

The Boundaries of Care and Control: Stakeholder Struggles to Navigate the Challenges of Mandatory Sex Offender Treatment

Ruth T. Shefner

Nancy D. Franke

Follow this and additional works at: <https://digitalcommons.law.umaryland.edu/jhclp>

Recommended Citation

Ruth T. Shefner, & Nancy D. Franke, *The Boundaries of Care and Control: Stakeholder Struggles to Navigate the Challenges of Mandatory Sex Offender Treatment*, 27 J. Health Care L. & Pol'y (2024). Available at: <https://digitalcommons.law.umaryland.edu/jhclp/vol27/iss1/5>

This Article is brought to you for free and open access by the Academic Journals at DigitalCommons@UM Carey Law. It has been accepted for inclusion in Journal of Health Care Law and Policy by an authorized editor of DigitalCommons@UM Carey Law. For more information, please contact smccarty@law.umaryland.edu.

THE BOUNDARIES OF CARE AND CONTROL: STAKEHOLDER STRUGGLES TO NAVIGATE THE CHALLENGES OF MANDATORY SEX OFFENDER TREATMENT

RUTH T. SHEFNER* & NANCY D. FRANKE**

Abstract

This study¹ examined the challenges, perspectives, and experiences faced by major stakeholders involved in mandatory sex offender therapy in one urban jurisdiction. The study collected data through semi structured qualitative interviews with therapists, probation officers, and client participants. Five major themes emerged: 1) disagreement about who is served by mandatory sex offender treatment (“MSOT”); 2) high criminal legal stakes pose ethical challenges for therapists; 3) therapist lack of training and experience strains stakeholder relationships; 4) role confusion over who protects the client creates conflict; and 5) the unique specter of sex offender dangerousness influences perspectives and constrains imaginative thinking. These themes characterize and describe the practical and ideological challenges faced by provider and client stakeholders, the strategies with which all three stakeholder groups reconcile inherent tensions associated with therapeutic service provision in coercive settings, and the ways

* Ruth Shefner, MPH, MSW is a doctoral candidate at Columbia University’s Mailman School of Public Health, and a predoctoral fellow in the NIDA funded T32 training fellowship in HIV, Substance Use, and the Criminal Justice System (T32-DA037801). Trained as a social worker and sociologist, her research focuses on policing, court based interventions, and collateral consequences of mass incarceration and criminalization.

** Nancy Digby Franke, PhD, MSW is an assistant professor at La Salle University’s Department of Social Work. Her work focuses on reentry experiences of people sentenced to life imprisonment as children, as well as policing and court based interventions. Both authors are former Directors of the Goldring Reentry Initiative at the University of Pennsylvania’s School of Social Policy & Practice, which provides therapeutic case management services to people pre and post release from the Philadelphia Department of Prisons, while training as Masters of Social Work students to work in criminal legal systems.

1. Given the interdisciplinary nature of this Article, and in preparation for its publication, the *Journal of Health Care Law & Policy* consulted with experts in the field to review the Article and verify that the propositions and methodologies used by the authors are sound.

in which providers understand their role in the support and surveillance of people convicted of sex offenses.

I. INTRODUCTION

Of the nearly 900,000 people on the sex offender registry in the United States,² many are required to attend mandated sex offender treatment (“MSOT”). MSOT may consist of individual and/or group therapy and may occur during or following a person’s incarceration.³ This required therapy may last several months or an entire lifetime, depending on jurisdictional requirements and individual assessments.⁴ Because therapy is criminally legally mandated and therapists collaborate with and report to probation officers, therapeutic goals are often obscured by or come into conflict with public safety priorities.⁵ In order to understand the practical and ethical challenges involved with this specialized form of coerced treatment—which this Article seeks to explore—and the barriers to innovation and improvement, it is essential to understand the sociolegal sex offender management policy landscape from which MSOT emerged and in which it operates.⁶

A. Sex Offender Management Policies: Historical Background

Since the 1990s, laws and policies imposing increasingly strict surveillance and restrictions over people convicted of sexual offenses proliferated throughout the United States.⁷ This movement originally spawned largely from a series of high profile cases focused on people committing sexual crimes against children, which heightened public fear of “sexual predators” and fueled concern about the risk of those previously convicted of sex offenses reoffending.⁸ In October 1989, a masked man abducted and killed eleven-year-old Jacob Wetterling at gunpoint, near Wetterling’s home in St. Joseph, Minnesota.⁹ While the perpetrator

2. *Registered Sex Offenders in the United States and Its Territories per 100,000 Population*, NAT’L CTR. FOR MISSING & EXPLOITED CHILDREN (May 24, 2017), https://api.missingkids.org/en_US/documents/Sex_Offenders_Map.pdf.

3. Beth M. Huebner et al., *Access to Health Care and Treatment Among Individuals Convicted of Sexual Offenses Paroled to Urban and Rural Communities*, 48 CRIM. JUST. & BEHAV. 964, 967 (2020).

4. Mary Ann Farkas & Gale Miller, *Sex Offender Treatment: Reconciling Criminal Justice Priorities and Therapeutic Goals*, 21 FED. SENT’G REP. 78, 78 (2008); MARTIN SCHMUCKER & FRIEDRICH LÖSEL, *THE CAMPBELL COLLABORATION, SEXUAL OFFENDER TREATMENT FOR REDUCING RECIDIVISM AMONG CONVICTED SEX OFFENDERS: A SYSTEMATIC REVIEW AND META-ANALYSIS* 20 (2017).

5. Andrea M. Walker, *A Delicate Dance: Ethical and Systemic Issues in Providing Community-Based Sex Offender Treatment*, 33 SEXUAL ABUSE 769, 771 (2021).

6. See *infra* Section I.A.

7. MARIE GOTTSCHALK, *CAUGHT: THE PRISON STATE AND THE LOCKDOWN OF AMERICAN POLITICS* 205 (2015); see generally CHRYSANTHI S. LEON, *SEX FIENDS, PERVERTS, AND PEDOPHILES: UNDERSTANDING SEX CRIME POLICY IN AMERICA* (2011).

8. LEON, *supra* note 7, at 107–18.

9. Caroline Louise Lewis, *The Jacob Wetterling Crimes Against Children and Sexually Violent Offender Registration Act: An Unconstitutional Deprivation of the Right to Privacy and Substantive Due Process*, 31 HARV. C.R.-C.L. L. REV. 89, 89 (1996).

remained unidentified, Wetterling's parents and community members suspected that the attacker lived in a nearby halfway house for released sex offenders.¹⁰ Wetterling's parents, through the formation of the Jacob Wetterling Foundation, lobbied Minnesota policymakers to enact its first sex offender registry in 1991.¹¹ The issue gained national attention and momentum, and as part of the 1994 Crime Bill, Congress passed the Jacob Wetterling Act. This Act was the first national sex offender registration legislation and required people convicted of sex offenses to provide state law enforcement with updated locations and identifying information.¹²

In 1996, Congress amended the Wetterling Act with Megan's Law, named after seven-year-old Megan Kanka, who was abducted and murdered by someone previously convicted of a sex offense near her house in Hamilton, New Jersey during the summer of 1994.¹³ The Kankas, like the Wetterlings, channeled their grief into legislative action, lobbying the state of New Jersey to enact "Megan's Law" legislation that would mandate public disclosure of registration information.¹⁴ When the law was federalized in 1996, it nationalized community notification requirements in addition to registration standards.¹⁵ Subsequently, amendments to the Wetterling Act required all states to post information online about people convicted of sex offenses.¹⁶

The year 2006 brought the most sweeping sex offender related federal legislation; President George W. Bush signed the Adam Walsh Act on the twenty-fifth anniversary of the abduction of Adam Walsh, a ten-year-old boy who was killed after being kidnapped from a Florida shopping mall in 1981.¹⁷ His father, John Walsh, the host of *America's Most Wanted*, advocated fiercely for legislation designed to prevent future instances of stranger perpetrated sexual

10. RICHARD G. WRIGHT, *SEX OFFENDER LAWS: FAILED POLICIES, NEW DIRECTIONS* 57 (2d ed. 2015).

11. Lewis, *supra* note 9, at 89.

12. Andrew J. Harris et al., *Registered Sex Offenders in the United States: Behind the Numbers*, 60 *CRIME & DELINQ.* 3, 4 (2014).

13. Jenny A. Montana, *An Ineffective Weapon in the Fight Against Child Sexual Abuse: New Jersey's Megan's Law*, 3 *J.L. & POL'Y.* 569, 569 (1994).

14. *Id.* at 571–73.

15. Harris et al., *supra* note 12, at 4; *Legislative History of Federal Sex Offender Registration and Notification*, OFF. OF SEX OFFENDER SENT'G, MONITORING, APPREHENDING, REGISTERING, & TRACKING, U.S. DEP'T OF JUST., <https://smart.ojp.gov/sorna/current-law/legislative-history> (last visited Oct. 15, 2023).

16. Richard Tewksbury & Matthew Lees, *Perceptions of Sex Offender Registration: Collateral Consequences and Community Experiences*, 26 *SOCIO. SPECTRUM* 309, 311 (2006); Kristen M. Zgoba & Jill Levenson, *Failure to Register as a Predictor of Sex Offense Recidivism: The Big Bad Wolf or a Red Herring?*, 24 *SEXUAL ABUSE* 328, 329 (2012).

17. Jennifer Iacono, *The Sex Offender Registration and Notification Act and Its Commerce Clause Implications*, 17 *WIDENER L. REV.* 227, 227 (2011).

violence and murder.¹⁸ The Act increased the duration of sex offender registration, increased penalties for noncompliance, and extended the jurisdictional reach.¹⁹ Notably, Title I of the Adam Walsh Act, known as the Sex Offender Registration and Notification Act (“SORNA”), stipulated federal standards for registration and notification. This portion of the Act mandates that states make information, such as physical description, criminal offense history, registration offense, photographs, fingerprint samples, DNA samples, and a copy of an identification card, publicly available on an internet-based registry.²⁰ SORNA also created a three tiered federal registration classification system to rank individuals based on the severity of their offense.²¹ Tier III offenders are required to provide law enforcement with updated addresses and identifying information four times a year for the remainder of an offender’s life, while Tier II and Tier I offenders are required to report less frequently and maintain active registration for twenty-five and fifteen years respectively.²²

Since the passage of Megan’s Law twenty-six years ago and the passage of the Adam Walsh Act sixteen years ago, the number of Americans subject to their requirements greatly increased.²³ As of 2017, there were approximately 861,000 people required to register as sex offenders in the United States, with an overall registration rate of approximately 238 individuals per 100,000 adult residents.²⁴ Black men are continually disproportionately represented; with a registration rate of approximately 119 per 100,000, Black men are twice as likely to be registered as White men.²⁵ This is largely a function of longstanding racist conceptualizations of Black sexual predation, as well as disparities in policing, prosecution, and punishment decisions.²⁶ Additionally, Black men are more than twice as likely as White men to fall prey to over classification (i.e., placed in a higher risk and more restrictive offense tier).²⁷

18. Karen J. Terry & Alissa R. Ackerman, *A Brief History of Major Sex Offender Laws*, in *SEX OFFENDER LAWS: FAILED POLICIES, NEW DIRECTIONS* 50, 58–59 (Richard Wright ed., 2015).

19. Zgoba & Levenson, *supra* note 16, at 329.

20. Jason D. Spraitz et al., *Adam Walsh Act Compliance in Pennsylvania: What Does the Future Hold? A Research Note*, 26 *CRIM. JUST. POL’Y REV.* 252, 253 (2015).

21. Terry & Ackerman, *supra* note 18, at 60.

22. Spraitz et al., *supra* note 20, at 253; Zgoba & Levenson, *supra* note 16, at 329.

23. Trevor Hoppe, *Punishing Sex: Sex Offenders and the Missing Punitive Turn in Sexuality Studies*, 41 *L. & SOC. INQUIRY* 573, 580–82 (2019).

24. NAT’L CTR. FOR MISSING & EXPLOITED CHILDREN, *supra* note 2.

25. Hoppe, *supra* note 23, at 584. As explained and articulated in Professor Sirleaf’s article, *Rendering Whiteness Visible*, the *Journal of Health Care Law & Policy* capitalizes Black, White, etc. See generally Matiangai Sirleaf, *Rendering Whiteness Visible*, 117 *AM. J. INT’L L.* 484 (2023).

26. KIMBERLY BARRETT & WILLIAM H. GEORGE, *RACE, CULTURE, PSYCHOLOGY, AND LAW* 66–71, 395–98 (2005).

27. Bobbie Ticknor & Jessica J. Warner, *Evaluating the Accuracy of SORNA: Testing for Classification Errors and Racial Bias*, 31 *CRIM. JUST. POL’Y REV.* 3, 9–10, 14 (2020).

The United States' modern legislative system of sex offender management developed in response to public fears and with the ostensible purpose of keeping people safe from violent sex crimes by strangers against children, as well as to keep those previously convicted of sex offenses from reoffending.²⁸ However, evidence overwhelmingly demonstrates that Sex Offender Registration and Notification ("SORN") policies do not reduce sexual re-offense or reincarceration rates and do not improve public safety.²⁹ This is likely due to the fact that these laws are designed based on stereotypical and inaccurate notions of sex offending.³⁰ While legislation focuses on protecting communities from assaults by strangers and against children, most sex crimes are actually committed against adults and by someone known to the victim (often a friend, acquaintance, or intimate partner).³¹

There is also a wide range of people and offenses captured under the umbrella of "sex offender" or "sex offenses," despite popular and political portrayals of homogeneous offending patterns and threats.³² Additionally, people convicted of sex offenses typically show extremely low rates of sexual recidivism compared to people in the criminal legal system generally, regardless of the presence of registration and notification requirements.³³ While recidivism varies widely based on the type of offense, individual characteristics, and the time since the initial offense, sexual re-offense rates range from 5% to 15%,

28. See *supra* notes 7–22 and accompanying text.

29. Amanda Y. Agan, *Sex Offender Registries: Fear Without Function?* 54 J.L. & ECON. 207, 209, 228 (2011); Kelly K. Bonnar-Kidd, *Sexual Offender Laws and Prevention of Sexual Violence or Recidivism*, 100 AM. J. PUB. HEALTH 412, 414, 418 (2010); Elizabeth J. Letourneau et al., *Effects of South Carolina's Sex Offender Registration and Notification Policy on Adult Recidivism*, 21 CRIM. JUST. POL'Y REV. 435, 452–55 (2010); Jill S. Levenson, *Sex Offender Management Policies and Evidence-Based Recommendations for Registry Reform*, 20 CURRENT PSYCHIATRY REPS. 21, 21 (2018); Jeffrey Sandler et al., *Does a Watched Pot Boil? A Time-Series Analysis of New York State's Sex Offender Registration and Notification Law*, 14 PSYCH., PUB. POL'Y, & L. 284, 286–87, 297, 299 (2008); Bonita M. Veysey et al., *A Preliminary Step Towards Evaluating the Impact of Megan's Law: A Trend Analysis of Sexual Offenses in New Jersey from 1985 to 2005*, 10 JUST. RSCH. & POL'Y 1, 3–4 (2008); Sarah Welchans, *Megan's Law: Evaluations of Sexual Offender Registries*, 16 CRIM. JUST. POL'Y REV. 123, 135 (2005); Kristen M. Zgoba & Meghan M. Mitchell, *The Effectiveness of Sex Offender Registration and Notification: A Meta-Analysis of 25 Years of Findings*, 19 J. EXPERIMENTAL CRIMINOLOGY 71, 90–91 (2023).

30. See *infra* Section II.B.

31. ROGER N. LANCASTER, *SEX PANIC AND THE PUNITIVE STATE* 77–78 (2011); WRIGHT, *supra* note 10, at 64–65.

32. LANCASTER, *supra* note 31, at 78–79, 81, 89.

33. GOTTSCHALK, *supra* note 7, at 210–12; Wendy Sawyer, *BJS Fuels Myths About Sex Offense Recidivism, Contradicting its Own New Data*, PRISON POL'Y INITIATIVE (June 6, 2019), <https://www.prisonpolicy.org/blog/2019/06/06/sexoffenses/>; U.S. DEP'T OF JUST., *RECIDIVISM OF SEX OFFENDERS RELEASED FROM STATE PRISON: A 9-YEAR FOLLOW-UP (2005–14)* (2019), <https://www.bjs.gov/content/pub/pdf/rsorsp9yfu0514.pdf>.

depending on the sample and follow up period.³⁴ Individuals assessed at low risk are *less likely* than people convicted of nonsexual offenses to be arrested for a new sex crime.³⁵ Risk of reoffending also drops dramatically over time; after sixteen years offense free in the community, even high risk individuals are no more likely to experience a rearrest for a new sex crime than someone convicted of a general nonsexual offense.³⁶ Overall, the most common reason for recidivism (which is variably defined as a revocation of probation, new arrest, charge, conviction, or incarceration) for individuals required to register in many states is failure to maintain updated compliance with administrative registration requirements, such as incomplete address information, failure to update employment or educational information, or missed appointments for registration.³⁷

Despite a lack of impact on community safety and well-being, sex offender management policies immensely impact those subject to registration and notification.³⁸ Today, people convicted of sex offenses must contend with blanket, and often lifelong, restrictions for a wide array of offenses that range from nonviolent or noncontact offenses, to consensual relationships with differently aged partners, assault, and rape.³⁹ Seventeen states currently require lifelong registration regardless of the severity of the offense, which may range from child rape to public nudity.⁴⁰ Registration and notification related restrictions significantly limit access to public assistance, social services, housing, employment, and educational opportunities,⁴¹ often resulting in housing instability, houselessness, unemployment, stigma, and poor mental health.⁴² In addition, at least fourteen states passed residency restrictions, which prohibit people convicted of sex offenses from living, working, or visiting locations

34. Harris et al., *supra* note 12, at 7.

35. *Id.*

36. Levenson, *supra* note 29, at 3.

37. Grant Duwe & William Donnay, *The Effects of Failure to Register on Sex Offender Recidivism*, 37 CRIM. JUST. & BEHAV. 520, 520–22, (2010); Letourneau et al., *supra* note 29, at 440–41.

38. Michael P. Lasher & Robert J. McGrath, *The Impact of Community Notification on Sex Offender Reintegration: A Quantitative Review of the Research Literature*, 56 INT'L J. OFFENDER THERAPY & COMPAR. CRIMINOLOGY 6, 7–8, 10–11, 19–20 (2012).

39. LEON, *supra* note 7, at 86, 122; Richard Tewksbury, *Collateral Consequences of Sex Offender Registration*, 21 J. CONTEMP. CRIM. JUST. 67, 69–70, 76 (2005).

40. GOTTSCHALK, *supra* note 7, at 207.

41. Levenson, *supra* note 29, at 21.

42. Shawn M. Rolfe et al., *Homeless Shelters' Policies on Sex Offenders: Is This Another Collateral Consequence?*, 61 INT'L J. OFFENDER THERAPY & COMPAR. CRIMINOLOGY 1833, 1834, 1844 (2017); Tewksbury, *supra* note 39, at 68–69; Michael P. Lasher & Robert J. McGrath, *The Impact of Community Notification on Sex Offender Reintegration: A Quantitative Review of the Research Literature*, 56 INT'L J. OFFENDER THERAPY & COMPAR. CRIMINOLOGY 6, 9–11, 19 (2012).

within a certain distance (ranging from five hundred feet to a quarter mile) of schools, parks, day cares, or bus stops.⁴³

Residency restrictions are more than just a logistical headache. One study in Florida found that due to residency restrictions, 50% of people convicted of sex offenses reported that they needed to move, 25% said they could not return to their homes post release, 48% percent experienced financial suffering, and 60% described emotional suffering.⁴⁴ Apart from these various restrictions and reporting requirements, many people who are convicted of sex offenses are required to attend group and/or individual therapy.⁴⁵

B. Mandated Sex Offender Treatment (“MSOT”)

Medicalized ideas of sex offending as a treatable condition first emerged in the United States during the mid-twentieth century, when “corrective” methods like castration, electric shock therapy, and frontal lobotomies gained popularity as tools to treat deviancy.⁴⁶ At the same time, psychiatry was gaining professional legitimacy and panic over sex offending was used as an opportunity to increase psychiatry’s credibility, through claims that therapists could identify, treat, and cure “sexual psychopaths.”⁴⁷ By the 1970s, however, a disjuncture between academic psychiatry versus forensic assessment and treatment of sex offenders emerged, and public trust in psychiatry’s ability to assess and treat sexual offending diminished.⁴⁸ Instead, a focus on risk assessment and prediction materialized.⁴⁹ To meet the criminal legal system demand for more objective and standardized tools for assessing and predicting risk, a new field of forensic psychology arose, which relied on actuarial and psychophysiological technologies (including polygraph and phallometric testing) to predict future sexual conduct and direct approaches to treatment.⁵⁰

Today, forensic psychologists’ assessment and treatment methods are still widely used in the treatment and management of people convicted of sexual

43. Jill S. Levenson & Leo P. Cotter, *The Impact of Sex Offender Residence Restrictions: 1,000 Feet from Danger or One Step from Absurd?*, 49 INT’L J. OFFENDER THERAPY & COMPAR. CRIMINOLOGY 168, 168 (2005).

44. *Id.* at 170–73.

45. Huebner et al., *supra* note 3.

46. LEON, *supra* note 7.

47. STEFAN VOGLER, SORTING SEXUALITIES: EXPERTISE AND THE POLITICS OF LEGAL CLASSIFICATION 55 (2021).

48. LEON, *supra* note 7; VOGLER, *supra* note 47, at 55.

49. See VOGLER, *supra* note 47, at 54 (“[A]most all states currently use risk assessment technologies in some decisions about sex offenders, including determinations ranging from probation requirements to treatment efficacy.”).

50. *Id.* at 55.

offenses.⁵¹ Almost everyone who is convicted of a sexually violent offense is assessed for risk of future offending towards the end of their criminal sentence.⁵² If someone is deemed a sexually violent predator (“SVP”)—a widely contested legal classification⁵³—they may experience further evaluation and potential civil commitment.⁵⁴ Beyond assessment and SVP determinations, jurisdictions often require individuals to attend a form of MSOT, either during or after incarceration.⁵⁵ Treatment can last anywhere from six months to a lifetime, based on a therapist’s determination, individual progress, and statutory requirements.⁵⁶

Treatment models are generally highly manualized, often based on principles of cognitive behavioral therapy,⁵⁷ and frequently involve a mix of individual and group therapy sessions.⁵⁸ Typically, the goal of treatment is to contain future sex offending risk by addressing and altering thought patterns, beliefs, and behaviors associated with the original offense.⁵⁹ Individuals are required to admit to and recount their offenses and instructed to create detailed safety and relapse plans to prevent future offending.⁶⁰ While specific protocols vary by jurisdiction and program, individuals who refuse to admit guilt are often placed in a denier’s group and may ultimately take a polygraph test and/or be discharged from treatment.⁶¹ Beyond any therapeutic goals, this may lead to important criminal legal implications; treatment is generally a condition of community supervision and therapists regularly report on treatment compliance

51. L. Maaiké Helmus, *Sex Offender Risk Assessment: Where Are We and Where Are We Going?*, 20 CURRENT PSYCHIATRY REPS. 46, 46 (2018).

52. *See id.* (“[R]isk assessments guide nearly every decision made about offenders and are ubiquitous in the criminal justice system.”).

53. Eric S. Janus & Robert A. Prentky, *Sexual Predator Laws: A Two-Decade Retrospective*, 21 FED. SENT’G REP. 90, 90 (2008); John Petrila, *Because They Do Horrible Things: Fear, Science, and the Erosion of Civil Liberties in Sexually Violent Predator Proceedings*, 36 J. PSYCHIATRY & L. 359, 369 (2008).

54. Jill S. Levenson & John W. Morin, *Factors Predicting Selection of Sexually Violent Predators for Civil Commitment*, 50 INT’L J. OFFENDER THERAPY & COMPAR. CRIMINOLOGY 609, 610 (2006).

55. Huebner et al., *supra* note 3.

56. In some jurisdictions, SVPs are required to attend treatment for the duration of their lifetime. *See* SCHMUCKER & LÖSEL, *supra* note 4, at 9, 19 (noting that treatment durations can vary drastically across different settings); *see generally* Farkas & Miller, *supra* note 4 (outlining various treatment methods for sex offenders).

57. Huebner et al., *supra* note 3; Isabella Carvalho Oliveira Rocha & Alexandre Martins Valença, *The Efficacy of CBT Based Interventions to Sexual Offenders: A Systematic Review of the Last Decade Literature*, 87 INT’L J.L. & PSYCHIATRY 101856, 101857, 101860 (2023).

58. SCHMUCKER & LÖSEL, *supra* note 4, at 27.

59. *Id.* at 9–10.

60. Farkas & Miller, *supra* note 4, at 78.

61. *See id.* at 79–80 (“The Supreme Court upheld the admission of guilt as a requirement for participation in treatment programs . . .”).

to probation officers or judges.⁶² Failure to successfully complete treatment can result in a revocation of probation and additional incarceration.⁶³

Programs vary widely in terms of program specifications, duration, environment, and therapeutic providers.⁶⁴ Empirically, this—in addition to the enormous heterogeneity of individuals required to attend treatment—challenges assessments of effectiveness.⁶⁵ Effectiveness is also a contested category; while the idea of therapeutic treatment presumes a measure of disorder or disease, there is no all-encompassing diagnostic criteria to qualify as a convicted sex offender who is mandated to attend treatment.⁶⁶ Therefore, effectiveness is typically measured in criminogenic, rather than clinical terms, with reductions in sexual reoffending as the most common metric of success.⁶⁷ There is some evidence that treatment can reduce rates of recidivism,⁶⁸ but levels of effect are found to vary by the therapeutic model,⁶⁹ treatment timing and duration,⁷⁰ therapeutic climate and setting,⁷¹ therapist characteristics,⁷² and offending and individual characteristics of the participants.⁷³

MSOT poses complicated ethical and practical challenges for therapeutic providers who must grapple with policies that often conflict with their

62. Jill Levenson & David D'Amora, *An Ethical Paradigm for Sex Offender Treatment: Response to Glaser*, 6 W. CRIMINOLOGY REV. 145, 148–49 (2005).

63. Farkas & Miller, *supra* note 4, at 78.

64. Bitna Kim et al., *Sex Offender Recidivism Revisited: Review of Recent Meta-Analyses on the Effects of Sex Offender Treatment*, 17 TRAUMA, VIOLENCE, & ABUSE 105, 115 (2016).

65. *Id.* at 109.

66. WILLIAM MARSHALL ET AL., TREATING SEXUAL OFFENDERS: AN INTEGRATED APPROACH 1–15 (2006).

67. SCHMUCKER & LÖSEL, *supra* note 4, at 16.

68. Kim et al., *supra* note 64, at 115; Friedrich Lösel & Martin Schmucker, *The Effectiveness of Treatment for Sexual Offenders: A Comprehensive Meta-Analysis*, 1 J. EXPERIMENTAL CRIMINOLOGY 117, 138 (2005); SCHMUCKER & LÖSEL, *supra* note 4, at 24.

69. Leigh Harkins et al., *Evaluation of a Community-Based Sex Offender Treatment Program Using a Good Lives Model Approach*, 24 SEXUAL ABUSE 519, 521 (2012) (noting that treatment programs using a Risk/Need/Responsivity approach are effective in reducing recidivism).

70. See generally Andrew Day et al., *The Intensity and Timing of Sex Offender Treatment*, 31 SEXUAL ABUSE 397 (2019).

71. See SCHMUCKER & LÖSEL, *supra* note 4, at 8 (“We found significant effects for treatment in the community and in forensic hospitals, but there is not yet sufficient evidence to draw conclusions regarding the effectiveness of sex offender treatment in prisons.”).

72. G. Serran et al., *Process Issues in Treatment: Application to Sexual Offender Programs*, 34 PRO. PSYCH. 368, 369 (2003).

73. Leigh Harkins & Anthony R. Beech, *A Review of the Factors That Can Influence the Effectiveness of Sexual Offender Treatment: Risk, Need, Responsivity, and Process Issues*, 12 AGGRESSION & VIOLENT BEHAV. 615, 619 (2007); see also Kim et al., *supra* note 64, at 109–13 (arguing that participant age impacts treatment effect).

professional standards and ethics of practice.⁷⁴ MSOT therapists navigate between—often with very little training or preparation—health and criminal legal bureaucracies with divergent professional agendas and methods for reaching their individual and shared goals.⁷⁵ Therapists are tasked with simultaneously considering the needs of their clients (the primary charge of traditional therapy and therapeutic intervention), as well as with the explicit duty to protect the community from potential risks posed by their clients.⁷⁶ The latter often entails close criminal legal system collaborations, reduced protections for client confidentiality, and proscribed treatment pathways and protocols—all of which take place in the context of potential coercion and reduced client agency.⁷⁷ In particular, because treatment is a component of criminal legal sanctioning, therapists are generally expected to work closely with probation or parole officers by providing regular updates on treatment adherence and sharing any client disclosures that may be violations of probation or parole.⁷⁸

Practically, therapists must also struggle with questions of how to engage in efficacious practice, given the mixed evidence of MSOT effectiveness—especially for certain types of offenses—and the potential for the therapeutic process and alliance to create preemptive harm by client concerns about possible ramifications of participating honestly and openly in sessions.⁷⁹ Scholars further argue that the stress associated with juggling these competing demands, often in resource limited and high stakes environments, contributes to professional stress and burnout, potentially reducing the quality of treatment and further reducing the effectiveness of MSOT.⁸⁰

While a body of literature explored MSOT efficacy for reducing recidivism, as well as debated the ethical, legal, and practical challenges of MSOT at a field or system level, studies exploring the perspectives of stakeholders are relatively more limited. A few recent studies explored provider perspectives on the ethical challenges of MSOT. For example, a 2002 study investigated provider

74. See Walker, *supra* note 5, at 777 (finding that mandatory reporting requirements created a conflict with maintaining client confidentiality that complicated treatment delivery, and that organizational conflicts arose when working with Department of Corrections' clients while being "policed" by Department of Health).

75. *Id.* at 771.

76. Levenson & D'Amora, *supra* note 62, at 146–47; see also Robert J. McGrath et al., *Collaboration Among Sex Offender Treatment Providers and Probation and Parole Officers: The Beliefs and Behaviors of Treatment Providers*, 14 *SEXUAL ABUSE* 49, 52 (2002); see also Walker, *supra* note 5, at 770–71.

77. Bill Glaser, *An Ethical Paradigm for Sex Offender Treatment: A Response to Levenson and D'Amora*, 6 *W. CRIMINOLOGY REV.* 154, 156 (2005).

78. Walker, *supra* note 5, at 771.

79. *Id.* at 770–71.

80. *Id.* at 771.

relationships with community corrections officials.⁸¹ A number of studies also examined MSOT from the perspectives of clients, seeking to gauge factors related to client engagement and satisfaction with treatment, and whether and under what conditions mandated or coerced care can still create and maintain the therapeutic alliance.⁸² This study seeks to build upon this existing literature base by exploring MSOT from the simultaneous perspectives of the three biggest MSOT stakeholders: treatment providers, clients, and probation officers (“POs”). By engaging one system of care from a variety of vantage points, this study elucidates the many challenges and tensions inherent to mandated treatment settings, as well as the unique issues that arise in response to our current systems of sex offender management policies.

Furthermore, this study theoretically positions provider stakeholders using the conceptualization of street level bureaucracy. Street level bureaucrats (“SLBs”) are frontline workers who, through their daily work, determine how policies are implemented.⁸³ Though they operate with limited discretionary power, limited by the agencies within and with which they work, as well as larger systems, they make important decisions that impact the lives of the clients they work with.⁸⁴ Frontline workers must navigate implementation of policies while juggling large caseloads, vague agency goals, and inadequate resources within complex policy settings.⁸⁵ Both therapists⁸⁶ and probation officers⁸⁷ are typically considered as SLBs in the literature, though not within the context of MSOT. Using a street level bureaucracy lens to consider how various SLBs maneuver through policy implementation decisions provides a unique frame that allows us to examine how and why discretion is exercised by these individual actors, rather than simply understanding the technical policies of their agencies.

81. McGrath, *supra* note 76, at 55–62.

82. Farkas & Miller, *supra* note 4, at 78; Jill S. Levenson et al., *Sex Offender Treatment: Consumer Satisfaction and Engagement in Therapy*, 54 INT’L J. OFFENDER THERAPY & COMPAR. CRIMINOLOGY 307, 323 (2010); Carollyne Youssef, *The Importance of the Therapeutic Alliance When Working with Men Who Have Committed a Sexual Offense*, 7 J. CRIM. PSYCH. 206, 207–11 (2017).

83. MICHAEL LIPSKY, STREET-LEVEL BUREAUCRACY: DILEMMAS OF THE INDIVIDUAL IN PUBLIC SERVICES xi–xii (1983).

84. *Id.*

85. *Id.*

86. Michael Lipsky, *The Critical Role of Street Level Bureaucrats*, in SOCIAL WORK 194, 194 (Vivienne E. Cree & Trish McCulloch eds., 2023); Margo Trappenburg et al., *Social Workers in Modernising Welfare State: Professionals or Street-Level Bureaucrats?*, 50 BRIT. J. SOC. WORK 1669, 1684 (2000).

87. Lipsky, *supra* note 86, at 194; Brice Terpstra & Philip Mulvey, *Special Probation Officers as Street-Level Bureaucrats: Exploring How Discretion is Perceived and Employed on a Mental Health Caseload*, 66 INT’L J. OFFENDER THERAPY & COMPAR. CRIMINOLOGY 670, 687–89 (2022).

II. METHOD

This study, and Article, aims to better understand MSOT by simultaneously exploring the experiences of three major stakeholder groups involved in the provision of mandatory sex offender therapy in one large urban jurisdiction: therapists who provided MSOT, specialized probation officers working with individuals in MSOT, and individuals who are or were in MSOT themselves.⁸⁸ The researchers conducted one time, semi structured interviews with therapists, probation officers (“POs”), and people in MSOT. This cross sectional study included participants recruited through convenience and snowball sampling in a large city in the northeastern United States. The semi structured interviews used guides tailored for each of the three roles and designed to be participant driven. Professional stakeholders did not receive incentives, but people in MSOT as clients received a \$40 gift card. Verbatim interview transcriptions are included below with participant-selected pseudonyms. The researchers used NVIVO to conduct thematic analysis, with the goal of identifying patterns and broader concepts,⁸⁹ and a combination of open, selected, and axial coding to analyze qualitative data.

III. RESULTS

Five key themes emerged from our data, all of which highlight the challenges and tensions inherent to working in and around this mandatory and coercive treatment setting. These five themes were: (A) who is being served?; (B) “a very complicated space to be in”; (C) “a younger and less experienced therapist”; (D) who protects the client?; and (E) the specter of dangerousness.

A. *Who is Being Served?*

The first notable finding is the unresolved question of “who is being served” by therapists and treatment settings. While social workers and therapeutic professionals generally think of treatment as “for the client,” this is clearly a more complicated question in the context of mandatory and coercive therapy. In many ways, the probation offices, who send clients to treatment and oversee their compliance, could actually qualify as the client that is served. A therapist, Rachel, described:

[Engaging probation and parole] was a big part of treatment ... which complicates things a bit. Informed consent and confidentiality look different than they would in normal treatment because technically the

88. See *infra* Sections III.A–E.

89. Moira Maguire & Brid Delahunt, *Doing a Thematic Analysis: A Practical, Step-by-Step Guide for Learning and Teaching Scholars*, 8 ALL IR. J. TEACHING & LEARNING HIGHER ED. 3351, 3357 (2017).

probation and parole offices were the client as far as all the confidentiality stuff goes. If there were certain concerns, we had to report them to probation and parole. So, it wasn't as private as therapy would generally be elsewhere.

In nonmandatory therapy, clients receive the benefit of confidentiality, which is only broken if the client indicates that they will harm themselves or someone else. In mandatory therapy coordinated through criminal legal systems, clients do not experience the same degree of confidentiality or privacy. Rather than elevating confidentiality and trust as hallmark values of their therapeutic process, clinicians are forced to prioritize reporting to probation and parole.

Interviews revealed that probation's status and power derived from economic considerations, in addition to inherent power structures within criminal legal system mandated treatment. As the main source of treatment referrals, MSOT agencies relied heavily on maintaining positive working relationships with probation. A probation supervisor, Paul, reiterated that the choice to seek or stop services depended on probation's satisfaction with services rendered, rather than the client's satisfaction, as is the case with typical therapy. As Paul said, "I'm not going to lie. There was a time when we froze [the therapy service provider] out. We weren't even sending them referrals because they just weren't giving us the service we wanted." Regardless of client needs, decisions relied on probation's evaluation of standards met. Therapist Nicole saw the power that probation exerted over her organization. "The higher ups were by the book. I think they didn't want to hurt the relationship that they had [with probation] because really, that was what was keeping the doors open." Both the economic and power structures prioritized probation's needs and goals, making probation seem sometimes like the primary client.

In a broader sense, the community at large could be considered the true client, as the intended recipient of value and benefit from treatment services. As PO Rocky explained: "Although our ultimate goal with probation is to help these individuals succeed and to move forward with their lives after committing these offenses, we can never—we cannot—forget about the victims and the community and the potential [threat] that an individual could pose in the future." Conflicting understandings of who treatment is for guided the provision of services and facilitated a context that sometimes devalued or overlooked harms to the treatment participant. This may lead to important implications for services rendered in treatment settings. Focusing on protecting the community *from* the participant requires an assumption of the participant's potential future dangerousness and is, inherently, a pessimistic orientation that decenters the participant. Approaching therapy from a position of cynicism and fear of the client, based on potential future dangerousness, may impede the development of an effective therapeutic or supportive relationship.

B. “A Very Complicated Space to Be In”

Because treatment adherence and linear treatment progression was linked to compliance with criminal legal supervision, the stakes of treatment seemed extremely high for participants. This leads to our second finding: these high stakes posed particular challenges to therapists, who struggled to reconcile the enormous power that their reports to probation could wield over the lives of their clients. Therapists discussed navigating the constant threat of a client returning to incarceration as a result of their reporting, and the strategies therapists employed to limit client exposure and mitigate harm. Therapist Geoff, for instance, explained: “I would share less information with certain POs because I just knew that they either didn’t like a client or they had an attitude about therapy. There were some POs that were . . . wanting them to be in the program for years and years and years.” Another therapist, Xenon, explained:

I feel like I personally kind of walked on eggshells being worried about like, I don’t want to tell the PO anything unless I really, really have to because [the participant is] going to get sent to prison. They don’t get a slap on the wrist. They don’t get scolded. They don’t get told, “[y]ou have five more chances.”

A third therapist, Rachel, described how she would approach this difficult dynamic with her clients:

I was always very candid with my clients about [having to share with probation and parole]. I would always make sure, if I felt like they were edging close to something that might get them in trouble, I would kind of put a hand up and stop them and remind them of the confidentiality. And if they would tell me something that I needed to disclose, I would let them know. Then we’d kind of process how to handle that and the importance of them telling the officer first, because that tended to go over better with the officers. Like if they came and said, “[h]ey, I did this thing” before I called them and told [the PO], then the officers tended to go a little easier on them.

Therapists reported struggling with the emotional toll of navigating through systems that required them to cooperate with probation and punishment systems in ways that felt at odds with traditional therapeutic goals and philosophies. Collaboration with POs and courts meant that therapists sometimes actively participated in clients’ incarceration for minor transgressions, something which made them feel like, as therapist Nicole said, “a [horrible] extension of the system.” Therapist Rachel described:

I think my ethics came into question the most when a client would be telling me something that I knew I had to tell. And if it was something that was, from my perspective, minor and not necessarily harmful to that person or to others, it was very difficult to say, “this is going to

get this person in trouble, but I have to.” And so that was a very complicated space to be in.

Specifically, therapists were generally expected to report to the PO when a participant failed to comply with supervision requirements, regardless of if those requirements were related to the content of therapy. Therapist Geoff described the following situation:

It’s just really heartbreaking. This guy came in seven minutes late. And he had been late like four or five times before . . . , I was like, I can’t send this guy to jail just for a couple minutes. But then a supervisor of mine was like if you don’t set a boundary, he’s just going to take advantage of it, and kind of made me [report it] . . . and he was sent back to prison.

Therapist Rachel described a similar situation:

So, the colleague I worked with . . . had a case where one of his clients had driven like two miles on a suspended license. And he was really on the fence like, “[i]s this worth reporting if this person is going to go back to jail?” Because that’s the reality, is they’re going to go all the way back for something that feels so minor. You know the person didn’t get into a car accident. Their license was suspended because of I think like parking tickets, like it wasn’t even that they had done anything major in a car. So, I think, at the end of the day, after a lot of conversation, [my colleague] decided this isn’t worth it for this person, who’s doing really well in a lot of ways, to have to get stuck.

Deciding whether and how to disclose to a PO in situations like these, when a client made a mistake, missed a session, or arrived late too many times, often served as a major stressor for therapists working to support their clients under the parameters of the criminal legal system. Challenges arose especially when probation’s requirements butted up against a therapist’s training and expertise. For example, therapist Rachel noted:

As far as clinical work, the biggest area where I think it became an issue was [with] . . . denial and how that works within treatment. So, if someone was denying the offense, the officers often wanted us to pretty much force a confession out of them. And as a therapist, that’s clearly not my role. And there’s a lot of research that says that if you commit an offense, admitting to the details of the offense is not necessary for recovery So, that was very challenging, and trying to work through that with the officer, while still trying to have a healthy rapport with the client.

Working with clients who had intersecting or compounding vulnerabilities exacerbated the difficulties of navigating community supervision goals and demands. Therapist Nicole described one of her clients, who was “severely intellectually disabled,” “very suicidal,” and required to attend weekly group

therapy sessions, despite seeming not to understand what was happening and getting bullied by his peers. He told Nicole in their individual session that he left the state to get a tattoo:

He told me he went to New York. I was supposed to report that. I don't remember if I did, but I remember being a mess about it. Because when I told him, "[t]hat's a parole violation," he just lost it, like hysterically crying. Not mad, just sad, . . . I do not remember, though, what I did. I might have told his parole officer. I don't know.

In this scenario, therapist Nicole struggled to reconcile her competing obligations to her client and to report to probation.

In some ways this second theme connects to the first finding: if therapists or POs see their overarching goal as protecting the community from perceived future harm that clients might possibly pose, they may lose sight of or deprioritize participant goals and needs. In the first theme, POs saw the stakes as high in that if a person reoffended, it could cause real harm to others and the community more broadly. Here, though, therapists grappled with the impact that their reporting and decision making had on the participants themselves, and how criminal legal considerations and regulations conflicted with their professional training and judgment.

C. "A Younger and Less Experienced Therapist"

Many of the therapists reported that this was their first job after their master's or doctoral education, and for some, they completed the position as an intern. This role is a common early career position and many therapists do not stay in the job for more than a few years. Therapist Rachel explained:

If you were a warm body who had some level of education, they would hire you. And they unfortunately didn't provide adequate training to new hires, so people were getting thrown in with no history of working with sex offenders. [They] would really come right out of school. And so, there was just kind of a hodgepodge of backgrounds.

Similarly, Therapist Peter said: "A lot of [my colleagues] were using it as a steppingstone to get into other positions in the criminal justice field . . . that's what the culture was: let's stop here, make some money, and go to the next best thing." Therapists reported that this quick departure occurred for a variety of reasons, including low pay, a fee-for-service pay model in which therapists received payment for the units of therapy they provided (which meant no paid time off or even paid time to complete paperwork), and the emotional toll of often difficult, ethically complicated, and traumatic work. As a result of this high turnover and tendency towards acting as an early career job, therapists providing services in these settings generally lacked the training and expertise needed to support this complicated, high need population. All three stakeholder groups

identified this issue. Walter, a mandatory treatment client himself, explained: “These people that ran this program, the only background they have was what they read in a book! And I couldn’t accept that. You can’t know what we feel and what we’ve experienced in our heads and our hearts and not know what’s going on.” Walter found the lack of training and lack of experience working with individuals convicted of sex offenses, as well as the fact that therapists lacked firsthand experience, insulting and inexcusable. He argued that the peer support groups he attended while in state prison benefitted him more than those facilitated by therapists with only formal training.

Therapists in this study opened up about their lack of experience, training, supervision, and preparedness. Therapist Nicole admitted, “[t]ruly, I don’t feel like I was a great therapist. I feel like I was just, most of the time, going through the motions, because I didn’t know what I was really doing with [participants].” Therapist Xenon, who was “fresh out of grad school” understood that the “very broad work [was to] ‘help this person understand what they did wrong and [ensure that they] are apologetic and show empathy,’” but questioned, “how do you do that?” Without clear training, supervision, or guidance, therapists largely needed to navigate this challenging task on their own. For therapist Peter, that meant “as a new practitioner, I was just reading right off the worksheets.” His lack of training and newness in the field is typical. Therapist Geoff, with a doctorate in psychology, intentionally sought out population specific trainings, and explained a problematic cycle in which therapists who stayed long enough to gain expertise and knowledge did not feel compensated well enough to stay:

The kind of clinician that ends up at a place like this [agency] is typically not trained at a certain level. You know, that’s the kind of pay that you are accepting for your work. There’s a certain level at which, like, you’re too trained to be getting paid that little. And that’s another really big reason why I left: my training ha[d] exceeded the amount of money [I was] getting paid for my expertise. I don’t think there’s a lot of expertise at a place like that.

Interestingly, POs were most likely to endorse the specialized expertise of treatment providers, often making statements such as “[w]ell, I’m not a licensed sex offender therapist” or noting that they lacked the training to assess and treat client needs. It seemed that by differentiating themselves from the therapists and implicitly highlighting the therapists’ unique qualifications, POs could feel more comfortable trusting treatment recommendations and “staying in their lane” as enforcement officials. As PO Supervisor Paul noted: “Treatment has really taught us a lot, and we’ve learned to let treatment be the experts.” However, staffing practices at the treatment facilities often tested their confidence. POs noted that it seemed clients often got assigned to a student intern or brand new clinician for therapy. PO Laura noted: “I think, not to put down anybody, but

when you have a younger or less experienced therapist who is still following all the book guidelines, they don't have the experience to really get with the person like, '[o]kay, what does *this* person need?'" Without the training and experience to recognize the unique needs of clients and tailor services accordingly, PO Laura saw therapists as not adequately serving clients. She also noted that she was "not a fan" of the agency where many clinicians were so new and inexperienced. Probation supervisor Paul said, "as far as [agency] therapists, I can't tell you their names like I can at [other agencies] because there is constant turnover." Several POs noted that the high rate of turnover produced an issue not just for fostering collaborative relationships, but also for a client's clinical progress. PO Rocky explained:

Guys seem to be in a program an awfully long time and I know a lot of it had to do with the clinician turnover. At one point at [this agency] someone would be in treatment for three years! Their therapist would leave and then they would be assigned a new therapist. But from what we were understanding, it was essentially like they were starting that person over again.

Overall, it seemed that PO confidence in treatment providers was often tested by the reality of the partnerships and proved to be much more of an aspirational confidence than an actual one.

D. Who Protects the Client?

Based on our professional and academic experiences in the field, we initially hypothesized that therapists bore the unique and challenging burden of balancing (and sometimes resisting) public safety demands and coercive conditions imposed by the criminal legal system to protect clients and their freedom. Indeed, as noted in earlier themes, therapists did see these external conditions and tensions between therapeutic and carceral goals as interfering with their ability to provide high quality care to clients and causing significant additional stress and anxiety. Therapists felt the burden of negotiating their desire to shield their clients from criminal legal system sanctions by limiting what they shared with POs or applying some amount of discretion in their work, while maintaining their commitments to criminal legal reporting and public safety. However, one of the most surprising findings, which emerged during interviews with POs, is that the envisioned role of client protectorate is not unique to therapists. Instead, POs also described feeling like they were charged with protecting and shielding clients. Most surprisingly, POs most often saw clients as in need of protection *from the overzealousness of treatment providers*.

Despite wanting to trust that therapists are subject matter experts acting in the best interests of their clients, POs described concerns about encounters with punitive and obstructionist therapists who attempted to impose more restrictions

and limitations on clients. Every PO interviewed discussed experiences with therapists who seemed to want to create additional restrictions or keep clients in treatment for longer than probation believed necessary. PO supervisor Paul described his response to a treatment provider recommending a client stay in treatment for excessively long periods of time:

We're like, come on now. You know he's been there for three years. We think you gave him significant gain, we want to move forward with decreasing his reporting and all that other crap. But if treatment's [sic] seein' him once a week, then obviously we can't just say, "[o]kay, this guy's doing great."

The therapist's decision to not successfully discharge a person, in this case, meant more stringent and frequent supervision for a longer period. Without clearly delineated therapeutic expectations, POs and clients grew confused and frustrated about what exactly would lead to the client's successful termination from therapy. Another PO, Laura, gave this example of the weight of never ending therapy:

I had a guy who was there for like three, four years and he's like, "I can't talk about what I did anymore! I've talked about it for three or four years every single day! I can't do it anymore." It was almost like messing with him in that way. Where do we say, "[o]kay, did he finish this portion? Did he go through the cycle? Did he finish all his modules?"

To protect her client, PO Laura tried to figure out the benchmarks required to discharge her client. Another officer, PO Tabitha, tried to use a proactive, collaborative team approach to protect her client and preemptively avoid conflicts with the therapist. She described:

I like to have the opportunity to intervene with my offender before they're going to face a discharge or an issue. So, I try to stay closely involved with the therapist by email, like, "[h]ow is this person doing?," every once in a while or sometimes, even getting involved on the behalf of my offender if I think they have a lot going on[.] [I make] sure that the therapist is aware, like, "hey, can we work with this guy a little bit?" if there's issues with attendance or illness or drug issues that are going on that might be creating issues with treatment.

Therapist descriptions of their inability or unwillingness to clearly communicate their therapeutic goals or strategies offer insights into why POs might experience frustration. Therapist Xenon noted that she had her "own agenda" and added tersely: "I went to grad school for a couple years . . . I can't describe to you in a 10 minute hearing how therapy works and explain why someone can be attending and not making the progress that you want." Therapist Peter expressed a similar sentiment to the POs, noting that a clear end date was

“never established for any of our clients.” As a therapist—an insider in the agency—even Peter felt unsure of the expectations for program participants or how the agency defined success.

Every PO interviewed described situations in which they felt frustrated by a therapist’s treatment of a client, and where they felt compelled to advocate on behalf of the client, to the therapist. Overall, POs did not enjoy this advocacy role they felt forced into playing and resented that it blurred both their professional boundaries and role. PO Tabitha went on to say:

I also think that I shouldn’t be advocating, [but] I can’t help myself because they’re not violating. I take treatment recommendations very seriously but I’ve had people told—where in no way was the offense involved in any of these scenarios—but people being told they couldn’t go to a place of worship, people being told they couldn’t go to the gym, people being told they couldn’t do other things . . . That’s not against their rules . . . I’ve had people coming in, telling me that the therapist told them, “[o]h, well, you’re going to get this charge and you’re going to go to jail.” And I’m like, “[t]hey don’t decide if you go to jail!” It’s not even just like this stepping on the toes thing. It’s like, why are you threatening people? I don’t even like to threaten my people if I can avoid it. . . . I don’t think that creates a healthy relationship.

PO Tabitha found the role blurring, incorrect information, and decision to hold the stick of incarceration over the client by clinicians unacceptable, which forced her to adopt an advocacy role that she did not want. While this blurring of her boundaries and role for the client ultimately aligned her more closely to social work than law enforcement values, ethically, PO Tabitha felt she had no choice but to defend and protect the client.

Interestingly, therapists described almost parallel struggles and identical processes of standing up both for and with clients against probation imposed restrictions. Mirroring PO Tabitha’s concerns about a therapist keeping a client away from church, therapist Rachel explained how she would navigate discussions about religious spaces with clients and POs:

The biggest one would be religious services. So, even though constitutionally, you have a right to your religion, because of their offenses, a lot of guys weren’t allowed physically in a place of worship . . . Guys would want to go because faith and the community around that is so pro social and so we’d have to navigate that with the officer. And sometimes if we had been working with the client long enough, we would develop a safety plan regarding like a specific place, so this is the exact church, Majid, temple; here is what it looks like, here are all the details, here are some potential situations that could pop up, here’s how I would deal with them. And we’d have to

come up with this really long safety plan, they would sign it, we would sign it, and then we'd send it to the officers. And if the officers felt that was sufficient, then they could go to services.

The fact that both a therapist and a PO provided identical anecdotes of advocating for clients to attend religious services (to a PO and a therapist, respectively) is notable for at least three reasons. First, it demonstrates a lack of clarity around rules and regulations governing people on supervision who were required to register—even among professionals specialized to work in that specific arena. Second, there is a missed opportunity for collaboration; evidently there existed like-minded therapists and POs interested in similar client outcomes, which could have been a chance for alignment rather than conflict. Finally, these anecdotes highlight the power and influence of individual discretion. Clearly, if Tabitha's client received therapeutic treatment from Rachel as his therapist, he would have encountered a different experience, whereas Rachel's client would have experienced an easier process with Tabitha as his PO.

Unsurprisingly, people who went through MSOT themselves mostly discussed *both* therapists and POs as threats against which they needed to protect themselves. Walter described intentionally violating his probation to escape from under the surveillance of a PO he found difficult. Alejandro, who also received mandated treatment, did not describe either his PO or therapists as allies. Instead, he discussed tactics he used to protect himself from criminal legal system repercussions, including complete transparency with his PO to the point of oversharing. Therapy often appeared as something to endure. As Walter said about "this stupid program:" "I never understood it, but I did it anyway. I hope what I said to those people or those guys helped them somehow." Rather than considering therapists as protectors, Walter saw them as essentially bystanders who, along with others in MSOT, hopefully learned from his experience. Ultimately, all the people interviewed from all three stakeholder groups saw themselves as forced to protect those mandated to sex offender treatment from the other parties involved.

E. The Specter of Dangerousness

The final theme that emerged from our data is that deep commitments to the belief of sex offenders and sexual offending as uniquely dangerous led members of all stakeholder groups to perceive systems of both MSOT—and SORN more generally—as necessary, inevitable, and largely unalterable. This finding is somewhat adjacent to the primary topic of investigation but provides important context to understand the landscape of MSOT and to consider potential barriers to future reform or adaptation.

Participants from all stakeholder categories described the MSOT care landscape as frustrating, ethically complicated, largely ineffective, and potentially extremely harmful to client participants. More broadly, stakeholders acknowledged the myriad collateral consequences associated with SORN policies. They generally agreed that registration and notification policies complicated and limited the lives of people on the registry in significant ways, noting difficulties finding a job, navigating burdensome requirements, and confronting stigma. PO Tabitha noted that “resources and opportunities are so limited” for people on the registry, because “there’s so many funding blocks on these individuals.” PO Rocky similarly explained:

It can be very difficult to have to register as a sex offender . . . [because] they’re on a public registry, anyone could come look them up. I have guys come in sometimes and tell me that somebody put a picture of their Megan’s Law registration around the neighborhood Guys have difficulty getting jobs. Once their criminal background check is done by the employer, they wind up telling them “[n]o, we can’t hire you because of your background.” So, it’s very difficult for these guys, and it’s understandable, you know. I think if I was in that position and had to register for an offense, I’d probably feel the same way they do.

In short, study respondents unanimously agreed that the registry and related policies simply made life harder for people.

Given the widely acknowledged flaws, limitations, and harms associated with both MSOT and SORNA, it is notable that not a single person from any stakeholder group endorsed eliminating either MSOT or SORN policies. PO Rocky asserted that the registry was a “great tool for the community and the victims” and that the value outweighed the significant harms, especially because of the potential of child victims. Overall, participants cited a range of reasons for their commitment to maintaining current policies. Generally, the rationale involved deeply held and often ambiguous beliefs about the unique potential dangerousness of sex offenders, even if that narrative did not align with personal experiences or knowledge.

Several participants struggled to reconcile divergences between their firsthand experiences or observations of SORN’s impact and utility with visceral commitments to SORN’s important (if ambiguous) public safety function. For example, PO Tabitha described “complicated feelings towards the registry.” She acknowledged that the registry produced “a little bit of fear mongering” and existed “to make people feel safe,” even though largely ineffective, since the vast majority of sexual violence takes place within families or among acquaintances. She noted that the registry “just creates a list for the people we should be looking at first if something happens, when in all reality, they should probably look at a

family tree before they look at a registry.” Further, PO Tabitha explained, even if people checked the registry, it is unlikely they would remember the faces of people on it and notice them walking down the street in real life. Despite this, she admitted to using the registry to check for registered individuals in her own neighborhood.

Therapist Rachel readily acknowledged the immense harms of the current system, emphasizing the weight that individuals on the registry live with knowing that they are constantly watched and monitored every day. Rachel is one of the study’s most fervent advocates for treating people convicted of sex offenses with humanity, compassion, and forgiveness. Yet, even as she advocated for a more restorative and healing approach to addressing sexual harms, she refused to fully endorse divorcing sex offender treatment from the criminal legal system. While she wished that probation could play a more consistent and case managerial role, her ideal system still included collaborative relationships between POs and MSOT providers.

Perhaps most surprisingly and impactfully, even Alejandro, an individual listed on the registry and formerly in MSOT, felt strongly enough about the potential community risks of sexual violence that he endorsed maintaining SORN policies. He did so even while acknowledging that the registry did nothing to keep *him* from reoffending, and despite significant personal harm. Alejandro told us:

This should exist. I mean, I’m going through what I’m going through. I’m miserable . . . but I really think this whole system needs to exist, as bad as it is. I’m homeless, I can’t go nowhere, I’m not allowed to work retail or fast food But there [are] predators out there. Real ones! I see it every day.

When asked if he felt these policies prevented people from reoffending, Alejandro replied, “[n]o, but what happens is, the registration causes real fear to mess up and go back for any indeterminate amount of time.”

IV. DISCUSSION

This study provided a useful lens into how mandated treatment is perceived by the major stakeholders in one large urban jurisdiction.⁹⁰ Overall, the five themes that emerged from our interviews revealed a complicated treatment landscape.⁹¹ Importantly, all professional stakeholders seemed well-intentioned, expressed genuine commitment to completing their work well, and wanted to benefit their client and the community. While professional stakeholders expressed cynicism with the practicalities of their work, everyone approached

90. See *supra* Part II.

91. See *supra* Sections III.A–E.

their roles with a genuine interest in goals of rehabilitation, safety, and well-being; no one appeared motivated by a desire for punishment, retribution, or control. Given this universal commitment towards producing quality work for the benefit of others, it is notable that, overwhelmingly, no one seemed satisfied with the system's functioning or the quality of the "product" (treatment). The frustration and dissatisfaction are attributable to a number of practical and philosophical features of the MSOT landscape. Most of these challenges relate to barriers that kept POs and treatment providers from feeling like they could effectively work towards common goals as collaborative colleagues on a treatment team. These challenges have been documented elsewhere within other criminal legal system problem solving "teams."⁹²

To understand these challenges and how they impacted study participants and their work, it is helpful to conceptualize both therapists and POs as street level bureaucrats, who operate within complicated constraining systems with limited but powerful discretion—a hallmark of street level bureaucracy.⁹³ Within these contexts of constraint, conflicting mandates, and limited resources, POs—and therapists especially—struggle to exert "moral entrepreneurship," which is the ability to push back against people, rules, and agency policies that they consider problematic and harmful.⁹⁴ In our study, moral entrepreneurship often manifested as conflict and impeded collaboration. Therapists demonstrated moral entrepreneurship when they withheld or limited information they shared with probation officers. Meanwhile, POs' moral entrepreneurship was exerted when they pushed back against therapists who they saw as needlessly extending treatment, limiting client behavior, or failing to share pertinent information.

Ultimately the powerful coercive conditions of the criminal legal system, in conjunction with challenging occupational conditions in MSOT, limited the scope of moral entrepreneurship for many therapists, contributing to the common decision to exit the agency or the field quickly.⁹⁵ This, in turn, meant that the therapists staffing MSOT agencies are typically younger and more inexperienced, and thus, poorly equipped to navigate complex bureaucracies as successful SLBs with effective moral entrepreneurship.⁹⁶ This produces

92. See Nancy D. Franke & Corey Shdaimah, "I Have Different Goals Than You, We Can't Be a Team": Navigating the Tensions of a Courtroom Workgroup in a Prostitution Diversion Program, 16 ETHICS & SOC. WELFARE 193, 202 (2022) (finding that prostitution diversion programs are filled with tensions because sex workers are seen as both victims and offenders and because goals of criminal legal system are at odds with rehabilitation).

93. Lipsky, *supra* note 83, at xi–xii.

94. Yeheskel Hasenfield, *Organizational Forms as Moral Practices: The Case of Welfare Departments*, 74 SOC. SERV. REV. 329, 331 (2000).

95. See *supra* Section III.B.

96. See *supra* Section III.C.

enormous implications for MSOT. For instance, newer therapists could not adequately advocate for client needs and priorities balanced with or prioritized above probation or public safety goals.⁹⁷

The high prevalence of new therapists in an agency and high turnover rates impeded the ability of the therapists and POs to collaborate effectively, even when morally and practically in agreement. POs reported much lower turnover than therapists in this study. This provided the POs with expertise and experience working with this population, and, in some ways, more power and discretion. However, without a basis of trust and mutual confidence between POs and therapists, dissatisfaction, role confusion, and suspicion predominated.

In typical, nonmandated therapy, the client's goals and well-being are the top priority. Typically, effective therapy is tailored to the needs of the individual client,⁹⁸ with agreed upon client centered goals,⁹⁹ a strong therapeutic alliance between client and therapist,¹⁰⁰ and therapists who approach clients with "unconditional positive regard,"¹⁰¹ and confidentiality.¹⁰² In mandatory therapy, the relationship inevitably changes somewhat, given the coercive nature of mandated treatment, the inherent power dynamics, the lack of confidentiality, and the fact that the client is neither the one who sets their goals, nor the one who decides to end therapy.¹⁰³ There is some evidence that MSOT is effective in reducing recidivism, in spite of the coercive nature of the therapeutic relationship and the inevitable differences between traditional and mandated treatment.¹⁰⁴ That said, many components of therapy and client characteristics can impact the efficacy of therapy—sometimes in ways that are not yet clear in the literature. In studies highlighting MSOT effectiveness, researchers point to several important components: a strong therapeutic alliance,¹⁰⁵ cognitive behavior therapy as a useful approach,¹⁰⁶ and both program content and peer support of group

97. See *supra* Section III.C.

98. John C. Norcross & Bruce E. Wampold, *What Works for Whom: Tailoring Psychotherapy to the Person*, 67 J. CLINICAL PSYCH. 127, 131 (2011).

99. See generally William Rowe, *Client-Centered Theory and the Person-Centered Approach: Values-Based, Evidence Supported*, in SOCIAL WORK TREATMENT: INTERLOCKING THEORETICAL APPROACHES 34 (Francis Turner ed., 2017).

100. Youssef, *supra* note 82, at 206.

101. Carl R. Rogers, *The Necessary and Sufficient Conditions of Therapeutic Personality Change*, 60 J. CONSULTING & CLINICAL PSYCH. 827, 827 (1992).

102. Jeffrey N. Younggren & Eric A. Harris, *Can You Keep a Secret? Confidentiality in Psychotherapy*, 64 J. CLINICAL PSYCH. 589, 589 (2008).

103. Walker, *supra* note 5, at 770–71.

104. Kim et al., *supra* note 64; Lösel & Schmucker, *supra* note 68, at 138; SCHMUKER & LÖSEL, *supra* note 4, at 20.

105. See W.L. Marshall & G.A. Serran, *The Role of the Therapist in Offender Treatment*, 10 PSYCH., CRIME, & L. 309, 310 (2004); see also Youssef, *supra* note 82, at 206.

106. See Marshall & Serran, *supra* note 105, at 310.

sessions.¹⁰⁷ However, this list leaves many yet unexplored gaps and questions for future research. In short, there is much we do not know about best practices for MSOT.

However, this study did not focus on the content or quality of therapy, but rather centered on how MSOT operates within the criminal legal system context.¹⁰⁸ Instead of considering the clinical components of MSOT, we examined the macro or structural components of how it operates. We worry that high quality therapy is nonviable when the central focus in therapy is not the client; therapists are busily trying to manage the high stakes of therapy, they lack training and experience, and each stakeholder feels isolated in their need to protect the client. Furthermore, some of the themes¹⁰⁹ (such as those related to a lack of clinician training and a lack of clear definition about success and program completion) may indicate poor quality therapy provided by some therapists. Without addressing these structural components, even the best, most evidence based therapy MSOT could offer may fall short. It is beyond the scope of this study to delve into clinical practices, but we hope that future clinical studies consider the broader ways that systems and agencies impede stakeholder collaboration and impactful clinical intervention.

In the United States, close to a million people are currently required to register as sex offenders¹¹⁰ and many of those people are required to participate in MSOT while incarcerated or in community based settings.¹¹¹ Understanding the issues and challenges associated with the provision of MSOT and the barriers to providing quality therapeutic services within these settings is potentially far reaching for the people who are required to participate. Further, to the extent that MSOT is envisioned as an important tool for both public safety and client rehabilitation and well-being, it is critical to understand the factors that prevent the treatment from effectively serving either function. This is especially true given the high stakes of MSOT; treatment failure can often result in incarceration or further criminal legal sanctioning, which is both harmful to participants¹¹² and expensive for jurisdictions.¹¹³

107. See Levenson et al., *supra* note 82, at 323.

108. See *supra* Part I.

109. See *supra* Part III.

110. See NAT'L CTR. FOR MISSING & EXPLOITED CHILDREN, *supra* note 2.

111. See SCHMUCKER & LÖSEL, *supra* note 4, at 18.

112. Lauren Brinkley-Rubinstein, *Incarceration as a Catalyst for Worsening Health*, 1 HEALTH & JUST. 3, 5–8 (2013); Dora M. Dumont et al., *Public Health and the Epidemic of Incarceration*, 33 ANN. REV. PUB. HEALTH 325, 327 (2012); Dora M. Dumont et al., *Incarceration, Community Health, and Racial Disparities*, 24 J. HEALTH CARE FOR POOR & UNDERSERVED 78, 79 (2013).

113. See CHRISTIAN HENRICHSON & RUTH DELANEY, VERA INST. OF JUST., THE PRICE OF PRISONS: WHAT INCARCERATION COSTS TAXPAYERS 8, 10, 13 (2012).

There are a number of barriers to addressing the significant challenges and limitations that study participants identified about MSOT in its current form, including concerns about the quality of treatment and the potential for causing participant harm. Some of these problems are not unique to MSOT or to people convicted of sex offenses; issues of adequate training and compensation for behavioral health and social service providers,¹¹⁴ complex bureaucratic organizations with competing health and safety priorities,¹¹⁵ and inadequate wrap around supportive services for people with complex health and social needs¹¹⁶ are all deeply rooted and fundamental issues with the American criminal legal and social service infrastructure. However, there are some unique, or at least characteristic, features of MSOT described by our stakeholders that pose particular challenges for progress.

Several of these problems related to definition and measurement. The systems of and around MSOT appeared to rest upon a fairly precarious foundation.¹¹⁷ As demonstrated through the interviews, stakeholders did not align in their basic understanding of who MSOT served, the appropriate nature and duration of MSOT, what other rules and restrictions mandated clients needed to follow, and who retained the power to make and enforce those rules. The ambiguity, confusion, and conflict around core features of MSOT precluded the effective provision of care in many cases and seemed prohibitive to productive conversations about collaboration and improvement. Practically speaking, the high turnover rate of therapists and the constantly changing legal landscape also likely contributed to this ongoing confusion and misalignment.

Additionally, it was unclear how stakeholders measured success. As noted above, most empirical evaluations assessed MSOT effectiveness in terms of criminal recidivism, rather than in terms of any clinical outcome.¹¹⁸ However, that limited practical application on a case by case basis and is an exceptionally limited view of “success.” In this study, treatment completion generally seemed a consideration of the main metric of success by all stakeholders, but the steps to accomplish that goal, or the clinical or practical implications of achieving it,

114. Michal E. Mor Barak et al., *Antecedents to Retention and Turnover Among Child Welfare, Social Work, and Other Human Service Employees: What Can We Learn from Past Research? A Review and Metaanalysis*, 75 SOC. SERV. REV. 625, 655 (2001).

115. Simon Halliday et al., *Street-Level Bureaucracy, Interprofessional Relations, and Coping Mechanisms: A Study of Criminal Justice Social Workers in the Sentencing Process*, 31 L. & POL'Y 405, 424 (2009); see also Walker, *supra* note 5, at 785.

116. Nicole D. Gehring et al., *Social Service Providers on Caring for Structurally Vulnerable Hospital Patients Who Use Drugs: A Qualitative Study*, 22 BMC HEALTH SERVS. RSCH. 1138, 1139 (2022); Janice L. Pringle et al., *Unmet Needs for Comprehensive Services in Outpatient Addiction Treatment*, 30 J. SUBSTANCE ABUSE TREATMENT 183, 183–84 (2006).

117. See *supra* Sections III.A–E.

118. See *supra* notes 57–73 and accompanying text.

often ended up too murky, unstandardized, and open to individual interpretation across stakeholders.¹¹⁹ In the absence of well-defined outcome measures or processes for achieving them, stakeholders struggled to measure participant success, progress, or treatment quality, leading to further strained relationships and continued lack of trust between stakeholders.¹²⁰

Finally, the nature of sex offending, or more accurately, the uniquely visceral reactions that sex offenses and offending generate, provide a challenging context for evaluating and addressing challenges and re-envisioning current policies and practices. We found that participants from all stakeholder groups favored maintaining current MSOT programming and SORN policies in some form, despite serious practical and ideological concerns about their effectiveness and impact on participants.¹²¹ This consistent, if sometimes tepid, endorsement of policies that provide little durable benefit, and indeed make the lives and jobs of all stakeholders *harder*, speaks to the intensity with which stereotypical and hyperbolized conceptualizations of predatory sex offenders are ingrained into societal imaginations.¹²² This unique perceived dangerousness of people convicted of sex offenses, which previously is noted in the literature,¹²³ is a major barrier that stymies imaginative thinking about treatment, punishment, and policy alternatives to current sex offender management regimes.

V. LIMITATIONS

Our study is subject to several limitations. First, our sample size was relatively small, especially once stratified by stakeholder position. Our study began as focused only on therapists; we iteratively increased our scope after completing a first round of interviews. While this expansion improved our study quality, it meant that our recruitment window was shorter and more limited for probation officers and MSOT participants than for therapists. Client participant recruitment proved especially challenging and would have benefited from a longer recruitment window and more intensive recruitment process.

As is typically the case in qualitative interview studies, our project is subject to selection and nonresponse bias; those who chose to participate in our study are likely substantively different than those who declined to participate or who were not exposed to our recruitment materials. While we reiterated study confidentiality, there is also always the potential that social desirability bias

119. *See supra* Section III.D.

120. *See supra* Section III.D.

121. *See supra* Section III.E.

122. *See supra* Section III.E.

123. LANCASTER, *supra* note 31, at 77, 78; Robert Werth, *More than Monsters: Penal Imaginaries and the Specter of the Dangerous Sex Offender*, 25 PUNISHMENT & SOC'Y 977, 982–93 (2023).

influenced the responses that we received from participants. Due to these risks, this study makes no claims at generalizability, and instead aimed to provide an exploratory investigation.

VI. CONCLUSIONS AND FUTURE RESEARCH

This exploratory study investigated the experiences and perspectives of client participants, specialized sex offender probation officers, and MSOT therapists in one large, urban, northeast jurisdiction.¹²⁴ We identified a number of emergent themes that related practically and ideologically to the provision of MSOT. Our themes highlighted structural considerations, such as therapist training and pay, as well as ideological and organizational problems, including high, punitive stakes and misaligned definitions of mission and responsibilities. All of these commonalities posed significant challenges and conflicts for providers and client participants. Underlying these practical and ideological concerns is a pervasive and visceral sense of the potential dangerousness of MSOT participants that colored stakeholder perspectives and decision making. Our findings establish implications for future research, as well as for social work, law enforcement, and legal practitioners working in criminalized therapeutic spaces broadly. To realize the possibility of effective treatment in mandatory settings—which previous literature suggests is possible—new and better strategies are needed for unifying understandings of the definitions, rules, and goals of MSOT uniformly for all stakeholders. Further, efforts are needed to explore how to recenter the humanity and needs of client participants within the context of competing criminal legal and safety priorities that too often demonize and devalue human lives. Because, as therapist Rachel reminded us:

“These folks aren’t monsters. We like to paint these people as the villains and the monsters. They’re just people who’ve made some really unhealthy choices By painting them as monsters, we isolate them and we don’t take accountability as a culture . . . [for] how we create these systems and these dynamics.”

124. *See supra* Part II.