Dear all,
I’ve cut this down from a longer paper, but I’m afraid it’s still on the long side. However, it’s possible to skip section 3. Those who have seen/heard an earlier version, I’d be most interested in your thoughts on section 5, which is new.

Medical Interventions as Criminal Remedies

Tom Douglas

1 Introduction

Criminal offenders are sometimes required to undergo medical interventions that are intended, at least in part, to reduce the risk that they will re-offend. For example, drug-addicted offenders may be required to take medications intended to replace their drug of addiction and thereby prevent further drug-related offending. Similarly, sex offenders may be required to receive injections of testosterone-lowering drugs—so called ‘chemical castration’—intended to suppress their sex drive and thus prevent further sexual offending. In some cases, the imposition of these interventions is triggered solely by forward-looking considerations, such as the offender’s risk to others; it is not linked to any specific past criminal offence. In other cases, however, they are imposed by the criminal justice system as part of its response to a particular crime. In such cases, they are, in effect, used as supplements or alternatives to more traditional criminal remedies such as incarceration, fines, probation regimens, community service, and psychological rehabilitation programmes. Let us say that when medical interventions are used in this latter way, they are used as criminal remedies.1

The use of medical interventions as criminal remedies has, to date, been limited.2 However, on some influential views concerning the goals of criminal justice, there is good reason to take an interest in the possibility of more widespread use. These are anti-recidivist views—views according to which one of the goals of criminal justice is to prevent recidivism. Adherents of such views (henceforth, anti-recidivists) have reason to be disillusioned with traditional criminal remedies, for these are frequently poor at preventing recidivism. Indeed, the archetypal criminal remedy, incarceration, is notoriously poor. Although incarceration does help to prevent re-offending by separating offenders from most potential victims, it often does little to prevent

1 I use the term ‘criminal remedy’ in preference to the more widely used ‘criminal sanction’ and ‘criminal punishment’ because the latter two terms are both naturally understood as referring only to interventions which are intended, at least in part, to inflict harm on the recipient. I wish to include, within the category of criminal remedies, interventions for which the infliction of harm is no part of their intended purpose, such as purely rehabilitative or preventative interventions.

2 An exception is the use of lethal injection pursuant to a death sentence. Lethal medical injections are not the focus of this discussion.
offending against other inmates.\textsuperscript{3} There are, for example, typically very high rates of rape and assault within prisons.\textsuperscript{4} In addition, incarceration does little to reduce the risk of re-offending after release, and may have a criminogenic effect in some cases.\textsuperscript{5}

There is thus, for anti-recidivists, a case for exploring alternative means of preventing recidivism, and medical intervention is one promising avenue. There is already some evidence that pharmacological interventions significantly reduce the risk of recidivism in certain sex offenders\textsuperscript{6} and substance abusers.\textsuperscript{7} Moreover, we might reasonably expect the range of medical interventions capable of preventing recidivism to grow in coming years, perhaps to include a range of aggression-lowering drugs capable of preventing violent recidivism.\textsuperscript{8}

Suppose that we will indeed, in the future, have available a range of medical interventions capable of preventing recidivism. For those who believe that one of the aims of criminal justice is anti-recidivism, these interventions will be candidates for use as criminal remedies. However, many would, I think, wish to question the permissibility of using medical interventions in this way. Certainly, there has been significant opposition to the use of chemical castration as a criminal remedy, and many of the concerns that have been raised regarding that practice would also apply more widely. In this paper I wish to consider whether a general objection to the use of medical interventions as criminal remedies can be sustained.

\section*{2 Assumptions}

To define the scope of my discussion, I need to make several assumptions. First, I assume that, were medical interventions used as medical remedies, they would be imposed as compulsory criminal remedies: they would be imposed on criminal offenders (either at initial sentencing or subsequently) without the offender being offered any choice in the matter. To date, when medical interventions have been used as criminal remedies they have often instead been imposed as a condition of parole or early release. They have thus been included as part of a

\begin{itemize}
  \item Some might argue that criminal offending against other inmates is a less bad outcome than offending against innocent members of the public. Acceptance of this view would make the preventive deficiencies of incarceration look less problematic, but these deficiencies would still be serious in cases where incarceration is limited in duration and rates of recidivism post-release are high.
  \item See, for example, Wolff, Nancy, Cynthia L. Blitz, Jing Shi, Jane Siegel, and Ronet Bachman. “Physical Violence Inside Prisons Rates of Victimization.” Criminal Justice and Behavior 34, no. 5 (May 1, 2007): 588–599.
  \item See, for example, Bahr, Stephen J., Amber L. Masters, and Bryan M. Taylor. “What Works in Substance Abuse Treatment Programs for Offenders?” The Prison Journal 92, no. 2 [June 1, 2012]: 155–174.
\end{itemize}
requirement to either undergo a medical intervention or endure further incarceration. However, I will focus on the more controversial case of using medical interventions as compulsory medical remedies and indeed will assume that the ‘disjunctive requirement’ approach is not on the table. I assume this because I believe that we will need to be clear about the permissibility of using medical interventions as compulsory medical remedies before we can give an informed answer to the question whether they might be imposed as part of a disjunctive requirement. Arguments against the latter approach have typically maintained that this is tantamount to forcing the medical intervention on the offender. But clearly such an argument will be able to succeed only if forcing the medical intervention on the offender—that is, using it as a compulsory medical remedy—would itself be impermissible, and as we shall see, this is not straightforward to establish.

Second, I need to make a number of assumptions about the nature and effects of the medical interventions in question. I will consider only the permissibility of imposing medical interventions that would be somewhat effective at preventing recidivism, and at least as effective as any species of incarceration that might justifiably be imposed. I assume also that the these medical interventions consist, as does chemical castration, in the regular injection of a drug whose effects are reversible. I thus evade some of the issues that might surround the use of more invasive forms of intervention, such as surgery, while nevertheless focusing on a type of intervention that is clearly to some degree invasive. Furthermore, I assume that these pharmaceuticals, unlike chemical castration, have unintended adverse side-effects that are comparable in their quality, frequency and severity to those of existing routinely used mind-active drugs, for example, commonly used antidepressants such as fluoxetine (Prozac) and citalopram. I reserve the term ‘Medical Preventives’ for medical interventions that satisfy the conditions set out in this paragraph.

Finally, third, to avoid being diverted by general questions concerning the justifiability of criminal justice, I will assume that we are considering the permissibility of imposing medical interventions on offenders whom it would, absent any available medical alternative, be permissible to incarcerate for a substantial period of time. Moreover, I assume that incarceration would be justified at least in part by its (putative) anti-recidivist effect. To render the permissibility of incarceration maximally plausible, I will assume that, though incarceration involves severe and ‘fulltime’ restrictions on freedom of movement and association, it involves no additional exclusions from the forms of political participation, healthcare, and security made available to the unincarcerated citizenry. I take it that these are the least restrictive conditions that deserve the name ‘incarceration’ and henceforth reserve the term ‘Incarceration’ for these conditions.

The assumption that Incarceration is permissible allows me to formulate my question in a comparative way: given that it would be morally permissible for the state to subject an offender to

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9 Medical interventions could also, of course, be offered as an ‘optional extra’ to traditional remedies. That is to say, a criminal offender could be offered a medical intervention in such a way that the decision whether to accept that offer will have no effect on the length or severity of any traditional criminal remedies that are to be imposed. However, I take it that, in this sort of case, the medical intervention would not qualify as a criminal remedy.


11 Note that this assumption, and the assumption of reversibility, exclude killing by lethal injection from the scope of the discussion.
Incarceration, what objection could there be to the imposition of a medical intervention as an alternative or supplement to Incarceration?

3 Preliminary Objections

I begin by considering three objections that can, I think, quickly be set aside.

3.1 Risk of Misuse

The first objection adverts to the risk that Medical Preventives might be misused. The state could only impose Medical Preventives by authorising other agents—namely, the courts and other institutions of criminal justice—to impose them. But it might be argued that these institutions would be prone to misuse Medical Preventives: they could be expected to frequently impose them even in cases where it would not be justified to do so.\footnote{This objection has been raised in relation to the use of chemical castration as a criminal remedy. See, for example, Laurence R. Tancredi & David Weisstub, “Technology Assessment: Its Role in Forensic Psychiatry and the Case of Chemical Castration”, \textit{International Journal of Law and Psychiatry} 8 (1986): 257-271.}

There is some legal and historical basis for the claim that Medical Preventives will be prone to misuse. Where medical interventions have, to date, been used as criminal remedies, they have often been provided within a rather lax legislative framework. For example, in both California and Montana, chemical castration may be imposed on an offender without any input from a medical professional, with the result that it may be imposed even in cases where it can be expected to be ineffective, or where it is medically contraindicated.\footnote{Daley, Matthew V. “A Flawed Solution to the Sex Offender Situation in the United States: The Legality of Chemical Castration for Sex Offenders.” \textit{Indiana Health Law Review} 5 (2008): 87–122. A significant difference between the California and Montana statutes is that the former makes chemical castration...} In addition, the twentieth century is awash with examples of the misguided use of highly intrusive medical procedures, such as psychosurgery and electrical brain implants, to prevent behaviour deemed to be criminal or otherwise antisocial.

Experience with chemical castration and other medical means of crime prevention suggests that objections adverting to the risk that Medical Preventives will be misused should be taken seriously. However, I will not pursue them here. This is in part because I believe that they cannot be properly assessed until we have a clear empirical understanding of the ways in which the use of compulsory medical remedies could be monitored, and the likely success of these techniques in preventing misuse. This is something we do not currently have. For example, though we know that the European countries that permit chemical castration for sex offenders have rather more stringent controls on its use than is characteristic in the US, to my knowledge, there has been no systematic effort to assess the effectiveness of these regulations in preventing misuse.

There is also a second reason to set aside concerns regarding misuse: even if we currently have no effective means of regulating the use of Medical Preventives to ensure that they are not misused, we may well have such means in the future, so it seems worth considering whether the state could permissibly impose them as compulsory criminal remedies in such circumstances.

3.2 Insufficient Harm
A second objection to the imposition of Medical Preventives as medical remedies maintains that they would inflict insufficient subjective harm.\textsuperscript{14} We are assuming that one of the goals of incarceration is to prevent re-offending. However, it may also serve other goals. If these goals include retribution and deterrence, then there will plausibly be reasons not to replace incarceration with alternative interventions that inflict less subjective harm. It might be thought that merely being injected with a drug on a regular basis is unlikely to cause sufficient harm to realise these goals, particularly given our assumption that the drug in question would have side-effects comparable to those of existing routinely-used drugs.\textsuperscript{15}

One problem with this objection is that it could arguably be avoided by purposely developing Medical Preventives that have, and are intended to have, serious negative effects.\textsuperscript{16} It might be argued that there is something specific about the \textit{kind} of harm inflicted by incarceration that makes it suited to realizing the deterrent or retributive goals of criminal justice. For example, perhaps criminal offenders deserve to suffer precisely the kinds of harm that characterise incarceration.\textsuperscript{17} But even if this is so, concerns about insufficient retribution and deterrence would at most constitute a decisive objection to the use of Medical Preventives as the sole criminal remedy. They would not militate against the use of Medical Preventives alongside more traditional remedies. Indeed, there might be certain advantages in using Medical Preventives to realise the anti-recidivist goals of criminal justice while more traditional remedies are used to deter criminal behaviour and mete out deserved harm; separating anti-recidivism from retribution and deterrence might allow these elements to be more closely tailored to the circumstances in a particular case.

### 3.3 Excessive Harm

A third objection takes the opposite course to the second, maintaining that imposing a Medical Preventive on an offender would inflict too much subjective harm. This objection might be advanced against the backdrop of the thesis, sometimes known as negative retributivism, that criminal remedies are unjustified if they inflict on an offender more harm than the offender deserves. It might be thought that Medical Preventives, imposed as criminal remedies, would do just that.

This objection is, however, in tension with our earlier assumption that the state may permissibly subject some criminal offenders to Incarceration. The restrictions of movement and association entailed by Incarceration reliably cause significant subjective harms. They frequently damage existing personal relationships while making it difficult to form new ones, they seriously restrict sexual and reproductive freedoms, they make it impossible to pursue most careers, and they generally prevent the realisation of many life-plans.

It is plausible that many Medical Preventives would be substantially less harmful to offenders than Incarceration. I have specified that Medical Preventives would have negative side-effects comparable in their quality, frequency and severity to those of existing routinely used

\textsuperscript{14} I henceforth frequently omit ‘subjective’ and use ‘harm’ to refer to subjective harm unless otherwise specified. I remain neutral between hedonistic and desire-based accounts of subjective harm.

\textsuperscript{15} This is an objection that has been advanced by a US court against the use of chemical castration as a criminal remedy. See State v. Estes, 120 Idaho 953, 821 P.2d 1008 (Idaho App. 1991).


\textsuperscript{17} Though see, for a response to this suggestion, Ryberg, ‘Punishment, Pharmacological Treatment, and Early Release.’
mind-active drugs. Those effects are typically much less harmful than the effects of Incarceration outlined above. To these side-effects we also, of course, need to add the intended effects of the Medical Preventive, which may also be somewhat harmful. For example, we can imagine that an aggression-lowering drug would cause subjective harm to an individual to the extent that the individual enjoys and wishes to retain the aggressive urges that the drug attenuates. However, there seems no reason to suppose that the intended effects of Medical Preventives would necessarily involve substantial subjective harm. Consider a drug that attenuates only the most extreme impulses towards violent aggression and suppose it is imposed on an offender who dislikes and reflectively rejects those violent impulses. Such a drug could be expected to cause significantly less subjective harm than Incarceration.

4 Bodily Integrity

Even if Medical Preventives are no more subjectively harmful than Incarceration, their imposition might nevertheless be more problematic, morally speaking. One might argue, for example, that imposing Medical Preventives would violate the offender’s moral rights, or set back his objective interests, in a way that Incarceration would not. Thus, there remains scope to argue that imposing Medical Preventives would always be unjustified, though imposing Incarceration is not.

Perhaps the most obvious objection to imposing Medical Interventions as criminal remedies would appeal to a right to bodily integrity—that is, a right against bodily interference. It is plausible that, if people possess any rights, a right to bodily integrity is among them. Our possession of such a right arguably explains why it is normally wrong to perform a medical procedure on someone without her consent. Moreover, it is plausible that this right would be violated by the imposition of Medical Preventives as criminal remedies; this would, after all, constitute a form of nonconsensual medical intervention.

There are, however, difficulties with invoking the right to bodily integrity against the use of Medical Preventives as criminal remedies. An initial difficulty is that Incarceration, though ostensibly non-invasive, arguably impinges upon bodily integrity as much as does the imposition of Medical Preventives. There are at least two considerations that might be offered in support of this thought. First, Incarceration involves a (normally latent) physical threat of the form ‘if you attempt to escape incarceration, we will use physical force against you’. Second, incarcerated individuals are, due to their forced proximity to other inmates and guards, exposed to physical threats (such as pathogens, and in many cases physical attacks) that they cannot freely avoid.

I will not pursue this line of thought here, however, because I believe that the appeal to bodily integrity faces another and more serious problem. The more serious problem is that, even if the right to bodily integrity rules out the permissible imposition of Medical Preventives on most of us, there are some reasons to suppose that it might fail to do so when the intervention is imposed as a criminal remedy on a criminal offender. In committing crimes, criminal offenders plausibly make themselves morally liable to certain intrusive interventions—interventions that would otherwise violate their rights.

For example, ordinarily it would be impermissible to incarcerate someone for any significant period of time—this would plausibly violate his rights to freedom of movement and

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18 An alternative objection would appeal not to a right to bodily integrity but rather to an objective interest in bodily integrity. I will not discuss this objection, but I believe it will have the same fate as it’s rights-based variant.
association. However, it can be permissible for the state to incarcerate certain criminal offenders, or so we are assuming. In committing certain crimes, one makes oneself liable to some restrictions on freedom of movement and association that would otherwise violate one’s rights.

There are various ways of accounting for this effect. Perhaps, in offending, one waives one’s rights to free movement and association. Alternatively, perhaps one activates an exception clause already built into those rights. Or perhaps one confers on others a right to restrict one’s movement and association. But however we account for the change, it seems that there is a change: criminal offending makes permissible restrictions on free association and movement that would otherwise be impermissible. It causes the rights to free association and movement to lose their normal protective force.

One might wonder whether similar points could be made with respect to bodily integrity. True, it is normally impermissible to impose a Medical Preventive on someone. But perhaps in committing a crime one makes oneself liable to the imposition of certain Medical Preventives whose imposition would otherwise violate one’s right to bodily integrity, making it the case that these no longer violate that right.

Against this possibility, it might be argued that the right to bodily integrity is more robust than the rights to freedom of movement and association. The idea here is that it typically takes a greater deviation from normal circumstances for the right to bodily integrity to lose its protective force than for the rights to freedom of movement and association to lose their protective force; beginning from a normal situation in which these rights provide their usual level of protection, it generally takes more to render oneself liable to impositions on bodily integrity than to render oneself liable to impositions on free movement and association. If this is correct, then, even though committing a crime makes one liable to the restrictions on free movement entailed by incarceration, it may not make one liable to impositions on bodily integrity of the sort entailed by compulsory medical remedies. The right to bodily integrity may remain in place, and retain its normal protective force.

We can make this reply more precise by specifying the relevant rights, and the relevant dimensions of robustness, more fully. The right to bodily integrity and rights to free movement and association are most naturally thought of as general rights that protect against a wide range of kinds of treatment. For example, the right to bodily integrity may protect its bearer against forms of bodily interference ranging from minimal physical contact to major surgical procedures and extreme forms of physical violence. However, for our purposes it will be helpful to think of the general right to bodily integrity as being composed of more specific rights to bodily integrity that protect against specific kinds of bodily interference, and likewise for rights to free movement and association.

The proponent of the line of argument that I am considering here compares two sets of rights: (1) the specific rights to bodily integrity that protect against the imposition of Medical Preventives and other similar forms of bodily interference, and (2) the specific rights to free movement and association that protect against Incarceration and other comparable restraints on free movement and association. She maintains that rights of kind (1)—henceforth simply ‘rights to bodily integrity’—are more robust than rights of kind (2)—henceforth simply ‘rights to free movement and association’.

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19 I assume that rights to free movement and free association are the only rights that protect against the imposition of Incarceration.
Moreover, she maintains that these rights are more robust on one dimension in particular. There are various kinds of deviation from normal circumstances that may cause a right to lose its protective force, and these correspond to different dimensions of robustness. The proponent of the present reply is interested in one kind of deviation, namely, the commission of a crime by the rightholder. She maintains that it takes more serious or numerous criminal offences for the right to bodily integrity to lose its protective force than for the other two rights to lose theirs. She claims, in other words, that rights to bodily integrity are more robust in the face of criminal offending than rights to free movement and association. I henceforth take ‘robustness’ to mean ‘robustness in the face of criminal offending’ unless otherwise specified.

The suggestion that rights to bodily integrity are more robust than rights to free movement and association gains some initial credibility from the observation that committing a crime clearly does not cause all rights to lose their ordinary protective force. For example, it does not make one liable to killing, torture or public humiliation. We appear to possess some rights that are more robust than rights to free movement and association such that they would retain their protective force even if we committed serious crimes. Thus, the proponent of the present reply need not argue that rights to bodily integrity are exceptional in any way. She need only argue that they are, in respect of their robustness, more like rights against torture, killing and public humiliation than they are like rights to free movement and association.

Nevertheless, there should, I think, be a presumption against the view that rights to bodily integrity fall into this category of more robust rights. Rights to bodily integrity are standardly understood as a species of property right, and property rights, like rights to free movement and association, are widely thought to lose much of their protective force in the face of criminal offending: it is widely thought that committing a crime can make one liable to the alienation (temporary or permanent) of at least some of one’s property.

Can this presumption be overridden? The most promising strategy for overriding it would, I think, be to argue that the factors which make rights against torture, killing and public humiliation so robust apply also to rights to bodily integrity.

One consideration that many would appeal to in seeking to explain the great robustness of rights against torture, killing and public humiliation is the fact that they protect against forms of treatment that typically cause very serious subjective harm, more serious harm than constraints on free movement and association of the sort involved in Incarceration. Certainly, it is very plausible that killing is typically more subjectively harmful than Incarceration. However, this consideration could not be invoked to show that rights to bodily integrity are more robust than rights to free movement and association. Bodily interference of the sort we are considering here need not inflict more subjective harm than constraints on movement and association, and it is difficult to see why it should typically impose more subjective harm.

A second consideration that may justify the great robustness of rights against killing, torture and public humiliation has a more Kantian flavour. It might be argued these rights are so robust because they protect against forms of treatment that constitute, in some sense, an attack on agency. Killing, torture and public humiliation are all forms of treatment that, many would argue, threaten agency in a way that constraining someone’s free movement and association does not. We can distinguish two different ways in which they may constitute a threat to agency. First,

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20 In a longer version of this paper, I consider also whether an appeal to case-based intuitions might suffice to override the presumption, I argue that it does not.

21 I assume here that subjective harms can consist in the loss of positive future subjective wellbeing.
when $A$ kills, tortures or publicly humiliates $B$, this may express a denial of, or at least disregard for, $B$'s agency. It may express the view that $B$ is not an agent, or that $A$ does not care whether $B$ is an agent. Let us call this type of threat a *communicative* threat to agency. Second, when $A$ kills, tortures or publicly humiliates $B$, this may constitute an attack on $B$'s agency in the more straightforward sense that it is intended, or can be expected, to interfere with or diminish $B$'s agency, or sense of agency. Call this a *causal* threat to agency.

It seems somewhat plausible that rights against killing, torture and public humiliation are so robust because killing, torture and public humiliation all involve, or at least typically involve, serious communicative or causal threats to agency. And it might be thought that rights to bodily integrity are highly robust—and more robust than rights to free movement and association—for the same reason.

For this suggestion to be plausible, however, there will need to be some reason for thinking that interfering with someone’s body constitutes a more grave threat to agency than does constraining his freedom of movement and association. Given the distinction between communicative and causal threats to agency introduced above, we can distinguish two different respects in which bodily interference could constitute a more serious threat to agency than restriction of movement and association. It could be more serious in that it (typically) involves a more severe reduction in the victim’s agency or sense of agency. Or it could be more serious in that it (typically) expresses a more thorough denial of or disregard for the victim’s agency.

It is difficult to see why it need be more a more serious threat to agency in either of these respects. Arguably, nonconsensual interference with another’s body invariably expresses *some degree* of disregard for the other’s agency, for it involves ignoring the preferences of that individual. But the same can be said for nonconsensual restrictions on free movement and association. Bodily interference may also express a more thoroughgoing disregard for the agency of another. If one injects someone with a drug because one believes he is no different from a dangerous animal and should be treated as such, one clearly expresses a serious disregard for his agency. But this is because one’s action is motivated by a set of beliefs and desires which presuppose that the other is not an agent, or ought to be treated as though he not an agent. Interference with another’s free movement could also be motivated by such desires and beliefs, and where it was, it would, it seems to me, constitute a comparably serious communicative threat to agency. Moreover, it is difficult to see any reason why interference with bodily integrity would be any more likely to be driven by such motives than restrictions on free movement and association, so it would be difficult even to argue that bodily interference typically involves a more serious communicative threat than restrictions on free movement and association.

Similar thoughts apply to causal threats to agency. Bodily interference could interfere with agency, for example, by inducing apathy, or depression, or perhaps extreme alienation from one’s self. But so too could constraints on free movement and association, and I see no reason to suppose that bodily interference would be more likely to produce such effects than restrictions on free movement and association. Agency resides in the mind, and the mind is, of course, dependant on and influenced by the body in various ways. Thus, there is certainly a risk that anything that interferes with our bodies will also interfere with our agency. But the mind is also dependant on, and influenced by our natural and social environment, which in turn is affected by restrictions on free movement and association. (An incarcerated individual occupies a very different social and natural environment than a free person.) Thus, those restrictions also risk interfering with our agency.
I have suggested that some rights may be highly robust because they protect against interventions that (typically) inflict great subjective harm or constitute a grave threat to agency. But I have argued that these considerations cannot be extended to rights that protect against the kinds of bodily interference involved in the imposition of Medical Preventives. I thus tentatively conclude, in accordance with my initial presumption, that rights to bodily integrity are not more robust than rights to free movement and association. If this is correct, then we might expect that, if a criminal offender has made himself liable to the restrictions on free movement and association involved in Incarceration, he has also made himself liable to the bodily interference involved in the imposition of a Medical Preventive.

5 Mental Integrity

I suggested above that imposing Medical Preventives need not, in virtue of the fact that it involves bodily interference, constitute a more serious threat to agency than Incarceration. But there may be other reasons to think that imposing Medical Preventives would constitute a more serious threat to agency, and would thus, on a broadly Kantian view, be protected by more robust rights. The most obvious reason is that Medical Preventives would, in order to achieve their anti-recidivist effect, need to influence the mental states or processes of the offenders on which they were imposed. This suggests that one might object to the imposition of Medical Preventives as criminal remedies on the grounds that this would violate a robust right that protects us not against bodily interference, but against mental interference—a right to mental integrity.

One difficulty that we face in seeking to assess this objection is that there are clearly very many different ways in which Medical Preventives might affect an offender’s mental states; there are many different kinds of mental interference that they might involve, and the rights to mental integrity that protect against these various kinds of mental interference may differ in their robustness. For example, we may enjoy much more robust rights against highly intrusive kinds of mental interference than we do against minimally intrusive kinds. We need some strategy that can accommodate this possibility. I propose to approach the problem by asking whether there is any type of mental interference such that (i) there is a robust right against such mental interference, and (ii) imposing a Medical Preventive would invariably involve mental interference of that sort.

5.1 Rational Influence

One way in which we can interfere with the minds of others is through rational influence. One rationally influences another when one presents the other with reasons to desire, believe, intend or do one thing rather than another, and, as a result of appreciating those reasons, the other chooses to form that desire, belief, or intention, or to perform that action.

It is clear that we possess no robust right against rational influence. There may be cases in which it is morally impermissible to present someone with reasons: when a conference presenter is giving her talk, it may be impermissible for others to interject and present their own reasons. Perhaps, then, there is a limited right against rational influence. But this is clearly not a very

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22 In theory a medical intervention could prevent recidivism through wholly physical channels (that is, without having mental effects), for example, by causing physical incapacitation. But it seems highly doubtful that any such intervention would satisfy our assumption of having no more serious side-effects than a typical routinely used pharmaceutical.
robust right; there are many and varied circumstances in which it is permissible to present others with reasons, even reasons they do not want to hear.

However, this will not much help a defender of the use of Medical Preventives, since Medical Preventives clearly affect mental states through arational processes—processes other than the giving of reasons. The important question, then, is whether there is a robust right against the use of arational means to influence the mental states of others.

5.1 Arational Control

Let us begin with the most psychologically invasive kind of arational mental interference: what I will call arational control. This consists in influencing an agent’s thought or behaviour by overriding the agent’s choice. I am thinking of choice as the mental process by which we freely form intentions, desires and beliefs and freely perform actions. Arational control involves bringing it about, through some non-choice process, that an agent believes, intends, desires or does x when he would otherwise have chosen whether or not to believe, intend, desire or do x. As an example of arational influence, we can imagine science fiction cases in which A inserts a chip in B’s brain such that whenever B chooses, or is about to choose, to commit some criminal act, the chip inserts, through some neural mechanism, an intention to take a nap instead.23

It is, I think, intuitively plausible that we enjoy very robust rights against arational control. Moreover, it is possible to give a plausible theoretical explanation for the robustness of such rights by invoking the Kantian ideas discussed in the last section; arational control plausibly constitutes a profound attack on the agent given that it involves replacing the free exercise of agency with other psychological or neural processes. This right might well be sufficiently robust that it would protect criminal offenders against the use of arational control to prevent them from re-offending.

However, it is difficult to see why Medical Preventives would need to operate in this way. In arational control, the interfering agent overrides another agent’s choice, replacing chosen mental states or actions with unchosen ones. But Medical Preventives could instead operate by enabling choice—that is, by negating internal psychological factors that would otherwise override choice. Consider a case in which an offender is given injections of an aggression-lowering drug. Suppose that the drug attenuates the offender’s most powerful and impulsive urges towards aggression. Most theorists would agree that if these urges are irresistible, and not themselves chosen, then the violent actions they produce will be unchosen. In these circumstances, an aggression-lowering drug would enable the agent to choose whether to act violently whereas before the agent would have been compelled to do so.

Alternatively, a Medical Preventive might operate neither by enabling nor overriding choice, but simply by influencing it. It would most plausibly do this by influencing how easy, salient or attractive the various options seem to the agent. Consider a case where an aggression-lowering drug is used to attenuate unchosen aggressive impulses that are not so powerful as to be irresistible. Suppose that, even when experiencing these urges, the offender can choose not to act violently, it is simply that acting violently seems the easiest or most attractive or salient option. In that case, the aggression-lowering drug could be thought of as decreasing the relative ease or attractiveness or salience of violent action, all the while preserving the agent’s freedom to choose whether to engage in violence.

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It might be thought that, in these cases, though the agent's choice whether to engage in violent action is not overridden, there is interference with choice at a prior stage. Perhaps in attenuating the agent's aggressive impulses the drug overrides the agent's choices about how impulsively aggressive to be. It replaces the agent's chosen level of aggression with an unchosen one, and only by doing this does it enable or influence subsequent choices about whether to act violently.

This could, but need not, be so. Many of our mental states are not the product of choice but are instead the product of perceptual or brute neurological processes. It seems likely that impulses towards aggression are often unchosen, and insofar as a drug is used to attenuate unchosen aggressive impulses, it need not override choice. More generally, it is possible for a drug to enable or influence choice without overriding choice at a prior stage; it's most direct mental effect may be simply to replace one unchosen mental state with another.

5.3 Arational Influence

Given these possibilities, to determine whether there is a right to mental integrity that would rule out the imposition of Medical Preventives, we will need to consider whether there is a robust right against forms of mental interference that enable or influence choice, and not by overriding choice at a prior stage. I will focus on interventions that influence choice through arational means, and will refer to such interventions as arational influence.

I have suggested that an aggression-attenuating drug could qualify as a kind of arational influence. But there are many more familiar examples of such influence. Consider the following scenarios:

1. Cafeteria staff place healthy foods at eye level because they know that this will make the option of eating healthy food more salient to customers.
2. The government requires an image of a diseased and tar-filled lung to be displayed on the front of each packet of cigarettes, knowing that this will make the purchase of cigarettes less attractive to some.
3. The makers of Coca-Cola commission a series of television advertisements that show young, healthy and beautiful people drinking the beverage while partying at the beach. Each of these interventions could make one course of action easier, more attractive or more salient than it would otherwise have been. It is possible that these interventions would constitute arational control in some cases: the images on the cigarette packet might produce a disgust reaction that overturns an agent’s choice to buy cigarettes. Similarly, these interventions could enable choice in some cases: those same images might attenuate an addictive desire that would otherwise have overridden the agent’s choice not to buy cigarettes. But in many cases, interventions of this sort will merely influence choices, and in those cases they will be examples of arational influence.

Reflection on interventions like these suggests that, though we may possess rights to mental integrity that protect against some kinds of arational influence, these are not highly robust rights. There may be cases in which it would be wrong to subject someone to interventions of the kind described in (1)-(3), but there are also many cases in which it seems permissible. Of more direct relevance to our concern, it seems clear that similar interventions would, if imposed by the criminal justice system on criminal offenders, be permissible in at least some circumstances. Thus, consider the following case:
4. Prison authorities attempt to reduce criminal violence between prison inmates by painting the walls of the prison food hall in a soothing shade of a green—a colour that tends to have a calming influence. Few, I think, would find this morally problematic, let alone morally impermissible. This provides at least some support for the view that any rights we possess against arational influence are not highly robust, which in turn tends to undermine the suggestion that the imposition of Medical Preventives on criminal offenders might be ruled out this right.

Of course it might be argued that there are more specific robust rights that protect against arational influence of certain kinds. Perhaps it would be possible to delineate some robust right against the kinds of arational influence that would be exerted by Medical Preventives, but not against the kinds of arational influence described in examples (1)-(4) above.

5.4 Internal versus External Modes of Influence

A Medical Preventive would influence choice by directly modulating the agent’s bodily states. By contrast, the interventions described in (1)-(4) influence choice by modulating the agent’s environment. This raises the possibility of arguing against the imposition of Medical Preventives by appealing to a robust right against only those varieties of arational influence that operate via the direct modulation of bodily states.

The difficulty is that it is hard to see why there should be such a right, for, setting aside concerns about bodily integrity, it is difficult to see why the distinction between modulating the mind by modulating the body and modulating the mind by modulating the environment should be morally significant.

It might be thought that the different role played by perceptual processes in the two varieties of arational influence makes an important moral difference. When one arationally influences an individual through environmental modulation, for example by painting prison walls in a calming colour, one’s effects on the minds of others are mediated by perceptual processes. Painting the walls influences the minds of the inmates only because they see the colour of the walls. By contrast, when one acts on someone’s body directly, for example, by injecting an aggression-attenuating drug, it might seem that no perceptual process is involved. Rather, one directly alters the brain states on which the mind supervenes. This difference might be thought significant because perception might be thought to be an agential process of sorts; we do not choose or deliberate about what mental states to form through perception, but perception is nevertheless a process that engages the agent in a way that directly modulating brain states does not. Perhaps, then, one might argue that modulating the environment in order to influence someone’s choices treats an individual as an agent in a way that modulating the body for the same end does not. On certain Kantian views, this might make an important moral difference.

The difficulty with this line of argument, however, is that forms of arational influence that act directly on the body could also affect the mind via perceptual processes. Just as we can perceive our external environment, so too, we have ways of perceiving our internal, bodily environment. Certain bodily perceptions give us pleasure, while others give us pain, and one quite plausible way in which some Medical Preventives might operate is by attaching pleasurable
bodily sensations to noncriminal behaviour (or thoughts conducive to it) or displeasurable bodily sensations to criminal behaviour (or thoughts conducive to it).\(^{24}\)

The distinction between forms of arational influence that operate via perception and forms that do not may, I think, be morally significant. I am doubtful whether it is significant enough to sustain the view that there is a highly robust right against nonperceptual forms of arational influence, though not against perceptual forms. But even if it is, one could not appeal to this right in order to defend a general objection to the imposition of Medical Preventives, for some such Preventives—those that do operate via perception—would fall outside its scope.

5.5 Connection to Reasons

Besides the fact that Medical Preventives would act directly on the body, while interventions of the sort described in cases (1)-(4) act on the environment, there might seem to be another important difference between these two sets of interventions. This concerns the way in which these forms of interference connect to normative reasons bearing on the agent.

None of the interventions described in cases (1)-(4) consists in the giving of reasons, as that phrase would normally be understood; none involves an utterance with the content ‘you have a reason to do \(x\)’. However, it might be thought that these environmental manipulations do serve to draw attention to reasons that bear on the agent. For example, when, in case (2), the government requires pictures of diseased lungs to be displayed on cigarette packages, it is presumably attempting to give greater salience to one possible consequence of smoking—a consequence that gives most people reason not to smoke. By contrast, Medical Preventives, such as aggression-lowering drugs, would, it might be thought, do nothing to draw attention to the recipients’ normative reasons for action. Thus, they do not appeal to the agent’s capacity to understand reasons. This might seem to be another way in which Medical Preventives fail to treat the recipient as an agent, and, at least on certain Kantian views, this might be of moral significance.

Again, however, it is difficult to see how this distinction could sustain a general objection to the imposition of Medical Preventives. One problem is that not all of the environmental interventions that I described above appeal to the agent’s capacity to understand reasons. When the prison authorities paint the walls of a prison in a soothing colour, they do not thereby highlight any reason that the offenders have, or might take themselves to have. Nevertheless, most would, I think, find this intervention unproblematic, suggesting that it violates no right. This casts doubt on the suggestion that there is a robust right against forms of arational influence that do not appeal to the agent’s rational capacities.

Second, it may well be that some Medical Preventives would, in fact, serve to draw the agent’s attention to normative reasons. A Medical Preventive might, for instance, enhance the offender’s empathetic ability, helping her to better appreciate the likely affect of a possible action on others. Since these effects might often give her reasons to or not to perform that action, the empathy-enhancement would have enabled her to appreciate reasons that she would not otherwise have appreciated. Such an intervention would engage the agent’s capacity to recognise reasons as much as would the placement of images of diseased lungs on cigarette packages. Thus, even if there were a robust right against forms of arational influence that do not

\(^{24}\) Antonio Damasio has argued that bodily sensations are in fact an important component of all human deliberation. See his *Decartes’ Error* (London: Vintage, 2006). If this is correct, there may be many and varied ways in which interventions that influence our bodily sensations could affect our minds.
engage the agent’s deliberative capacities, this would not rule out the imposition of Medical Preventives, because some Preventives would fall outside its scope.

6 Conclusions

I have considered two different rights that one might appeal to in objecting to the imposition of Medical Preventives as criminal remedies: the right to bodily integrity and the right to mental integrity. I have argued that neither right can sustain a universal objection to this practice.

The appeal to the right to bodily integrity ran into the problem that, just as committing a crime might render one liable to impositions on free movement and association, so too it might render one liable to certain kinds of bodily interference, perhaps including those involved in the imposition of Medical Preventives. I argued that there should be a presumption in favour of the view that rights to bodily integrity are, like other property rights, no more robust than rights to free movement and association. I then tried to show that the most promising strategy for overriding this assumption fails: the factors which explain the great robustness of rights against, for example, torture and killing, do not apply to the right to bodily integrity.

An appeal to the right to mental integrity seemed initially more promising, since it is easy to see why we might enjoy highly robust rights against certain kinds of mental interference: they could constitute a serious threat to agency. However, this attempt also ran into problems. Though I identified one variety of mental interference against which we perhaps enjoy highly robust rights—interference that involves overriding choice—there seemed no reason to suppose that Medical Preventives need involve interference of this sort. They could instead, for example, merely influence choice. The question thus became: do we possess a robust right against interventions that arationally influence choice? I argued that we possess no general right of this kind. Moreover, I was unable to identify any sound basis for positing a more specific right that would rule out the imposition of Medical Preventives.

None of this is to say that all Medical Preventives could permissibly be used as criminal remedies in all circumstances. For example, the above discussion does not rule out the possibility that it is impermissible to impose Medical Preventives that operate by overriding choice. However, if my arguments above are sound, it is difficult to see any basis for a general objection to the imposition of Medical Preventives as criminal remedies.