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ASSESSING RISK FOR PREVENTIVE DETENTION OF SEX OFFENDERS: THE DICHOTOMY BETWEEN COMMUNITY PROTECTION AND OFFENDER RIGHTS IS WRONG-HEADED

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1. INTRODUCTION

The debate regarding preventive detention of serious high-risk sex offenders is often played out as a dichotomy between proponents arguing for community protection versus opponents arguing for offender rights, as if the two positions are mutually exclusive. Advocates of community protection argue that serious high-risk offenders ought to be incapacitated and perhaps receive treatment as a risk management strategy (treatment-as-management). Advocates of offender rights argue that serious high-risk offenders should not be used as a means to an end and that they still possess human rights (treatment-as-rehabilitation). The role of mental health professionals currently influences court decision-making regarding preventive schemes, in terms of supervision or detention, based on their assessments of risk of re-offending.

Policy development in Canada, the United Kingdom and Australia has been heavily influenced by the risk management policy direction in the US, which relies upon risk management strategies such as community notification, sex offender registers, residency restrictions and civil commitment. Herzog-Evans noted that legal rules in the UK and Australia reflect the decline in the rehabilitative ideal while legal rules in France, Germany, and Spain support desistence from offending. Petrunik and Deutschmann described this difference in terms of a continuum from sex offender exclusion (US risk management in response to populist pressure) to offender exclusion-inclusion (UK and Canadian
rehabilitation programs) to sex offender inclusion (Canadian community-based restorative justice initiatives and European treatment models). This continuum is also influenced by the independence of bureaucrats: in Continental Europe, bureaucrats are fiercely independent; in the US, bureaucrats are elected and so subject to lobbying regarding public policy; and in Canada and the UK (and presumably Australia), bureaucrats are located somewhere in the middle in being accountable to the elected government of the day.

Public policy discourse around the topic of preventive detention tends to be based on an 'either/or' dichotomy between community protection and offender rights: for example, the balance between the rights of the community and potential victims versus the rights of offenders who have served a sentence with an ensuing tension between community protection and legal principles, the debate that all players in the criminal justice system ought to be concerned about 'making the best decisions about community safety, prevention, treatment, and the delivery of justice', and the dilemma between punishment in the criminal justice system versus treatment in the mental health system.

Preventive schemes are one public policy response to preventing future harm by serious high-risk sex offenders, purportedly to protect the community. This post-sentence strategy extends government control over sex offenders after they have served their prison sentences. In particular, sex offenders are considered to be exceptionally risky, requiring special legislative control directly linked to punitive penal popularism. Within this subgroup of sex offenders are those serious high-risk offenders who represent the pointy end of potential violations of offender rights and so require particular attention by practitioners regarding likely ethical problems. At 2013, such prevention schemes have been in Australia for a decade commencing with the Dangerous Prisoners (Sexual Offenders) Act 2003 (QLD), followed by the Dangerous Sexual Offenders Act 2006 (WA) and the Crimes (Serious Sex Offenders) Act 2006 (NSW), and then followed by the Serious

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3 Ibid.
8 B McSherry and P Keyzer, Sex Offenders and Preventive Detention: Politics, Policy and Practice (Federation Press, 2009).
Sex Offenders (Detention and Supervision) Act 2009 (VIC). Preventive schemes restrict the liberty of serious sex offenders who may re-offend in the future and, as a consequence, subjects them to coerced treatment and management. Restricting liberty on the basis of what an individual may do undermines legal principles and core rights such as the presumption of innocence, finality of sentencing, the principle of proportionality and the principle against double punishment. This significant departure from accepted criminal justice practices has implications for serious high-risk sex offenders in Australia. The following chapter will first consider the implications of assessing risk for preventive schemes in terms of science (does it work?) and ethics (is it the right thing to do?) and then recommend improvements to preventive schemes regarding procedures and roles of mental health professionals.

Craisatti has devised a useful structure for considering practical and policy implications in managing high-risk offenders in the community. Adapted to preventive schemes, the following normative framework will be proposed. Risk considerations include offenders’ risk of re-offending, the likely harm to the victims and what level of risk is posed in labelling offenders as serious high-risk. Scientific considerations require the risk of re-offending to be determined in order to predict risk, address dynamic risk factors and meet human needs. Ethical considerations include the sociopolitical risk management context, ethical principles that should be enacted by practitioners, regardless of the contemporary political environment, and the style of interaction with sex offenders that ethical practice therefore entails. At present, preventive schemes do not address the shaded areas (figure below) – risk considerations (risk to offender), scientific considerations (human needs), and the entirety of ethical considerations (the socio-political context, ethical principles and an ethic of care). If these areas were to be addressed in the procedures and roles of legal actors, then it is possible that offender rights would be met and community protection therefore enhanced.

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11 J Craisatti, Managing High Risk Sex Offenders in the Community: A Psychological Approach (Brunner-Rutledge, 2004).
Sentencing principles generally capture retribution, deterrence, incapacitation and rehabilitation.\(^\text{12}\) In common, preventive schemes in Australia are designed to protect the community from the harm that sex offenders pose in re-offending. The emphasis here is on community protection by managing risk through detention or supervision, rather than emphasising rehabilitation. This is despite social science evidence based on meta-analyses of general offenders that lengthy detention actually increases the likelihood of re-offending, and intensive supervision alone does not reduce re-offending.\(^\text{13}\) In current preventive legislation in the four Australian states, the primary objective is to ensure community protection and the secondary objective is to provide control, care, or treatment to facilitate rehabilitation (QLD), to merely provide control, care, or treatment (WA), or facilitate treatment and rehabilitation (VIC and NSW). Presumably Queensland considers that control alone can facilitate rehabilitation, and Western Australia is unconcerned about whether rehabilitation occurs. These objectives in legislation are applied whether sex offenders like it or not.

Within the objectives, conditions or directions are imposed upon offenders placed on supervision orders (there are no conditions for detention orders it seems). Under the *Serious Sex Offenders (Detention and Supervision) Act 2009* (VIC), the primary purpose of conditions imposed on offenders is to reduce the risk of re-offending and the secondary purpose is to consider the safety and


welfare of the victims (s 1). Regarding supervision orders, numerous conditions are listed and offenders may be ordered to reside in a residential facility if there is no other accommodation available (s 18). A residential facility is gazetted by the government and is designed to: case manage and supervise offenders; provide safe accommodation; protect the community; and support offenders to comply with the conditions on their orders (s 133). Eight core conditions that must be fulfilled are listed, and they are all focused on surveillance and management of the individual (s 16). Fifteen suggested conditions are listed that again focus on surveillance and management (s 17). Suggested condition (e) refers to treatment or rehabilitation programs or activities that the offender must attend and participate in. Provision is made for discretionary conditions that promote rehabilitation and treatment to reduce re-offending or provide for victims’ safety and welfare such as restricted internet access or banned alcohol use (s 19). As a consequence, legislative intervention relies on surveillance and management to afford community protection rather than the state being obliged to meet identified offender needs that lead to an offending pathway in the first place.

As entry into preventive schemes turns on assessment, it is important to note the difference between a serious sex offender and a high-risk sex offender. Offender seriousness is determined in legislation. For example, ‘serious offender offences’ are defined in Schedule 1 of the Sentencing Act 1991 (Vic) and include violent offences, serious violent offences, drug offences, arson offences and sexual offences (rape, indecent assault, and sexual penetration of a child under 16 years etc). Offender risk means the assessed risk of re-offending. However, the two constructs are often conflated in policy. The Victorian Attorney-General requested that the Sentencing Advisory Council provide ‘advice about the merit of introducing a scheme that would allow for the continued detention of offenders who have reached the end of their custodial sentence but who are considered to pose a continued and serious danger to the community’. This term of reference infers that repeat offenders are serious offenders. A more accurate descriptor is ‘serious high-risk offenders’. Nevertheless, both risk and seriousness are normative judgements that try to resolve complex moral, social and ethical issues; they are not scientifically-based. Judgements regarding seriousness are determined by legislative definitions (frequently driven by public opinion rather than science and ethics). Judgements regarding risk are often made by mental health professionals categorising ‘low’, ‘medium’ and ‘high’ risk (where cut-off levels of risk are driven by resource capacity rather than science and ethics). The normative nature of this issue raises scientific and ethical concerns regarding the assessment of risk and its consequences.

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14 McSherry, above n 4, 1.
2. ISSUES: RISK, SCIENCE, AND ETHICS

At 2008, there were 82 sex offenders subject to preventive schemes in Australia, and in the period 2010–11 there were 36 offenders subject to supervision orders in Victoria. Despite the likely increase in numbers, there is no outcome data regarding the efficacy of prevention schemes since they emerged in the Australian context in 2003. The following section will raise scientific and ethical concerns regarding risk prediction and risk management.

2.1. RISK PREDICTION

Preventive strategies rely upon judgements regarding the risk of re-offending, and a finding of high-risk opens the gateway to preventive detention and supervision. In legislation, the risk of re-offending is ultimately determined by the court. The *Serious Sex Offenders (Detention and Supervision) Act 2009 (VIC)* indicates that a detention or supervision order is to be imposed if the court is satisfied that there is an unacceptable risk (s 35), even if the likelihood that the offender will commit a relevant offence is less than a likelihood of more likely than not (s 35(4)). In regard to a supervision order specifically, the court must be satisfied by acceptable, cogent evidence and a high degree of probability that the evidence is of sufficient weight to justify the decision (s 9(2)). In making this determination, the court relies upon the opinion of mental health professionals. Briefly, there are three possible methods for mental health professionals to determine the likelihood of re-offending—clinical judgement, actuarial assessment and structured clinical judgement. Clinical judgement involves predictions based upon the collection of information about offenders and their situations, relying on unstructured interview, files searches, psychological testing and so on. Monahan in a seminal review concluded that psychiatrists and psychologists who used clinical judgement were inaccurate in two out of three predictions of violence in mentally disordered clients released from institutions. Actuarial assessments are based on empirical research and theories to develop a list of risk factors, empirically test them on

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17 Victoria, Legislative Assembly, 26 October 2011.
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various populations, and create a common set of questions applied to everyone and weighted to produce a score to categorize the person. *Structured clinical judgement* is a more comprehensive analysis of theoretically and empirically determined static and dynamic risk factors linked to re-offending with an overall opinion of re-offence risk provided rather than a probability estimate. It has been argued on the one hand, that actuarial methods should completely replace clinical judgement and on the other hand, that clinicians should be able to revise actuarial risk estimates on the basis of clinical judgement.

In assessing risk, psychiatrists tend to apply clinical judgement while psychologists tend to apply actuarial assessment and/or structured clinical judgement. Whether assessors are to be psychiatrists or psychologists varies between states. For example, assessors in Victoria may be medical experts (psychiatrist, psychologist or other health provider), assessors in New South Wales may be psychiatrists or psychologists, and assessors in Western Australia and Queensland must be psychiatrists. On the one hand, psychologists have argued that the profession is in a better position to conduct risk assessments as psychologists tend to conduct more research in the area and psychiatrists have not been shown to be any better at predicting risk. On the other hand, psychiatrists have criticised psychologists for being too reliant on actuarial assessments at the expense of clinical judgement and diagnostic abilities. At present, across three Australian states, psychiatrists conduct risk assessments for the courts regarding preventive schemes more often than psychologists at a 6:4 ratio.

As stated, psychologists administer actuarial tools to determine the risk of re-offending. The Static-99 is the most utilised actuarial risk assessment tool applied in the courts in North America to assess recidivism in adult male sex offenders. The Static-99 measures ten static (or unchangeable) risk factors that include previous sexual and non-sexual offences and unrelated/stranger/male victims. In Victoria, the Static-99 is utilised to screen for risk, and those offenders who score greater than 6 (high-risk) are then referred to an independent

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21 See, eg, Hanson, above n 19.
23 McSherry and Keyzer, above n 9.
psychologist for a full risk assessment.\textsuperscript{27} As it is a popular tool, the scientific and ethical concerns regarding the Static-99 will be discussed in more detail.

The Static-99 has been empirically shown to provide explicit probability estimates of sexual re-offending, albeit at a moderate predictive accuracy.\textsuperscript{28} However, the Static-99 has also been found to both over-estimate re-offending for those individuals who score above 4 (moderate- to high-risk) and under-estimate re-offending for a score of 0 or 1 (low-risk) with re-offending at twice the predicted rate.\textsuperscript{29} This is of concern because if a screen on the Static-99 identifies that a person is high-risk then the psychologist conducting the more detailed clinical assessment may be influenced by that result. Additional versions of the tool, including the Static-99/R and the Static-2002/R, have been developed with updated age weights as it was found that older offenders are less likely to re-offend when released. Most recently, Helmus et al evaluated the absolute predictive accuracy of these two tools. They found that while there was stability in relative risk (comparing recidivists to non-recidivists) there was instability in absolute recidivism rates (eg, a ten-year predicted rate ranging between 3 per cent and 20 per cent in different samples of offenders). This means that such tools can lead to different conclusions regarding the same offender’s predicted recidivism rate. The authors warned that the linking of scores to recidivism rates ‘turned out to be a gross simplification [which] complicates the interpretation of these Static risk measures...evaluators cannot, in an unqualified way, associate a single reliable recidivism estimate with a single score on the Static-99/R or Static-2002/R risk scales’.\textsuperscript{30} Structured clinical judgement was recommended as a consequence to supplement these tools. Moreover, in 2012 a United States judge in Wisconsin barred the result of a Static-99/R administered for a sexually violent predator case. According to Franklin, this was the result of the refusal of one of the expert witnesses- and developer of the tool- to provide the Static-99/R data requested by the defence as part of a Daubert challenge (to establish the scientific reliability and validity of expert testimony before the court).\textsuperscript{31}

In response to these findings, Franklin warned that the Static-99 tools are normed on high-risk offender groups (who are more easily accessible for developing

\textsuperscript{28} Harris et al, above n 26.
\textsuperscript{30} Ibid 22–3.
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She provided the unethical scenario where a sex offender is referred in a biased manner (e.g., based on race or sexual orientation) and is then subjected to a tool that has not been peer-reviewed regarding its validity and reliability and will undoubtedly elevate the risk level in comparison to 'ordinary' offenders. Franklin concluded that such tools are therefore inadequate for legal proceedings. Evidence regarding the use of the Static-99 in an internet chat room case in the United States discounted the psychologist's evidence. Upon appeal, the Seventh Circuit highlighted problems with the Static-99 such as moderate predictive accuracy, low base rates for sex offending and too limited a number of potentially relevant characteristics; the Court's view was that the judge was entitled to discount the prediction.

Regardless, best practice in predicting risk of re-offending is considered to be the application of empirically validated actuarial measures combined with specific dynamic (i.e., changeable or treatable) risk factors for sexual re-offending. It would be expected that mental health professionals conducting risk assessments for the court in Australia are doing so in the context of structured clinical judgement that includes assessment of dynamic risk factors. Andrews and Bonta have identified eight empirically-derived dynamic risk factors for general offenders. However, they view less promising dynamic risk factors as: increasing self-esteem without addressing anti-social attitudes, associates, and groups; conventional ambition regarding education and employment without providing concrete assistance; focusing on vague emotional/personal complaints not linked to offending; improving neighbourhood conditions without targeting dynamic risk factors; and showing respect for anti-social thinking or attempting to turn the offender into a 'better person' when that standard is not linked to re-offending.

Various static and dynamic risk factors have been identified in sex offenders. These include: the number and type of victims and offences (particularly diverse sexual offences, non-contact offense, extra-familial child victims, male child victims, and stranger victims); commencing sex offending at a young age; having never been married; conflict in intimate relationships; psychopathy and hostility; deviant sexual arousal; attitudes tolerant of sexual assault; emotional identification with children and negative emotional states, exacerbated by mood

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34 Vess and Eccleston, above n 27.
35 'Dynamic risk' and 'criminogenic need' are the same construct.
changes and substance use; poor interpersonal skills/self-management; poor social support; and treatment drop out.37

An example of a tool that utilises structured clinical judgement is the Sexual Violence Risk-20 (SVR-20).38 The SVR-20 is a 20-item checklist identified from a literature review and includes the history of sex offending, psychosocial adjustment and future plans. Further, the SVR-20 considers some rare but contextualised risk factors such as relationship breakdown or job loss, frequent contact with potential victims and poor attitude toward treatment. On the one hand, Wood and Ogloff indicated that the SVR-20 has been found to have better predictive value than the Static-99 with the proviso that it still needs to be tested on a range of populations for use in court.39 On the other hand, Singh et al, in comparing the Static-99 and the SVR-20, concluded that they were roughly equivalent using a ranking system for predictive validity.40

It is important to note that dynamic risk factors are correlational in that they do not ‘cause’ re-offending. Dynamic risk factors are also yet to be empirically derived and so are currently based on clinical experience, theoretical inference and common-sense.41 As a consequence, the assessment criteria for the risk areas are vaguely defined as ‘non-rewarding family relationships’, ‘attitudes supportive of crime’, ‘could make better use of time’ and so on.42 Therefore, such structured clinical judgement tools are still in their early stages of development and cannot yet be relied upon to identify treatment targets or likely changes in risky behaviour or determine changes in risk levels; they are better at making commitment than release decisions.43 Dynamic factors include risk factors that increase risk and protective factors that decrease risk.44 Protective factors and situational factors are less well articulated in the literature and ought to include social relationships that

41 Andrews and Bonta, above n 36.
43 Mercado and Ogloff, above n 22.
may counteract risk factors and lower re-offending and environmental factors such as unsupervised release environments. Nonetheless, structured clinical judgement provides a shift from risk prediction to risk management in order to determine risk factors, type of harm, and likelihood that harm will occur.

In general, all risk assessment tools pose scientific and ethical problems. Szmukler has contrasted the 'numbers' in risk assessment (the statistical likelihood of re-offending within a particular timeline) and the 'values' in risk assessment (attaching a value to the risk assessment outcome and determining what to do about it). The former is an evidence-based consideration, and the latter is an ethical consideration. First, risk assessment tools are wholly or partially based on static (ie, unchangeable or untreatable) risk factors, which means that although they may identify certain risk factors and predict risk, they do not provide guidance on how to manage future risk. Second, contrary to popular opinion, sex offenders have very low re-offending rates and tend to not have previous convictions. This low base rate effects the accuracy of predicting risk. Accurate risk prediction can best be achieved when the base rates of re-offending are 30 to 60 per cent. Most recently the sexual re-offending rate in 23 samples (N=8,106) was measured and was found to be between 4 and 12 per cent at five-year follow-up (most likely 7% or less) and between 6 and 22 per cent at ten-year follow-up. In Australia, one study found that the sexual re-offending rate was also low for untreated adult rapists (4.5%) and untreated child sex offenders (5.6%) at up to seven-year follow-up. Based on 17 Australian studies, Lievore concluded that most base rates for sexual re-offending were below 10 per cent. Third, actuarial risk assessment tools provide probability estimates as opposed to a certainty (eg, a 60% likelihood of re-offending) that compares an offender to a group of 'like' offenders but cannot determine whether the offender actually belongs to the group who is likely to offend (ie, 60% category) or is unlikely to offend (ie,
40% category). This problem raises issues for the court who consider each sex offender on a case-by-case basis. For example, in 1998 the Western Australian Parole Board determined that while sex offenders who refuse treatment may be moderate- to high-risk, 'the Board generally accepts these assessments, but in the end is obliged to deal with each prisoner individually'.

Fourth, risk assessment tools can result in 'false positives' (the detention of an ineligible sex offender) or 'false negatives' (the release of an eligible sex offender). Further, Fazel, Singh, Doll, and Grann conducted a thorough systematic review and meta-analysis of 24,827 offenders subject to risk assessments across 13 countries (1995–2011) and concluded that tools that predicted violent offending were more accurate than those that predicted sex offending, and all such tools identified low-risk offenders with more accuracy than high-risk offenders. Of concern is that, of sex offenders judged to be moderate- or high-risk, only 23 per cent went on to re-offend; for every one offender correctly identified, three will be falsely identified as recidivists. The authors concluded that while risk assessment tools can be used to guide rehabilitation and management decisions in corrections, they should not be used as sole determinants of detention or discharge in courts. Put another way, they should 'only be used to roughly classify individuals at the group level, and not to safely determine criminal prognosis in an individual case', although at least such tools can be used to rule out low-risk offenders being subject to preventive schemes.

Fifth, risk assessment tools are insensitive to sex offender types and individual characteristics. Different re-offending rates are found for different types of sex offenders, and sex offenders are not homogenous. In terms of individual characteristics, cultural and gender insensitivity has been of concern. The authors of the Static-99 argued that, although the tool is mainly normed on a white sample, race is not a risk factor for re-offending and therefore the Static-99 is considered culturally neutral. Meanwhile, Singh, Grann and Fazel compared numerous risk assessment tools, including the Static-99, in a meta-regression analysis of 25,980 offenders and concluded that predictive validity was better in those samples with white participants. In discussing indigenous offenders in Canada in general, Rugge noted that there is over-representation regarding socioeconomic disadvantage such as unemployment, poor education, poor health, dysfunctional families, community police presence and so on which, while it does not mean that being indigenous causes offending, indigenous

56 Ibid 5.
57 See Gelb, above n 5.
58 Harris et al, above n 26.
59 Singh, Grann and Fazel above n 40.
peoples are over-represented on certain risk factors. In Australia, Hsu, Caputi and Byrne considered a generalist actuarial risk assessment tool – the Level of Service Inventory-Revised – applied to 13,911 male and female indigenous offenders in New South Wales Corrective Services between 2004 and 2007. They found that indigenous offenders scored higher than non-indigenous offenders on every subscale and on the total score. Overall, Hsu et al found that indigenous offenders had lengthier criminal records, more violent crimes, lower education and employment status, more living arrangement issues, more anti-social peers, and offended at a younger age and re-offended more promptly. Note that these observations are in relation to general offending, not sex offending per se. Rugge supported the view that all these problem areas (not just those to be empirically found to be correlated with re-offending) ought to be included in the initial development of risk assessment tools.

Last, the statistical nature of actuarial tools masks the range of discretionary and value judgments that occur, informed by personal knowledge, experience and beliefs; Canadian practitioners reported that they would ensure a high-risk designation for sex offenders or, conversely, for more general offenders 'modify the strict interpretation of risk criteria and fill out scores by incorporating preconceived and non-actuarial knowledge of offenders [reducing] the overall risk by score by choosing to ignore various criminogenic factors or by scoring certain factors as relatively low'. Overall, Fazel et al concluded that an important message has to be provided to bureaucrats, the media, the community (and presumably the judiciary): the view that risk assessment tools are accurate in most cases is not evidence-based.

2.2. RISK MANAGEMENT

Once subjected to preventive detention, risk then needs to be managed. To reiterate, in the four Australian states the secondary objective in legislation is to provide control, care, treatment and/or rehabilitation. In practice, it is expected that strategies such as incapacitation, residence in identified facilities, intensive supervision and offender rehabilitation result. However, where incapacitation goes beyond the least restrictive means or utilises burdensome restrictions,
the treatment process becomes punishment. What ‘rehabilitation’ means in legislation is undefined. Based on legislative objectives, it is assumed that the emphasis is on what has been described by Birgden and Cucolo as treatment-as-management (ie, managing offender risk) rather than treatment-as-rehabilitation (ie, meeting offender need). Heseltine, Day and Sarre noted that, where relevant, Australian legislation only mentions rehabilitation as a legal requirement rather than to guide the value, purpose and structure of rehabilitation, allowing the government to avoid concrete commitment to the rehabilitative ideal.

According to the North American Association for the Treatment of Sexual Abusers (ATSA), the treatment of male sex offenders is designed to: (1) assist offenders to identify and change thoughts, feelings, and behaviours that lead to re-offending; (2) develop strategies and plans to control, avoid, and productively address risk factors for re-offending (a risk management approach); and (3) develop offender strengths and competencies to address needs. Addressing ‘needs’ can either be a risk management approach (if targeting dynamic risk factors and providing treatment-as-management) or an offender support approach (if supporting human needs and providing treatment-as-rehabilitation), but ATSA is silent on this distinction. Sex offender treatment and rehabilitation in Australia has been found to follow prescribed international standards based on the Risk-Need-Responsivity (RNR) model of offender rehabilitation. The RNR model is the dominant approach in Canada, the United Kingdom, New Zealand and Australia. The RNR model is based on ‘what works’ empirical literature developed by Andrews and Bonta and their colleagues. The model is a science of criminal conduct which links risk prediction and classification (described above) with treatment targets and treatment intensity and directs service delivery to reduce the risk of re-offending by addressing identified dynamic risk factors. Briefly, the model includes principles regarding risk (who should be targeted for treatment), need (what should be targeted for treatment), and responsivity (how treatment should be delivered). The problem with the RNR approach is that it emphasises risk management for community protection.

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69 Heseltine, Day and Sarre, above n 67.
71 See Birgden, above n 15.
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Heseltine et al provided an updated audit of all sex offender programs in Australia, noting that legislative developments had increased the focus on rehabilitation of high-risk and dangerous sex offenders. Of the four states with preventive schemes, Heseltine et al found that there were well-developed case management systems to identify, assess, and allocate sex offenders. Again, the Static-99 is used to identify the level of risk and then the level and type of need is determined through interview and further actuarial assessment with additional determination of treatment readiness or responsivity, the rehabilitation options available and extensive pre-post testing of change. As in other jurisdictions, the program content utilises cognitive-behavioural treatment and aims to develop insight into offending, increase understanding of the effects on the victims, challenge cognitive (or thinking) distortions that justify offending, modify deviant sexual arousal, explore the role of fantasy, develop appropriate intimacy and relationship skills, enhance problem solving, and develop an individualised relapse prevention plan with places and situations to avoid.

3. IMPROVING PREVENTIVE SCHEMES

As previously indicated, the implementation of preventive schemes does not address the entirety of ethical considerations and only aspects of scientific or risk considerations. Current preventive schemes lack consideration of the impacts of the current sociopolitical context, applied ethical principles, the style of service delivery, meeting human needs, and determining the risk imposed upon offenders and what this all may mean for community protection; RNR is an inadequate model to address these issues.

Therapeutic jurisprudence (TJ) considers social science evidence regarding law, legal procedures and legal roles based on the value stance that the law ought to be therapeutic rather than anti-therapeutic. As an inter-disciplinary endeavour, TJ produces scholarship that is particularly useful to law reform. However, in TJ terms, preventive schemes are unlikely to be reformed; the High Court of Australia, in reviewing the Dangerous Prisoners (Sexual Offenders) Act 2003 (QLD), confirmed that preventive detention was constitutional in Fardon v Attorney-General (Qld) and was a legitimate, preventative and non-punitive purpose in the public interest (ie, community rights). However, this does not mean that the procedures and roles of legal actors (in this case mental health professionals) cannot aim to be therapeutic rather than anti-therapeutic when implementing preventive schemes.

72 Heseltine, Day and Sarre, above n 67.
3.1. ETHICAL CONSIDERATIONS

Ethical considerations include the sociopolitical risk management context, ethical principles that should be enacted by practitioners regardless of the contemporary political environment, and the style of interaction with sex offenders that ethical practice therefore entails. While legislation does consider offender rights, it is questionable whether these rights are implemented in practice due to the sociopolitical environment. For example, the *Serious Sex Offenders (Detention and Supervision) Act 2009* (VIC) indicates that any conditions, other than the core conditions, must minimally interfere with the offender's liberty, privacy or freedom of movement and be reasonably related to the gravity of the risk of re-offending (s 15(6)). Most recently, the *Serious Sex Offenders (Detention and Supervision) Amendment Act 2011* (VIC) has allowed that the obligation to apply for periodic reviews is suspended if a renewal application is being made and to remove the obligation to apply for a periodic review for offenders held on remand. In *Fletcher v the Secretary to the Department of Justice 2006*, a child sex offender placed on an extended supervision order in the community under previous legislation – the *Serious Sex Offenders Monitoring Act 2005* (VIC), which back then did not authorise preventive detention – argued that being directed by the Adult Parole Board to reside at the secure facility meant he was denied freedom of movement and was not able to leave the facility unless escorted by Corrections Victoria staff. The facility was on a portion of land degazetted from Ararat Prison but within the prison walls. The Supreme Court acknowledged that Mr Fletcher's freedom of movement was severely impacted, concurred that this situation could not be described as 'residing in the community', found that the Adult Parole Board had engaged in improper and unlawful exercise of power in ordering him to reside there, and determined that the Department of Justice was responsible for providing appropriate residential accommodation (although the Court did not define what 'residing in the community' meant). The Court did support the Adult Parole Board imposing conditions regarding the level of supervision in the community. In response, the Victorian government amended the legislation to provide the Adult Parole Board with the power to direct an offender on a supervision order to reside within the perimeter of a prison, and later 'Corella Place' on the grounds of Ararat Prison but outside the wall of the prison was established as a residential facility under the *Serious Sex Offenders (Detention and Supervision) Act 2009* (VIC). In practice, there currently appears little distinction between community supervision and detention for some sex offenders.

While legislation may or may not support human rights, practitioners ought to regardless. As highlighted by Ward and Salmon, 'every aspect of practice [with sex offenders] is shot through with value commitments, and each of us

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75 *Fletcher v Secretary to the Department of Justice* [2006] VSC 354.
is obligated to think deeply about our responsibilities to sex offenders, victims, the community and ourselves. Offender assessment and treatment necessarily involves moral values regarding community rights and offender rights. A community rights approach imposes rehabilitation for behaviour change upon the individual (treatment-as-management), while an offender rights approach engages the individual to consider rehabilitation to facilitate behaviour change (treatment-as-rehabilitation). There is no question that offenders as autonomous agents have enforceable human rights, and if human rights are held by all humans then sex offenders also possess human rights. The state should generally provide the offender with the same rights for a dignified life as it provides to non-offenders, and the violation of human rights occurs when individuals are treated as objects or as a means to other individuals’ ends. For example, subjecting serious but low-risk offenders or less serious but high-risk offenders to preventive detention in response to community outrage is a violation, and assessors ought not to provide recommendations that support preventive detention under those circumstances. As discussed, legislation in preventive schemes is clear that community protection overrides offender rights. However, from a human rights perspective, it is not morally acceptable for human beings to forfeit their human rights altogether, although they may be curtailed in some circumstances. In particular, preventive schemes cannot be justified if they do not provide access to ethical and effective rehabilitation. An individual’s universal entitlement to lead a dignified life can be a moral right (ie, based on a moral theory or principle), a social right (ie, guaranteed by a social institution such a prison), and a legal right (ie, prescribed by particular laws). Human rights reflect both social rights and legal rights (or policies and procedures) and moral rights (or principles).

Ward and Birgden have noted that there is a lack of theoretical and research attention paid to the application of human rights to offender rehabilitation, presumably as a result of popular punitivism. In particular, Perlin argued that there is a significant and disturbing disconnect between psychology practice

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79. Ward and Birgden, above n 77.
80. Ibid.
81. Ibid.
and human rights norms. Human rights violations arise because of abuse of power, the vulnerability of clients, blurred role boundaries and lack of respect for the individual's rights and dignity. Ward and Birgden argued that it is time for forensic psychologists to consider human rights to guide offender rehabilitation, and they subsequently proposed a human rights model. Briefly, the human rights model argues that the two core moral values of freedom (non-coerced situations and internal capabilities such as the capacity to formulate intentions, to imagine possible actions and to form and implement valued plans) and well-being (physical, social and psychological well-being as defined by offenders) should be ensured. Even if serious high-risk offenders are rights-violators, a human rights perspective would consider that they still possess well-being rights and some freedom rights which should not be overridden by community rights. Understanding that human rights support autonomy and dignity assists practitioners to deliver ethical rehabilitation.

From a human rights perspective, offenders are simultaneously rights-holders (with a right to non-interference in personal affairs unless they infringe upon the rights of others), duty-bearers (in that they are able to pursue goals as long as they do not infringe upon the rights of others), and rights-violators (when they infringe upon the rights of others through offending behaviour). Therefore, although rights-violators, sex offenders are also rights-holders and duty-bearers or carry both rights and responsibilities. Sex offender programs based on a human rights model would treat sex offenders as rights-holders (addressing histories of neglect, abuse and inadequate socialisation that require support to achieve goals in socially acceptable ways) as well as duty-bearers (providing learning experiences and resources to develop due regard for the rights of others through increasing empathy skills, problem solving capacity, supportive social networks and intimacy skills or appropriate alternatives). If sex offenders are acknowledged as rights-holders and duty-bearers as well as rights-violators, then this will support 'rights and duties, duties and rights: the ethical foundations of a liberal and flourishing community and a fairer and more humane criminal justice system'. Equipping sex offenders with the capabilities necessary to both secure their own rights and those of others ought to reduce the risk of re-offending.

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83 Ward and Birgden, above n 77.
84 See ibid; Ward, Gannon and Birgden, above n 78.
85 Ward, Gannon and Birgden, above n 78.
86 Ward and Birgden, above n 77, 642.
Australian national standards for offender program delivery are currently being developed. However, nowhere in the national audit of current programs is the issue of consent to rehabilitation, or coerced rehabilitation, addressed. Presumably sex offenders subject to preventive schemes are coerced to some extent to engage in treatment. Lack of treatment engagement while serving a sentence can lead to consideration for prevention schemes. Informed consent is made up of capacity, information and voluntariness. While the informed consent process may include the provision of adequate information and the capacity of the offender to understand, the voluntariness of the decision within corrections is vexed. Coerced treatment interferes with offender autonomy. Autonomous individuals develop an integrated life (or a good life) by reviewing and shaping their projects, motives and conduct. Autonomy may be restricted by lack of rights and capacity such as poor decision-making or by lack of rights and skill such as poor control of deviant arousal. Whether the criminal justice system should be concerned with autonomy is a normative question, but at present it is expected that individuals should be protected in this way; it is a basic moral obligation. Threats to autonomy ought to be of concern to practitioners who need to consider the ethical complexities in working effectively with coerced sex offenders subject to preventive schemes.

This major ethical issue regarding coerced treatment and violating offender autonomy has not been explicitly acknowledged by the authors of RNR. For example, Birgden criticised Andrews and Dowden for failing to address offender autonomy and argued that therefore RNR could not claim to be ethical, humane or respectful. In response, Andrews and Dowden acknowledged their inattention to respect for personal autonomy as a basic value and later stated, '[W]e think respect for personal autonomy should be underscored in a field of practice in which so much emphasis is placed upon structure, discipline, accountability and state-sanctioned imposition of restrictions and punishment'. It is difficult to determine in what way autonomy is supported in sex offender programs at

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87 Heseltine, Day and Sarre, above n 67.
88 See Birgden and Vincent, above n 7.
94 Andrews and Bonta, above n 18, 7.
present. In terms of program completion, Doyle et al conducted an analysis of 50 male sex offenders across three Australian states who had been subject to risk assessments for preventive schemes. They found that 74 per cent had commenced sex offender treatment with 54 per cent completing a program. The remaining men had refused treatment (38%), had been removed from a program (18%), were deemed ineligible due to denial (8%), and one offender had dropped out of treatment. Overall, treatment amenability was considered by the authors to be poor. It is expected that coerced treatment within preventive schemes was not conducive to engaging 65 per cent of the targeted offenders. A practice that engages offenders in change attends to ethical principles and practices and delivers services within an ethic of care.

Codes of ethics exist to guide practitioners. For example, the International Union of Psychological Science provided a Universal Declaration of Ethical Principles for Psychologists which enumerates four principles: (1) respect for dignity; (2) competent caring for well-being; (3) integrity of psychologists; and (4) professional and scientific responsibilities to the community. Glaser considered sex offender rehabilitation within the context of harsh and disproportionate punishment, denial of human rights, and practitioners serving both clients and the state, which undermines the rehabilitative ideal. Glaser argued that in corrections, practitioners breach ethical codes such as confidentiality, beneficence and autonomy; sex offender treatment programs are currently 'a systematic sabotage of traditional ethics', and 'this sort of control comes perilously close to brainwashing, with the aversive stimulus being the threat of further punishment if the offender does not comply'. It is expected that this problem particularly arises for sex offenders subject to preventive schemes. When faced with ethical dilemmas in balancing offender rights and community rights, practitioners may override traditional ethical guidelines and weight their responses toward community rights. Ward and Salmon also argued that current ethics codes are actually insufficient in guiding ethical professional practice in that each

96 Doyle, Ogloff and Thomas, above n 24.
99 Ibid 144.
100 Ibid 146.
traditional ethical theory they may rely upon has its own area of applicability but then suffers limitations particularly when conflict between principles arise.\textsuperscript{101}

In response to Glaser,\textsuperscript{102} Levenson and D'Amora argued that sex offender treatment is consistent with ethical codes for various mental health professionals, citing programs combining punishment, rehabilitation and management such as civil commitment, community notification sex offender registration and coerced treatment.\textsuperscript{103} They concluded the ethical guidelines provided by ATSA conform to the principles of autonomy (empowering offenders to take long-term behaviour change), non-maleficence (clinicians are trained to develop a therapeutic alliance), beneficence (balancing community rights and offender rights) and justice (community protection is enhanced and repercussions for the offender is diminished through collaborative risk management). However, problems with their response to Glaser are: the ATSA guidelines are weighted towards community rights anyway; ‘approved and qualified providers’ does not address choice of treatment or providers or that inadequately trained correctional staff may deliver treatment programs (including in Australia); stating that breaches in confidentiality do not occur because informed consent is obtained ignores the capacity to meet the ‘voluntariness’ element of informed decision-making in corrections; and often offenders who have pled not guilty are required to engage in treatment programs to obtain parole or avoid ongoing monitoring, which would be expected to be the same for sex offenders subject to preventive schemes who would ‘need to be seen’ to engage prior to a review.

From a TJ perspective, preventive schemes with their violation of autonomy rights would be considered anti-therapeutic. Treating a sex offender without dignity is likely to result in poor treatment compliance.\textsuperscript{104} Ward and Salmon have articulated five categories of problematic approaches that arise in working with sex offenders: (1) a risk management approach – lacking attention to offender interests and well-being; (2) a ‘one size fits all’ approach – relying on inflexible manuals rather than responding to the offenders context in an individualised manner; (3) a technical approach – focusing on content rather than process in terms of therapist and relationship factors; (4) a community protection approach – failing to address the tension with offender interests; and (5) a poor therapeutic approach – failing to ensure therapist factors such as supporting self-care, addressing bias and dual roles, and avoiding conflicts of interest. The authors propose an alternative, feminist ethical position described as \textit{an ethic of care}. An ethic of care builds a

\textsuperscript{101} T Ward and K Salmon, ‘The Ethics of Care and Treatment of Sex Offenders’ (2011) 23(3) Sexual Abuse: A Journal of Research and Treatment 397–413.

\textsuperscript{102} Glaser, above n 98.


\textsuperscript{104} Ward and Salmon, above n 101.
relationship based on trust and a strong therapeutic bond. An ethic of care views offenders through a lens of empathic concern that supports them as fellow human beings rather than over burdened by feelings of fear, dislike, anger or guilt. Brookbanks described TJ as a sea change in ethical thinking about the role of the law and proposed that an ethic of care could be incorporated to provide for ethical legal practice based on trust, social relationships and 'grace' – a far cry from current legislative approaches to managing serious high-risk offenders.

Utilising an ethic of care, Ward and Salmon addressed the problematic approaches outlined above: (1) a risk management approach – considering the offenders' true interests which may result in making recommendations that may be restrictive and with which offenders may not agree; (2) an individualised approach – delivering interventions that are attentive, responsive and respectful of offenders; (3) a therapeutic alliance – establishing a helping relationship with genuine interest and concern; (4) a community protection approach – focusing on offender needs, strengths and capabilities as well as risk management; and (5) a therapeutic approach – therapists caring for themselves as they are expected to care for others. These statements are applicable to the assessment process in preventive schemes.

3.2. SCIENTIFIC CONSIDERATIONS

Scientific considerations include meeting human needs; court assessments need to address the human needs underpinning offending behaviour, not just the risk factors. With its focus on addressing empirically-derived risk factors, RNR is an inadequate model to address offenders needs as rights-holders and duty-bearers. In Australia, Doyle et al conducted an analysis of 50 male sex offenders across three Australian states who had been subject to risk assessments for prevention schemes. They found that problem areas included: developmental history (50% familial instability, 72% physical and/or sexual abuse, 54% learning difficulties, and 24% learning difficulties and behavioural problems); substance use (in childhood/adolescence 48% alcohol abuse and 36% illicit substance abuse, in adulthood 54% alcohol abuse and 46% illicit substance abuse); and diagnoses (in addition to...
current diagnoses of 70% with paraphilia and 52% with antisocial personality disorder, 32% having lifetime diagnoses of depression, anxiety, paraphilia, and psychosis, 26% with a history of suicide attempts, and 28% with a history of self-harm). Clearly, these are complex clients with multiple problem areas who exhibit characteristics that may be viewed as immaterial in a risk management approach 'characterised by disrupted home environments, inconsistency of caregiving, self-reported exposure to physical and sexual abuse, poor education, learning difficulties, behavioural problems, and unstable employment histories ... significant sexual deviance antisocial and maladaptive personalities, and moderate rates of mental illness'.

Of eight vulnerability factors identified by the authors, 50 per cent of the sex offenders experienced five or more of them. In response to these findings, Doyle et al concluded that these offenders needed to be more effectively engaged in utilising well-validated treatment programs and required a comprehensive treatment approach to address the vulnerability factors in addition to the dynamic risk factors.

The Good Lives Model (GLM) is a psychological theory of offender rehabilitation that can serve to broaden the assessment in court and provide a comprehensive treatment approach that includes meeting human needs. The GLM acknowledges that offenders have human needs as all other individuals do. Humans seek physical well-being (healthy functioning of the body), social well-being (family life, social support, meaningful work opportunities and access to leisure activities), and psychological well-being (relatedness, competence and autonomy). The GLM posits that sex offenders use anti-social means to meet their human needs, and while the identified dynamic risk factors in the RNR are problems in achieving human needs, they are merely 'red flags' of problem areas that need to be addressed. By focusing on the offenders' needs and wants, offender rehabilitation motivates offenders to ask, 'How can I live my life differently?' This humanistic approach directs rehabilitation programs to support offender capabilities so human needs are met in pro-social ways, which in turn improves quality of life and so reduce the likelihood of re-offending. That is, the primary goal is to support offenders through meeting needs, and the secondary goal is to control offenders through managing risk. Treatment therefore focuses on both avoidance goals to eliminate undesirable outcomes and approach goals to provide desirable outcomes. The GLM is in a good position to address protective factors

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109 Doyle, Ogloff and Thomas, above n 24, 45.
114 Ward and Maruna, above n 105.
and offender-environment interactions. Offender rehabilitation can serve to assist sex offenders to develop the internal capacities and external conditions necessary to achieve personal goals, and if the aim is to encourage them to appreciate the rights and interests of victims, then it is obviously counterproductive to violate their own rights and interests.\textsuperscript{115}

In the national audit of sex offender programs in Australia, Heseltine et al did not mention the application of case formulation,\textsuperscript{116} which is a natural extension of a GLM approach. A case formulation is a functional analysis using clinical interview and assessment results to develop a hypothesis about the offender's pathway to offending and allows for individual differences to be addressed in a rehabilitation plan.\textsuperscript{117} To individualise the case formulation in complex cases, the psychologist can reconstruct vignettes that reveal themes, events, offender or contextual factors, or offender-context interactions.\textsuperscript{118} The case formulation should be applied therapeutically by ensuring that offenders clearly understand the assessed likelihood of re-offending, which factors may place them at future risk of re-offending, the opportunities available to address identified dynamic risk factors and human needs, and what strategies may be put in place to increase treatment readiness.\textsuperscript{119} Subsequent adjustments to the rehabilitation plan are to be made in collaboration with the offender throughout the detention or supervision order.

\subsection*{3.3. RISK CONSIDERATIONS}

Risk considerations determine what level of risk is posed to offenders by being labelled as serious high-risk. Sex offenders subject to prevention schemes are dehumanised and stigmatised by the community and, possibly, correctional staff. In Australia they have been subject to violence and vigilante activity. For example, community harassment of the now deceased Dennis Ferguson has been both fuelled and documented by the media.\textsuperscript{120} The Supreme Court acknowledged this potential issue in \textit{Fletcher v the Secretary to the Department of Justice 2006}, noting that:

115 ibid.
116 Heseltine, Day and Sarre, above n 67.
119 See Birgden, above n 15.
120 See McSherry and Keyzer, above n 8.
[He] must not overlook the fact that the purposes include not only a concern for the community, but also a concern for him. It should not be lost upon him that there may be sections of the community who find his views repugnant and his past deeds appalling, and who may seek to cause him harm. There has to be a balance.\(^2\)

As a consequence, an assessment report to the court should include the likely anti-therapeutic impact of a prevention scheme upon offenders in terms of restrictions imposed and likely community responses.

4. **CONCLUSION**

Despite issues with ethics and evidence, prevention schemes are likely to remain in Australia. An offender-community balance acknowledges that punishment through incapacitation is not against human rights, as long as it is reasonable and for a finite period; preventive schemes break this rule. While the law may not be reformed, the procedures and the role of mental health professionals can be adjusted to deliver therapeutic rather than anti-therapeutic outcomes. These adjustments are supported by the humanistic approaches of TJ and the GLM. Indeed, in *Fletcher v the Secretary to the Department of Justice*, the Supreme Court noted that it is the Department of Justice and the Adult Parole Board who implement the supervision conditions in the community, not the Court. The following recommendations, at an individual and policy level, are based on the suggested improvements above.

At an individual level, the assessment report to the court needs to be broadened to include clear statements regarding: (1) whether the offender is both serious and high-risk; (2) the scientific and ethical problems with actuarial assessment tools and structured clinical judgement; (3) the risk of harm to the offender upon being labelled; (4) the human needs, determined through case formulation, that ought to be addressed in rehabilitation; and (5) the coerced nature of procedures and the likely impact on compliance with conditions. In this way, the assessment report counterbalances the current weighting toward community rights by considering offender rights. Both assessment and treatment ought to be delivered within an ethic of care.

At a policy level, ethical rehabilitation ordinarily requires that only those offenders who would benefit should be offered treatment, the offender ought to provide an informed decision to participate in treatment, and treatment needs to be rationally justified (ie, an explicit value-judgement). In order to salvage an

\(^{2}\) *Fletcher v Secretary to the Department of Justice* [2006] VSC 354 [69].
unethical situation posed by prevention schemes, it is preferable that treatment is offered as an attractive alternative at the point where bureaucrats consider applying to the courts for detention or extended supervision. The offer for treatment should allow offenders to provide an informed decision to refuse, and then offender rights may be over-ridden in the interests of community rights (ie, coerced treatment is justified because the offender poses a high likelihood of harm to the community). In this instance, rehabilitation is quasi-coerced in offering a constrained choice – through an offer not a threat – that recognises some voluntary interests (eg, between rehabilitation and no preventive scheme or no rehabilitation and a preventive scheme). While quasi-coerced treatment can match individuals to treatment, it ultimately cannot coerce them to actively participate. If offenders are not willing to engage in rehabilitation then decision-making opportunities should again be emphasised with more stringent standards set for continued refusals, while emphasising an ethic of care. Alternatively, a motivational module that encourages the development of a plan for a fulfilling life and/or a focus on managing external conditions can be offered. Mediation by a nominated and independent third party may assist.

If the offender still continues to refuse treatment, then the outcome is supervision or detention. This approach should only be considered for serious high-risk sex offenders to avoid wider nets (increase in sex offenders being subject to prevention schemes), denser nets (increase in intensity of treatment) and different nets (new agencies and services supplementing existing control mechanisms). This chapter proposes that procedures and roles can balance offender rights and community rights to enhance community protection – a ‘rights and rights’ or ‘win-win’ proposition not an ‘either/or’ or ‘win-lose’ proposition. To support this approach, bureaucrats need to acknowledge that, in the long-term, treatment-as-rehabilitation in meeting needs is likely to be more effective than treatment-as-management in managing risk.

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122 Miller, above n 65.