment. That is, while it is acceptable for coercive authority to be used in the treatment referral process on the basis of a public interest, lines must be drawn to prevent this from resulting in coerced treatment.

This framework for the correctional treatment process relies upon the contention that it is possible for correctional staff to utilise the coercive authority at their disposal without resulting in coerced treatment. In other words, IPO’s can pressure or motivate treatment resistant clients to attend the treatment setting without actually denying inmates a right to refuse treatment. The proper place to exercise this right is the clinical setting, and therefore the obligation falls upon the clinician to ensure the consent to treatment is indeed voluntary. Again, as will be discussed in the concluding sections of this thesis, the need arises for clear boundaries between treatment settings and the “custodial-punitive” aspects of corrections, to assist clinicians in this task. In particular, treatment staff should not play any role in administrative or disciplinary decision making, nor be seen to be influential in decisions with respect to the transfer or release of inmates. If programs are to have
integrity as a treatment setting, the clinician must be seen as a treatment provider only, and not as a jailer. To safeguard against the effect of coercion in treatment, clear guidelines need to be prescribed to ensure clinicians are able to honour the obligation to secure voluntary consent to treatment, and any direct links between treatment providers and release decision making need to be removed.\textsuperscript{236}

How does this contention as to how correctional treatment could operate compare with how current treatment processes actually do operate? Do the practices and procedures of CSC with respect to placing of inmates in treatment programs sufficiently address the presence of pressures that may compromise voluntariness of consent, as to adequately protect the right to refuse treatment? Some of the critiques of the rehabilitative ideal considered to this point suggest that the overwhelming effect of an "inherently coercive" environment such as a prison setting renders treatment questionable in terms of both ethics and effectiveness.\textsuperscript{237} Others suggest that the link between treatment and prospects of release that is necessarily coercive in effect, creating a "corrupting link between coercion and cure".\textsuperscript{238} However, these views beg the question of whether it is possible to achieve voluntariness of consent in such an environment.

Inmates are not incapable of consenting to treatment per se, but in light of the potential for coercion in the correctional treatment process, we need to be "alive to the risk that what

\textsuperscript{236} Compare the conclusions drawn by Ericson & Burtch, supra note 24, at 65.
\textsuperscript{237} See supra notes, 215 and 216 and accompanying text; also Retribution, Justice and Therapy, supra note 56, at 162.
\textsuperscript{238} Morris supra note 152, at 13; see also Carlson, supra note 74, at 112.
may appear, on the face of it, to be a real consent, is not in fact so. That this matter is essentially an investigation of fact illustrates the difficulty in drawing a general conclusion as to whether the referral process is coercive. The question is more easily answered if directed specifically: has this inmate been coerced in this instance? Thus we arrive at the essential empirical element, how inmates feel about their decision to enter treatment, in determining whether or not the treatment process is actually coercive in effect. Even if the intentions of correctional service providers are benevolent and rehabilitative, the experience and perspective of the inmate may be entirely different, and indeed vary drastically between inmates.

239 Freeman v. Home Office (No. 2), supra note 93, at 812, 813.
3. Empirical measures of coercion

As noted in the introductory chapter, there has been growing recognition of the relevance of clients' perceptions of treatment processes to discussions of coercion: how and in what circumstances potentially coercive treatment processes are perceived to be coercive by the client has become an area of research interest.

Arguments have been made in the previous chapter as to the need to ensure the voluntariness of consent to treatment in the face of the potentially coercive correctional treatment process. However, given the public interest in achieving treatment goals, and the needs of offenders for rehabilitation, there is an obligation to utilise the experience of imprisonment to facilitate treatment of offenders. If these two interests are to be reconciled, the contention must be that coercive authority can be used to facilitate treatment that is ultimately attended on a voluntary basis. An empirical project was conducted to gauge inmates' perceptions of the correctional treatment process, to use the results for further discussion of the arguments raised in this thesis.

3.1 Relevance of client perceptions

In the past decade, there has been a growing body of research on the impact of coercive pressures in health care.\textsuperscript{240} For ease of analysis, many studies have equated court mandated treatment or involuntary admission processes with coercion. Such simplification

\footnote{240 See e.g. \textit{supra} note 8.}
overlooks the empirically validated fact that perceived coercion is not necessarily linked to a client’s legal status.\textsuperscript{241} Although this observation arises from civil commitment and drug treatment settings, it may be applicable to the correctional setting, given it involves involuntary detention. The finding suggests that it may be possible for inmates to draw a distinction between detention and treatment and to perceive themselves as voluntary participants in programs.

Researchers have also suggested that those clients who perceived a higher degree of coercion may benefit less from treatment.\textsuperscript{242} This fact highlights the importance of the principle of informed consent and, in particular, of both the voluntariness of consent and the client’s perception of voluntariness, in creating a positive therapeutic environment in a coercive setting. Empirical studies of the role of coercion and motivations for treatment could assist in upholding ethical treatment practices, and in improving the efficacy of treatment programs in correctional settings.

Given the effect that coercion may have on treatment outcome, the question of why and in what circumstances clients experience or perceive coercion has become a central research concern. There is a developing recognition in the debate over the use of


\textsuperscript{242} See “Impact of Coercion”, supra note 8, at 320. This is an inference from the empirical finding that perceived coercion accords with resentment towards treatment providers and the treatment process.
coercion in treatment of the need to consider the client's perspective and, in particular, their perceptions of referral, admission and treatment processes. As part of this trend, several studies have utilised both quantitative and qualitative assessments of client perceptions of coercion to contribute to the debate on the use of coercion in civil commitment settings. Although the context of civil commitment raises a unique set of issues not directly relevant to this thesis (e.g. the effect of mental disorders upon perceptions, involuntary administration of pharmaceutical treatments, assessments of competency), the core concept of treatment under detention overlaps sufficiently with correctional treatment processes for these assessment tools to be of significant assistance.

For the purposes of this thesis, an empirical project was conducted using methods to measure inmates' perceptions of coercion similar to those used in the studies discussed above. A short questionnaire was administered to a group of inmates and the results analysed to determine the extent to which inmates perceive the CSC treatment processes to be coercive. The results of such analysis assist in considering the extent to which correctional treatment is actually coerced.

The objective of the project was to consider whether coercive authority can be used to facilitate treatment without denying a right to refuse treatment. In addressing coercion

243 E.g. Gardner et al., supra note 241; and Hoge et al., supra note 8.
244 Discussion of the potential differences between actual and perceived coercion appears above under Chapter 2, section 2.1.3.
on an empirical basis, some individual factors need to be accounted for (e.g. length of sentence, length of time served, the inmate's attitude towards CSC and his relationship with his Institutional Parole Officer (IPO), the harshness of the particular institutional setting) to understand the different levels of motivation and perceptions of coercion. For this reason, demographic information was collected and a short interview was conducted with participating inmates to provide a context for the measurement of perceived coercion.

This chapter will present the design, implementation and results of this empirical project. The statistical information will be analysed, and issues arising from the comments offered by inmates in interviews will be reviewed, to reflect upon the discussion of treatment in correctional settings from Chapter 2. A central question to be addressed will be whether the results as a whole provide evidence of coercive authority impinging upon the treatment process as to suggest a need for reform. In particular, there may be a need to recognise legitimate use of coercive authority to facilitate therapeutic relationships. Acknowledging the role coercive authority plays in the correctional treatment process may assist efforts to ensure appropriate limits are placed upon its use, and promoting the importance of voluntariness of consent to treatment.

3.2 Methodology and design

To obtain both a quantitative and a qualitative assessment of inmate perceptions of
coercion and motivation for treatment, a short questionnaire and interview were conducted with a group of inmates participating in sex offender treatment programs (N=30). The questionnaire was compiled by grafting some of the basic elements of assessment tools previously used to measure client motivation in psychotherapy, and patient perceptions of coercion in mental health and drug treatment settings.\textsuperscript{245} The questionnaire seeks inmates' opinions of 20 separate statements regarding their decision to enter treatment on a five point Likert type scale from “Strongly Agree” to “Strongly Disagree”. Motivation is examined in terms of external motivating factors, such as the prospects of release or transfer, as well as internal motivation (or self-motivation) and absence of motivation. Decision making pressures are assessed in accordance with the Admission Experience Interview (AEI) scale for measuring coercion in civil commitment, using the following concepts: (1) the idea of entering treatment; (2) freedom to enter treatment; (3) choice to enter treatment; (4) control over entering treatment; and (5) influence over the decision to enter treatment.\textsuperscript{246}

The questionnaire allowed for quantification of responses along a scale from -2 to +2 for each response. The questions adapted from the AEI also enable quantification of perceived coercion on a scale from 0 to 5. In this way statistical analysis can be done for each item on the questionnaire, to test for significant differences between groups of

\textsuperscript{245} See Gardner \textit{et al.}, \textit{supra} note 241; Marlowe \textit{et al.}, \textit{supra} note 241; and L. Pelletier, K. Tuson & N. Haddad, “Client Motivation for Therapy Scale” (1997) 68 J of Personality Assessment 414; A copy of the questionnaire appears in Appendix A.

\textsuperscript{246} See Gardner \textit{et al.}, \textit{supra} note 241, and the questionnaire in Appendix A.
participants. Two short answer questions relating to advantages of program involvement and disadvantages of not being involved in the program were also included. The answers to these questions can also be analysed in terms of whether they reveal external or internal motivations.

Revisions of the questionnaire were made in consultation with Dr. D. Boer (Regional Adviser Psychology/Research), on behalf of the CSC Research Committee (Pacific Region), and with Dr. J. Ogloff, from the Psychology Department of Simon Fraser University. In particular, in an effort to account for any self-deception or impression management when analysing inmate responses, the Balanced Inventory of Desirable Responding (BIDR) was added to the questionnaire.

Participants for the interviews were recruited from groups attending the 5 month Sex Offender Program (SOP) at Mountain Institution and the 8 month Intensive Treatment Program for Sex Offenders (ITPSO) at the Regional Health Centre (Pacific Region). The Regional Health Centre (RHC) specialises in treatment; it is an accredited hospital and a multi-security level institution offering intensive treatment to inmates who are assessed as high risk. In general, inmates attending the SOP at Mountain Institution

\[247\] In particular, comparing those inmates who had recently completed a treatment program (n=15), with those who had just commenced a treatment program (n=15); and comparing those inmates from Mountain Institution (n=14) with those from the Regional Health Centre (n=16).

\[248\] Compare the study by Marlowe et al., supra note 241.

(Mountain), a medium security institution offering a range of general programs, are of lower risk levels, have committed less serious offences, and are serving shorter sentences than those who attend the RHC.

I met with potential candidates in both a group and individual setting to inform them of the purposes of the study, and of their opportunity to participate. Those inmates who agreed to complete the questionnaire were required to sign a consent form, advising them of their rights in respect of the study. Particular care was taken to explain the content of the form to inmates, with emphasis placed on the fact that:

1. the study was conducted independent of CSC;
2. participation in the study was voluntary;
3. the answers given were confidential; and CSC would only have access to the results in anonymous form, and would not be able to identify participants in the study;
4. the inmate had a right to withdraw from participation in the study at any time; and
5. the answers given, or the inmate's participation in or withdrawal from the study could not have any bearing or influence on the inmate's relationship with CSC.

No incentives or inducements were provided to inmates who participated.

Out of 51 inmates approached, 30 agreed to participate in the study. Four different

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250 See the consent form in Appendix A.
groups completed the questionnaires: a completed SOP group (n=8), a recently commenced SOP group (n=8), a completed ITPSO group (n=7), and a recently commenced ITPSO group (n=7). Participants were asked to raise any other concerns or questions they might have, with specific reference to difficulty answering any aspect of the questionnaire, or any additional comments they may wish to make.

Completed questionnaires were coded alphanumerically for identification purposes, to allow anonymous matching of "demographic" information. This information was obtained from inmate files on the CSC's computerised Offender Management System (OMS), and included the nature of the offence for which the sentence was being served, the length of sentence, the time served at the date of interview and the age, education, race and marital status of each offender. Initially, attempts were made to obtain information on any previous time served in federal prisons; however, due to the age of some of these records, this information was not reliably available through the OMS. As the information available was incomplete, this aspect was not pursued further. Upon having completed the compilation and analysis of statistical information, any documentation linking names to alphanumeric coding was destroyed, to ensure confidentiality could be maintained.

3.3 Hypotheses

Under the current treatment practices described under Chapter 2, section 2.3.1 above, the inducement to enter a treatment program comes from the IPO assigned to each
inmate, rather than from the clinicians who facilitate the program itself. Given the five to eight month duration of the treatment programs considered in this study, if the inmate is aware of a right to refuse treatment, or to withdraw from the program, the consent given will be of a continuing nature. If, as is the aim of treatment, some therapeutic relationship is allowed to develop between a clinician and an inmate, it is possible that the role of coercive authority in motivating inmates to remain in treatment will diminish over time. Indeed, if some progress were not made towards this end, the presence of coercive authority would tend to work against the goals of the treatment program. This is a practical formulation of the contention made earlier has to how the correctional treatment process should operate, and is in effect the hypothesis to be examined: whether coercive authority can be used to facilitate treatment that is ultimately attended on a voluntary basis.

If the treatment process does operate as contended, it would be expected that most respondents will demonstrate some perceived coercion in relation to entering the treatment program, and greater levels of external motivation (particularly the prospects of release or transfer) than of internal motivation for treatment. It would further be expected that the group which has completed the program will demonstrate a significantly lower degree of perceived coercion and external motivation, and higher levels of internal motivation when compared to the group which has not as yet completed the program. Beyond testing these two limbs of this hypothesis, the range of groups and demographic information considered allows for a broader analysis of a
more investigative nature, in terms of characteristics that may correlate with perceptions of coercion or levels of motivation.

3.4 Results of questionnaires

The questionnaire was designed to enable comparison of the extent to which inmates were self-motivated for treatment, had a lack of motivation for treatment (amotivation), were motivated by non-specific external factors, and the extent to which they acknowledged parole and transfer to lower security as a motivator for treatment. Also included were items relating to the AEI scale to measure perceived coercion, and a single item addressing the motivation for treatment if the inmate were not in prison. Each item on the questionnaire was allocated a score in accordance with the answer given, ranging from -2 for “Strongly Disagree” to +2 for “Strongly Agree”. The scores for related items (other than the AEI) were then added together, and the totals divided by the number of items to give a measure on a linear scale from -2 to +2 for “self-motivation”, “amotivation”, “external motivation”, “parole as a motivator”, “transfer as a motivator”, and “would be in treatment if not in prison”.^251

The AEI perceived coercion scores were calculated using “weighted” scores rather than the linear scale. This method was adopted from the original study in which the scale was devised, and is based on a “correspondence analysis” of the sample scores in the original

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^251 The questionnaire appears in Appendix A. The items relating to the AEI are numbers 1, 6, 11, 15, and 18. Those relating to self motivation are 3, 5, 7, 12, 13 and 16; to amotivation are 2 and 10; to external motivation are 8 and 17; to parole are 4 and 14; to transfer are 9 and 19, and the item in relation to “if not in prison” is number 20.
study.\textsuperscript{252} This technique provides values for the scale that reflect the fact that the intervals within the response range on a Likert type scale may not be equal.\textsuperscript{253} The resulting scores are on a scale from -0.2 to 5.3. Finally the BIDR scores were calculated for both the self-deception and impression management measures, using the method described by Paulhus.\textsuperscript{254}

All of these measures were then entered into a spreadsheet, along with the corresponding demographic information obtained from the offender management system files: (a) the institution at which treatment was attended; (b) whether treatment had been recently commenced or completed; (c) age; (d) race; (e) marital status; (f) education level obtained; (g) offence type; (h) length of sentence; and (i) time served for each inmate.

Several statistical tests were then conducted to examine all of the data. First, an analysis of variance was conducted for the measures of perceived coercion and motivation across the demographic variables that are dichotomous (e.g. the institution at which treatment was attended, and whether treatment had been recently commenced or completed). Correlations with the measures of perceived coercion were then calculated for all of the remaining continuous variables. The analyses of variance and correlations enable

\textsuperscript{252} See Gardner et al., supra note 241. This study used a 4 item AEI - this was slightly modified here into a 5 item scale imputing weighted values for the “idea” item from the “freedom” item (“idea” was absent from the original AEI), and imputing two extra values for “choice” from the “control” item values (on the original AEI, choice was a yes/no item). A 4 item AEI score was also calculated, and was seen to make no significant difference to the tests conducted.

\textsuperscript{253} That is, the difference between “Strongly Disagree” and “Disagree Somewhat” may be more than the difference between “Disagree Somewhat” and “Don't Know”.

\textsuperscript{254} Paulhus, supra note 249.
conclusions to be drawn as to whether there are any statistically significant relationships between the measures of perceived coercion and the other variables.

To measure the impact upon the results of any self-deception or impression management amongst inmate responses, an analysis of covariance with the BIDR scores was conducted. Finally, chi-square tests were conducted to assess whether any significant differences existed in the demographic information between the four groups, which could possibly explain any other observed differences. The results emerging from these analyses are discussed below.\textsuperscript{255}

3.4.1 Description of the offender sample

Although the sample of sex offenders interviewed is relatively small, it does appear to be representative of the institutional population in terms of racial distribution and average age of sex offenders when compared to a recent review of CSC's offender management system conducted to profile the sex offender population.\textsuperscript{256} Eighty percent of the sample was Caucasian (compared to 75 percent under the review) and 13 percent was Aboriginal (compared to 19 percent); the average age was 41 (compared to 42).

The sample was slightly skewed towards inmates serving longer sentences, a logical consequence of focusing upon two medium to high security institutions. Seven of the

\textsuperscript{255} Throughout this analysis, statistical significance is determined on a probability (p value) of 0.05; that is to a 95\% confidence level. Where the confidence level is 99\% or greater, this has been noted.

\textsuperscript{256} Motiuk & Belcourt, \textit{supra} note 5.
inmates interviewed were serving life sentences, and 5 indeterminate sentences (under Part XXIV of the *Criminal Code*). The mean determinate sentence being served was 5 years 8 months (compared to 4 years 3 months under the review). Just under one half of the sample (47 percent or 14 inmates) had received a grade 12 education, with only 20 percent (6) having failed to reach a grade 10 education level. Nine of the sample of 30 were married or in a common law relationship at the time of the interview, 13 were single, with the remaining 8 either separated or divorced.

Broken down by type of offence, the sample included 17 inmates convicted of sexual assault, 8 inmates convicted of sexually motivated murders, and 5 convicted paedophiles.

### 3.4.2 Admission Experience Interview scores

As a whole, the sample indicated relatively little perceived coercion on the AEI (a mean of 0.76 on a scale of -0.2 to 5.3, with a standard deviation (SD) of 1.16). The low levels of perceived coercion are also corroborated by scores indicating reasonable levels of self-motivation for treatment (a mean of 1.4, SD = 0.1), and low levels of amotivation (a mean of -1.7, SD = 0.1) across the sample. The majority of inmates indicated, through both their AEI scores and comments made during the interviews,

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257 *Supra* note 92.
258 Note that one of these inmates is also one of the 5 inmates serving an indeterminate sentence under Part XXIV of the *Criminal Code*, *ibid.*, the other 7 have a mandatory parole ineligibility, 1 for 10 years, and 6 for 25 years (see ss 745.4, 745.5 and 746.1 of the *Criminal Code*, *ibid.*, and s. 120 of the Act, *supra* note 12).
259 Note that, with the exception of the AEI scores, all other measures are on a scale from -2 to +2.
that ultimately they perceived that they had a right to refuse the treatment offered. Although these findings support the argument that linking treatment to prospects of release need not be coercive, the hypothesis that many of those inmates commencing treatment would feel coerced was not supported.

It is important to note that the AEI scale was developed within the context of assessing perceived coercion in the civil commitment process. Its reliability and internal consistency have been shown within this setting, where it has repeatedly been observed as having a bimodal distribution (most scores being grouped at 0 or at 5).260 This suggests that those patients who felt coerced in their admission to treatment generally indicate this on all the "dimensions" of coercion evident in the scale (idea, freedom, control, influence and choice). The sample of AEI scores obtained here in the context of correctional treatment does not replicate this distribution (as shown in Figure 1).

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260 Gardner et al., supra note 241.
Figure 1: Distribution of AEI scores in the sample, as grouped according to the nearest 0.5.

This difference in distributions is most likely a reflection of a matter discussed in Chapter 2: that the nature of coercion is dependent upon the context in which it is being considered. In civil commitment scenarios, there exists express powers to detain a person involuntarily for treatment purposes, and the AEI can be administered shortly following an exercise of such authority. In contrast, involuntary detention in the prison setting is a consequence of conviction for an offence, and although there is pressure upon inmates to enter treatment, there is no express power to compel participation. Admission to treatment may not occur until a significant portion of the sentence has been served, and is not immediately linked to the experience of detention. The AEI may not detect the influence of such pressures where an inmate has spent a great deal of time assessing his alternatives before arriving at a decision.

In the absence of powers to compel treatment, treatment is offered as a means of
enhancing prospects of release, and is required to be on a voluntary basis. In light of this important difference, I would suggest that in the correctional context there is cause for concern in relation to AEI scores registering in the middle range on the scale. To further illuminate this issue, the correlations of other variables with the measure of perceived coercion can be considered (particularly sentence length and prospects of release, given the correctional context), to ascertain whether there are any particular circumstances in which perceptions of coercion are more likely to arise.

3.4.3 Correlates of Admission Experience Interview scores

As noted above, the low AEI scores, low levels of amotivation and high levels of self-motivation for treatment did not support the first limb of the hypothesis (that those commencing treatment would feel coerced and lack motivation). Although the AEI scores for those inmates commencing treatment were greater than for those completing treatment, the difference was not statistically significant, and therefore the second limb of the hypothesis (that those completing treatment would feel less coerced) was not supported either.

Interestingly, there was a difference approaching statistical significance between AEI scores grouped according to the institution at which inmates in the sample attended treatment ($F(1, 3) = 3.708, p < 0.065$), with the mean AEI score for inmates at Mountain (1.14, SD = 0.785) greater than that for RHC (0.33, SD = 0.305). Despite a significant difference between length of time served by inmates when grouped according to
institution, the difference between AEI scores across institutions still approached significance when covaried with time served (F(1,3) = 3.74, p < 0.065). That is, even accounting for the significant difference in sentences between the institutions, there was still a difference observed in the AEI scores obtained. Given the small sample size and large standard deviation evident in the AEI scores sampled, this appears to be an important finding worthy of further consideration.

There was also a significant correlation between age and AEI scores (r = 0.371, p < 0.044), suggesting the older an inmate is, the more likely he is to perceive a degree of coercion in the treatment process. Although the correlation between AEI and sentence length was not significant, it is interesting to note that the trend is to a negative correlation. That is, the trend was towards less coercion perceived by those inmates serving longer sentences. As might be expected, there was a strong correlation between the measure of amotivation and AEI scores (r = 0.522, p < 0.003).

Given that the linking of treatment to prospects of release and transfer is in theory the major source of motivating pressure in correctional settings, the next set of findings to be considered is the extent to which inmates acknowledged chances of release, parole or

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261 The mean for Mountain was 3.7 years (SD = 4.1), and for RHC was 9.9 years (SD = 7.8), F(1,3) = 8.96, p < 0.006.
262 The correlation coefficient for these measures was -0.274, and the limit of significance for a sample of this size is -0.31 (p < 0.05). This trend may in part be due to the group of inmates serving periods of mandatory parole ineligibility. With release a distant prospect for most of these inmates (for 5 out of 7, still 10 years to be served) the link between treatment and release may be of less impact. Note that there were no inmates in the sample serving life sentences without parole ineligibility. For the purposes of this correlation life sentences with parole ineligibility and indeterminate sentences were arbitrarily assigned a value of 25 years.
transfer as a significant motivator for treatment, or were otherwise self-motivated.

3.4.4 Motivation for treatment

The questionnaire assessed motivation for treatment on a number of different dimensions: the extent to which prospects of transfer to lower security or release on parole provide motivation, the extent to which unspecified external pressures provide motivation, the extent to which inmates are self-motivated, and finally the extent to which inmates lack motivation for treatment.

As well as scoring lower on the AEI, the sample from RHC had a higher mean score in relation to acknowledging transfer to lower security as a motivator for treatment, and the difference was statistically significant ($F(1,3) = 13.83$, $p < 0.001$), with mean scores of 0.1 (SD = 0.2) for Mountain, and 1.2 (SD = 0.2) for RHC. This appears to be an issue related more to the sentence length for particular inmates, rather than the differences between institutions. There was a positive correlation with length of time served ($r = 0.363$, $p < 0.049$) and a difference in scores was also observed when the samples were grouped according to sentence length. Those inmates serving life or indeterminate sentences had a higher mean score on transfer as a motivator (1.1, SD = 0.6) than those serving sentences of 5 years or less (-0.1, SD = 0.8), and this difference was statistically significant ($F(1,4) = 5.31$, $p < 0.011$).²⁶³

²⁶³ No other significant differences between measures were noted when inmates were grouped according to sentence length in this way.
The overall scores for acknowledging parole as a motivator for treatment were similar to those for transfer. There was no significant difference in acknowledging chances of parole as a motivator for treatment across institutions. There was however a difference approaching significance across the groups commencing and completing treatment (F(1,3) = 3.79, p < 0.062), with the mean score for those beginning (1.1, SD = 0.26) higher than those completing treatment (0.35, SD = 0.26). There was also a strong negative correlation between the self-deception measure and acknowledging parole as a motivator (r = -0.517, p < 0.003), although it must be acknowledged that the self-deception scores were low. That is, the trend was towards those inmates who were not acknowledging parole as a motivator being self-deceivers.

In considering parole or release prospects as a motivator for treatment, it is important to take into account the differences in eligibility for parole across the sample. Of the 18 inmates serving determinate sentences, 9 had already served sufficient time to be eligible for parole at the time of interview. Of the 7 inmates serving life sentences with mandatory parole ineligibility, only one was within 5 years of being eligible for parole, 5 were over 10 years away, and the remaining inmate was 9.7 years away. Note again there were no inmates in the sample serving life sentences without parole ineligibility. References in this discussion to those inmates serving life does not include, therefore, life sentences with

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264 Overall mean for parole of 0.7 (SD = 0.19), and for transfer 0.65 (SD = 0.15).
265 Only two inmates registered scores higher than 10 out of 20 on the self deception scale, see infra, note 263.
266 "Regular" inmates are eligible for parole after serving the lesser of one third of their sentence or 7 years; see s. 120 of the Act, supra note 12. Note also the "statutory release" date which is two thirds of an inmates sentence for those sentenced after 1 November, 1992 (prior to this date, it is calculated by taking into account remission earned by the inmate; see s. 127 of the Act). There are more stringent criteria to be met for the NPB to justify detaining an inmate beyond his statutory release date than beyond his parole date.
267 Note again there were no inmates in the sample serving life sentences without parole ineligibility.
inmates serving indeterminate sentences, all had served the 3 years required before the first mandatory parole review.\textsuperscript{268} Analyses of variance performed for measures of motivation across the sample when grouped according to parole eligibility did not yield any significant results. However, for those inmates not serving life or indeterminate sentences, the correlation between AEI scores and proportion of sentence served was significant (n = 18, $r = 0.343$, $p < 0.05$).

In terms of other external pressures as motivation for treatment, the results were mixed. The overall mean for the measure of external motivation was zero (SD = 0.2), and there were no findings of significance. As noted above, the scores for self-motivation were high, and those for amotivation were low. This was consistent across the groups. As would be expected, there was a strong negative correlation between amotivation and self-motivation measures ($r = -0.582$, $p < 0.001$).\textsuperscript{269}

The final item in relation to motivation addressed the issue of whether inmates would seek similar treatment were they not in prison. There was a strong correlation between the scores on this item and the age of inmates ($r = 0.596$, $p < 0.001$), with older inmates being more likely to indicate they would be willing to seek treatment outside of prison. A

\textsuperscript{268} Up until amendments come into force on 1 August 1997 under the Criminal Code (high risk offenders) Amendment Act S.C. 1997, c. 17, s. 8, the first parole review for inmates serving indeterminate sentences was at 3 years. This period is now 7 years. Further reviews are held every 2 years thereafter; see s. 761 of the Criminal Code, supra note 92.

\textsuperscript{269} Also noted above was the strong correlation between AEI scores and amotivation. As might be expected, the self-motivation scores approached a significant negative correlation with AEI scores ($r = -0.358$, $p = 0.052$).
further finding in relation to this item is that the difference between mean scores across institutions was statistically significant (F(1,3) = 5.02, p < 0.034), with mean scores of 0.8 for Mountain (SD = 0.4) and -0.4 for RHC (SD = 0.4).

Two final points need to be made in relation to the statistical analysis. First, analyses of covariance performed with the BIDR scores indicated a lack of any significant impact of self-deception or impression management in responses by inmates upon the results discussed to this point. The BIDR scores were generally within a normal range.\(^{270}\) Secondly, the chi-square tests showed no significant differences in demographic characteristics across the groups in the sample that might otherwise explain any observed differences.

In discussing what these statistical results reveal about the “big picture” in relation to inmates’ perceptions of the correctional treatment process, it may provide a greater sense of context if they are briefly reviewed along with comments offered by inmates during the course of the interviews.

\(^{270}\) See Paulhus, \textit{supra} note 249; studies performed on the validity of the scale show higher impression management scores are obtained when the test is performed “publicly”, as is the case here. The sample means for the measures of self-deception (5.8, SD = 3.0) and impression management (6.1, SD = 4.7) are similar to those obtained by larger samples of “college students” and “religious adults” in previous studies. If it is accepted that scores of 11 or greater indicate a higher than usual level of desirable responding, only 2 inmates fell into this range on the self-deception scale, and 5 inmates on the impression management scale.
3.5 **Analysis of results**

The findings discussed under section 3.4 that are of statistical significance or that approached statistical significance are set out in summary in Tables 1 and 2. Table 1 lists the major findings that arose from considering the sample in groups according to the institution at which the inmate attended treatment, and according to whether the inmate had recently commenced or completed treatment.

<table>
<thead>
<tr>
<th>Variables</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>AEL across Institution attended</td>
<td>Mountain 1.14</td>
</tr>
<tr>
<td>Acknowledging transfer as a motivator across Institution attended</td>
<td>1.2</td>
</tr>
<tr>
<td>Indicating willingness to seek treatment outside of prison across Institution attended</td>
<td>0.8</td>
</tr>
<tr>
<td>Acknowledging release as a motivator across Stage of treatment</td>
<td>Commencing 1.1</td>
</tr>
</tbody>
</table>

Table 1: Summary of findings approaching statistical significance across dichotomous variables.

Table 2 lists the major findings in relation to the remaining continuous variables, such as age of inmates, time served, and the measures of coercion and motivation. The following sections will briefly review what the statistical analysis indicates about the correctional treatment process when considered in the context of the comments made by inmates, and the results of the questionnaires as a whole.
### Table 2: Summary of significant correlations amongst continuous variables.

<table>
<thead>
<tr>
<th>Variables</th>
<th>Correlation</th>
</tr>
</thead>
<tbody>
<tr>
<td>AEI and Age</td>
<td>positive correlation (0.371)</td>
</tr>
<tr>
<td>AEI and Amotivation</td>
<td>positive correlation (0.522)</td>
</tr>
<tr>
<td>AEI and Proportion of sentence served</td>
<td>positive correlation (0.343)*</td>
</tr>
<tr>
<td>Acknowledging transfer as a motivator and Time served</td>
<td>negative correlation (0.363)</td>
</tr>
<tr>
<td>Indicating willingness to seek treatment outside of prison and Age</td>
<td>positive correlation (0.596)</td>
</tr>
</tbody>
</table>

*This finding was for part of the sample only (n=18), see section 3.4.4.

#### 3.5.1 What do the Admission Experience Interview scores show?

For the majority of the inmates in the sample, little or no perceived coercion was indicated by the AEI scores (19 inmates were placed between 0 and 1 on the scale). When this finding is combined with the reasonably high levels of self-motivation and low levels of amotivation across the sample, it suggests that the low AEI scores reflect more than inmates rationalising that, in the face of substantial pressure for treatment, they are making their own decision. That is, it appears the majority of decisions to enter treatment were in fact voluntary and not mere exercises of volition.

There remains, however, a group of 11 inmates who scored between 1 and 4 on the AEI scale. The question arises, then, at what point does this measure become a “significant” perception of coercion? When these scores are considered in the context of explanations given by the inmates, scores of greater than 1.5 tend to be associated with an inmate indicating he does not feel that he has been afforded a full right to refuse treatment. In the
sample interviewed, five inmates scored over 1.5. Of these five inmates, four made additional comments indicating that they felt they had not been given a meaningful right to refuse treatment, for example:

They hang things over people's head, rather than talk it over ... I really had no choice in this.

They are gonna ... keep you in full time, so there's no real decision to be made.

The remaining inmate offered no comment. Furthermore, of the four inmates grouped under a score of 1.5, three offered comments demonstrating recognition of the pressure to enter treatment, but that ultimately they felt they had a right to refuse treatment if they so wished, while the fourth was silent on the issue. That five inmates in the sample indicated that, in their view, they did not have a meaningful right to refuse treatment is a significant result. It suggests that some reform is necessary to prevent the presence of coercive authority in the referral process from extending beyond its limits and resulting in coerced treatment.

As well as providing greater context for the AEI scores, the comments made during the course of the interviews also provide a more specific indication as to the concerns of inmates regarding the correctional treatment process. Of particular interest in is whether inmates feel that the treatment process sufficiently addressed the presence of pressure as to adequately protect their right to refuse treatment. The complexity of this issue is evident in the range of attitudes toward the decision made to enter treatment amongst inmates who had low scores on the AEI. The views ranged from those
indicating some ambiguity about the issue:

[these inmates had AEI scores of 0.5 and 1.0 respectively]

It is pushed on people; you won’t get paid, you don’t get considered for parole – that sort of says you have to take the program. I wanted to from day one; I was jumping up and down.

The NPB is continually suggesting I retake programs, without programs they won’t reconsider; I am forced into it, but I am also interested in it – it’s about 35 per cent me and 65 per cent them.

to those whose responses indicate an exercise of free choice, despite evident pressures:

[both of these inmates had AEI scores of 0]

it was totally my choice, but they did pressure me … It was left up to me over the weekend after the interview … I could’ve said no at anytime.

the decision was mine – it was suggested by the Judge, and I was in pretty much straight away.

Inmates also recognised the problems that coercion and the resent it may cause presents for treatment efforts:

I’m not an expert, but the coercion of resistant inmates can be counterproductive, you’re just gonna make them really angry about everything, and then they’re released.

You don’t retain or use what you learn if you have no choice - it defeats the purpose of being in treatment.

I believe strongly in the voluntary aspect, it doesn’t work when it is forced; some people
are simply ready to say what is required.

To be told "you are going to take this program" - hold it, before anyone can benefit you
have to be honest with yourself. A negative attitude won't do any good, you'll sit
around with 10 people and turn the program into a game.

The suggestion from these comments is that, from the inmates' point of view, the concern
is that coercion makes for ineffective treatment, rather than it resulting in unethical
treatment practices.

Generally, the comments made acknowledged the presence of pressure for treatment,
and also observed that there is a significant degree of pressure. Although the pressures
in the correctional treatment process are in theory of a similar nature for all inmates,
only a few of those sampled perceived the pressure as being unfair. As noted above,
most inmates indicated they felt that ultimately it was their decision to accept or refuse
treatment.

That the AEI is a meaningful measure in the prison setting appears to be given support by
the finding of a significant difference between mean scores across institutions.
Interpreting this difference is not an easy task. There are a multitude of differences
between the two institutions; the most obvious being that RHC is a more treatment
oriented setting, and tends to deal with inmates classified at a higher security level and
serving longer sentences than those at Mountain. However, even though there was a
significant difference between length of time served by the samples grouped according to
institution, the difference between AEI scores still approached significance when this was accounted for in the analysis. Further, although there were also correlations between AEI scores and both inmates’ ages and measures of amotivation, neither age nor amotivation varied significantly across institutions. This suggests the difference in AEI scores is more likely to be related to institutional factors (such as the security level, or staff attitudes towards inmates) than to characteristics specific to inmates (such as age or length of sentence).

The strongest suggestion of AEI scores being linked to sentence related factors is the finding in relation to the proportion of sentence served by inmates. That is, amongst those inmates serving a determinate sentence, there was a significant positive correlation between AEI scores and proportion of sentence served. It should also be noted there was a lack of any correlation between time served and AEI scores. Considered together, these results suggest that inmates who are closer to, or have passed parole eligibility or statutory release dates may be more likely to perceive coercion in the treatment process. It is possible there is greater resentment for the correctional treatment process amongst those inmates who have been denied parole or statutory release. This supports arguments for offering treatment to inmates at as early a stage as possible. Support was also found in

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271 Supra note 261 and accompanying text.
272 This result is complicated by those inmates serving life with mandatory parole ineligibility and indeterminate sentences for whom no “proportion of sentence served” could sensibly be calculated, and were excluded from the correlation. Of the seven inmates serving life, all but one were close to 10 years away from eligibility for parole. Five registered 0 on the AEI, two scored 0.5 and the remaining inmate scored 1. All of the inmates serving indeterminate sentences had passed the 3 year period for the first parole review, and all but one registered 0 on the AEI scale (an inmate who had served over 28 years had an AEI score of 2).
several of the comments offered by inmates:

I think it is better to do programs straight away - you can get back on track rather than be warehoused and making it worse.

It makes sense to get programming rather than warehousing, get out on the street, and live what we've learnt in the community, under supervision.

I think [treatment] should be started prior to imprisonment where possible. Because of warehousing, I have a lot of baggage, and it is now harder to recall.

Programming should be earlier ... they should sit down and talk to them as soon as they get in.

The final point emerging from the AEI scores is the strong correlation with the measure of amotivation. This finding, although somewhat self-explanatory, illustrates the essence of the dilemma presented by the need to limit coercion in correctional treatment: it is those inmates who lack any motivation who are more likely to resent pressure for treatment, but are in more need of pressure as a motivator. The question then becomes how to motivate this hard core of inmates in a manner that respects autonomy and does not foster resentment of the treatment process.

It is noticeable that such a "hard core" was almost entirely absent from the sample. Only one positive score was indicated on the amotivation measure (by the inmate with the highest AEI score), and another inmate scored a zero on this measure. From this sample,
therefore, it appears that few unmotivated inmates find their way into treatment programs.
The problem of motivation for treatment, like the problem of denial, is one that requires
resolution outside of the treatment setting, as a precursor for entry into treatment. By
sampling a group of inmates involved in treatment, little light is shed on the problem of
motivating those inmates who lack motivation for treatment.

3.5.2 What do the measures of motivation show?
Aside from the consistently low measures of amotivation and high measures of self-
motivation, the most significant findings are in relation to the prospect of transfer to lower
security as a motivator for treatment. The explanation for these observed differences in
this measure (greater scores for inmates at RHC, for inmates serving longer sentences and
for inmates who had already served a longer period) is self-evident: for those inmates at
higher security and serving longer sentences, transfer to lower security is more of an issue,
flowing from a natural desire to serve time in as comfortable an environment as possible.

In contrast, although the scores for acknowledging parole as a motivator for treatment
were of a similar level, there were no significant differences across institutions or
according to sentence length or time served. This suggests that enhanced prospects of
release does not play a more significant role in motivating inmates than the shorter term
interest of transfer to lower security. This result is of interest, given that it might be
expected that the link between treatment and prospects of release or parole is the
"coercive essence" of the correctional treatment process, especially for those inmates serving longer, life or indeterminate sentences. There did not appear to be any correlation, however, between AEI scores and prospects of either transfer to lower security, parole, or release as motivators.

However, as noted above, there was a significant trend towards higher AEI scores amongst those inmates who had served a greater proportion of their sentence. Again, this suggests that linking treatment to release may be more likely to be perceived as coercive by those inmates who are approaching or have passed parole eligibility or statutory release. It is difficult to extrapolate this finding beyond those inmates serving determinate sentences. Both the nature of indeterminate sentences and the length of the periods of parole ineligibility complicate the relationship between parole and treatment. For most of those inmates in the sample serving life sentences there remained as ineligibility period of around 10 years at the time of interview. It is not clear from this sample, therefore, whether there is greater perception of coercion as the end of the mandatory ineligibility approaches or is passed.

The one finding that can be related back to the original hypothesis is the difference in parole or release as a motivating factor across groups according to whether they had just completed or commenced treatment. Although the score on the "parole" items is not an indication of perceived coercion, this observed difference nonetheless accords with the

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273 See particularly, views of Allen and Morris discussed above in Chapter 2, section 2.2.5.
model of correctional treatment discussed in Chapter 2, section 2.3. That is, the manipulation of coercive authority in the form of an apparent offer of early release is being used to bring inmates to the treatment table, but this factor is a less important motivator by the end of treatment. However, the correlation between scores on the self-deception measure and scores indicating parole was not a motivator for treatment must be taken into account. This suggests the possibility that the observed difference is due to inmates at the end of the program rationalising that they must have obtained something worthwhile to have put themselves through such an experience, rather than actually beginning to adopt treatment goals. The likelihood of this explanation is, however, decreased by the fact that very few of the inmates had scores indicating significant levels of self-deception.274

Further light can be shed on this by considering some of the comments made during the interviews about perceived benefits of treatment:

[from 2 inmates who had completed treatment]
I argued with the facilitators throughout ... 3 months into the program I had the realisation that I could get something out of it.

It has definitely been a big help .... I'm looking forward to a whole new beginning.

[from 2 inmates who had just commenced treatment]
I didn't know much about the program ... Now that I've been in it for a week, I know that I'm going to benefit.

I didn't know if I needed it or not; I didn't think I had any problems ... but even after

274 Supra note 270.
two weeks, I have realised it is a good program – I will get a lot out of it.

Comments such as these appear to indicate most inmates find something worthwhile in the program at some stage of treatment. Most of the inmates interviewed made comments about personal benefits gained from treatment. When asked about the advantages of being in treatment, 90% of the sample made reference to issues of self-development (e.g. “a better understanding of myself”), whereas only 50% acknowledged institutional benefits (e.g. “chance of parole is higher”) as an advantage of being involved in treatment. Along with low scores overall on the self-deception aspect of the BIDR (which suggests the answers provided by inmates are reliable), these comments suggest the finding that prospects of parole is a less important factor upon completion of treatment is not simply due to rationalisations made by inmates, but rather indicates these inmates are actually beginning to adopt treatment goals by the end of the program.

The final measure of motivation for treatment, in terms of a willingness to seek treatment if not in prison, provided rather cryptic results. The correlation between age and willingness to seek treatment outside of prison is straightforward, being suggestive of a “maturing out” process being involved in recognising a need for treatment. However, this finding appears to contradict the correlation seen between age and AEI scores. These findings suggest that those older inmates who felt coerced may be more motivated for

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275 Research into the prediction of violence and dangerousness has suggested these decrease with age, and the finding here appears consistent with such results. See e.g. C.D. Webster, M.H. Ben-Aron & S.J. Hucker, Dangerousness: Probability and Prediction, Psychiatry and Public Policy (Cambridge: Cambridge University Press, 1985) at 37, 127; and D. Klassen & W.A. O’Connor, “A Prospective Study of Predictors of Violence in Adult Male Mental Health Admissions” (1988) 12 Law & Human Behav. 143 at 155.
treatment than the younger inmates, and harbour resent towards the correctional treatment process for other reasons. This explanation lacks support in the absence of correlations between willingness to seek treatment and measures of self-motivation and amotivation. The difference across institutions in mean scores for willingness to seek treatment outside of prison is also difficult to interpret.

Intuitively, one would expect this measure to correspond with perceived coercion. That is, it might be expected that those inmates who had higher AEI scores would be more likely to have low scores on this measure, indicating they would not seek treatment if they were not in prison. However, the lower mean score on this measure was for the group of inmates from RHC, which was also the group with lower AEI scores.

The lower score from the RHC group suggests that those inmates are more readily admitting that it is the experience of imprisonment that has lead them to treatment. Given the generally low scores on the AEI, this is a finding that again supports the argument that linking treatment to prospects of release need not be coercive. The fact that more inmates at Mountain indicated they would be willing to seek treatment on their own terms, and also indicated greater levels of perceived coercion than those at RHC, is a rather unexpected result. Again, this suggests that even inmates with some motivation for treatment may be amongst those who feel they have been denied a right to refuse treatment. A possible explanation may arise from the combination of inmates serving shorter sentences with the aim of CSC to ensure all sex offenders partake in treatment.
before their release. It may be that because those inmates are handled with a greater sense of urgency in the referral process (given that one of the factors considered in ranking priority for treatment may be sentence length and approaching release dates), they perceive more coercion. It was certainly evident from comments offered by inmates serving life sentences that this can be a disadvantage to those motivated for treatment:

[both of these inmates had above average self-motivation scores]

I have been prepared to take programs, but there are many guys doing short time, and I have been “bumped” because I’m a lifer.

I was rejected twice ... because of a backlog of people due for parole.

This explanation lacks support however, in the absence of any correlation between willingness to seek treatment outside of prison and time served. It should be remembered in considering the higher score on this measure at Mountain that the AEI scores are in general low across this group (although significantly higher than for RHC), and that this may create difficulties in extrapolating the correlation to a hypothetical sample of inmates with consistently higher AEI scores.

What then, do these results as a whole, in terms of perceived coercion and motivation for treatment, tell one about actual coercion in the correctional treatment process?

276 There is some support from the negative correlation seen between AEI scores and sentence length, although this finding did not approach statistical significance.
3.5.3 Perceived and actual coercion

A major issue to be addressed in considering the implications of the results is the relationship between perceived and actual coercion. Although it may be expected that perceived coercion corresponds with the incidence of actual coercion in most situations, as noted under Chapter 2, section 2.1.3, this will not necessarily be the case. The question then arises, how reliable are the results in terms of indicating the incidence of actual coercion? Is it possible that the majority of inmates were coerced into treatment, but that low AEI scores and comments offered are actually a result of inmates rationalising that they have a meaningful right to refuse treatment when in fact they do not? Or, conversely, could it be that the minority of inmates who did indicate perceptions of coercion were simply exhibiting resentment towards an authority and a process that has, in all the circumstances, dealt with them as fairly as possible? Resolving these questions requires further consideration of the nature of coercion.

In considering what perceived coercion can indicate about actual coercion, two issues arise: the validity of inmates’ accounts and AEI scores (coercion as an empirical concept), and the question of fairness that goes to the heart of coercion as a moral concept. A study conducted by Lidz et al. considered the validity of patients’ accounts of coercion in the civil commitment setting.277 The study found that, although in a large sample there are inevitably some discrepancies between patients’ accounts and the “most plausible factual account”278 of the admission and treatment process, patients’ accounts are generally more

277 See Lidz et al., supra note 10.
278 This is a tool developed by Lidz et al. to enable comparison of clinician, patient and family member
reliable than other sources (such as clinicians or family members). An inference can be drawn from this result to suggest that inmates' accounts of the correctional treatment process are generally valid.

When this finding is also considered in light of the general lack of response bias in the sample (as indicated by the low BIDR scores) it appears that the answers provided by inmates are, for the most part, a reliable source of information. It remains the case, however, that an inmate's account is not necessarily determinative of the presence or absence of coercion in the sense of actually coerced treatment. Further consideration must be given to the inmate's circumstances, and to the context of the treatment process. Of particular concern is whether the consequences of either refusing or accepting treatment involve any unfair advantage being taken of an inmate's vulnerability.

In the context of civil commitment, unfairness may arise from utilising diagnosis of an illness as a basis for threats or inducements to immediately override a person's wishes in the admission process. In the correctional context, the concern over coercion arises not from admission to the treatment setting, but from the relationship between treatment and the prospects of release. This may explain the difference in AEI scores seen in this project as compared to studies utilising the AEI in civil commitment settings. The low mean and skewed distribution of AEI scores in the sample suggests that coercion in the correctional treatment setting is perhaps a more subtle phenomenon than the "all or nothing" findings in civil commitment. If further empirical work is to be conducted in the correctional
setting, there may be a need to devise a measure that is more sensitive to the context, particularly to the role of prospects of transfer and release in decisions to enter treatment.

In light of this focus on enhanced prospects of release, it is notable that there were no correlations observed between AEI scores and any of the factors related to this link (e.g., sentence length, time served and parole release or transfer as a motivator) other than the proportion of sentence served. This result, considered together with the AEI scores and indicators of self-motivation and amotivation, suggests the lack of perceived coercion supports the conclusion that linking treatment to prospects of release is not inherently coercive or unfair, and did not result in the presence of actual coercion for the majority of inmates in the sample.

A stumbling block for the generality of this empirically based conclusion is the practice of indeterminate sentencing, which presents pressures for treatment of a significantly higher degree. In contrast to standard sentences, there is no certainty of a release date for those inmates declared to be dangerous under Part XXIV of the Criminal Code. The link between treatment and release is stronger in these circumstances, and has led to possible suggestion of a right to treatment for such inmates.\textsuperscript{279} However, the nature of an indeterminate sentence does not preclude the possibility of a voluntary consent to treatment.\textsuperscript{280} Murphy's argument to this effect is based on adequate explanation of the

\textsuperscript{279} \textit{R. v. Forster, supra} note 235.
\textsuperscript{280} Notably, the indeterminately sentenced inmates in the sample (n = 5) did not indicate a higher level of perceived coercion.
link between treatment and release.\textsuperscript{281} Importantly, it must be made clear that release is not predicated upon involvement in treatment per se. Rather, as indeterminate incarceration is based upon assessments of risk and of dangerousness, treatment should be explained in relation to those concepts. That is, treatment, if successful, may result in a re-assessment of an inmate as a lower risk, or as no longer dangerous. Therefore, the enhanced prospects of release from being involved in treatment follow from the likelihood of such a successful result. Related to this issue, but entirely separate from the possibility of voluntary consent to treatment by an inmate serving an indeterminate sentence, is the question of the justification for the use of such sentences. In particular, if indeterminate detention is accepted as legitimate correctional practice, the prospect that it creates a setting of inherent coerciveness as to render voluntary consent to treatment suspect in most cases is an issue that can only be addressed by taking extra care to meet the obligations of consent.\textsuperscript{282}

If it is accepted that (at least for determinate sentences) the unfairness in the correctional treatment process is not simply a result of linking treatment to release, then there must be some additional factors present for those inmates who indicate perceptions of coercion. For the few inmates who did indicate a degree of perceived coercion on the AEI scale, comments were generally offered suggesting the harbouring of resentment towards some aspect of the treatment process:

[from inmates with AEI scores of 4, 4, 2, and 2 respectively]

\textsuperscript{281} See "Consent to Organic Therapies", supra note 56.  
\textsuperscript{282} Ibid. at 188.
They didn't inform me sufficiently about the ability to access programs ... and now I have to stay past my [statutory] release date ... I have to fight like hell to ensure I am released.

I got very little out of the program, it was like an interrogation session.

They use police reports and innocent comments against you in this place - notes on a file record can haunt you. Both my case management officer and my lawyer had advised me not to discuss incidents relating to charges against me which had been dropped, but the therapist made notes about “not fully participating”.

Therapists get more information from file than from the group. The attitude is “if it is on your file, we can use it” ... There are errors ... that I have been trying to clear up ... and now, I’ll get a negative report to the NPB.

The last three comments indicate a perception of unfairness in relation to CSC’s use of information in the treatment process. Similar comments were also apparent amongst those inmates who indicated lower levels of perceived coercion on the AEI scale:

[from inmates with AEI scores of 0.5, 0.5 and 1.5 respectively]

[an inmate who had been involved in treatment programs since 1993] I need to take a break, but fear it will be used against me if I do.

If you get into trouble in the system, you have to take a program to prove something, that there's nothing wrong with you. You are under a whole lot of scrutiny here.

I think they hear what they want to hear, and translate it to their own ends ... it is quite
disturbing that they put so much faith into the paperwork.

A point that is tangential to this study but relevant to the use of information by CSC arose from the reactions of inmates to the assurances of confidentiality regarding their participation in the project. Some inmates reacted by suggesting confidentiality was simply no longer a concern, as “CSC knows everything there is to know” about them. Another reaction that was evident was that the assurances were meaningless: if CSC wanted to use what was said in the course of the study against the inmate, they would be able to do so. The attitudes ranged therefore from complacency on the one hand to near paranoia on the other. It is possible that an attitude of complacency may result in lower AEI scores, with some inmates simply resigned to complying with the system imposed upon them. Although this was not directly addressed in the study, it does not appear to be supported by the general tenor of the comments made, nor by the low scores on the BIDR scale.283

As well as concerns regarding inmate’s perceptions of CSC’s use of information arising from treatment, there also appear to be difficulties in inmates being properly informed about the nature of treatment programs. This includes a degree of misinformation about programs:

There is so much negative talk about the program in here, from those that didn’t get

283 Supra note 263; It would be expected that those inmates who had resigned themselves may be engaging in a degree of self-deception and impression management in suggesting they were not coerced. It would also be of interest in considering the effect of “complacency” to obtain data on the number of inmates who actually refuse to participate in (rather than withdraw from) CSC programs annually.
through ... people are afraid of the program.

I thought the program was about being hooked up to a machine, and being shown dirty
tables, so they can label you as a deviant.
as well as a lack of information being provided by CSC:

I would’ve worked harder toward programs at the beginning if I had known ... I spent
all my time in a welding shop: 6 to 8 hours a day for 2 years, and didn’t have the
faintest clue. I wasn’t informed about what you could gain in programs ... no one gave
me the opportunity to prove myself.

Two factors in particular that may relate to the “unfairness” component of coercion
emerge from the results of the project: the perceived attitudes of correctional staff towards
an inmate in the treatment process, and CSC’s use of information arising from the
treatment process. These factors reflect two aspects of coercion in the correctional
treatment process. First, there is a need to ensure inmates are afforded something in the
nature of procedural fairness, as a means of respecting their autonomy. In particular, it is
important that staff involved in the case management and correctional treatment process
address any concerns inmates may raise and provide inmates with an opportunity to voice
their opinion in attempts to encourage participation in treatment.

Secondly, there is a need to avoid attaching unfair consequences to a decision to accept or
refuse treatment. If inmates do not accept treatment, it is likely they will serve a longer
sentence. This consequence is not unfair, in so far as the longer sentence is based not
simply on the refusal to accept treatment per se. Rather, release decision making is based
upon assessments of the risk an offender presents to the community, balanced against the need to work towards reintegration.\textsuperscript{284} A greater concern evident among those inmates who participated in the project is the adverse consequences that may follow from information being recorded "on file" about their participation or lack of participation in a treatment program.

Of particular concern is the possibility of adverse reports being made to release decision makers as a consequence of refusing treatment, or withdrawing from a treatment program. This consequence does appear to be unfair, in so far as any negative reports failing to take into account issues of risk assessment or dangerousness independently of the decision to accept or refuse treatment. If an inmate has a real fear of such a consequence, this may lead to a conclusion that the decision to accept treatment was not voluntary. Also of some concern is the use of programs to gather information disclosed by inmates on a therapeutic pretext for file records outside of the treatment setting. This consequence is not one of coercive authority resulting in coerced treatment, but rather is an impact of coercive authority upon the treatment setting. Fear of treatment information being used for other than treatment purposes may work against building an open relationship between clinician and inmate and, ultimately, work against treatment effectiveness. Both of these concerns are able to be addressed by placing greater emphasis upon the confidentiality of

\textsuperscript{284} See the Act, \textit{supra} note 12, s. 108. I note that risk assessments do take into account some treatment related information, such as assessment of motivation for treatment, and of denial and minimisation. It should not be permissible to include, however, prior refusals to enter treatment, or withdrawals from treatment programs, if assessments are to be independent from treatment in the way described here. Compare Serin \textit{et al.}, \textit{supra} note 185, at 9.
the treatment setting and the professional autonomy of program facilitators (rather than being mere agents of the correctional service).

Overall, the comments considered here suggest that the inmates sampled are well aware of the pressure to enter treatment that is evident in the case management and treatment process. There is also support to be found for the few instances in which inmates indicated perceived coercion on the AEI scale, given that comments made by some of those inmates suggest they felt as if they did not have a meaningful right to refuse treatment. Finally, there is recognition of the problems coercion can create in terms of the effectiveness of treatment, and also of the difficulties presented by CSC’s use of information about inmates arising out of the treatment process. What then do these matters arising from inmates’ perceptions of coercion suggest for the correctional treatment process, as it currently operates, and as it should ideally operate, to minimise the impact of coercive authority?

3.6 Discussion

The empirical project was undertaken in an effort to gain insight into inmates’ perceptions of coercion in the correctional treatment process. The most outstanding result is the relatively low mean for scores obtained on the AEI perceived coercion scale across the sample.\(^{285}\) These low scores are corroborated by comments made by a majority of inmates in the sample that ultimately, they felt as if they had a right to refuse treatment. As

\(^{285}\) 0.76, on a scale from ranging from -0.3 to 5.3.
discussed above, the low levels of perceived coercion indicate there is little evidence from this sample of the correctional treatment process being actually coercive.

Much of the literature canvassed under Chapter 2, section 2.2 assumes that in the correctional environment treatment is necessarily coercive, particularly as a result of the link between treatment and prospects of release. Indeed, given that the deprivation of liberty through a sentence of imprisonment is one of the most extreme exercises of coercive authority by the state, there is a natural expectation that coercion will be evident in the correctional setting, including in the treatment programs offered. Yet, this expectation is not met by the results of the empirical project conducted here.

It is of significance, however, that 5 of the 30 inmates interviewed scored higher than 1.5 (out of a possible 5), that there was a difference approaching statistical significance between scores when grouped according to the institution in which the inmate was attending treatment, and that several of the comments made by inmates indicated they felt coerced into treatment. These findings suggest that a few inmates are being coerced into treatment, and that the extent to which coercion is perceived may vary with individual factors such as the institutional setting and the proportion of sentence served.

However, a key finding is that the correctional treatment process as described does not necessarily result in the coerced treatment of inmates. The results of the empirical project

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286 See above, section 3.5.1.
support the conclusion drawn earlier that linking treatment to prospects of transfer and release is not inherently unfair or coercive. The link does however create a strong, constant source of pressure for treatment, as a result of which some inmates may perceive the process as unfair. This perception of unfairness may arise from a failure to listen to inmates’ concerns, or from the possible adverse consequences for inmates that may follow from refusing or withdrawing from treatment.

It also appears that those inmates less motivated for treatment are more likely to feel as if they are dealt with unfairly, given the correlation between AEI scores and the measure of amotivation. This presents a considerable dilemma for the practice of correctional treatment: it is those inmates assessed as needing treatment but who are not motivated for treatment that need to be pressured if CSC is to meet its obligation to work towards “protection of society”. In addition, there is also a problem created by the lack of understanding by inmates of what treatment actually involves. Some pressure is therefore required to have inmates attend the treatment setting and become fully informed about programs. The suggestion is that to properly exercise a right to refuse treatment requires some understanding of what is involved, and the place in which the right is properly exercised is the clinical setting. In effect, in light of the public interest in treatment, inmates do not have a right to remain ignorant of treatment and what it can offer.

However, there remains a need to ensure that the use of coercive authority to motivate the unmotivated, or to inform the ill-informed, does not spill over into the treatment setting
and create problems for treatment ethics and effectiveness. It is evident from concerns raised by inmates that the treatment programs are seen in the shadow of the imbalance of power that exists between CSC and inmates, with clinicians appearing as potential adversaries in the brokering of information about the inmate for CSC and the NPB. As discussed under Chapter 2, if the program is to be truly a treatment oriented setting, there is a need to create clear boundaries between treatment and the coercive, punitive environment of corrections. In essence, there is a need to afford programs a clinical space in which the ethics of treatment can be adhered to (particularly voluntariness and confidentiality) in an effort to foster inmate self-determination and motivation for treatment goals. The difference in AEI scores across institutions suggests that institutional characteristics may play an important role in creating such a space for programs.

Although the vast differences between RHC and Mountain prevent the drawing of any firm conclusions, it may be possible that a separate, treatment oriented location may be more conducive to establishing clear boundaries between treatment and the coercive environment of corrections. Other reforms that would enhance the sense of a clinical space include affording clinicians some independence from CSC, and strengthening the confidentiality of the treatment setting.

In my view, the effort to maintain this clinical space could be further assisted by expressly recognising the role coercive authority plays in the correctional treatment process, and the potential it creates for unfairness and coercion. This recognition could take the form of a

[287] See the conclusions drawn by Weinberger, supra note 2, as to the need for therapeutic services to be organised independently of correctional administration.
"presumption of coercion" in the referral to treatment process, the presumption being that inmates referred to treatment programs are attending initially on a non-voluntary basis. It is important to emphasise that this is not suggested because the use of coercion is easily justified, but precisely because it is not easily justified. If the role of coercion in correctional treatment is acknowledged in this way, the onus is then upon CSC to ensure that the ethical concerns arising from the presence of coercive authority that are currently ignored are able to be directly addressed by clinical staff.

3.6.1 A presumption of coercion - implications for reform

Although the exact nature of amendments may depend on the result of further empirical work in this area, I would suggest a separate section in the Act should be drafted to deal with the issue of consent to treatment for the purposes of an inmate’s “correctional plan”, as opposed to general medical care. These amendments could effectively incorporate an operational “presumption of coercion”. It could be expressly provided for in the Act that referrals to treatment programs for the purposes of the selection interview process are presumed to be non-voluntary.

By erring on the side of caution and including possibly voluntary referrals within the category of “non-voluntary” rather than vice versa, extra procedural safeguards could be imposed to ensure the treatment process from referral onwards is not coerced. The obligation upon clinicians to obtain informed consent of inmates immediately prior to commencing treatment could be provided for in greater detail. In particular, obligations
should be placed upon clinicians to clearly explain the treatment process, the consequences of being involved in the treatment program, the use to which information obtained in treatment is to be put, and the right to refuse treatment or to withdraw from treatment without fear of punitive action or of adverse reports to case management. If there is a legitimate aim to help inmates reach treatment goals, then it is important that there is a commitment to addressing the ethical values of the clinic such as voluntariness of consent.

It is essential that the therapeutic environment be based upon efforts by clinicians to foster inmate self-determination and motivation for treatment goals. In practice, some emphasis could be placed on inmate involvement in setting the goals of attending treatment, rather than merely the pre-defined goals of CSC. Also, given the heightened concerns in ensuring voluntariness of consent for inmates serving indeterminate sentences, or for consent to physically invasive treatment, or techniques based on conditioning, a mandatory independent review of the consent to treatment is a warranted safeguard in these circumstances. Access to specialist grievance procedures for inmates in relation to the treatment process may assist in enforcing these requirements.

To further clarify the clinical space in correctional settings, there is also a need to strengthen the confidentiality of the treatment relationship. To open the entire clinical record to the scrutiny of the case management system and the NPB is to debase treatment programs; they become mere tools of surveillance, serving risk management purposes. While the aim of rehabilitation presupposes a link between treatment and release, it need
not be so direct as to place the clinician as a release decision maker standing between the inmate and the NPB. In explaining the nature of treatment to an inmate during the process of obtaining informed consent, the clinical benefits of treatment should be emphasised first and foremost, with the link between progress in treatment and enhanced prospects of release a secondary consequence. Further, the confidentiality of the program setting should be strengthened, to provide for disclosure of information only where there are reasonable grounds to believe the inmate poses a serious or immediate threat to his own safety or the safety of others, or is otherwise legally required.288

The bulk of treatment information should not be provided as a matter of course for release decision making or risk assessment purposes, but rather the inmate should have property in treatment progress reports, and disclosure should be at his option. A limited exception could be made in the case of carrying out risk assessments. These assessments tend not to require the substantial disclosure of sensitive information such as those that may be made during therapy.289 This exception could be included without weakening the confidentiality of the treatment relationship if risk assessments were performed by qualified staff not directly involved with program facilitation. If further assessments are required for case management or release decision making purposes, they should also be carried out by clinicians who are not associated with the treatment programs offered by CSC.

288 This last proviso is not intended to give CSC a loophole by requiring disclosure under the Act, but rather refers to requirements such as mandatory reporting of certain diseases or disorders for health policy of epidemiology purposes.
289 See Serin et. al, supra note 185.
These sorts of changes would assist in limiting the impact of coercive authority upon the
correctional treatment setting, and ensure that programs respect the autonomy of inmates
in accordance with the ethics of treatment. With clearer guidelines for clinicians to assist
in delineating between treatment and punitive goals, and the creation of a therapeutic
environment that more closely resembles those existing outside of correctional settings,
there may be potential for greater effectiveness of treatment to be realised.
4. Conclusion

4.1 Summary of argument

This thesis is concerned with the mandate of CSC to offer sex offender programs to inmates, and the potential for conflict with the obligations to adhere to the ethics of treatment in those programs. A particular focus is the role of coercive authority in the correctional treatment process and its impact upon consent to treatment. Statistics documenting a trend towards increased numbers of sex offenders being incarcerated and increased volume of incarcerated sex offenders being involved in treatment programs are testimony to the importance of the topics raised in this discussion.

Because of the severe consequences of sex offending upon those affected by it, there are high expectations upon correctional programs to effectively prevent reoffending.\textsuperscript{290} Public debate over the appropriate correctional response to sex offending to achieve the ends of justice is often fuelled by outrage and fear. Ultimately, if the problem is to be addressed rationally, it must be recognised that most sex offenders originated from our community and social network, and will return to it upon release from prison.\textsuperscript{291} If programs are undertaken as treatment for inmates, with inmate interests at heart, they may fulfil a role as a link between the punishment of imprisonment and reintegration of inmates upon release.

\textsuperscript{290} See e.g. Hall, \textit{supra} note 207, at 802.
\textsuperscript{291} See e.g. Williams, \textit{supra} note 210, at 33.
It is clear that the doctrine of informed consent applies as a legal and ethical requirement in inmate decision-making regarding treatment programs. If voluntary consent to treatment is to be a meaningful requirement in this setting, some respect for inmate autonomy must be afforded by the treatment process. That is, the decision to enter a treatment program must be more than the mere exercise of volition; there must be some limit to the pressures placed upon inmates as to enable the exercise of a right to refuse treatment. However, the nature of incarceration is such that it necessarily entails constraints upon inmate autonomy above and beyond the deprivation of liberty. The presence of a link between treatment and prospects of release from such settings raises the question of whether consent to treatment can be truly voluntary.

Further, the power imbalance inherent in the relation between the correctional service and its inmates gives rise to concerns regarding the role of coercive authority in effecting treatment. The ethics of the clinical setting with clinicians working on behalf of persons who have acknowledged their need for treatment, is compromised to some extent by the punitive and coercive nature of correctional deprivation of liberty. The nature of the prison setting presents obstacles for creating an ethical and effective treatment environment, and has been seen to have subverted past treatment efforts to punitive and social control ends. These sorts of difficulties do not tend to arise for community based treatment programs.
Although it may be possible to reduce the use of incarceration as a punishment, it is unrealistic to suggest it could ever be eliminated as a sentencing option for the offenders under consideration in this thesis. On the basis that incarceration alone has had little impact on reducing reoffending, and that treatment has been shown to be of some impact, efforts to rehabilitate offenders through the provision of treatment programs in prison settings remain a legitimate undertaking of correctional services. Indeed, both the public interest in reducing offending through rehabilitation, and the evident treatment needs of inmates, suggests an obligation upon CSC to facilitate inmate involvement in programs. However, given that the predominant aims of incarceration tend to be “custodial-punitive”, clinicians operating in this setting must be aware of the risk that treatment, or elements of the treatment process, may be perceived by inmates as part of the experience of punishment.

Of particular interest in this thesis were the views of inmates involved in programs of the correctional treatment process: whether inmates were motivated by the link between treatment and release, and whether they felt coerced into treatment. It was evident from the empirical project that inmates tended to be motivated in part by the prospects of both transfer to lower security and of release. This was not, however, seen to be associated with any perceptions of coercion. Generally, the levels of perceived coercion were low across the sample of inmates interviewed. A minority of inmates did, however, indicate a significant level of perceived coercion. Higher levels of perceived coercion appear to arise from inmates who are older, less motivated for
treatment, or serving shorter sentences.

Importantly, perceptions of coercion were not directly related to the link between treatment and release, but whether inmates felt their views or concerns were adequately addressed in the treatment process, or whether they perceived unfair consequences arising from CSC’s interest in treatment related information.

4.2 Conclusions

In conclusion, it is my view that in many instances, the CSC does not appear to fully discharge the obligations it has set down for itself to secure voluntary consents to treatment when referring inmates to treatment programs. There appears to be little concern with informed consent in the correctional treatment process, other than offering a “treatment agreement” as token evidence of apparent consent. The ideal pursuit of rehabilitation envisages therapy occurring on an entirely voluntary basis; the ethics of traditional clinical settings suggest clinicians work on behalf of persons who recognise their need for treatment, actively seek it out and are voluntary participants. However, this does not seem to be a realistic option if programs are to continue to be offered in higher security settings. Nor does it seem sensible to consider dispensing with treatment programs altogether in these settings. Despite frequent revisions to correctional policy and practice, it has always been the legitimate scope of correctional authority to seek transformations of individuals to reduce the likelihood of criminal behaviour. To the extent this may require using coercive authority to facilitate the
appropriate treatment, this must be accepted. The inherent conflict this presents with the ethics of therapy makes it important to minimise impact of coercive authority to prevent the potential for coerced treatment being realised.

The use of coercion, in the sense of coerced treatment, is not justifiable for competent inmates in the correctional context because of the threat such practices pose to the value of autonomy in a wider, social sense. However, the use of coercive authority to refer inmates to treatment is a necessary part of the correctional treatment process if CSC is to fulfil its duty to society to reduce the risk of harms from reoffending. The aim of the reforms to the correctional treatment process that have been suggested in this thesis is to minimise the potential for the presence of coercive authority to result in coerced treatment. Essentially, this involves providing sufficient space for clinicians to operate independently of the coercive pressures that have led the inmate to the treatment table. In particular, clinicians must be able to ensure that inmates make a voluntary choice, accepting or refusing treatment, with the reassurance that they are being handled fairly by the treatment process. It is the question of fairness (particularly procedural fairness and fairness of consequences flowing from accepting or refusing treatment) that is at the heart of preventing coercive authority from resulting in both perceived and actual coercion, to the detriment of treatment.

In my view, recognising the role of coercive authority will lead to acceptance that changes to the current provisions regulating treatment in CSC facilities of the nature
outlined above are warranted. Acceptance of the potential for referrals to treatment as being “non-voluntary” need not be construed as to the detriment of voluntariness in treatment. Rather such a step should be an impetus for setting out more clearly the obligations upon CSC to protect and promote the inmate’s right to refuse treatment without fear of punitive response.

Greater understanding of the impact of coercive authority upon the treatment process would assist in the upholding of ethical treatment practices in correctional settings. It is often asserted in discussion of rehabilitative ideals, that the goals of inmate reformation and reintegration can only be effected in a truly humane environment; and that ethical practices are therefore a prerequisite to treatment effectiveness. The need to remain vigilant should not be underestimated as, in the pursuit of more effective treatment interventions, the types of programs promoted in corrections are apt to change as new theories are provided to ground them.292 As understanding of criminal behaviour continues to develop, so too must discussions of ethical concerns regarding correctional programs and practices.

292 J.W. Ekstedt & M.A. Jackson, supra note 11, at 115.
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Legislation


Mental Health Act R.S.B.C. c. 288, s. 31.


Cases


Rogers v. Whitaker (1992), 175 C.L.R. 479 (H.C.).

Schloendorff v. Society of New York Hospital, 211 N.Y. 125 (Ct. App. 1914).


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Appendix A

Consent Form and Questionnaire
CONSENT TO PARTICIPATE IN TREATMENT DECISIONS STUDY

1. GENERAL INFORMATION

Principal Investigator: Professor Isabel Grant, University of British Columbia, Faculty of Law. Ph 822-3140 or 731-1686

Co-Investigator: Jeremy Rigg, Masters Candidate, University of British Columbia, Graduate Law Programme. Ph 738-4897

If you have any questions or require further information with respect to this study, please contact either Isabel Grant or Jeremy Rigg on the numbers above.

If you have any concerns about your treatment or rights as a research subject, contact the Director of Research Services at University of British Columbia, Dr. Richard Spratley at 822-8598.

Study purpose and procedure:

Your participation in this study is by way of completing a short questionnaire/interview in relation to your views and your reasons for deciding to undertake treatment programmes offered by the Correctional Service of Canada. It is hoped that the information you and other participants provide will assist in enabling a better approach to programming and offering of programmes within prisons.

Confidentiality

The information resulting from the study will be kept strictly confidential. Completed questionnaires will be identified only by code number, and will be stored securely at all times. Computer stored information will be password protected. Participants will not be identifiable by name in any reports of the completed study.
2. PARTICIPANT'S CONSENT

It has been explained to me, and I understand that:

this study is being undertaken by a graduate student in association with the Faculty of Law at the University of British Columbia, and is entirely independent of the Correctional Service of Canada;

my participation in the study is voluntary, and only involves completing a short questionnaire/interview;

the answers I give are entirely confidential; and in particular no one in the Correctional Service of Canada will be able to identify me as a participant in the study;

I have the right to withdraw from participation in the study at any time; and

the answers I give, and my participation or withdrawal will have no bearing or influence on my relationship with the Correctional Service of Canada or its staff.

I have been provided with a copy of this form for my own records.

I consent to participate in this study

Signed: ________________________________

Date:

Witnessed: ______________________________

Date:
TREATMENT DECISIONS QUESTIONNAIRE

Participant ID:

A. Please read each of the following numbered statements carefully, and circle the answer beneath it that reflects your attitude towards that statement.

1. It was my choice whether I started the treatment program or not.
   Strongly Agree  Agree somewhat  Don't know  Disagree somewhat  Strongly disagree

2. I don't really know why I’m in the treatment program, I haven't thought about it before.
   Strongly Agree  Agree somewhat  Don't know  Disagree somewhat  Strongly disagree

3. I am involved in the treatment program because I am interested in understanding more about myself.
   Strongly Agree  Agree somewhat  Don't know  Disagree somewhat  Strongly disagree

4. I am involved in the treatment program to improve my chances of parole.
   Strongly Agree  Agree somewhat  Don't know  Disagree somewhat  Strongly disagree

5. I am involved in the treatment program because I believe it will help me to deal with things better.
   Strongly Agree  Agree somewhat  Don't know  Disagree somewhat  Strongly disagree

6. I had more influence than anyone else on whether I started the treatment program or not.
   Strongly Agree  Agree somewhat  Don't know  Disagree somewhat  Strongly disagree

7. I am involved in the treatment program because I feel I need to have a better understanding of myself.
   Strongly Agree  Agree somewhat  Don't know  Disagree somewhat  Strongly disagree

8. I am involved in the treatment program because other people think it is a good idea.
   Strongly Agree  Agree somewhat  Don't know  Disagree somewhat  Strongly disagree
9. If I was not involved in the treatment program, I wouldn’t get transferred to a lower security classification.

   Strongly Agree    Agree somewhat    Don’t know    Disagree somewhat    Strongly disagree

10. I don’t understand what I can get out of the treatment program.

   Strongly Agree    Agree somewhat    Don’t know    Disagree somewhat    Strongly disagree

11. I had a lot of control over whether I started the treatment program or not.

   Strongly Agree    Agree somewhat    Don’t know    Disagree somewhat    Strongly disagree

12. I am involved in the treatment program for the satisfaction of achieving personal goals.

   Strongly Agree    Agree somewhat    Don’t know    Disagree somewhat    Strongly disagree

13. I am involved in the treatment program because I would like to make changes to my current situation.

   Strongly Agree    Agree somewhat    Don’t know    Disagree somewhat    Strongly disagree

14. If I was not involved in the treatment program, I wouldn’t get parole.

   Strongly Agree    Agree somewhat    Don’t know    Disagree somewhat    Strongly disagree

15. I felt I was free to become involved in the treatment program or not.

   Strongly Agree    Agree somewhat    Don’t know    Disagree somewhat    Strongly disagree

16. I am involved in the treatment program because I would feel bad if I was not doing anything about my problems.

   Strongly Agree    Agree somewhat    Don’t know    Disagree somewhat    Strongly disagree

17. I am involved in the treatment program to satisfy other people who want me to get help for my situation.

   Strongly Agree    Agree somewhat    Don’t know    Disagree somewhat    Strongly disagree
18. It was my idea to become involved in the treatment program.

Strongly Agree  Agree somewhat  Don't know  Disagree somewhat  Strongly disagree

19. I am involved in the treatment program to improve my chances of transfer to a lower security classification.

Strongly Agree  Agree somewhat  Don't know  Disagree somewhat  Strongly disagree

20. If I was not in prison, I would try to become involved in this sort of program.

Strongly Agree  Agree somewhat  Don't know  Disagree somewhat  Strongly disagree

B. Please answer the following short questions:

1. What advantages do you think will result from your involvement in the treatment program?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

2. What disadvantages do you think would result if you were not involved in the treatment program?

________________________________________________________________________

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Appendix B

Treatment Referral Form and Treatment Agreements
<table>
<thead>
<tr>
<th>Program</th>
<th>Institution</th>
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<tbody>
<tr>
<td>1. Does the Offender Intake Assessment (OIA problem indicators, CLAI results, etc) reflect a criminogenic need for this program?</td>
<td>Y</td>
</tr>
<tr>
<td>2. Is this program on this person's Correctional Plan?</td>
<td>Y</td>
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<tr>
<td>3. Has this person refused to take this program? The answer here (either way) must be confirmed with the offender.</td>
<td>Y</td>
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<tr>
<td>4. If this program has any pre-requisites, has this person already taken them?</td>
<td>Y</td>
</tr>
<tr>
<td>5. Has this person successfully completed this program before?</td>
<td>Y</td>
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</table>

**Factor 1:** (Select the most applicable statement)

1. The criminal risk is such that this program must be successfully completed at the current security level in order to facilitate reintegration.
2. The criminal risk is such that this program should be successfully completed at a lower security level in order to facilitate reintegration.
3. The criminal risk is such that this program should be successfully completed in the community in order to facilitate reintegration. (If release is pending, check with PO to confirm program availability in the community).

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**Factor 2:** What is the potential date of CMT support (for FP, Avoiding Det., Suspension Cancel., DP, Transfer, SR, UETA or ETA) following successful completion of this program (assuming other decision criteria have been met)?

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<th>Factor 2</th>
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**Factor 3:** For which type of decision will the successful completion of this program be taken into consideration? (Check one)

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<tr>
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**Factor 4:** What is the rank (in the CP) of the criminogenic factor which this program addressed? (If more than one factor is addressed, mark the rank of the highest factor)

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* Reason: 
Treatment Agreement

I ________________________________ am aware of and accept the following conditions as a candidate for participation in the Personality Disordered Sex Offender Treatment Program at Mountain Institution:

1. The Program is my top priority. For example - I will schedule all appointments such as medical, case management, A & D, visits, etc., outside program hours. Private Family Visits will only be scheduled on weekends.

2. All program absences must be covered with official documentation, (i.e. sick chits) or pay will be docked for being absent. Three absences without official documentation will mean an automatic expulsion from the program.

3. I will adhere to the program hours. If I don't my commitment to the program will be questioned and I may be asked to leave.

4. During my involvement in the program I will have no other work location.

5. I agree that if I am successful in becoming a participant in the group that I will not participate in any other self help sex offender groups during the five-month program.

6. I will maintain a daily log and monitor my five risk factors three times a day.

7. I am aware that dropping out of the program after the first two weeks will have the same effect as being suspended from a work location. I will be placed on "0" pay.

8. I am aware that the written homework component is approximately two to three hours EVERYDAY and will be handed in on a regular basis to the therapist(s). Failure to complete homework assignments will result in suspension from the program.

9. I will complete psychological testing prior to and at the completion of the program.

10. I am aware that correctional staff and practicum students may attend program sessions from time to time. I am aware that my progress in the program is shared with my Case Management Team.

11. I understand that I may be video taped during some modules for treatment purposes and my own personal growth. These tapes will be erased at the conclusion of the program.
12. I am aware that my completed Crime Cycle will be part of my official file.

13. I am aware that I will receive a written summary of my progress throughout treatment at the end of the program.

14. I am aware the Treatment Team will not make recommendations in terms of supporting/not supporting release. The written report will reflect progress made in the program and will address recommendations for further treatment, if deemed necessary.

15. Any information shared by other group members is confidential and shall not be shared with or in the presence of other inmates.

______________________________  _____________________________
Candidate's Signature              Group Psychotherapist
REGIONAL PSYCHIATRIC CENTRE (PAC)

CONSENT FOR TREATMENT
(MENTAL HEALTH ACT - SECTION 19, R.S.B.C. 1979, c. 256)

RPC (Pacific) provides treatment to inmates/patients who have psychiatric/psychological disturbances that are interfering with their adjustment, both within CSC institutions and the community at large. By requesting a voluntary admission to RPC(Pacific), I am prepared to demonstrate self-control of hostile, negative, and antisocial behaviour. In order for me to benefit from treatment programs, I understand it is important and necessary that positive relationships are developed with treatment staff.

It is expected that I will not take illegal drugs or alcohol (brew) while in RPC(Pacific), and I will actively participate in socialization and treatment programs as requested by my treatment team professionals. I also agree and understand that I will submit to urinalysis or blood-alcohol testing when requested to do so if substance abuse was a factor in my history. My complete program plan will be arranged, with my cooperation, by my multi-disciplinary treatment team, and I will be expected to follow the treatment commitments that I agree to.

I understand and agree that during my stay at RPC(Pac), I may have to double bunk. I also understand and agree that group therapy sessions may be video monitored and/or videotaped for clinical reasons by members of my treatment team.

AGREEMENT

I, _______________________________, understand the above program expectations and agree to abide by them to the best of my ability. Upon my withdrawal from treatment, or upon termination, or completion of treatment requirements at RPC(Pac), I understand and agree that I may be returned to the sending institution. Return to a sending institution shall not be considered an involuntary transfer.

Should transfer to an alternate institution be indicated, the assessment and recommendations of the treatment team at RPC(Pac) shall be considered by the Case Management staff of my parent institution, and processed accordingly if the transfer is viewed to be appropriate to my security classification and correctional plan.

I, the undersigned, hereby consent to undertake such treatment at the Regional Psychiatric Centre(Pacific) as deemed necessary by the staff, including admission examinations, procedures, investigations, and treatment (including treatments or examinations in other hospitals) as ordered by doctors in attendance to me.

The aims of the Regional Psychiatric Centre (Pacific) have been explained to me and I have been given the opportunity to ask questions about the treatment here.

Patient Signature __________________________ Date __________________________

Witness Signature __________________________ Date __________________________

CR 120 (94-07)