TREATMENT OF OFFENDERS WITHIN THE COMMUNITY: THE ISSUE OF CONSENT

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CONTENTS

INTRODUCTION

> "The plaintiff submitted that this condition infringed his rights under the New Zealand Bill of Rights Act not to undergo medical treatment in the form of psychological treatment. But this condition does not require Mr Wilson to undergo medical treatment. He is only required to attend the sessions. He is not required to participate."[1]

Justice Ronald Young made this statement in a case in which a man, released from prison, challenged his release conditions. It suggests a potential incompatibility between the imposition of treatment as a condition of a sentence or parole and the right to consent to (or refuse) medical treatment. Although unsuccessful, this challenge raises further important questions that warrant consideration. In what circumstances can treatment be imposed as a condition of a sentence or parole? Could its imposition deny a person the right to consent to, or refuse, treatment? How should we define, or what constitutes, 'consent' to treatment in this situation? This dissertation seeks to consider these questions through a close examination of the relationship between treatment conditions and consent.

Community-based sentences and orders are a huge part of the New Zealand criminal justice system. In 2014, 36,451 people were under a community sentence or order (such as parole),[2] compared to 6,776 sentenced to imprisonment.[3] A convicted criminal offender is therefore far more likely to be dealt with in the community than behind bars. For this reason, the focus here will be on two particular forms of community sentence and order: supervision and parole.[4]

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[1] *Wilson v New Zealand Parole Board* [2012] NZHC 2247 at [43].

[2] Department of Corrections "Community sentences and orders facts and statistics – December 2014" (26 March 2015) <http://www.corrections.govt.nz/resources/community_sentences_and_orders/CP_Dec_2014.html>.

[3] Department of Corrections "Prison facts and statistics – December 2014" (26 March 2015) <http://www.corrections.govt.nz/resources/quarterly_prison_statistics/CP_December_2014.html>.

[4] Together, supervision and parole account for 26% of all community sentences and orders (Department of Corrections, above n 2).

When an offender is sentenced to supervision or released on parole, there is discretion to impose conditions.[5] Among these conditions are those involving some form of treatment.[6] The discretion to impose such conditions may be exercised only if designed to reduce the risk of reoffending, or facilitate the rehabilitation of the offender.[7] There can be no doubt that this will often be considered necessary in the case of many offenders, given the greater prevalence of, for example, psychiatric conditions and drug and alcohol problems among criminal offenders.[8]

Out of all possible treatment conditions, only the imposition of a requirement to take prescription medication statutorily requires the consent of the offender.[9] This does not mean, however, that the right to consent to, or refuse, treatment is automatically abrogated by the imposition of other kinds of therapeutic conditions on a sentence or order. On the contrary, there is express recognition that no condition imposed affects the rules of law relating to consent.[10]

Section 146 of the Sentencing Act 2002 provides that 'no sentence or condition imposed or order made under this Act limits or affects in any way any enactment or rule of law relating to consent to any medical or psychiatric treatment'. Thus, the effect of other legal rules that guarantee the right to consent to treatment is preserved.

For consent to be legally effective, there are, in general, several factors that must be present.[11] The person must be competent to consent, understand what they

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[5] Sentencing Act 2002, s 48; Parole Act 2002, ss 29 and 29AA.
[6] Including psychiatric counselling or assessment, attendance at a medical or psychological programme, or the taking of prescription medication (Sentencing Act 2002, ss 51 and 52; Parole Act 2002, ss 15 and 16).
[7] Sentencing Act 2002, s 50; Parole Act 2002, s 15.
[8] Although related to offenders sentenced to imprisonment, the Ministry of Health "Results from the Prisoner Health Survey 2005" ((2 December 2008) <http://www.health.govt.nz/publication/results-prisoner-health-survey-2005>) found that mental illness, alcohol and drug abuse occurred at levels in excess of those found in the general population.
[9] Sentencing Act 2002, s 52; Parole Act 2002, s 15.
[10] Sentencing Act 2002, s 146.
[11] It is noted, however, that the requirements for legally effective consent vary from one context to another (PDG Skegg "The duty to inform and legally effective consent" in PDG Skegg and R Paterson (eds) *Medical Law in New Zealand* (Brookers Ltd, Wellington, 2006) 205 at 219).

are consenting to, and be free of undue influence and coercion.[12] The crucial element discussed here is the last: that consent must be freely given. Consent that is not freely given, but proffered under duress or other coercion is, in law, no consent at all.[13]

It is arguable that the imposition of a condition of supervision or parole involving treatment occurs in a highly coercive environment.[14] There are two points at which the ability to consent to treatment may be affected by such influence: when the condition is imposed, and when the treatment is being carried out under the order. If unacceptable levels of coercion are present at these moments, this may subvert the voluntariness of the consent when an offender apparently agrees to accept treatment. It is this disparity that will be the major focus of this dissertation. How we define consent in such a situation, and what qualifies as 'effective consent', has important consequences for the acceptability and limits of treatment conditions.

In exploring the relationship between treatment conditions and consent, this dissertation has four chapters. Chapter one examines the statutory regimes in New Zealand that govern the imposition of conditions on criminal offenders within the community. The focus is on the scope of permissible conditions and the discretion to impose them, as well as exploring the degree of coercion that is arguably present.

Chapter two delves into the traditional common law definition of consent. Of particular interest is the requirement of voluntariness, and the power to treat without consent in certain situations.

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[12] See Skegg, above n 11, at 219-228; Tom L Beauchamp and James F Childress *Principles of Biomedical Ethics* (7th ed, Oxford University Press, New York, 2013) at 124-125; In *re T (Adult: Refusal of Medical Treatment)* [1993] Fam. 95; *Freeman v Home Office* [1984] QB 524.
[13] *R v Lee* [2006] 3 NZLR 42 at [326].
[14] Coercive in the sense that there is an external pressure brought to bear on the decision, and, as such, that the offender cannot be free in their mind from all feeling of constraint (see *Bowater v Rowley Regis Corporation* [1944] KB 476).

Chapter three scrutinises the meaning of 'consent' in an inherently coercive situation. By analysing cases from other jurisdictions in differing coercive environments, an overall conclusion will be drawn as to what the current legal definition of 'consent' should be, in relation to treatment as a condition of a community sentence or parole.

Finally, chapter four considers the permissible limits of treatment conditions in New Zealand and the practical importance of voluntary consent. In essence, it is argued that effective consent to, or under, a treatment condition imposed as part of supervision or parole depends on two factors: the nature of the coercion and the nature of the treatment. The relationship between these factors is an inverse one: the more extreme the treatment, the less coercion is needed to vitiate consent, and vice versa. When this approach is applied, it is contended that valid consent is possible for most standard forms of treatments, even under the terms of a sentence or order. This reflects the current practice within New Zealand's criminal justice system. But, where the treatment in particularly invasive or experimental, the degree of coercion inherent in the situation may be such that legally effective consent is not possible. It may, therefore, be inappropriate to impose these forms of treatment from the outset.

CHAPTER ONE:
TREATMENT CONDITIONS

The focus of this dissertation is on two forms of community-based sentence and order in which conditions, including treatment, can be imposed on an offender: supervision and parole. These are not the only forms of sentence or order that can involve treatment conditions. Intensive supervision, home detention, and release conditions following short-term imprisonment can also involve imposition of similar conditions.[15] However, for simplicity, supervision and parole have been chosen as examples of two different regimes under which the imposition of conditions intersects with consent to treatment.

This chapter discusses supervision and parole in depth. It will examine the Sentencing Act 2002 and Parole Act 2002, specifically focusing on permissible treatment conditions, the requirements of consent, and legal limits on the conditions that may be imposed. Chapters Two and Three will explore the common law definition of consent. One important aspect of consent is that it is voluntary, a decision not affected by coercion or duress. For this reason, this chapter will also consider whether the treatment conditions in question are imposed, and result, in an inherently coercive situation.

A. Background

Supervision is a sentence governed by the Sentencing Act 2002 and imposed by a judge upon conviction of an offender. It is a mid-range sentence, sitting above a fine or reparation and below intensive supervision or community detention in terms of the severity of restrictions.[16] It replaced the former sentence of probation under the Criminal Justice Act 1985.[17] An offender may be sentenced to supervision if convicted of an offence punishable by imprisonment or community-based sentence, but only if the court is satisfied that supervision

[15] See Sentencing Act 2002, ss 54E, 80D and 93.
[16] Sentencing Act 2002, s 10A.
[17] G Hall *Sentencing in New Zealand* (Butterworths, Wellington, 1987) at 161.

would reduce the likelihood of further offending through the rehabilitation of the offender.[18] The duration of the sentence may be between six months and one year.[19]

Parole is regulated by the Parole Act 2002. It is an order granted by the Parole Board if an imprisoned offender is deemed fit for release from prison before the end of their sentence.[20] An offender becomes eligible for parole once they have served the non-parole period of a long-term sentence of imprisonment.[21] The Parole Board may direct that an offender be released on parole only if satisfied that the offender will not pose an undue risk to the safety of the community, having regard to the support and supervision available to the offender and the public interest in reintegrating the offender into society.[22] An offender must not be detained any longer than is consistent with the safety of the community, which is the paramount consideration.[23] Parole ends either when an offender reaches their statutory release date, or resumes detention in prison.[24]

Although there are some differences between supervision and parole, mainly in terms of who imposes the sentence or order and its length, what is important is that conditions relating to treatment can be imposed under both.

B. Conditions

Both supervision and parole have two forms of conditions: standard and special. Standard conditions are automatically imposed, and include stipulations such as reporting to a probation officer, restrictions on moving residential address, and non-association orders.[25]

[18] Sentencing Act 2002, ss 45(1) and 46.
[19] Sentencing Act 2002, s 45(2).
[20] See New Zealand Parole Board "Parole FAQ's" <http://www.paroleboard.govt.nz/utility/faq.html>.
[21] Parole Act 2002, s 20.
[22] Parole Act 2002, s 28.
[23] Parole Act 2002, s 7.
[24] Parole Act 2002, s 32.
[25] Sentencing Act 2002, s 49; Parole Act 2002, s 14.

Conditions that involve a form of treatment are special conditions. In this dissertation, 'treatment' will be used broadly to refer to all medical, psychological or psychiatric intervention, and 'treatment condition' to refer to the conditions requiring compliance with such interventions. This is because this dissertation is concerned with forms of treatment to which the consent of a person is usually required.

There are two kinds of conditions under which a form of treatment can be imposed. Firstly, the offender can be ordered to participate in a 'programme', which, for this purpose, means:

> (a) Any psychiatric or other counselling or assessment; or
>
> (b) Attendance at any medical, psychological […] programme.[26]

Secondly, the offender can be required to take prescription medication.[27]

C. Statutory Consent Requirements

The right to consent to treatment, as will be discussed in Chapter Two, is an important facet of the common law,[28] the New Zealand Bill of Rights Act 1990 (NZBORA),[29] and the Code of Health and Disability Services Consumers' Rights.[30] Consent to the imposition of supervision or parole per se is not required.[31] But, when looking to the consent requirements regarding the imposition of treatment conditions, the legislative regimes make a distinction between the different types. The statutes only refer specifically to consent being required to a condition involving the taking of prescription medication. Both the Sentencing and Parole Acts state that no offender may be made subject to a special condition that requires prescription medication to be taken unless the offender:

> (a) Has been fully advised […] about the nature and likely or intended effect of the medication and any known risks; and

[26] Sentencing Act 2002, s 51; Parole Act 2002, s 16.
[27] Sentencing Act 2002, s 52(2)(a); Parole Act 2002, s 15(3)(d).
[28] *R v B* [1995] 2 NZLR 172.
[29] Sections 10 and 11.
[30] Right 7.
[31] G Hall (ed) *Hall's Sentencing* (online looseleaf ed, LexisNexis NZ) at [SA45.3].

(b) Consents to taking the prescription medication.[32]

When imposing a condition that the offender participate in a 'programme' (such as psychiatric counselling), however, no such requirement for consent is mentioned in the statute.[33] It is may be argued that although such a condition might require the offender to 'attend' or 'participate' in the programme, it is very difficult to 'force' someone to participate in something like counselling, in a practical sense. This is not necessarily the same as requiring a person to undergo medical treatment, so perhaps should not require consent from the outset.[34] However, interestingly, under the precursor to the Sentencing Act 2002, the Criminal Justice Act 1985, consent was required to impose a condition on probation related to undertaking a specified course of education or training.[35]

In practice, sentencing and Parole Board decisions in which a 'programme' condition is imposed do not appear to make reference to consent either being sought or having been given.[36] It is possible that the offender's agreement is referred to in pre-sentence reports prepared by probation officers, or noted at sentencing or a Parole Board hearing. However, the fact that the offender's agreement has been obtained does not appear to be specifically mentioned in court or Parole Board decisions.[37] In practice, little thought appears to be given to the issue of consent.[38] Rather, such conditions are often expressed in vague terms such requiring the offender to 'attend and complete any counselling or treatment as directed by your probation officer'.[39]

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[32] Sentencing Act 2002, s 52(4); Parole Act 2002, s 15(4).
[33] Nor does it appear to have been a consideration when the Sentencing and Parole Reform Bill was being passed through Parliament.
[34] *Wilson v New Zealand Parole Board* [2012] NZHC 2247 at [43].
[35] Hall, above n 17, at 163.
[36] For example, see *Police v Heke* [2015] NZDC 3370; *Walsh v Police* [2014] NZHC 320; *R v Darrell* [2013] NZHC 1860; New Zealand Parole Board Decision "Parole hearing: Ronald Joseph Krynen" (17 March 2011) (Obtained under Official Information Act 1982 Request to the New Zealand Parole Board).
[37] Parole Board Decisions have not been widely considered here, as they can only be obtained by request under the Official Information Act 1982.
[38] It is possible that judges and the Parole Board take the submission that supervision or parole is appropriate as implicit acceptance of any conditions that will be imposed.
[39] *R v Darrell* [2013] NZHC 1860 at [14].

Despite this, section 146 of the Sentencing Act 2002 dictates that 'no sentence or condition imposed or order made under this Act limits or affects in any way any enactment or rule of law relating to consent to any medical or psychiatric treatment'. The imposition of treatment conditions on supervision do not, therefore, set aside the usual rules about consent. Whilst there is no equivalent provision in the Parole Act, it may not be necessary to state the matter expressly, because, in order to restrict and the usual right to consent, the statute would need to explicitly state this.[40] This would be required, for instance, to set aside the effect of section 11 of the NZBORA, which affirms the right to refuse treatment. Thus, the clear implication is that, although a condition relating to treatment might be able to be imposed without consent, such an offender under that condition retains their right to consent or refuse at the time of treatment. This will be discussed further in Chapter Two.

D. Limits on Imposing Treatment Conditions

When acting under a statutory power, a person or body must keep within the bounds of the power conferred on them.[41] For that reason, any condition imposed that is beyond their powers would be unlawful. Along with the requirements for consent discussed above, the ability of a court or the Parole Board to impose a treatment condition is fettered by several factors.

i. Statutory Limits

The imposition of a special condition, including one that involves some form of treatment, is subject to certain statutory criteria being satisfied.

In terms of supervision, special conditions, including a condition related to a programme, can be imposed if there is a significant risk of further offending, the standard conditions alone would not adequately reduce that risk, and special

[40] *Lloyd v Museum of Te Papa Tongarewa* [2002] 1 ERNZ 774 at [19].
[41] *CREEDNZ Inc v Governor General* [1981] 1 NZLR 172 at 182-183.

conditions or a programme would be required to reduce the likelihood of further offending through rehabilitation and reintegration of the offender.[42]

Similarly, with parole, a special condition must not be imposed unless designed to reduce the risk of reoffending, facilitate or promote the offender's rehabilitation and reintegration, or provide for the reasonable concerns of the victim(s) of the offender.[43]

Therefore, under both statutes, there is a clear focus on the necessity of the condition. If imposing a treatment condition, that treatment must be aimed at reducing the likelihood of further offending or promoting the rehabilitation and reintegration of the offender. It can only be imposed if the standard conditions alone will not suffice. This becomes important when one considers the degree of coercion that such a condition places on an offender to agree to this treatment.

ii. Statutory purpose

When acting pursuant to statutory authority, the purpose of the empowering legislation must be complied with.[44]

Section 7 of the Sentencing Act 2002 details a number of purposes for which a court may sentence or otherwise deal with an offender. In particular, the court should provide for the interests of the victim and protect the community from the offender, as well as assist in the offender's rehabilitation and reintegration.[45] The Sentencing Act also contains important sentencing principles. The court must impose the least restrictive outcome appropriate in the circumstances, in accordance with the hierarchy of sentences.[46] They must also take into account any particular circumstances of the offender that mean a particular sentence, which would otherwise be appropriate, would be disproportionately severe.[47]

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[42] Sentencing Act 2002, ss 50 and 52.
[43] Parole Act 2002, s 15.
[44] *Padfield v Minister for Agriculture, Fisheries and Food* [1968] AC 997 at 1039.
[45] Sentencing Act 2002, paras (c), (g) and (h) of s 7(1).
[46] Sentencing Act 2002, s 8(g).
[47] Sentencing Act 2002, s 8(h).

In terms of parole, when the Parole Board is deciding on the release of an offender, the paramount consideration is the safety of the community.[48] Principles that must guide the Board's decisions include the notion that offenders must not be detained longer, or be subject to release conditions that are more onerous, than is consistent with the safety of the community.[49] Offenders must also be provided with information about decisions that concern them and be advised on how to participate in these decisions.[50]

Thus, the sentence or order must conform to these principles and purposes of the Sentencing and Parole Acts. Importantly, the relevant purposes indicate that treatment conditions must be the least restrictive or onerous alternative that is reasonable in the circumstances.

iii. The New Zealand Bill of Rights Act 1990

The New Zealand Bill of Rights Act 1990 (NZBORA) applies to acts done by the judicial branch of government, as well as any body in the performance of a public function conferred on that body pursuant to law.[51] It therefore applies to sentencing and Parole Board decisions.

Under NZBORA, everyone has the right not to be subjected to medical or scientific experimentation without that person's consent.[52] Further, everyone has the right to refuse to undergo medical treatment.[53] As noted above, there is nothing in the statutes to suggest these rights are abrogated by the imposition of a treatment condition.

Thus, if a condition purported to force treatment on an offender without their consent, it would be contrary to their right to refuse to undergo medical

[48] Parole Act 2002, s 7(1).
[49] Parole Act 2002, s 7(2)(a).
[50] Parole Act 2002, s 7(2)(b).
[51] New Zealand Bill of Rights Act 1990, s 3.
[52] New Zealand Bill of Rights Act 1990, s 10.
[53] New Zealand Bill of Rights Act 1990, s 11.

treatment, and the condition would be unlawful. This precise question was the subject of a challenge to release conditions in *Wilson v New Zealand Parole Board.*[54] In holding that section 11 was not breached, a distinction was made between being required to attend counselling, and active participation in it. The former did not constitute being required to 'undergo medical treatment'.[55]

However, it is arguable that if a condition were levied, to which it would be impossible for an offender to give valid and effective consent, then imposing it would be unlawful. An offender retains the right to consent to treatment imposed as a condition of supervision or parole.[56] The right to consent is the natural corollary of the right to refuse consent to treatment,[57] and the right to personal privacy and bodily integrity are regarded as fundamental human rights.[58] As will be discussed in Chapter Two, the requirements of valid consent include voluntariness, a decision made free of coercion. What will be argued below is that the situation in which an offender consents to, and is treated under, a treatment condition can be categorised as coercive. Because of this, legally effective consent may not be possible, particularly in relation to certain types of treatment. It is argued that, if this were the case, such conditions would be unlawful to impose from the outset.

E. Coercion

The issues surrouding the imposition of treatment conditions therefore, in part, depend on what constitutes 'coercion', or illegitimate coercion, in this situation. Instinctively, one thinks of coercion as some form of external, improper pressure brought to bear on a decision: 'the action of persuading or controlling a voluntary agent to do something by force or threats'.[59] Coercion aims to induce

[54] *Wilson v New Zealand Parole Board* [2012] NZHC 2247.
[55] At [43].
[56] Sentencing Act 2002, s 146.
[57] As affirmed in the New Zealand Bill of Rights Act 1990, s 11.
[58] See *R v B* [1995] 2 NZLR 172 at 182; *Universal Declaration of Human Rights* GA Res 217 A, III (1948), art 3.
[59] *Shorter Oxford English Dictionary* (6th ed, Oxford University Press, New York, 2007) at 445.

replacement of a chosen option with another.[60] According to Nozick's classic formulation, P coerces Q, in order to have result A[61] brought about by Q, by communicating a claim to Q that, if A does not occur, P will bring about a consequence which renders result A not occurring less desirable than A occuring. P's claim is credible to Q, such that Q brings about result A, and part of the reason for Q acting that way is to lessen the likelihood that the less desirable consequences will eventuate.[62] The focus of coercion is therefore on mechanisms that influence the will of the coercee. These mechanisms generally take the form of a conditional threat: a person is coerced into performing an action because of the threat of an undesirable consequence occuring if they do not.[63]

Applying this formulation, it is arguable that when an offender agrees to a form of treatment imposed as a condition of supervision or parole, the state[64] is coercing the offender into accepting treatment. The state seeks to have the offender comply with treatment, and therefore communicates the claim that if the offender does not comply with treatment, the state will bring about a consequence which will make the offender's non-compliance less desirable than their compliance. As will be dicussed below, this consequence may be a harsher sentence, further imprisonment, or a conviction. The state's claim is credible to the offender, and the offender may then comply with the treatment condition, in part to lessen the likelihood that the state will bring about the threatened consequences.

There are two points at which the ability to consent to treatment may be affected by this allegedly coercive influence: when the treatment condition is imposed, and when the treatment is carried out under the order.

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[60] Michael Blake "Distributive justice, state coercion, and autonomy" (2002) 20 Philosophy and Public Affairs 257 at 272.
[61] Which may be the either the performance or non-performance of a specific action.
[62] R Nozick "Coercion" in Sidney Morgenbesser, Patrick Suppes and Morton Gabriel White (eds) *Philosophy, Science, and Method: Essays in Honor of Ernest Nagel* (St Martin's Press, New York, 1969) 440 at 441-442.
[63] At 458.
[64] This term is used broadly to refer to whoever is imposing the treatment and will exact a sanction if compliance is not achieved. This could be the judge, Parole Board or probation officer.

i. Consent at the time condition is imposed

Firstly, consent may be affected when the offender appears to agree to the treatment condition being imposed. This is particularly relevant to the infliction of a condition to take prescription medication, where consent is statutorily required from the outset. It is possible that if a person did not agree to such a condition, that supervision or parole may not be regarded as appropriate. As noted above, a special condition, including those that involve treatment, can be imposed where designed to reduce the risk of reoffending or facilitate the rehabilitation of the offender, only when standard conditions alone would not suffice.[65] The focus therefore appears to be on the necessity of the condition. This suggests that if an offender did not consent, in a situation where the condition was genuinely necessary, they may be subjected to a harsher sentence, one more restrictive on liberty, or be deemed ineligible for parole and thus remain in prison. In terms of Nozick's formulation, it might be said that if the offender knows this will be the consequence, and they consent to the condition in part to avoid it occurring, then their agreement was coerced.

There may be a difference, however, between a 'coercive' threat and a 'coercive' offer.[66] A threat attempts to ensure that a particular option is chosen by making other alternative options undesirable. For this reason, it sits more naturally with the idea that coercion renders choices involuntary.[67] The state can be seen to coerce an offender to accept a treatment condition if it proposes or threatens to violate the offender's rights if they do not consent.[68] Offers, in contrast, tend to create options that would otherwise not exist; this does not fit the same idea that the choice between those options is 'involuntary'.[69] An offer, therefore, may not be seen as truly coercive.[70] However, there is not complete agreement on this conclusion. Some commentators argue that an offer can be coercive, given the

[65] Sentencing Act 2002, ss 50 and 52(1); Parole Act 2002, s 15(2).
[66] Alan Wertheimer *Coercion* (Princeton University Press, New Jersey, 1987) at 204.
[67] John McMillan "The kindest cut? Surgical castration, sex offenders and coercive offers" (2013) J Med Ethics 1 at 4.
[68] A Wertheimer and FG Miller "There are (still) no coercive offers" (2014) 40 J Med Ethics 592 at 592.
[69] McMillan, above n 67, at 3.
[70] Wertheimer, above n 66, at 211.

similar effect it has on the decision-maker.[71] On this view, an offer can be viewed as similar to a threat in some situations: that is, when properties akin to those of a threat are present.[72]

Whether the imposition of a treatment condition occurs in a coercive environment may depend on how the condition is presented to the offender. If acceptance of a treatment condition was presented as the only way for the offender to be granted parole, or to avoid a sentence of imprisonment, and the judge or Parole Board was in a position to ensure this undesirable outcome occured if the offender did not consent, then this might be viewed as a coercive threat.[73] But, if presented as a genuine offer of an option not otherwise available, it may be seen as non-coercive. If it is reasonable or just for the judge or Parole Board to impose a harsher sentence or keep an offender imprisoned if they do not consent to the treatment condition, then one cannot say that the state threatens to violate the offender's rights if they do not consent.[74] No right to liberty is being limited if the offender otherwise qualifies for imprisonment. Thus, if the proffering of a treatment condition merely extends the options available to the offender, then this might not be categorised as a 'coercive offer'; it is simply an offer.

ii. Consent at time of treatment

The second instance is where an offender consents at the time of treatment. It is argued that this later consent is given in an inherently coercive situation, as, if an offender does not comply with the treatment conditions of their supervision or parole, they will be subject to sanction.

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[71] See Robert Stevens "Coercive offers" (1988) 66 Australasian Journal of Philosophy 83; Joan McGregor "'Undue inducement' as coercive offers" (2005) 5 American Journal of Bioethics 24.
[72] Such as a tendency to insult or degrade Q (Daniel Lyons "Welcome threats and coercive offers" (1975) 50 Philosophy 425 at 436).
[73] See McMillan, above n 67, at 4, where the author discusses the hypothetical scenario of a prison governor proposing to commute a death sentence only if the prisoner agrees to participate in a medical experiment.
[74] Wertheimer and Miller, above n 68, at 593.

Violations of both supervision and parole conditions carry similar sanctions. Under a sentence of supervision, it is an offence if an offender fails, without reasonable cause, to comply with any condition of supervision. Such an offender will be liable to a sentence of three months imprisonment or a fine of $1000.[75] An offender does not breach their conditions if they withdraw consent to taking prescription medication, but a failure to take the medication may give rise to grounds for variation or cancellation of the sentence of supervision.[76]

It is also an offence if an offender breaches, without reasonable excuse, any special conditions imposed by the Parole Board. The offender will be liable to one year's imprisonment or a fine of $2000.[77] A breach of release conditions of parole also forms a ground for recall to prison.[78] An offender does not breach their conditions and commit an offence if they withdraw consent to taking prescription medication, but the failure to take it may give rise to a ground for recall.[79]

Thus, there are clear sanctions if an offender, when required to participate in a 'programme' or take prescription medication as per their sentence or parole, refuses consent to these procedures. Because of this, it is arguable that such a situation falls within Nozick's formulation. The state seeks to have the offender comply with their treatment condition. There is a clear claim by the state, through statute, to bring about a consequence which makes the offender's non-compliance with treatment less desirable than consenting to treatment – that of being liable to a sentence of imprisonment, a fine, or recall to prison to serve the rest of a sentence. If the offender does consent, and the reason is to avoid the sanction set out in the statute, then that decision to consent can be seen as coerced.

[75] Sentencing Act 2002, s 70.
[76] Sentencing Act 2002, s 52(5).
[77] Parole Act 2002, s 71(1).
[78] Parole Act 2002, s 61.
[79] Parole Act 2002, s 15(5).

It is this idea of coercion, and how it interplays with consent to treatment, especially highly intrusive treatments, that will be considered in the following chapters.

CHAPTER TWO:
THE REQUIREMENTS AND RIGHTS OF CONSENT

This chapter considers concepts related to consent to treatment. It will explore the origins and requirements of effective consent, as well as the notion of a 'right' to consent to or refuse treatment. Often, the literature refers to these as the requirements of *informed* consent. Because this dissertation is focused mainly on the voluntariness of the consent, rather than the extent of the information disclosed, it will refer to 'consent' only.

A. Origins of Consent

The origins of requiring consent to treatment stem from the tort of battery, a form of trespass to the person. Battery may be committed if force is applied to another without consent; thus, if there is no consent to a medical intervention, it may constitute the tort of battery.[80] Consent is therefore transformative, changing what would otherwise constitute a tort and violation of rights into a morally legitimate intervention.[81]

However, requiring consent arguably goes beyond the mere avoidance of tortious liability. Consent is a cornerstone of the ethics of medical treatment and clinical research.[82] In very few situations will medical, psychiatric or psychological treatment be carried out without first getting the participant's consent. It is contended that consent serves four key bioethical norms: respect for autonomy, non-maleficence (the obligation to do no harm), beneficence

[80] Stephen Todd "Defences" in Stephen Todd (ed) *The Law of Torts in New Zealand* (6th ed, Brookers Ltd, Wellington, 2013) 1093 at 1114.
[81] Anne E Silver "An offer you can't refuse: Coercing consent to surgery through the medicalization of gender identity" (2013) 26 Colombia Journal of Gender and Law 488 at 502.
[82] Daniel B Rounsaville, Karen Hunkele, Caroline J Easton, Charla Nich, and Kathleen M Carroll "Making consent more informed: Preliminary results from a multiple-choice test among probation-referred marijuana users entering a randomized clinical trial" (2008) 36 Journal of the American Academy of Psychiatry and the Law 354 at 354.

(promoting the welfare of the patient), and justice (ensuring a patient is treated according to what is fair, just and owed).[83] Although all are important, autonomy has generally been regarded as the most pre-eminent of these principles.[84] In particular, it is autonomy that has largely shaped the current practice of medicine and related disciplines.[85] It is also autonomy that underpins the legal approach to consent to treatment.

Autonomy concerns individual freedom and choice, liberty and dignity.[86] Few choices are more private, intimate or integral than those involving the use to be made of one's own body.[87] By requiring consent to medical intervention, the law protects bodily integrity; every individual has, as Cardozo J said, "a right to determine what shall be done with his or her own body".[88] It is for this reason that, with some exceptions, a person is entitled to make a choice about their treatment.[89]

Autonomy is linked to ideas of privacy, voluntariness, self-determination and responsibility for choices. Consent to treatment, therefore, is conceptualised as a type of autonomous action. A person can be said to act autonomously if they act intentionally, with understanding, and without controlling influences.[90] These elements feed into the requirements of legally effective consent.

B. Requirements of Legally Effective Consent

Consent is said to occur when a patient, with substantial understanding and in the absence of control by others, intentionally authorises a professional to carry

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[83] Silver, above n 81, at 503.
[84] R Gillon "Ethics needs principles, four can encompass the rest, and respect for autonomy should be 'first among equals'" (2003) 29 Journal of Medical Ethics 307 at 310.
[85] Tom L Beauchamp and James F Childress *Principles of Biomedical Ethics* (7th ed, Oxford University Press, New York, 2013) at 101-140.
[86] Alasdair Maclean *Autonomy, Informed Consent and Medical Law: A Relational Challenge* (Cambridge University Press, London, 2009) at 10.
[87] Peter H Schuck "Rethinking informed consent" (1994) 103 The Yale Law Journal 899 at 924.
[88] *Schloendorff v Society of New York Hospital* 211 NY 125, 105 NE 92 (NY Ct App 1914) at 129.
[89] Sue Johnson (ed) *Health Care and the Law* (3rd ed, Brookers Ltd, Wellington, 2004) at 92.
[90] Ruth R Faden and Tom L Beauchamp *A History and Theory of Informed Consent* (Oxford University Press, New York, 1986) at 238.

out treatment.[91] There are three main requirements for consent to be effective: capacity or competence to consent, understanding about the treatment, and voluntary authorisation.[92] These serve to ensure that a choice to consent to treatment is an autonomous one. This formulation of consent is supported by the New Zealand legislation. The Health and Disability Commissioner Act 1994 defines 'informed consent' as consent that is 'freely given' and obtained in accordance with the requirements prescribed by the Code of Health and Disability Services Consumers' Rights (the Code).[93] The 'requirements' include the right to information, and competent ability to consent to treatment.[94] Thus, like the common law, valid consent under the Code entails competence, understanding, and voluntariness. Each requirement must be satisfied if consent is to be legally effective.

i. Capacity or competence

The law presumes that every adult has the capacity to decide whether or not to accept treatment, unless the contrary is shown.[95] It can therefore be assumed that every offender subject to a community-based sentence or order has the capacity to consent or refuse consent to treatment. While this presumption is rebuttable if it is shown the person lacks capacity in fact, there is no general legal test of capacity to give or refuse consent to treatment in all contexts. This means that, even where a person would normally be regarded as being sufficiently competent to give consent, there may be additional factors that give rise to the conclusion they lack capacity to consent to the treatment in question.[96] This may extend to being unduly influenced by the views of others.[97] Because the situation in which an offender consents to the treatment imposed as a condition of their supervision or parole can be characterised as coercive, it is arguable that such

[91] Ibid at 278.
[92] See Skegg, above n 11, at 219-228; Beauchamp and Childress, above n 85, at 124-125; In *re T (Adult: Refusal of Medical Treatment)* [1993] Fam. 95; *Freeman v Home Office* [1984] QB 524.
[93] Health and Disability Commissioner Act 1994, s 2(1).
[94] Code of Health and Disability Consumers' Rights, rights 6 and 7.
[95] *In re T (Adult: Refusal of Treatment)* [1993] Fam. 95 at 115.
[96] PDG Skegg "Capacity to consent to treatment" in PDG Skegg and R Paterson (eds) *Medical Law in New Zealand* (Brookers, Wellington, 2006) 171 at 179.
[97] *Re Z (Local Authority: Duty)* [2005] 3 All ER 280 at [13].

influence could vitiate their capacity to consent. This would depend on the facts of a given case.[98] It may go too far, however, to say that the coercive elements of the situation will, in general, vitiate a person's capacity, as it would mean that no person subject to such conditions could ever consent to treatment. That interpretation would be problematic.

ii. Understanding

A person who is to undergo treatment must have sufficient understanding to give effective consent.[99] 'Consent' is not given generally but must be consent to a particular action. For this reason, a person must have at least some understanding of what it is they are consenting to. It has been held that, so long as the patient is informed in broad terms about the nature of the procedure intended, consent will be real.[100] If there is no such understanding, then consent will be vitiated and treatment can constitute a battery.[101] So, for the present context, as long as treatment is understood in general terms and consented to, consent will be effective.

Beyond a mere understanding of the treatment, a failure to disclose all material risks and the availability of alternative treatments may leave a practitioner liable for negligence.[102] However, this does not vitiate the patient's consent.[103]

iii. Voluntary authorisation

For current purposes, the key requirement is that consent must be voluntary, or 'freely given', as described in the Health and Disability Commissioner Act.[104] As

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[98] Skegg, above n 96, at 174.
[99] *Kaimowitz v Department of Mental Health for the State of Michigan* 42 USLW 2063 (Mich Cir Ct 1973), as reproduced in (1976) 1 Mental Disability L Rep 147.
[100] *Chatterton v Gerson* [1981] QB 432 at 443.
[101] For example, see *Mohr v Williams* 95 Minn 261, 104 NW 12 (Minn SC 1905) where it was held that because consent was obtained only for an operation on the right ear, an operation on the left ear was without consent and therefore constituted an assault and battery.
[102] See *Montgomery v Lanarkshire Health Board* [2015] UKSC 11; Rogers *v Whittaker* (1992) 175 CLR 479.
[103] It may, however, undermine the right to give informed consent under the Code of Health and Disability Consumers' Rights.

The Nuremberg Code, a founding document on medical ethics, states, 'the voluntary consent of the human subject is absolutely essential'.[105] Such a statement reflects the notion that consent is only real and effective if it is the result of a free exercise of choice.[106] The patient must, therefore, make their choice to consent (or refuse consent) voluntarily, without coercion.[107] As such, apparent consent, given as a result of duress, coercion, or other external pressure, is not valid in law.[108] When another person or body influences a decision, the decision cannot truly be regarded as that of the person consenting. Coercion therefore deprives a person of autonomous choice, and is thus wholly incompatible with fundamental underpinnings of consent.[109] Therefore, a person who is giving consent should be able to exercise a free power of choice, 'without the intervention of any element of force, fraud, deceit, duress, over-reaching, or other ulterior form of constraint or coercion'.[110]

This consent requirement is problematic when considering the situation where an offender appears to consent to treatment as a condition of their supervision or parole, as such a situation can be viewed as inherently coercive. In effect, the state has informed the offender that there will be sanctions if they do not comply with treatment, and the offender may then consent in order to avoid such sanctions. Therefore, this external influence may partly, if not wholly, control the offender's decision. This does not fit with the notion of consent as a voluntary, autonomous act.

C. The Right to Consent and Refuse Consent to Treatment

There is thus a necessity for consent to treatment, both legally and ethically. Moreover, at common law, there is a right to consent to treatment before it is

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[104] Health and Disability Commissioner Act 1994, s 2(1).
[105] US Department of Health and Human Services "The Nuremberg Code" <http://history.nih.gov/research/downloads/ nuremberg.pdf> at [1].
[106] Lene Bomann-Larsen "Voluntary rehabilitation? On neurotechnological behavioural treatment, valid consent, and (in)appropriate offers" (2013) 6 Neuroethics 65 at 67.
[107] *In re T (Adult: Refusal of Treatment),* above n 95, at 100.
[108] See *Kaimowitz v Department of Mental Health for the State of Michigan,* above n 99; *In re T (Adult: Refusal of Treatment)*, above n 95; *R v Lee*, above n 13, at [326]; Skegg, above n 11, at 224.
[109] Faden and Beauchamp, above n 90, at 339.
[110] Ibid at 256.

carried out, as treatment without consent will be unlawful.[111] Such a right has been held to protect the "privacy, dignity and bodily integrity" of a person from non-consensual procedures.[112] In addition, both the freedom from invasion of physical privacy and a right to bodily integrity are regarded as fundamental human rights, encompassed in the right to security of person.[113] Such rights can only be compromised in certain limited circumstances.[114]

Right 7 of the Code of Health and Disability Services Consumers' Rights provides that consumers have a right to make an informed choice and give informed consent. Services may be provided to a consumer only if they give such consent,[115] including to any 'services' to promote or protect health, or provide treatment, rehabilitation, psychotherapy or counselling.[116]

In some jurisdictions, such a right is afforded entrenched constitutional protection. For example, Article 7 of the Canadian Charter of Rights and Freedoms provides that 'everyone has the right to life, liberty and security of the person and the right not be deprived thereof except in accordance with the principles of justice'. It has been held that this bars the state from compelling treatment without consent.[117]

New Zealand, of course, does not have an entrenched constitution. However, various rights surrounding bodily integrity are affirmed in the New Zealand Bill of Rights Act 1990. Section 10 provides that every person has the right not to be subjected to medical or scientific experimentation without that person's consent. Such a right is consistent with the ethical requirements set out in the Nuremberg Code.[118]

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[111] *X v Y* [2004] 23 FRNZ 475 at [74].
[112] *R v B* [1995] 2 NZLR 172 at 177.
[113] *Universal Declaration of Human Rights* GA Res 217 A, III (1948), art 3.
[114] JK Mason and GT Laurie *Mason and McCall Smith's Law and Medical Ethics* (8th ed, Oxford University Press, New York, 2011) at 65.
[115] Code of Health and Disability Consumers' Rights, right 7(1).
[116] Health and Disability Commissioner Act 1994, s 2(1).
[117] *R v Rogers* (1990) 61 CCC (3d) 481 at [13].
[118] Above n 105.

Further, under section 11 of the NZBORA, everyone has the right to refuse to undergo any medical treatment. The word 'medical' is intended to be comprehensive, encompassing surgical, psychiatric, dental, psychological and similar forms of treatment.[119] In applying section 11, the courts have given the right a wide interpretation, holding it applies to any direct interference with the body or state of mind.[120]

Thus, prima facie, an offender under a treatment condition, whether it requires taking prescription medication, or participating in a medical programme or psychiatric counselling, retains this right to consent to treatment on every occasion on which the treatment is offered. Under the NZBORA, they also retain the right to refuse consent to treatment. Consent must therefore be obtained before such treatment is provided, or, in the case of prescription medication, when the condition is imposed, as the statute requires. However, the rights enunciated above are not absolute. There may be justifications for derogating from these rights.

D. Derogation of the Right to Consent

There are recognised exceptions to the right to consent or refuse consent to treatment, with certain justifications provided for an invasion of personal privacy and bodily integrity without consent. In an emergency, the common law doctrine of necessity enables a person to be treated when a person is unable to give (or refuse) consent.[121] The Mental Health (Compulsory Assessment and Treatment) Act 1992 provides that patients under a compulsory treatment order 'shall […] be required to accept such treatment for mental disorder'.[122] This gives explicit statutory authorisation for treatment to be provided without consent, and over the objections of a patient refusing consent.

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[119] Geoffrey Palmer "A Bill of Rights for New Zealand: A White Paper" [1984-1985] I AJHR A6 at 109.
[120] *New Health New Zealand Inc v South Taranaki District Council* [2014] NZHC 395 at [86].
[121] Johnson, above n 89, at 100.
[122] Mental Health (Compulsory Assessment and Treatment) Act 1992, s 59(1).

Even where the right and necessity of consent is specifically recognised, this is not without limitation. The Code provides that services may be provided only if the consumer gives consent, 'except where any enactment, or the common law, or any other provision of this Code provides otherwise'.[123] Further, sections 10 and 11 of the NZBORA can be subject to 'justified limitations'; that is, 'such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society'.[124] It is suggested this would permit persons to be treated against their will where necessary to protect the health and safety of other persons.[125]

Therefore, the fact that there are recognised, permitted limits on the right to consent to or refuse treatment means it is arguable that requiring offenders to submit to treatment is also a legitimate limitation. It may not matter if an offender subject to a treatment condition does not or cannot give effective consent to treatment, because it is justified to derogate from their right to consent. Consent is predicated on recognising and respecting autonomy, but autonomy itself is not an unrestrained concept. Rather, it is often justifiably and non-contentiously limited on the basis of the harm principle.[126] According to John Stuart Mill, the only purpose for which power can be exercised over a member of a civilised society, against their will, is to prevent harm to others.[127] The state can therefore intervene in the life or liberty of an individual if necessary to reduce the harm to others. Indeed, such is the nature of a criminal sentence or order; the state places limits on the offender's liberty as a sanction for their criminal conduct. One major justification or purpose for this is to prevent harm to the community.[128] Therefore, one must ask the question: is a treatment condition any different to a regular condition? Does it matter if it limits the autonomy of an offender and derogates from a right to consent or refuse consent to treatment?

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[123] Code of Health and Disability Consumers' Rights, right 7(1).
[124] New Zealand Bill of Rights Act 1990, s 5.
[125] Palmer, above n 119, at 109.
[126] Maclean, above n 86, at 30.
[127] Nils Holtug "The Harm Principle" (2002) 5 Ethical Theory and Moral Practice 357 at 357.
[128] Sentencing Act 2002, s 7; Parole Act 2002, s 7.

It is argued that the answer to this is yes: an offender should and does retain a right to consent to, or refuse, treatment. In Canada, which has a similar limitation provision in its Charter of Rights and Freedoms to section 5 of the NZBORA, it has been held that protection of the public is insufficient to form a justified limitation to derogate the right to bodily integrity and security of person of an offender.[129] Although this is not a universally accepted argument,[130] it fits with the purpose and principles of supervision and parole in New Zealand. Treatment conditions can be imposed if necessary to reduce the risk of reoffending, but community sentences and orders, such as supervision and parole, will only be granted as an alternative to imprisonment if society is not at serious risk of harm from the offender.[131] As stated by the British Columbia Court of Appeal in *R v Rogers*, if the risk to society is so great that treatment is justified without consent, then it is arguable that only incarceration will afford the necessary protection.[132] Because of this, the harm principle does not provide a strong justified limitation to the rights expounded in the NZBORA and common law.

Further, it is submitted that a treatment condition is indeed different from other conditions of supervision or parole. The right to personal privacy and bodily integrity are regarded as fundamental human rights. Therefore, in order to restrict and derogate from the usual right to consent, the statute would need to explicitly state this.[133] As noted in Chapter One, the Sentencing Act states the opposite: no sentence or condition imposed under the Act limits or affects any enactment or rule of law relating to consent to medical or psychiatric treatment.[134] Thus, neither the Sentencing nor Parole Act explicitly permits deviance from the right to consent or refuse consent to treatment.

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[129] *R v Rogers*, above n 117, at [14].
[130] See *R v McGarroch* ([2003] OTC 97, 56 WCB (2d) 457) where it was held that treatment conditions to protect the public under a long-term supervision order constituted 'exceptional circumstances' and thus a justified limitation to the right to security of the person.
[131] For example, the guiding principle of parole is that offenders must not be detained any longer than is consistent with the safety of the community (Parole Act 2002, s 7(2)(a)).
[132] *R v Rogers,* above n 117, at [15].
[133] *Lloyd v Museum of Te Papa Tongarewa,* above n 40.
[134] Sentencing Act 2002, s 146.

Consent is still therefore required to provide treatment under a treatment condition. Because of this, there is arguably an inherent incompatibility between such an imposition and the requirements of consent. A fundamental requirement of effective consent is voluntariness, the result of an exercise of free choice. But, as argued, the situation in which an offender apparently agrees to treatment is a coercive one. The question, therefore, is whether, the validity of an apparent consent is vitiated when given in the coercive situation in which the offender is placed. This will be explored in Chapter Three.

CHAPTER THREE:
CONSENT IN A COERCIVE SITUATION

In this chapter, the meaning of 'consent' in a coercive situation will be considered. As has been argued, the situation in which an offender, who is subject to a treatment condition, consents to treatment can be categorised as inherently coercive. So, can we still say the offender is 'consenting' according to the usual, common law definition of the word? As determined in Chapter Two, an offender retains the right to give consent. Such consent must therefore be legally effective in order for treatment to lawfully proceed. The focus in this chapter will be on cases from various jurisdictions that can help to draw a coherent conclusion about what constitutes valid and effective consent in this coercive situation.

A. Consent and Coercion in the General Medical Context

As discussed in Chapter Two, a key requirement of valid consent is voluntariness. The choice to give (or refuse) consent must be made voluntarily and without coercion.[135] However, making a decision to accept a form of treatment, in any context, does not occur in a vacuum. External factors, such as family pressure, doctor advice, or the threat of an adverse medical consequence, will nearly always influence a person's consent.[136] Although coercion is felt to be improper, it is not uncommon. For example, in a New Zealand study, it was found that one-third of patients reported feeling coerced during admission to hospital.[137] Thus, coercion is not an entirely unfamiliar concept in a medical context. The question therefore becomes: at what stage will coercion render legally effective consent impossible?

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[135] *In re T (Adult: Refusal of Treatment)*, above n 95, at 100.

[136] Cameron Stewart and Andrew Lynch "Undue influence, consent and medical treatment" (2003) 96 Journal of the Royal Society of Medicine 598 at 599.

[137] Adam Sims "An investigation of coercion and autonomy in medical care: How much choice do patients really have?" (Master of Medical Science Thesis, University of Otago, 2014).

The English Court of Appeal considered this question in *Re T (Adult: Refusal of Medical Treatment)*.[138] T signed a form, in the presence of her Jehovah's Witness mother, refusing consent to blood transfusions. Her condition deteriorated and an application was made to the court to enable a blood transfusion to be performed. It was held that, in the circumstances, the pressure exerted on T by her mother was such that her refusal of consent was vitiated. Although a patient is entitled to receive advice and assistance from others in reaching a decision, what is key is that the decision is really that of the patient.[139] Not all influences are unlawful. But, pressure, of whatever character, if exerted to overpower the volition of the patient without convincing their judgment, may result in invalid consent. [140] Therefore, in an ordinary medical context, external coercive influences can vitiate apparent consent. The question that must be considered is whether the consent is expressed in form only, and not in reality.[141]

It is arguable, however, that the coercive influence exerted when an offender is subject to a treatment condition under supervision or parole is different to, and greater than, mere pressure from a third party. The key is that there is a coercive threat present. As discussed in Chapter One, this threat is evident where the state seeks to have the offender comply with treatment and threatens sanctions if the offender does not comply. The decision to comply with treatment is therefore, at least partly, out of a desire to avoid the threatened sanctions.

Further, and importantly, the offender's liberty may be at stake. If a family member or medical practitioner places pressure on a person to accept a particular treatment, no threat to the individual's liberty usually exists; there is no threat of sanction or restriction if they do not consent. In contrast, the situation of an offender under a treatment condition does involve such a threat. Under parole, a breach of release conditions can form a ground for recall to prison.[142] Under supervision, failure to comply with a condition can lead to a

[138] [1993] Fam 95 (CA).
[139] At 113.
[140] At 118.
[141] At 113.
[142] Parole Act 2002, s 61.

short sentence of imprisonment.[143] On an extreme view, it may be argued that an offender must 'barter his body for his freedom', as the offender is under threat of their liberty being compromised if they do not comply with treatment. [144] The situation can therefore before viewed as inherently coercive. Because of this, it is arguable that the current situation is more problematic in terms of the voluntariness of consent than pressure or influence from third parties. This raises questions as to how, in the New Zealand context, it can be said that an offender under a treatment condition can give valid consent to treatment at the time it is carried out.

B. Consent in Coercive Situations

In order to gauge a possible definition of 'consent' for the context under consideration, the validity of consent in a range of coercive situations – the prison environment, mental health system, and probation conditions – will be considered.

i. Prison environment

Prison, it has been argued, is an inherently coercive situation. Prisoners are regarded as a particularly vulnerable population, and in a situation where they are more likely to be susceptible to coercion or undue influence.[145] If a prisoner is offered a choice between staying in prison and undergoing a particular form of treatment, this is surely coercive, affecting the voluntariness of their consent.[146] The prisoner's intrinsic interest in being free compromises their ability to give voluntary and thus effective consent.

A coercive threat would be evident if prison authorities made it clear that a prisoner would never be able to be released unless they participated in

[143] Sentencing Act 2002, s 70.
[144] William Green "Depo-Provera, castration, and the probation of rape offenders: Statutory and constitutional issues" (1986) 12 U Dayton Law Rev 1 at 17.
[145] Paul S Appelbaum, Charles W Lidz and Robert Klitzman "Voluntariness of consent to research: A conceptual model" (2009) 39 Hasting Center Report 30 at 30.
[146] Bomann-Larsen, above n 106, at 68.

treatment. In a report by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, it was found that nearly all prisoners detained in a psychiatric hospital who accepted surgical castration did so, at least in part, due to fear of long-term detention.[147] Further, some prisoners claimed that their treating clinician had explicitly told them that surgical castration was the only option, and refusal would result in life-long detention. In response, the Committee suggested that, where medical interventions are irreversible, they should never be carried out on prisoners, unless justified by medical necessity.[148]

Moreover, it has been argued that the mere fact of being in the prison environment is so fundamentally coercive that a prisoner can never give effective consent. In *Freeman v Home Office,* the appellant, who was serving a life sentence of imprisonment, argued that he was incapable of consenting to treatment because of his prisoner status.[149] It was submitted that a prisoner could never, in the eyes of the law, give consent to treatment because the prison medical officer, as a prison officer, may have influence over the prisoner's life within prison and prospects of release.[150] Citing *Bowater v Rowley Regis Corporation*,[151] it was contended that a man cannot be truly 'willing' unless in a position to choose freely, which requires an absence of any feeling of constraint, so that nothing interferes with freedom of will.[152] Because of the nature of the prison environment, there was inevitably an 'atmosphere of constraint' such that the prisoner's freedom of will was overborne. However, the Court of Appeal rejected such a broad interpretation of the situation. Although the case was seen to afford an opportunity for 'interesting matters of principle and policy to be […] considered', ultimately the sole question, the court said, was whether, on the

[147] European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment "Report to the Czech Government on the Visit to the Czech Republic Carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment" (5 February 2009) <http://www.refworld.org/publisher> at [19].
[148] At [44].
[149] *Freeman v Home Office* [1984] QB 524.
[150] At 530.
[151] [1944] KB 476.
[152] *Freeman* at 536.

facts, there was real consent.[153] It was clear from the judgment that the court believed that 'real' consent could be given in a prison environment. But, the court did not dismiss the notion that, in certain cases, a prisoner may not be able to give effective consent. The right approach is to say that where a prison doctor has the power to influence a prisoner's situation, the court must be alive to the risk that what may appear to be a real consent is not in fact so.[154] Essentially, the court determined the matter to be one of fact, and, given that there was no evidence that the prisoner's will was overborne, the consent was held to be valid. Ultimately, the main premise that can be taken from *Freeman* is that a prisoner is not rendered incapable of consenting to medical treatment by virtue of his imprisonment alone; such a premise goes too far.

Essentially, what the court appeared to be most concerned with was avoiding the unattractive consequences of the proposition put forward by counsel for Freeman: that if prisoners were not able to give effective consent to treatment by the prison medical officer, they could not be treated in prison. If such an argument was accepted, prisoners may be denied a right *to* treatment, which, paradoxically, may decrease feelings of autonomy and increase perceptions of being coerced.[155] At the very least, it would make treatment far more difficult, as prisoners would need to be transferred out, or independent practitioners brought in, for treatment to proceed. Because of this difficulty, the court refused to fully examine the principles or policies behind the notion of a prisoner being rendered unable to give effective consent by virtue of imprisonment. Although it is not wrong to say that consent must be 'real', the Court of Appeal did not elucidate what 'real consent' means. No test or formulation was expounded as to what real consent, in a prison context, would be. Furthermore, to say that it is a question of fact, whilst also true, gives no guidance as to how those facts are to be applied to the relevant law. Thus, *Freeman* arguably represents a missed

[153] At 557.
[154] At 543.
[155] PS Appelbaum "Research subjects, informed and implied consent of" in NJ Smelser and PB Bates (eds) *International Encyclopaedia of the Social and Behavioural Sciences* (Online ed, Elsevier Science Ltd, 2001)13246 at 13248.

opportunity to engage with the difficult questions surrounding consent in a coercive situation.

ii. Involuntary patient under mental health system

The provision of mental health treatment is one situation in which treatment can be administered involuntarily. For example, under statutory authority in New Zealand, during the first month of being subject to a compulsory treatment order, the patient must accept such treatment for mental disorder as directed by their responsible clinician.[156] Consent of the patient is therefore not required for treatment to proceed. But, this is a limited exception to the usual consent rules. Where a form of treatment is not authorised by statute to proceed without consent, the patient retains a right of self-determination, a right to consent to treatment, so long as they have capacity. Thus, in *Re C (Adult: Refusal of Treatment)*, even an involuntary patient was found able to give an effective refusal of consent to leg amputation, despite having schizophrenia.[157] This ability to consent to treatment may often apply to treatment for mental disorder itself, although, in some cases, a refusal can be overridden in the interests of the patient under statutory authority. In some jurisdictions, for instance, a patient retains the right to consent to treatment when being treated in the community, under a community treatment order, even though they are still under the authority of the mental health legislation. For example, nothing in the Mental Health Act 1983 (UK) authorizes the treatment without consent in the community of a patient with capacity to refuse; only their treatment in hospital is authorized without consent. However, mental health patients are arguably in an inherently coercive situation, akin to that of prisoners; their chance of obtaining release from compulsory inpatient status often depends on their compliance with treatment. If they comply, they may get released back into the community; conversely, if they do not comply with treatment within the community, they may be detained as an inpatient. Thus, their interest in liberty may be at stake.

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[156] Mental Health (Compulsory Assessment and Treatment) Act 1992, s 59(1).
[157] *In re C (Adult: Refusal of Treatment)* [1994] 1 WLR 290.

In *Kaimowitz v Department of Mental Health*, the ability of an involuntary inpatient to give effective consent to experimental psychosurgery was considered by the Michigan Circuit Court.[158] To be legally adequate, a subject's consent must be competent, knowing and voluntary. In terms of the latter element, voluntariness, the most important thing for an involuntarily detained mental health patient, it was said, was freedom; it is therefore impossible for such a person to be free of coercion when their very release may depend on cooperating with such treatment.[159] The court drew an analogy with undue influence in the fields of wills and confessions: the law has always been meticulous in scrutinising the possibility of such influence in these situations and no lesser standard can apply to involuntary inpatients. Consent is not an idle or symbolic act; rather, it is fundamental for the protection of individual integrity.[160] Thus, ensuring such consent is truly voluntary was crucial. Despite this, the court drew a distinction between experimental psychosurgery and regular medical treatment. It held that valid consent could *never* be given in such a situation to experimental psychosurgery, given the dangers, irreversibility, and low benefits expected.[161] However, this did not mean that effective consent could not be given for regular surgery. Thus, what *Kaimowitz* demonstrates is that coercion does not influence all forms of treatment equally; rather, the more experimental or invasive the treatment, the more it is likely that even a small coercive influence will render effective consent impossible. The test of voluntariness, and thus validity of consent, will be far more difficult to satisfy where the treatment is of a highly experimental, risky, or intrusive nature.

Interestingly, in New Zealand, there appears to be a presumption that involuntarily detained patients, akin to those in *Kaimowitz*, can give effective consent to psychosurgery. The mental health legislation states that no patient can be subjected to any surgery or other treatment intended to destroy part of

[158] *Kaimowitz,* above n 99.
[159] At 151.
[160] Ibid.
[161] At 148.

the brain or its function unless the patient consents to the treatment.[162] This indicates that it is contemplated that the patient can in fact give effective consent, despite the fact that they are subject to a compulsory treatment order. However, possibly recognising the coercion present in the situation, the Mental Health (Compulsory Assessment and Treatment) Act 1992 also provides that a second psychiatrist must consider psychosurgery to be in the interests of the patient, and the Mental Health Review Tribunal must be satisfied that the patient has understood the nature of the treatment, and given consent freely.[163] This approach therefore also recognises that greater safeguards on consent to treatment are required in the mental health context when the treatment is of such an intrusive nature. Similar principles are therefore affirmed in *Kaimowitz* and in these provisions of the New Zealand mental health legislation.

In *R (on the Application of H) v Mental Health Review Tribunal*, the English High Court dealt with a challenge to discharge conditions imposed on a mental health patient.[164] The discharge condition at issue required that 'the patient shall comply with medication prescribed by his responsible medical officer'. Although H did not object to taking the medication, he wished to be free of the condition requiring him to do so, arguing that it did not meet the principle of legality. Such a principle holds that fundamental rights cannot be overridden by general or ambiguous words.[165] Essentially, H claimed that the words 'shall comply' imported an element of compulsion, which is in conflict with the fundamental right of a person to give or refuse consent to treatment.[166] Such an imperative interferes with the absolute right to choose, and is therefore unlawful. In resolving the case, the court drew a distinction similar to that drawn in this dissertation: even though the condition required compliance, H retained a right to consent or refuse consent at the time of treatment. It is for the treating clinician to be satisfied, on each occasion, that the consent is real and the independence of the decision has not been overborne. Thus, akin to the decision

[162] Mental Health (Compulsory Assessment and Treatment) Act 1992, s 61.
[163] Ibid.
[164] *R (on the application of H) v Mental Heath Review Tribunal* [2007] EWHC 884 (Admin).
[165] *R (on the application of H)* at [19], citing *R v Secretary of State for the Home Department ex parte Simms* [2004] 2 AC 115 at 131.
[166] *R (on the application of H)* at [21].

in *Freeman*, it is a question of fact for the doctor (or court, in the event of a legal challenge) that consent is freely given.[167] Importantly, the court emphasised the fact that there was no automatic sanction for failing to comply with the condition. Although there was a general power of recall, there was nothing in the relevant legislation that made recall an automatic sanction for non-compliance with treatment.[168] Therefore, in deciding whether to consent to treatment, H may take into account the imperative of the discharge condition, just as he may take into account medical advice or family persuasion. Because of this, the court held that consent could be validly given in this situation, despite the possibility that sanctions could follow non-compliance. Therefore, what can be taken from *R (on the Application of H)* is that not all treatment conditions will be treated as inherently coercive or different to other forms of influence; what is crucial are the consequences of not complying. If there is no immediate sanction, then it is difficult to view the condition as involving an unacceptable coercive threat that will vitiate consent.

iii. Probation conditions

Probation, in other jurisdictions, is similar to the sentence of supervision in New Zealand; it is a form of community-based sentence or order imposed as an alternative to imprisonment. It is viewed as a way of disciplining and reforming criminal offenders without the hardship and expense of prison.[169] As a condition of probation, a judge may order conditions that require compliance with some form of medical, psychiatric or psychological treatment.[170] It is, therefore, effectively the same as the situation being considered in this dissertation. In many jurisdictions, both probation and the carrying out of associated treatment require the offender's consent. However, there is often a stark contrast between accepting treatment and refusing it; refusal could directly lead to imprisonment. Thus, there is a threat to an offender's freedom if they do not consent. As a result,

[167] At [35].
[168] At [36].
[169] Jodi Berlin "Chemical castration of sex offenders: A shot in the arm towards rehabilitation" (1997) 19 Whittier Law Rev 169 at 183.
[170] Kari A Vanderzyl "Castration as an alternative to incarceration: An impotent approach to the punishment of sex offenders" (1994) 15 N Ill U L Rev 107 at 132.

such a situation can be viewed as coercive. It has therefore been questioned whether, when facing a choice between accepting treatment and imprisonment, voluntary, and therefore effective, consent is really possible.[171]

In *People v Gauntlett*, a defendant convicted of first-degree sexual conduct was sentenced to five years probation, with a condition to submit to hormonal drug treatment in order to reduce his sexual drive.[172] This condition was challenged on the basis that it was unconstitutional and unlawful, and therefore incapable of acceptance as a condition of probation. The appeal court held that the particular treatment failed as a lawful condition of probation due to its lack of acceptance as a safe medical procedure by the medical community.[173] It was, in effect, an experimental treatment, and one affecting sexuality. Further, the court asked the question: 'what about the problem of informed consent?' Concerns were raised over the ability of an offender to give effective consent in such a situation, noting that even mentally incompetent patients and prisoners enjoy a greater degree of protection from extraordinary medical procedures.[174] Such considerations demonstrated why that condition of probation was clearly unlawful. Therefore, *Gauntlett* suggests that effective consent to extraordinary medical procedures can never be given when that consent is premised on a coercive threat. It can therefore be viewed as commensurate with the principle in *Kaimowitz*: the more intrusive or experimental or unestablished the treatment, the less likely it is that consent can ever be viewed as voluntary, and thus effective, given the nature of the situation.

In *State v Brown*, the defendants were sentenced to 30 years' imprisonment for sexual offences, but provision was made for suspension of the sentence with probation for five years if they agreed to be castrated.[175] The appellants initially appealed the sentences, but then requested to dismiss the appeals and agree to the condition. However, it was held by the Supreme Court of South Carolina that

[171] Matthew V Daley "Flawed solution to the sex offenders situation in the United States: The legality of chemical castration for sex offenders" (2008) 5 Ind Health L Rev 87 at 101.
[172] *People v Gauntlett* 134 Mich App 737, 352 NW 2d 310 (Mich Ct App 1984).
[173] At 751.
[174] Ibid.
[175] *State v Brown* 326 SE 2d 410 (SC 1985).

such a condition was prohibited under the Constitution, as it amounted to the infliction of cruel and unusual punishment.[176] Whilst the judge had discretion in imposing conditions, such a condition abused this discretion. As a result, the conditions were declared illegal and void as against public policy.[177] Thus, despite the defendants wanting to agree to treatment, it was held they could not validly agree to those particular conditions. From *Brown,* it can be evinced that effective consent in a coercive situation is influenced by both the nature of the coercion and the nature of the treatment. In particular, where the contrast between accepting an extraordinary form of treatment and the alternative sanction is stark, such treatment will be incapable of voluntary acceptance.

C. General Principles

The question of whether a person can give valid consent in a coercive situation has therefore come to a court's attention numerous times in different jurisdictions. It has generally been accepted that prisoners, mental health patients, and those offered probation can be regarded as vulnerable populations when it comes to consenting to treatment. But, it is equally clear that there is no hard and fast answer to the question of what constitutes 'consent' in such circumstances. However, some general principles, applicable to the New Zealand context under consideration, can be discerned from the cases considered above.

Firstly, it is undesirable and impractical to hold that a person within a coercive situation can never give effective consent to treatment. It would mean that populations such as prisoners could never consent to treatment, and this may then deprive them of a right *to* treatment. Secondly, coercion, or a coercive threat, does not operate universally to vitiate consent to all forms of treatment. Rather, an inverse relationship exists: the more extreme or invasive the treatment, the less coercion is needed to invalidate consent. Thirdly, whilst a coercive situation will often be viewed as vitiating consent more readily than mere pressure from family or medical practitioners, this will not necessarily be

[176] At 411.
[177] Ibid.

so. What is crucial is the alternative or sanction that will follow from a failure to consent: the nature of the coercive threat. Finally, it is the mix between the coercion and the type of treatment, characterised as an inverse relationship, which is the key to whether legally effective consent is possible in a coercive situation.

Therefore, in a coercive situation, it is arguable the effectiveness or validity of consent is dependent on two factors: the nature of the coercion, and the nature of the treatment. The requirement that consent be given voluntarily may be satisfied to a greater or lesser extent, and may be regarded as located somewhere on a spectrum, rather than as an all-or-nothing phenomenon.[178] Decisions can be more or less autonomous; to say that a decision to consent must be fully autonomous or completely voluntary is arguably impractical in any situation. What is necessary, therefore, is that the consent can still be said to be the decision or action of the person consenting, and not of another.[179] In a coercive situation, this needs special scrutiny. There is arguably a point at which it can be said that consent is not voluntary, or cannot be given voluntarily, and therefore valid or legally effective consent is not possible. But, where that point lies depends on the nature of the coercion and the nature of the treatment.

In terms of the nature of the coercion, the question must be asked: what is the alternative route that will inevitably be followed should a person fail to consent? The degree of coercion or the nature of the coercive threat is directly relevant to the question of whether 'the patient means what he says, or is merely saying it for a quiet life… or because the advice and persuasion to which he has been subjected is such that he can no longer think and decide for himself.'[180] The important question is whether the coercion is of such a degree that it undermines the very premise of consent entirely.[181] This question is partly one of the legitimacy of the coercion; that is, whether the effect of the coercion is to

[178] Faden and Beauchamp, above n 90, at 238.
[179] See *In re T (Adult: Refusal of Treatment)*, above n 95, at 113; *R (on the application of H) v Mental Heath Review Tribunal*, above n 164, at [21].
[180] *In re T*, above n 95, at 113.
[181] F Focquaert "Mandatory neurotechnological treatment: Ethical issues" (2014) 35 Theor Med Bioeth 59 at 66.

offer the person an additional or permissible choice, between defensible alternatives. In some circumstances, the choice, as between a short sentence of imprisonment and probation with a treatment condition to undergo psychiatric counselling, is between two alternatives, neither of which are particularly unconscionable. But, where the choice is not defensible, is draconian, or is constructed as a threat, then the situation may be such as to virtually compel consent. In such circumstances, the coercion is arguably at an illegitimate level, and will vitiate even apparently willing consent. Thus, in a case like *State v Brown*, where the choice was between 30 years imprisonment or being castrated, it is arguable that a defendant would agree to virtually anything in order to avoid such a long deprivation of freedom. Such a stark choice arguably means such a condition can not possibly be agreed to voluntarily; the choice will undoubtedly be made out of a desire to have a 'quiet life', outside a prison cell. Conversely, in a case like *R (on the application of H) v Mental Health Review Tribunal*, the lack of a direct sanction for breaching a treatment condition was relevant as to why consent could be given on each treatment occasion.[182] Whilst it was possible that non-compliance could lead to recall to hospital, there was no direct threat of that sanction, nor was the alternative to consenting an unconscionable one. As such, coercion was not of such a degree as to vitiate otherwise apparent consent. Therefore, in terms of the nature and degree of coercion, it is clear that the greater the coercion – the more dire the alternative, and the directness of the link between consent and the alternative – the harder it is to see consent as voluntary and therefore effective.

The nature of the treatment is also relevant. In general, the more invasive, experimental or unestablished the treatment, the more likely it is that it will be held that an individual in a coercive situation cannot give valid consent.[183] This is because where the treatment is of a highly invasive nature, the test of voluntariness, and thus effective consent, will be far more difficult to satisfy. In effect, there is an inverse relationship between the nature of the treatment and the nature of the coercion. This was seen in *Kaimowitz*, where the court went so

[182] *R (on the application of H) v Mental Health Review Tribunal*, above n 164, at [36]-[37].
[183] Corey H Marco and Joni M Marco "Antabuse: Medication in exchange for a limited freedom – is it legal?" (1980) 5 Am J Law Med 295 at 315.

far as to say that an involuntarily committed mental health patient could never give effective consent to experimental psychosurgery, given its low benefit and high risk.[184] This did not mean, however, that, in the same situation, true consent could not be given to a regular procedure.[185] Similarly, in *People v Gauntlett*, the fact that hormonal treatment for sexual offenders had not yet gained acceptance as a safe and reliable medical procedure was one reason why the probation condition was not capable of acceptance.[186] In terms of invasiveness, things like castration and psychosurgery are regarded on the extreme end of the spectrum, implicating significant liberty interests as well as interests in bodily integrity.[187] Such treatments interfere with certain liberties, such as the freedom of thought and the right to retain the capacity to procreate. Therefore, in a coercive situation, it is questionable why an offender would agree to an invasive, experimental or risky treatment, if not for the coercive threat. Because of this, consent to these types of treatment may be difficult to view as being voluntary and therefore valid.

Thus, it is not possible to say that consent in a coercive situation is always invalid, nor that the coercive situation is irrelevant and consent will always be effective. It is a matter of fact and degree. The extent of voluntariness and reality of consent depends on the nature of the coercive threat as well as the nature of the treatment. What is important is that the treating clinician and court are alive to the fact that what appears to be a valid consent may not be so. These conclusions are relevant to the situation where an offender under supervision or parole is subject to a treatment condition, and must consent to that treatment. Importantly, it suggests that some forms of treatment may not be able to be imposed as a condition of community-based sentence or order.

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[184] Although note that, as discussed above, New Zealand does assume a patient subject to a compulsory treatment order could give consent to psychosurgery (Mental Health (Compulsory Assessment and Treatment) Act 1992, s 61). There are important safeguards, however, surrounding the consent process.
[185] *Kaimowitz*, above n 99, at 149.
[186] *People v Gauntlett*, above n 172, at 750.
[187] *US v Cope* 627 F 3d 944 (CA 9 Cal 2008) at [20].

These potentially impermissible treatments are likely to fall within one or more of three categories: experimental, invasive, or permanent. Experimental treatments, particularly those that are unestablished within the medical community, such as psychosurgery or other neurotechnological interventions, may be impermissible.[188] Further, highly invasive or intrusive treatments are likely to be considered illegitimate. There are several different ways in which a treatment could be considered 'intrusive'. It is might be physically intrusive upon the person, such as an invasive surgery, or intrusive upon the integrity of the mind, such as psychotropic medication. It may also be intrusive on particular aspects of the person, such as fertility or sexuality.[189] Physical and chemical castration would likely fit under this category, as might birth control. Finally, the degree of permanence is an important consideration. Where treatment is going to result in a permanent alteration to a person's body or mind, such as physical castration, it is less likely to be permissible. Clearly, some treatments may fit all categories: for example, psychosurgery may be defined as experimental (depending on the type), as well as being highly intrusive, and resulting in a permanent alteration to the brain. But, as medical knowledge develops, the categorisation of treatments may change, and alter their acceptability. For example, chemical castration was regarded as highly experimental in *Gauntlett*[190] but may now be regarded as an established, safe, and reversible (and therefore temporary) treatment, which may make it more permissible to be imposed as a treatment condition.

The implications of these conclusions for the New Zealand context will be addressed in Chapter Four.

[188] Such as those aimed at modifying the brain and thus behaviour. For example, central nervous system (CNS) intervention, by way of transcranial magnetic stimulation (TMS), that affects behaviour (see Elizabeth Shaw "Direct brain interventions and responsibility enhancement" (2014) 8 Crim Law and Philos 1).
[189] Personal decisions related to which arguably fit within a right to personal privacy (see Kristyn M Walker "Judicial control of reproductive freedom: The use of Norplant as a condition of probation" (1993) 78 Iowa L Rev 779 at 797).
[190] *People v Gauntlett* 134 Mich App 737, 352 NW 2d 310 (Mich Ct App 1984).

CHAPTER FOUR:
PRACTICAL APPLICATION AND PRAGMATIC CONSIDERATIONS

In this chapter, the principles extrapolated in Chapter Three are applied to the New Zealand context in which treatment conditions are attached to supervision and parole. Specifically, this chapter will examine the implications of accepting a particular formulation of 'consent' in a coercive situation, and what this means for certain types of treatment. A requirement to take psychotropic medication will be a particular focus, as this is a relatively invasive form of treatment condition that may be imposed. Finally, the pragmatic importance of obtaining the offender's voluntary participation will be emphasised as something deserving of greater consideration in sentencing and Parole Board decisions.

A. Conditions of Supervision and Parole and Consent

As formulated in Chapter Three, the two key elements in determining whether an offender can give effective consent in the coercive situation they face are the nature of the coercion and the nature of the treatment. When applied to the imposition of treatment conditions on supervision and parole, it can be said that, in general, consent is possible, to most standard treatments. But, there may be some important exceptions.

i. The nature of the coercion

The situation in which an offender is made subject to, and subsequently treated under, a treatment condition can be categorised as coercive. But, it is clear that the mere appearance of coercion is not enough to vitiate consent to treatment. What is crucial is the nature of the alternative to accepting treatment: its legitimacy, its impact on the person's interests (especially their liberty), and the likelihood of that alternative occurring. These factors influence whether the nature of the coercion is such as to render it impossible for consent to be given in certain situations.

a. When the condition is imposed

There are two points at which coercion may influence an offender's consent to, for example, taking prescribed psychotropic medication. Firstly, when that treatment condition requiring the taking of prescription medication is imposed, the offender must give consent.[191] The legislative guidance indicates that such a condition can only be imposed when necessary to reduce the risk of reoffending, and the standard conditions alone will not suffice.[192] Because of this, it seems probable that if an offender does not consent, then supervision will not be imposed, or parole not granted. Refusing to consent to such a condition may therefore have adverse consequences for the offender: that is, imprisonment. The offer of an alternative to imprisonment, conditional on accepting treatment, may be categorised as a coercive offer, rather than a threat, because it technically expands the options available to the offender, who may otherwise go to (or stay in) prison anyway.[193] There is disagreement as to whether this should even be categorised as 'coercion'.[194] But, in any case, when looking at the actual nature of the alternative, the adverse consequences for the offender will often not be particularly severe.

Regarding supervision, because is a largely rehabilitative, rather than deterrent, sentence, it falls at the lower end of the hierarchy of sentences.[195] So, if a judge has determined that a community-based sentence such as supervision is appropriate, they have likely determined that a lengthy sentence of imprisonment is not.[196] It is therefore highly unlikely that a judge would sentence an offender to a long term of imprisonment should they not agree to a treatment condition. A short period of imprisonment, at most, is the likely

[191] Sentencing Act 2002, s 52(4); Parole Act 2002, s 15(4).
[192] Sentencing Act 2002, s 52(1); Parole Act 2002, s 15(2).
[193] A Wertheimer and FG Miller "Payment for research participation: A coercive offer?" (2008) 34 Journal of Medical Ethics 389 at 390.
[194] See Wertheimer and Miller, above n 68; Robert Stevens "Coercive offers" (1988) 66 Australasian Journal of Philosophy 83; Joan McGregor "'Undue inducement' as coercive offers" (2005) 5 American Journal of Bioethics 24.
[195] Sentencing Act 2002, s 10A.
[196] G Hall *Sentencing Law and Practice* (3rd ed, LexisNexis, Wellington, 2014) at [I.4.1].

alternative. Certainly, New Zealand is not likely to see extreme alternatives offered to a sentence of supervision, such as 30 years' imprisonment, considered in *State v Brown.*[197] Thus, the alternative in this situation cannot be seen as particularly dire; rather, it can be viewed as opening up some choice between defensible alternatives.

Regarding parole, the coercive nature of the alternative on offer is slightly harder to gauge. In a typical situation, where an offender is under a finite sentence, they must serve one-third of their sentence before becoming eligible for parole.[198] This means that, if they do not consent to taking prescription medication, they may be ineligible for parole, and thus have to serve the remainder of their sentence. How long they would stay in prison, then, depends on the length of their sentence.

In the case of offenders under indeterminate sentences, however, the matter is more difficult to gauge. In theory, a failure to accept a treatment condition on their parole could see them remaining in prison for a very long time.[199] For this reason, the nature of the coercion, due to its impact on their liberty, may be sufficiently serious to vitiate their consent. In part, this might depend on the directness of the link between their consent and their chances of parole. If it is made clear that an offender will not get parole if they do not consent, and they will remain in prison indefinitely, then this could be considered highly coercive in relation to their consent.

b. When treatment is administered

The second occasion on which consent may be affected by coercion is when the treatment is being administered. Here, there are clear sanctions if an offender does not comply with the treatment condition; they may be sentenced to a short

[197] *State v Brown*, above n 175.
[198] Parole Act 2002, s 84. Where a minimum period of imprisonment has been imposed, an offender will have to serve that period before becoming eligible for parole, which must not exceed the lesser of two-thirds of the sentence or 10 years (Sentencing Act 2002, s 86).
[199] For example, an offender may be sentenced to life imprisonment if they are convicted of an offence such as murder (see Sentencing Act 2002, s 102).

period of imprisonment[200] or recalled to prison.[201] Thus, the state seeks to obtain compliance with the treatment condition through the threat of sanctions.[202] Arguably, this situation more problematic; such a coercive threat cannot be viewed as simply giving an offender a choice between two defensible alternatives. Rather, the threat is that the offender will lose their *current* liberty due to the failure to give consent, distinctly limiting their freedom of choice.[203] In many cases, however, when looking to the nature of the alternative, the actual sanction imposed for withdrawal of consent is not likely to be very harsh.

For breach of the conditions of supervision, the sanction available is a conviction and liability to a short, one-year sentence (or a fine of up to $1000),[204] and often the full sentence would not be imposed. The sanction for a breach of release conditions for parole is, again, harder to determine. As with supervision, a breach of the conditions may result in a conviction and a term of imprisonment not exceeding one year (or a fine of $2000).[205] Further, a breach of the release conditions, such as a treatment condition, can also form a ground for recall.[206] A breach includes a failure to take prescription medication.[207] Recall means the offender is returned to prison in order to serve the remainder of their sentence, which could, theoretically, be for 'life'. For this reason, the threat of recall from parole may be seen as more coercive than the sanctions for breach of supervision. Whether that extra coercion would be such as to vitiate consent would also depend on the nature of the treatment.

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[200] Sentencing Act 2002, s 70.
[201] Parole Act 2002, s 61.
[202] As per Nozick's formulation (Nozick, above n 62, at 441-442).
[203] McMillan, above n 67, at 3.
[204] Sentencing Act 2002, s 70. It must also be noted that a formal withdrawal of consent to prescription medication does not breach release conditions for the purpose of s 70, but a failure to take the medication may give rise to a ground for variation or cancellation of the sentence (Sentencing Act 2002, s 52(5)).
[205] Parole Act 2002, s 71.
[206] Parole Act 2002, s 61.
[207] Parole Act 2002, s 15(5).

ii. The nature of the treatment

There are numerous forms of treatment that could be imposed as a condition of supervision or parole. The offender may be required to take prescription medication, or attend psychiatric or other counselling, or take part in a medical or psychological programme.[208] These conditions are all described in broad terms in the legislation, and, when imposed by a judge or Parole Board, appear to be expressed in an expansive way.[209] For this reason, it is difficult to know exactly what types of treatments are in fact being authorised. Some of the treatments specified could be viewed as intrusive on the body or mind. At present, there is nothing to suggest that the legislation is used to impose any highly invasive or experimental treatments, nor that this is likely. This does not mean, however, that it could not happen in future.[210] As medical knowledge and technology develop, there is the potential for therapies, programmes or medication to be aimed at curbing anti-social behaviour. Such treatments might, in theory, be imposed as a condition of supervision or parole.

Arguably, the most problematic type of treatment that may currently be imposed is psychotropic medication. The prevalence of mental illnesses that need treatment, among criminal offenders, is high.[211] Psychotropic medications are aimed at modifying abnormal psychological symptoms, symptoms which often relate to a particular mental illness.[212] The intrusive nature of the treatment is difficult to deny, as psychotropic drugs are literally intended to alter the

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[208] Sentencing Act 2002, ss 51 and 52; Parole Act 2002, ss 15 and 16.

[209] For example, a direction that the offender undertake and complete any counselling and treatment in relation to drug abuse as may be directed by the probation officer (*Police v Heke* [2015] NZDC 3370 at [5]).

[210] For example, in the Australian state of New South Wales, a taskforce has only recently been assembled to examine whether chemical castration should be a sentencing option open to judges (ABC News "NSW Government taskforce to examine chemical castration of child sex offenders" (26 August 2015) <http://www.abc.net.au/news/2015-08-26>).

[211] See Department of Corrections "The National Study of Psychiatric Morbidity in New Zealand Prisons: An investigation of the prevalence of psychiatric disorder among New Zealand inmates" (1999) <www.corrections.govt.nz> which reported an elevated rate of mental disorder among prisoners when compared to the general community, particularly for psychotic illnesses, major depression, bipolar disorder, and post-traumatic stress disorder (PTSD).

[212] Ministry of Health "Guidelines for prescribing psychotropic drugs" (February 1996) < http://www.moh.govt.nz>.

functioning of the mind (albeit in a positive way).[213] Furthermore, they often involve undesirable, permanent side effects, and may affect several brain regions beyond the target area.[214] They also have the potential to be experimental. Research into the cause of mental illness is ongoing, and, as a result, new drug treatments are being developed.[215] For these reasons, psychotropic mediation could be regarded as an impermissible treatment condition, when imposed in a coercive situation.

iii. Ability to give effective consent

What is crucial is the relationship between the nature of the coercion and the nature of the treatment. As described in Chapter Three, the relationship between the two can be categorised as an inverse one. This means that the more intrusive the treatment, the less likely it is that consent will be considered voluntary, and thus effective, when coercion is present.[216] Thus, even a small degree of coercion will suffice to render consent to invasive or experimental treatments invalid. Additionally, where there is an overwhelming or irresistible amount of coercion, consent to even fairly standard treatment may be impossible.

When applying these principles to standard treatment conditions imposed on parole or supervision in New Zealand, it seems that, for the most part, an offender can give effective consent. The nature of coercion involved is not usually particularly extreme or overwhelming (with a possible caveat concerning long periods of imprisonment as an alternative to parole). In general, the alternatives on offer to consenting are not illegitimate or unconscionable. Further, in most cases, the nature of the treatment is unlikely to be highly invasive, experimental, or elicit permanent change to a person. For this reason, the nature of coercion and treatment would usually be considered to fall at the

[213] *Myers v Alaska Psychiatric Institute* 138 P 3d 238 (Alaska SC 2006) at 242.
[214] Ministry of Health, above n 212, at 1.
[215] See Y Agid and colleagues "How can drug discovery for psychiatric disorders be improved?" (2007) 6 Nature 189.
[216] Marco and Marco, above n 183, at 315.

low end of their respective continuums. Thus, consent is likely to considered valid.

However, if the nature of the treatment was to encroach on the 'impermissible', then this assessment might change. Here, a treatment such as psychotropic medication can be problematic. As argued in Chapter Three, impermissible treatments are likely to be those which can be categorised as experimental, intrusive, or permanent. Psychotropic medication certainly fits the 'intrusive' category. Further, it may sometimes be experimental. Thus, depending on the medication in question, the nature of the treatment may fall quite high on the 'impermissibility' spectrum. Because of the nature of the inverse relationship, this may mean that, despite low levels of coercion being present, effective consent could not be given. And, if that were so, imposing such a treatment condition might be impermissible from the outset.

B. The Practical Importance of Consent

Even if an offender can legally give consent in a certain situation, there are still good reasons to give careful consideration to the voluntariness of that consent when a treatment condition is imposed. When a condition involving a treatment programme is imposed, such as psychiatric counselling, the law does not require the offender's consent to be obtained.[217] But, research on effective treatment, such as psychotherapy, has shown how important it is to form a therapeutic alliance with the person undergoing the treatment. Where the cooperation of services users is engaged, the treatment is more likely to be successful.[218] There may be a relationship, therefore, between the voluntariness of the consent and compliance. Where voluntarily obtained, consent, as well as having ethical significance, may also indicate a willingness to actively comply.[219] Thus, the

[217] Sentencing Act 2002, s 51; Parole Act 2002, s 16.
[218] Peter Raynor "Consent to probation in England and Wales: How it was abolished and why it matters" (2014) 6 European Journal of Probation 296 at 300.
[219] Rob Canton "Yes, no, possibly, maybe: Community sanctions, consent and cooperation" (2014) 6 European Journal of Probation 209 at 220.

voluntariness of the consent may have value beyond simply making treatment ethically permissible.

In a pragmatic sense, consent symbolises the notion that people typically will do what they prefer to do.[220] Voluntary consent to a treatment condition is no guarantee of later compliance, but it can be meaningful and used to motivate a person to adhere to what they have previously agreed to.[221] So, even though consent that is effective in the eyes of the law can be given at the time of treatment, this does not mean that the practical value of ensuring voluntariness has been completely fulfilled. The coercive nature of the consenting situation may not subvert the legal effectiveness of the consent, but it could diminish a person's willingness to comply with the treatment. An offender whose consent to treatment is due to referral under the criminal justice system may lack the same internal motivation and desire to change as a person whose consent is truly voluntary.[222] For instance, a lack of internal motivation, in a drug-treatment context, was found to be associated with inferior outcomes of treatment.[223] In a study on psychiatric patients, more negative attitudes towards treatment were found in voluntary patients who felt coerced, and they were more likely to reject future help.[224] This is not to say that 'coerced' treatment will never be effective.[225] But, it is submitted that the advantages of promoting the full voluntariness of consent, when a treatment condition is being imposed, should not be overlooked. If ensuring voluntary consent at the outset garners greater compliance, attitudes and outcomes, then it is surely of importance.

The whole point of the conditions is to ensure offenders obtain the assistance needed to reduce their risk of reoffending and assimilate back into the

[220] Ibid at 210.
[221] Peter Raynor "Is probation still possible?" (2012) 51 The Howard Journal of Criminal Justice 173 at 179.
[222] D Farabee, M Prendergast and MD Anglin "The effectiveness of coerced treatment for drug-abusing offenders" (1998) 62 Fed Probation 3 at 7.
[223] DD Simpson, GW Joe and GA Rowan-Szal "Drug abuse treatment retention and process effects on follow-up outcomes" (1997) 47 Drug and Alcohol Dependence 227 at 234
[224] A Rogers "Coercion and 'voluntary' admission: An examination of psychiatric patient views" (1993) 11 Behavioral Sciences & The Law 259.
[225] See Farabee, Prendergast and Anglin, above n 222, who, in a meta-analysis, found pressure from the criminal justice system is often associated with positive treatment outcomes.

community.[226] This aligns with one of the key purposes of sentencing: assisting an offender in their rehabilitation and reintegration.[227] In order to promote these goals, autonomy and self-determination should be valued and respected as much as possible from the outset. Offenders' choices should be maximised as much as possible, within the legal framework, as a complete denial of choice appears wholly contradictory to the aim of encouraging participation and cooperation.[228] Thus, it may still be valuable to give greater prominence to the need to obtain voluntary consent to all treatment conditions, before they are imposed.

This may be achieved by, from the outset, ensuring the offender both understands the treatment condition and gives, as far as possible, voluntary consent to it. This should be uniform for all treatment conditions. The offender should be made aware, not only of the particular requirements of the treatment and any risks associated, but also of the potential benefits they will gain from the treatment.[229] Importantly, it should also be made clear that they will not necessarily be breached automatically for failure to attend a session or to take medication. Through this, the offender may be better placed in a position to exercise free power of choice in accepting treatment as a condition of their sentence or parole.

C. General Conclusions on Treatment Conditions in New Zealand

Thus, what appears to be an inconsistency between treatment conditions and a right to consent to treatment may not, in fact, be quite so straightforward. It is seems that, for the most part, conditions involving treatment, imposed on supervision or parole, do not render an offender unable to give effective consent to that treatment. This is because of the low degree of coercion and fairly standard nature of treatment usually involved. Generally, only when the nature of the treatment becomes intrusive, experimental or irreversible will the validity of the consent be affected by the coercive situation. It is doubtful whether

[226] Sentencing Act 2002, s 52(1); Parole Act 2002, s 15(2).
[227] Sentencing Act 2002, s 7.
[228] Raynor, above n 218, at 302.
[229] Such as a lower risk of reoffending.

treatments of that kind could be lawfully imposed on an offender as a condition of sentence. In some situations, psychotropic medication may fall into such a category.

Furthermore, greater attention could be given to maximising the voluntariness of the offender's consent in these situations. This is important, both because a high degree of voluntariness is necessary to secure legally effective consent in some situations, and because of the practical importance of voluntariness to the treatment process. Although, in certain instances, the degree of coercion may not be so great as to render consent involuntary in the eyes of the law, many may think the consent is not truly 'voluntary'.[230] The degree of coercion may result in an inferior treatment process, and thus undermine the entire purpose of imposing such treatment in the first place. For this reason, it is argued that every effort should be made to maximise the voluntariness of the consent obtained from offenders in both sentencing and Parole Board decisions.

[230] In the sense of acting according to one's free will.

CONCLUSION

When Mr Wilson challenged his release conditions, claiming they breached his right to refuse to undergo treatment, a potential incompatibility between the imposition of treatment as a condition of sentence or parole and the right to consent (or refuse to consent) to medical treatment was highlighted. This dissertation has canvassed that relationship between conditions and consent. Clearly, rehabilitating criminal offenders within the community is an invaluable facet of the criminal justice system. In order to do this, conditions that involve a form of treatment can, and should, be imposed on sentence or release from prison. But, this does not remove the right to consent to (or refuse) treatment. Bodily integrity and personal privacy are fundamental facets of the person, and cannot be derogated from lightly.

It is not suggested that the New Zealand legislation is necessarily incompatible with these important rights, nor is there any intimation that it is, in fact, being utilised in an impermissible way. An offender retains a right to consent to treatment, and, for the most part, will be able to exercise that right effectively. Although the situation in which an offender under a treatment condition gives consent can be categorised as coercive, it is not to such a degree as to vitiate consent to standard or routine forms of treatment. Consent in this coercive situation is still, therefore, possible. But, what is suggested is that there may be treatments for which effective consent cannot be given. These are the treatments that are invasive, experimental, or irreversible. Given the inverse nature of the relationship between coercion and treatment, the more intrusive the treatment, the less coercion will be tolerated when evaluating what constitutes legally effective consent. Whilst it is not argued that these intrusive or experimental treatments are being imposed, it is not beyond the realm of possibility that they could be. Psychotropic medication may be an example of such problematic treatment, in some situations: for instance, when its use is experimental or where it is applied to conditions for which there is no evidence of efficacy. In those situations, given the coercive environment, valid consent may not be

possible, and, as such, that kind of treatment condition would be impermissible from the outset.

Moreover, it is submitted that greater attention should be paid to voluntary consent when treatment conditions are imposed. Even if an offender can give legally effective consent, it does not mean that the purpose of requiring a voluntary authorisation has been fulfilled. The key aim of community-based sentences and orders is to foster the rehabilitation and reintegration of the offender. In order to achieve this, it is argued that the concepts that underpin consent – respect for autonomy, freedom of choice – should be valued to the greatest extent possible. This may aid treatment effectiveness, and compliance with the treatment process, better achieving the twin aims of the criminal justice system: protection and rehabilitation.

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