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Abstract

Public policy is necessarily a political process with the law and order issue high on the political agenda. Consequently, working with sex offenders is fraught with legal and ethical minefields, including the mandate that community protection automatically outweighs offender rights. In addressing community protection, contemporary sex offender treatment is based on management rather than rehabilitation. We argue that treatment-as-management violates offender rights because it is ineffective and unethical. The suggested alternative is to deliver treatment-as-rehabilitation underpinned by international human rights law and universal professional ethics. An effective and ethical community–offender balance is more likely when sex offenders are treated with respect and dignity that, as human beings, they have a right to claim.

Keywords

sex offender treatment, human rights, public policy, sex offender laws

Introduction

Criminal justice policy no longer focuses on what was previously “a progressive sense of justice, an evocation of what ‘decency’ and ‘humanity’ required, and a compassion for the needs and rights of the less fortunate” (Garland, 2001, p. 10). Instead, sex offender policy in the United States is influenced by legislation that increasingly

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characterizes sex offenders as “lifelong predators who will seek out new victims as long as they live,” (La Fond, 2005, p. xiii). In the 1960s sexual psychopath laws viewed offenders as those with mental health impairment and thus diverted them into treatment. By the 1980s, this rehabilitative ideal had been replaced with a law and order agenda. A decade later, unusual and heinous sex offenses were increasingly highlighted by the media. Washington State’s response was the Community Protection Act 1990 that mandated longer prison sentences, indeterminate sentences, sex offender registries, community notification, and civil commitment. This shift encouraged other states to create legislation to deter future offenses and disregarded offender rights by departing from accepted legal precedent (La Fond, 2005; Vess, 2009). At best, sex offenders are now labeled, stigmatized, and ostracized from the community and at worst, are subjected to violence and vigilante activity. The emphasis is on *treatment-as-management* (i.e., managing offender risk) rather than *treatment-as-rehabilitation* (i.e., meeting offender needs), and as such, community rights consistently outweigh offender rights.

The Association for the Treatment of Sexual Abusers (ATSA) is a well-respected, voluntary organization that represents multidisciplinary practitioners who engage in the assessment and treatment of sex offenders. The ATSA Code of Professional Ethics (2001b) “represents a framework for making professional decisions and is intended to augment our own ‘moral compass’ [that supports] values of basic human dignity and respect, as well as common goals related to community safety and the long-term eradication of sexual abuse and sexual assault” (p. ii). Although ATSA may be concerned with treatment-as-rehabilitation, the policy emphasis in the United States is on treatment-as-management requiring practitioners to participate in sex offender registries, community notification, residence restriction laws, civil commitment, cognitive behavioral treatment, and so on. Glaser (2003) warned that placing too much weight on the community’s interests might breach the treatment rules of various ethical codes concerning beneficence (benefiting the client), nonmalificence (do no harm), and autonomy (respecting self-determination). The Human Rights Watch (HRW, 2007) indicated, “These laws cause great harm to the people subject to them . . . proponents of these laws are not able to point to convincing evidence of public safety gains from them” (p. 3) and the United States “is the only country in the world that has such a panoply of measures governing the lives of former sex offenders” (p. 10). Indeed, a recent detailed survey of sex offender practitioners found that 68 of 98 Canadian respondents (69%) and 945 of 1,495 U.S. respondents (63%) had little confidence that these laws would enhance community safety (McGrath, Cumming, Burchard, Zeoli, & Ellerby, 2010). Even though public policy regarding serious offenders ought to focus on evidence and ethics, it is invariably driven by “ideology, tradition, politics, or anecdote” (Petrosino & Lavenberg, 2007, p. 1) that “does not reflect a clearly thought through ethical mandate and appears to be responsive to a quite sensate reaction based on popular anxiety uninformed by sound data” (Brookbanks, 2002, p. 129).

This article will focus on the public policy approach to sex offender treatment that is currently treatment-as-management (deterrence and community rights) that consequently undermines treatment-as-rehabilitation (autonomy and offender rights). In brief, we propose that current public policy for managing sex offenders is punitive, lacks social science evidence, and disregards human rights. In our view, sex offender treatment should be evidence based and ethical because, in the context of human rights and corrections, it works and it is the right thing to do (Coyle, 2009). With that objective in mind, the article will detail human rights laws and universal professional ethics, critique the evidence and ethics of contemporary laws based on treatment-as-management approaches, and argue that sex offender treatment should be guided by human rights law.

Human Rights Law and Sex Offenders

Human rights and freedoms are granted to all individuals (including sex offenders), and human rights law provides fundamental protections without qualification or exception. Offenders are both rights violators and rights holders (Ward & Birgden, 2007). Therefore, though the state is obliged to protect the community from sex offenders by preventing and deterring crime, it is also obliged to respect their human rights, protect them against violations, and promote a human rights framework (Gostin, 2000; HRW, 2007). As rights holders, sex offenders require particular attention, but threats to their autonomy in corrections have been virtually ignored by practitioners. For example, Birgden (2004) in an article in this journal examined the volumes from 1995 to 2003 and found only three articles expressing offender autonomy concerns (Freeman-Longo, 1996; Laws, 1999; Marshall, 1996). An update review of this journal between 2004 and 2010 found only three articles that explicitly addressed human rights concerns (Drapeau, 2005; Ward, Gannon, & Birgden, 2007; Ward & Moreton, 2008). Recently, in a response to a critique by Birgden (2009), Andrews and Dowden (2009) acknowledged that “Birgden (2004) opened Andrews’s eyes to our inattention to respect for personal autonomy as a basic value underlying our psychology of criminal conduct and the RNR¹ approach (and) making human rights part of a model of rehabilitation is a very attractive idea” (p. 119).

International Human Rights Law

What is known as the International Bill of Rights reflects contemporary human rights law and consists of the Universal Declaration of Human Rights (United Nations, 1948), the International Covenant on Civil and Political Rights (United Nations, 1966a), and the International Covenant on Economic, Social, and Cultural Rights (United Nations, 1966b). The International Covenant on Economic, Social, and Cultural Rights declares that the state may limit such rights but only in accordance with the law and the right for the public good (Article 4). The International Covenant

on Civil and Political Rights safeguards individual rights against state interference, including the right not to be subjected to torture or cruel, inhuman, or degrading treatment or punishment (Article 7) and, if deprived of liberty, the right to be treated with humanity and respect and the right to reformation and social rehabilitation (Article 10). The Universal Declaration of Human Rights states that individuals also have duties to the community that can be limited by law (Article 29). Thus, although sex offenders may have restrictions placed on them for community protection, their rights should not be suspended altogether. Any restrictions should certainly not be based solely on their offense (HRW, 2007).

There is no doubt that offenders have enforceable human rights and should expect humane treatment from corrections and its practitioners (Birgden & Perlin, 2009). In particular, the American Convention on Human Rights (1969) includes freedom from *ex post facto* laws preventing the imposition of a heavier penalty than what was applicable at the time of the offense (Article 9) and postulates that any restriction of movement and residence can only be done to prevent crime or protect the freedom and rights of others (Article 22). The more detailed Standard Minimum Rules for the Treatment of Prisoners (United Nations, 1977) emphasizes that loss of liberty for community protection should ultimately result in the release of offenders who are "willing and able" to lead a law-abiding and self-supporting life. To this end, the institution should provide individualized services, minimize the difference between loss of liberty and a life of liberty, and provide gradual community reintegration. More important, the rules emphasize social inclusion rather than social exclusion, echoing the sentiment that "if offenders are excluded from the moral community or given a marginal status then it becomes permissible to treat them in ways that would ordinarily be evaluated as deeply unethical" (Ward & Syverson, 2009, p. 95).

ATSA practitioners should be mindful of their obligations regarding negative and positive rights held by sex offenders. The International Covenant on Civil and Political Rights (United Nations, 1966a) proscribes negative rights; as rights holders, offenders are free from unjustified state interference (e.g., to ensure freedom from discrimination by staff and other offenders). The International Covenant on Economic, Social, and Cultural Rights (United Nations, 1976b) prescribes positive rights; as rights violators, offenders require particular support from the state (e.g., to provide humane sex offender treatment). Negative rights can be described as "a right to be free from" and positive rights can be described as "a right to have access to," and, in essence, a shield versus a sword (M. L. Perlin, personal communication, January 11, 2010). Ensuring negative rights and providing positive rights to sex offenders appears not to have systematically occurred among practitioners in corrections.

Universal Professional Ethics

We have argued that practitioners should support human rights to balance the rights of the community and offenders. To protect practitioners and sex offenders, ethical codes and practice standards such as those propounded by ATSA should be in

accordance with international human rights law. A recent example is the Universal Declaration of Ethical Principles for Psychologists, adopted by the International Union of Psychological Science (IUPS, 2008).² The declaration provides a set of aspirational moral principles based on shared human values of peace, freedom, responsibility, justice, humanity, and morality. Although historically psychologists have focused on the individual-clinical, psychological approach to offender rehabilitation, the declaration considers broader social contexts: individuals, families, groups, and communities. Four principles are enumerated in the declaration, reinforcing that psychologists are to balance offender rights and community rights.³ A similar approach would be applicable to ATSA practitioners. Principle I (Respect for Dignity) is the philosophical foundation upon which other ethical principles are based and assumes that all individuals are interdependent social beings; that is, treatment must integrate with environmental contexts and social supports. Principle II (Competent Caring for Well-Being) is for client benefit and, above all else, psychologists should do no harm. Practitioners must provide adequate treatment to effect release to the community from corrections or civil commitment. Principle III (Integrity of Psychologists) is vital to advance scientific knowledge and to maintain community confidence in the discipline of psychology. Although community confidence in psychology may be maintained by participating in strategies that lack social science evidence, it is at an ethical cost. Finally, Principle IV (Professional and Scientific Responsibilities to the Community) contributes to knowledge about human behavior and to the development of social structures and policies that benefit all individuals. Practitioners have the duty to provide evidence-based and ethical input into policy development rather than reinforcing moral panic. We propose that the guiding principles of the ATSA Professional Code of Ethics (2001b) ought to be revised in accordance with international human rights law.

Treatment-as-Management

In practice, there is political pressure for sex offenders to be effectively managed through deterrence-based law, not human rights law. Coercive treatment (i.e., applying external pressure to control sex offending) includes both incapacitation and treatment strategies (Burdon & Gallagher, 2002). The Center for Sex Offender Management (CSOM, November 2008) defined rehabilitation as “providing treatment and other interventions that are designed to address the underlying factors that are linked to sex offending and other problem behaviors, with a goal of increasing public safety through risk reduction” (p. 2). To this end, treatment-as-management emphasizes risk management on a continuum from treatment (cognitive behavioral treatment to manage risk) to incapacitation (sex offender registers, community notification, residence restrictions, and civil commitment).

Treatment-as-management approaches include cognitive behavioral treatment to recondition thoughts, feelings, and behaviors, relapse prevention to support and monitor self-management skills in avoiding high risk situations and places, and the RNR

model that targets high-risk offenders with more intensive treatment of problem areas empirically related to the risk of reoffending (see Andrews & Bonta, 2003). Incapacitation approaches are enacted through laws that register, monitor, and contain sex offenders. A Federal sex offender registry was first established under the Jacob Wetterling Crimes against Children and Sexually Violent Offender Registration Act 1994. What is popularly known as Megan's Law amended the Wetterling Act and required states to establish a community notification program that encompassed more than violent sexual offenders alone. Note that, at September 2008, there were 660,000 registered sex offenders (CSOM, November 2008) and offenses of adult prostitution, public urination, and genital exposure, and consensual sex between teenagers were included (HRW, 2007). The Adam Walsh Child Protection and Safety Act of 2006 established a national sex offender registry law. The Sex Offender Registration and Notification Act (SORNA) is Table 1 of the Adam Walsh Child Protection and Safety Act 2006 (Public Law 248-109). SORNA extended Megan's Law to a federal level, incorporating a "more comprehensive" group of sex offenders and expanding the amount of information available to the community (U.S. Department of Justice, 2007). Treatment within SORNA is mentioned once and is described as completing a certified sex offender treatment program as one means of achieving a "clean record." Residence restrictions increased from 2004 and by 2006 had extended beyond child sex offenders in 80% of 20 U.S. states (HRW, 2007). Lastly, civil commitment laws incarcerate "dangerous" and personality disordered sex offenders indefinitely until their risk to reoffense is reduced.

ATSA has produced various position papers regarding legislation that include cognitive behavioral treatment, monitoring laws, and civil commitment. Regarding cognitive behavioral treatment, ATSA (1996) supports relapse prevention based on risk assessment, in support of the RNR model. Discussing community notification, McGinnis (2006), on behalf of ATSA, responded to Congress suggesting that SORNA adopt a more precise definition of "sexual predator" and tier offenders according to risk level. Regarding sex offender registries, ATSA (2005) argued in an amicus brief to the U.S. Supreme Court that residence restriction increased harm to children, did not necessarily protect them, and are driven by fear not facts. Later, ATSA (2010b) suggested that offenders should be monitored and reintegrated through legal supervision, and treatment and housing decisions should be based on risk assessment and individually determined. ATSA suggested "loitering zones" as an alternative to residence restrictions. Although ATSA acknowledged that community notification does not necessarily reduce reoffending, prevent sex offenses, protect children, or enhance community safety, it nevertheless supported registration and community notification with particular conditions, including risk assessment, interagency collaboration, and community education. In contrast, ATSA (2001a) did not take a position regarding civil commitment, but proposed a number of minimum standards to be applied such as risk assessment, the least restrictive alternative, commitment for the most serious and chronic offenders, and appropriate treatment in a suitable facility. Whereas ATSA (2010b) "believes that whenever possible, development and implementation of social

policies should be based on research” (no page number), the problem is that “to date, the available research appears to skirt the most basic issue: ‘Is the legislation effective in reducing recidivism?’” (Cohen & Jeglic, 2007, p. 377).

Sex offenders are subjected to a range of deterrent strategies through treatment-as-management approaches. As previously indicated, we will now consider whether treatment-as-management approaches in the context of incapacitation and treatment are evidence based and ethical.

Evidence: Does It Work?

The social science evidence regarding the impact of treatment-as-management on reduced reoffending will be briefly summarized.

Incapacitation. Incapacitation of sex offenders is accomplished through registration, community notification, residence restrictions, and civil commitment. Although created as separate legislation, registration (police tracking and monitoring sex offenders) and community notification (increasing public awareness of where sex offenders work, study, and live) have become virtually interchangeable and are applied even if sex offenders have received treatment. Despite the substantial costs, little research has been conducted to examine whether such laws enhance community protection (CSOM, November 2008). In terms of community notification, it would appear that Megan’s Law has failed to significantly reduce reoffending. The legislative assumption was that community notification would deter new offenses and citizens would take protective measures against sex offenders; “exactly what action is expected is not clear” (Beck, Clingermayer, Ramsey, & Travis, 2004, p. 142). Unfortunately, these strategies are based on evidence that is “anecdotal or plain conjecture” (La Fond, 2005, p. 108). Most recently, Zgoba, Witt, Dalessandro, and Veysey (2008) thoroughly examined the efficacy and cost of Megan’s Law by tracking 550 randomly selected sex offenders released between 1990 and 2000 and comparing 10 years before and 10 years after the law was enacted. The authors found no reduction in reoffending, no reduction in the number of victims, and an exponentially increasing cost of US\$3.9 million per year by 2007. In response to this study, Megan’s mother (Maureen Kanka) informed the Star Ledger that the “purpose of the law was to provide an awareness to parents. . . . Five million people have gone to the state website. It’s doing what it was supposed to do . . . we never said it would stop them from re-offending or wandering to another town” (Cruz, 2009).

The conclusions regarding community notification drawn by Zgoba et al. (2008) are supported by similar empirically based research. For example, in New York State, there was no impact on rapists, child molesters, sexual recidivists, or first-time offenders, and 95% of arrests were first-time sex offenders anyway (Sandler, Freeman, & Socia, 2008). A sample of 10 states also found no impact on the number of rapes committed (Walker, Maddan, Vásquez, VanHouten, & Ervin-McLarty, 2005). An older study compared reoffending rates of 90 registered and unregistered sex offenders 4.5 years later with no significant difference, although registered sex offenders were

rearrested more quickly (Schram & Milloy, 1995). Barnoski (2005) found that Washington's Community Protection Act 1990 reduced reoffending and the 1997 revision reduced sexual and violent reoffending. However, Sandler et al. criticized this particular study and questioned whether the outcome was due to legislation since the impact of first-time sex offending and changes in patterns of offending over time were not considered. Likewise, Duwe and Donnay (2008) conducted a retrospective study comparing the reoffending rates of 155 "high public risk" offenders released from Minnesota prisons compared to 125 prelegislation sex offenders released between 1990 and 1996 and 155 nonnotification sex offenders released between 1997 and 2002. Community notification was found to reduce the time for rearrest, reconviction, and reincarceration for sexual reoffenses (presumably the result of supervision) compared to the prelegislation control group but not the nonnotification control group. The Justice Policy Institute (2008) warned that "coupled with the lack of evidence that registries and notification make communities safer, states should think carefully before committing to comply with SORNA" (no page number).

Residence restrictions determine where registered sex offenders can live and usually requires there to be a specific distance from schools, day care centers, and churches. To date, 30 states have incorporated residence restrictions into their laws despite studies that found that living close to schools and so on do not conclusively lead to reoffending. Not a surprising result, considering 93% of sex offenses are committed by individuals known to the victim (ATSA, 2010a). According to Zandbergen, Levenson, and Hart (2010) the impact of residence restrictions on reoffending remains largely unknown. The authors compared a matched sample of 330 recidivist and nonrecidivist sex offenders in Florida and found no significant difference between the two groups regarding proximity to schools and daycare centers. The Minnesota Department of Corrections (2007) analyzed 224 recidivists released between 1990 and 2002 who were reincarcerated for a sex offense prior to 2006 and concluded that not one of the sex offenders would have been deterred by the residence restriction law.

Lastly, civil commitment has been increasingly utilized after prison rather than in lieu of prison (Burdon & Gallagher, 2002). Gookin (2007) reported that 20 states had passed sexually violent predator laws committing 4,534 individuals for an annual cost of US\$97,000 per person (and the "treatment" column stated "NA" for 10 of 18 states), and only 494 individuals had been released. An exception may be Texas where, rather than placing a sexually violent predator in a secure facility, the state allows offenders to transition to the community with mandated outpatient sex offender treatment and supervision as an alternative route (Bailey, 2002). Disturbingly, there appears to be very little research into the efficacy of civil commitment, and, other than incapacitation, there is no empirical evidence of long-term benefits, and no research has explored the effectiveness on sexually violent predators (CSOM, November 2008). Schram and Milloy (1998) tracked the official records of 61 sex offenders who had been released during the first 6 years of the Washington Community Protection Act of 1990. They found that 41% of the group were not rearrested at a mean follow-up of almost 4 years,

and, of the 59% who were rearrested, only 28% ($n = 17$) had committed further sex offenses; the nonoffenders could have been subjected to life sentences without parole.

In summary, social science evidence indicates that treatment-as-management is not effective in reducing reoffending. Bonnar-Kidd (2010) stated that “segregating a class of citizens on the basis of emotionally driven laws is risky considering that the empirical evidence supporting their effectiveness is sparse. There is also evidence that these laws could be doing more harm than good” (p. 417). Lipsey and Cullen (2007) noted that “the theory of specific deterrence inherent in the politically popular and intuitively appealing view that harsher treatment of offenders dissuades them from further criminal behavior is thus not consistent with the preponderance of available evidence” (p. 302). Treatment-as-management can be described as the “politics of vengeance” repackaged as community protection on the grounds of risk management (Kemshall & Wood, 2007).

Ethics: Is It the Right Thing to Do?

Even if treatment-as-management strategies were effective, they still pose serious constitutional, moral, and philosophical questions (La Fond, 2005). Pressure to engage in treatment occurs in prison and in special commitment centers. Civil commitment in particular has been described by civil libertarians as preventive detention masquerading as coerced treatment that threatens rehabilitation, justice, and constitutional values, and legitimizes warehousing (La Fond, 2005). Indeed, Seattle literally converted a warehouse for civil commitment (Davy & Goodnough, 2007). High-risk sex offenders are ordinarily assessed for civil commitment during the last months of their incarceration after several months or years of imprisonment, regardless of whether they have completed treatment. Incarcerated offenders often first learn of impending commitment during the transfer to a forensic facility or are not notified of commitment recommendations until a few weeks before scheduled release. These evaluations can span months or years and once civilly committed, sex offenders are then encouraged to engage in treatment or recommence treatment altogether. Often treatment was denied while incarcerated leading to a “punish first, treat later” strategy (La Fond, 2005). McNichol (2008) provided the example of a civilly committed Californian patient who, 8 years later, having previously served a 10-year prison sentence, was still at Phase 2 of a five-phase treatment program.

In prisons and civil commitment centers, access to quality treatment varies across states, with treatment being implemented by staff of varying qualifications and skills, despite ATSA guidelines (Fitch & Hammen, 2003). A 2009 survey of 649 adult male and female sex offender treatment programs delivered in the United States and Canada was recently released (see McGrath et al., 2010). The authors found that of 1,414 staff in United States and Canadian residential settings, 555 (39%) had a bachelors degree only or no bachelors degree and that clinical supervision in 109 programs was *not* provided in 31 (26%) of these programs. Fantasy diaries and notes taken throughout treatment are entered into court evidence leading some lawyers to advise nonattendance;

in California's Atascadero State Hospital, 70% of patients refuse treatment as a result (Davy & Goodnough, 2007; McNichol, 2008). Offenders who act out in treatment are penalized and punished, oftentimes removed altogether for a period of time. Some sex offenders prefer to return to prison (Fitch & Hammen, 2003). The antitherapeutic consequences of civil commitment include the high cost of long-term placements, the diversion of limited resources from individuals with mental illness, and disincentives for participating in treatment in both prison and civil commitment centers (CSOM, November 2008).

Barbaree (2007) noted that although legal impositions on sex offenders can be seen as *restrictions* on their human rights, they have generally not been perceived as *abuses* of their human rights. Specifically, Duwe and Donnay (2008) noted that a possible decrease in sexual reoffending needs to be balanced against the antitherapeutic consequences of community notification. We believe that deterrence-based laws, epitomized by treatment-as-management, are the antithesis of respect for human rights and represent ineffective and unethical professional practice. Unfortunately, judgments by the U.S. Supreme Court regarding constitutional challenges have not aligned with international human rights law in general or the American Convention on Human Rights (1969) in particular. Numerous constitutional challenges to deterrence-based law have been made on the grounds of cruel and unusual punishment, proportionality (the punishment is incomparable to the severity of the offense), double jeopardy (punishment is applied to offenders who have already completed their sentence), equal protection (singling out sex offenders from other serious offenders), and *ex post facto* (retroactively applying a law after conviction; see HRW, 2007; La Fond, 2005). On occasion, such arguments have been rejected because the purpose of these laws are perceived as prevention, rather than punishment, and the state's interest in community protection can outweigh those of offenders (La Fond, 2005). Regarding treatment, in *McKune, Warden et al v. Lile* (2002), Mr. Lile was recommended to enter a prison treatment program a few years before release from the Kansas Department of Corrections. Treatment involved admitting past and present offenses, and refusal resulted in withdrawal of privileges and removal to a maximum-security prison. The U.S. Supreme Court held this was not a violation of protection against self-incrimination but was a sensible way for the state to reduce the danger of repeat sex offenders.

Regarding deterrence-based laws, the rush to confine or restrict sex offenders continues to override human and constitutional rights and ignores the antitherapeutic consequences. In *John Doe etc. v. Deborah Poritz* (1995) the U.S. Supreme Court found that sex offender registers and community notification did not violate *ex post facto* or double-jeopardy laws or pose cruel and unusual punishment. In *Smith v. Doe* (2003) the U.S. Supreme Court found that retroactive application of registration was constitutional, although the dissenting Justices held that the law was punitive and imposed severe deprivations of liberty. In *Connecticut Dept. of Public Safety v. Doe* (2003) the U.S. Supreme Court found that the right to due process had not been violated regarding a sex offender registry as it considered convictions, not dangerousness. In Florida residence restriction laws have famously culminated in sex offenders "living under

bridges” (Zarella & Oppmann, 2007). *Wendy Whitaker v. Purdue* (2006) raised the issue of every registered sex offender in Georgia being banned 1,000 feet from 100,000s of school bus stops. One consequence was immediate eviction notices to nursing home residents; some of whom were dying or physically incapacitated (see Geraghty, 2007). However, most recently in *People v. Oberlander* (2009), the New York State Supreme Court warned that the “not in my backyard” mentality was allowing residence restrictions to multiply unchecked.

Lastly, in evaluating civil commitment, the U.S. Supreme Court has found that such laws do not violate *ex post facto* or double jeopardy, giving the states the “green light” (La Fond, 2005) even though the laws may be viewed as “after-the-fact attempts to impose additional punishment” (Scott, 2008, p. 1427). Nonetheless, the U.S. Supreme Court has raised some concern regarding the application of treatment after incarceration. In *Kansas v. Hendricks* (1997), Mr. Hendricks was seeking release from civil commitment after having also served a prison sentence. The dissent in the 5-4 decision argued that sex offenders were being punished before being treated and were not provided with a least restrictive alternative. The court noted that without adequate treatment providing a pathway to release, civil commitment becomes state-imposed criminal punishment without procedural protections (Scott, 2008). In *Seling v. Young* (2001), the U.S. Supreme Court made it clear that adequate treatment is a fundamental prerequisite to civil commitment (Scott, 2008), although “adequate” was not defined. The courts continue to focus on the right of confinement rather than treatment once confined. More recently, *US v. Comstock* (2009) gave the federal government the power to override human rights and constitutional safeguards by transferring federally sentenced prisoners to civil commitment. The impact of the current decision allows federal overarching control and is a further example of moral panic. As a consequence, federal authorities can imprison people indefinitely under suspicion of future dangerousness. The issues surrounding treatment were again neither litigated nor addressed. As a result, there has been no mandate addressing specific requirements for adequate treatment, and the lower courts are left to develop their own frameworks. Yet as we have discussed, those frameworks are often lacking. An example provided by Scott is a 17-year litigation over Washington’s Special Commitment Center (SCC) in which residents claimed their civil rights were being violated; no individualized treatment, no monitoring, and no judicial oversight. By 2006 a report by the Inspection of Care Committee (a panel of independent experts appointed by the SCC) found that there was inadequate supervision and management by staff, unaddressed deficiencies in the treatment program, lack of integration with medical and psychiatric treatment, disorganized health care services, inadequate clinical and medical files, persistent concerns regarding personal sanitation and safety concerns, shortcomings in oversight mechanisms, and increased complaints of staff abuse and reduced numbers in treatment. By 2007 the District Court had in effect given up on obtaining compliance from the SCC. It would appear that the treatment process at the SCC was well below the standards established by international human rights law and universal professional ethics.

In summary, “States may be able to enact statutes that declare treatment as a goal, but in practice, that goal may prove to be sham” (Scott, 2008, p. 1426). In a detailed analysis, HRW (2007) concluded that deterrence-based laws were neither proportional nor necessary to achieve community protection. Treatment-as-management has anti-therapeutic consequences that increase the risk to reoffend. These consequences include unemployment, homelessness, shame, depression and anxiety, disconnection from social supports, and inadequate treatment (see Appelbaum, 2008; Bonnar-Kidd, 2010; HRW, 2007; Levenson, 2007; Levenson, D’Amora, & Hern, 2007; Scott, 2008).

Treatment-as-Rehabilitation

The CSOM (November 2006) recommended that treatment ought to be holistic in supporting offenders to lead a stable and productive life. Two approaches that dovetail with human rights, ethical practice, and improved well-being are the legal theory of therapeutic jurisprudence (TJ) and the psychological theory of the good lives model (GLM). Both theories are humanistic, concerned with improving offender well-being, and are based on an ethic of care (TJ) or a therapeutic alliance (GLM).

Therapeutic Jurisprudence

TJ is a framework proposed by Professors David Wexler and Bruce Winick.⁴ TJ studies of the role of the law as a therapeutic agent and is concerned with applying social science evidence to determine how existing laws and law reform can maximize therapeutic effects and minimize antitherapeutic consequences (Wexler & Winick, 1996). In a TJ analysis, Edwards and Hensley (2001) concluded that the criminal justice process is antitherapeutic for both sex offenders and their victims because the confrontational adjudicative process of traditional courts encourages advocacy of innocence, discourages acceptance of responsibility, and influences resistance to treatment once sentenced. The authors proposed an alternative “treatment tracking model” that defers sentencing contingent upon early cooperation, encourages guilty pleas that reflect the offense, and supports participation in treatment, with a failure to comply resulting in the remainder of the sentence being served. From a human rights perspective this is acceptable if the offender is supported to make an informed choice.

As a legal theory, TJ supports due process in law, rarely considered by practitioners in corrections. Due process ensures that any restrictions on freedom are rationally justified (Ward & Birgden, 2007). Utilizing social science evidence, Tyler (1996) concluded that effective due process in court is made up of participation (defendants are included in decision making), dignity (defendants’ rights and values as a competent, equal citizen, and human being are acknowledged), and trust (judges allow defendants to present evidence and they clearly explain decisions); being treated with respect translates into greater compliance with the law. Procedures in offender rehabilitation should rely on an ethic of care and be fair and reasonable, building “legitimacy in corrections” to minimize antitherapeutic effects and to maximize therapeutic effects of the law (Tyler, 2010).

Good Lives Model

The GLM of offender rehabilitation is a psychological theory devised by Tony Ward and his colleagues. The GLM draws on social science research, social policy, evolutionary theory, applied ethics, philosophical anthropology, and psychology (Ward & Stewart, 2003). Offenders are assumed to be constantly constructing purpose and meaning in their lives in order to pursue human needs (i.e., they are no different from “nonoffenders”). This conception of well-being assumes that increased offender capabilities will improve quality of life and, in turn, reduce the likelihood of reoffending. The GLM enacts the four universal ethical principles previously described in that practitioners attend to well-being, a sense of personal identity, and the individual–environment context (Ward & Stewart, 2003). In particular, the GLM (a) conceptualizes dynamic risk factors merely as “red flags” indicating human needs are being met in antisocial rather than prosocial ways, (b) provides a positive strength-based approach to sex offenders in viewing them as interdependent and so reliant on the good will of others to *support* them, (c) outlines the skills and capacities necessary to enhance treatment readiness, and (d) explicitly addresses practitioner attitudes toward offenders and the impact on the therapeutic alliance (Ward & Brown, 2004). In the 2009 survey of 1,379 sex offender treatment programs, about one third of U.S. adult and adolescent programs and one half or more of the Canadian adult programs listed the GLM among their top-three choices (McGrath et al., 2010).

The GLM applies the self-determination theory of human needs (Deci & Ryan, 2000) and is specifically concerned with autonomy (defined as the ability to function independently as a unified, integrated being, to form one’s own values and beliefs, and to make decisions; Ward, 2002). Treatment should balance risk management and offender autonomy and in doing so address approach goals that increase desirable outcomes (what the community wants from offenders as rights violators) and avoidance goals that decrease undesirable outcomes (what offenders want for themselves as rights holders). In determining what the offender wants, keep in mind that “there is no such thing as the right kind of life for an individual across every conceivable setting [as] limits [are] defined by circumstances, abilities, and preferences” (Ward & Brown, 2004, pp. 247-248).

Conclusion

The following article has outlined principles to be applied to the treatment-as-rehabilitation approach (supported by human rights principles) rather than the more popular, and more simply applied, treatment-as-management approach (ineffective and unethical practice). HRW (2007) has comprehensively argued that contemporary deterrence-based laws violate the right to privacy, family and home, freedom of movement and liberty, and physical safety and integrity and questioned whether such laws actually protect the community. Unfortunately, the U.S. Supreme Court has not actioned international human rights law even though treatment-as-management has been shown to be ineffective, unethical, and antitherapeutic. Fortunately, developments

enacting human rights law and universal ethics in offender rehabilitation, in which respect and dignity are core, are underway. Ward and Birgden (2007) designed a human rights model for corrections that articulates moral rights. Furthermore, Ward and Syverson (2009) have proposed an ethical framework that recognizes human rights as a resource that supports reparation, caring, beneficence, nonmalificence, communitarianism, redemption, justice, and autonomy. These ethical rules are in turn supported by international laws, human rights treaties, nongovernment organizations, ethical codes, and so on. Professional ethics serve to protect the human rights of offenders stemming from the core values of well-being and freedom.

The overall message we wish to emphasize is that sex offenders need to be treated as human beings who are legitimately part of the moral and political community and should be acknowledged as both rights holders and rights violators. Current ethics codes and position papers that guide sex offender practitioners, as espoused by ATSA, should be aligned with human rights law, and practitioners should actively seek a community–offender balance by emphasizing community inclusion through support rather than social exclusion through restraint.

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1. The Risk-Need-Responsivity model of offender rehabilitation.
2. The revised Australian Psychological Society Code of Ethics (2007) has been based on the Universal Declaration. Retrieved October 10, 2007, from <http://www.psychology.org.au/about/ethicscode>
3. Birgden and Perlin (2009) have proposed a detailed “checklist” against each principle for forensic psychologists delivering services in correctional settings.
4. See <http://www.therapeuticjurisprudence.org>

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