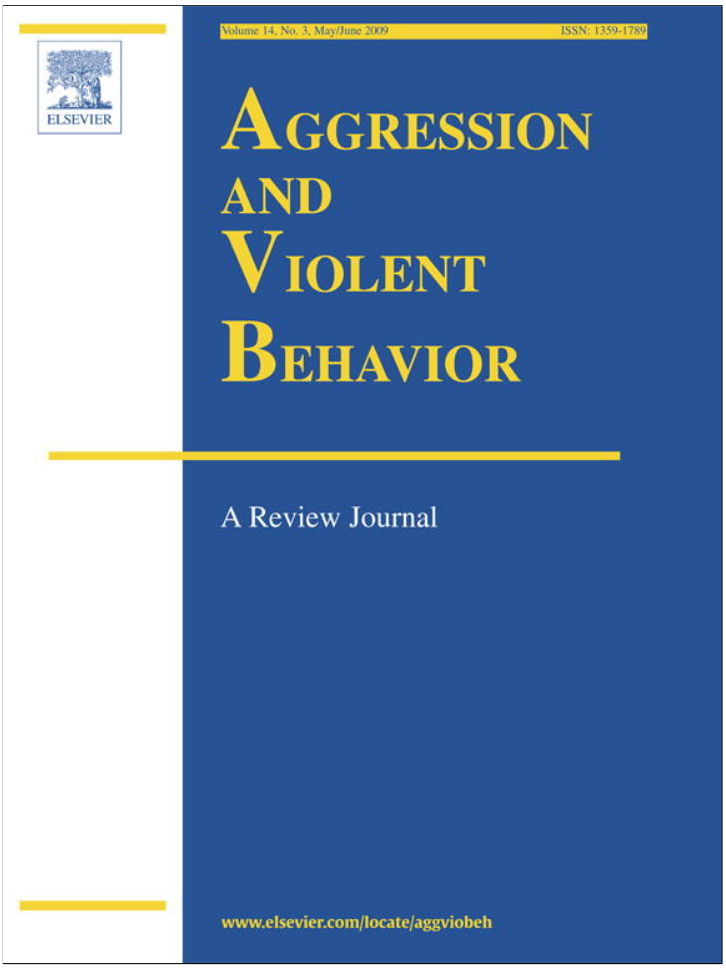

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Effective interventions and the Good Lives Model: Maximizing treatment gains for sexual offenders

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ABSTRACT

The effective risk management of sexual offenders is arguably one of the most contentious social issues of our day. The community is justifiably outraged by what it perceives to be a failure of correctional and mental health practitioners to demonstrate that rehabilitative and supervisory methods promote public safety. Those who treat offenders and attempt to manage risk are often frustrated by what appear, at times, to be emotion-based reactions to low base-rate incidents. The literature on effective correctional programming has produced a workable model—Risk/Needs/Responsivity (RNR)—in which interventions match intensity of treatment to level of risk, specifically target criminogenic needs, and tailor treatment to the personal and interpersonal needs and capacities of participants. However, this model has been criticized regarding an apparent failure to appreciate the totality of client needs, specifically with respect to offender responsivity concerns. The Good Lives Model (GLM) suggests that treatment for sexual offenders must regard participants as whole beings in need of focus in many principal life areas (e.g., family, employment, leisure, community, personal well-being). This article proposes that RNR and GLM are complementary and that, by emphasizing the merits of each, offender management and general well-being can be maximized while community safety is increased.

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The community has demonstrated an increasing intolerance to the presence of sexual offenders, responding in a manner that has been characterized as a "moral panic" (Silverman & Wilson, 2002). Public perception is that sexual offending is epidemic and that exceptionally stringent measures must be taken to ensure public safety. In some respects, this response may have resulted as a consequence of a perceived failure on the part of researchers and treatment professionals to clearly enunciate best practices and the empirical backing required to support those practices. Even now, more than 30 years since Martinson (1974) so famously declared that nothing works, and more than 25 years after Furby, Weinrott, and Blackshaw (1989) found no evidence that sexual offender treatment reduced recidivism, the field continues to debate whether or not there is any reason to believe that sexual offenders stop offending as a result of clinical interventions. However, while researchers and clinicians argue the point, the community has been left to manage the risk, and many of the measures subsequently instituted seem draconian and ill-advised (e.g., colored license plates, wide-spread community notification, 1000 foot

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rules). Like many treatment regimes, a good number of the measures introduced by legislatures and lawmakers have not been subjected to empirical validation. In some cases, the research literature has actually advised against such measures (see Levenson & D'Amora, 2007). Or, it has advocated for repealing or adjusting such measures so they better match the actual risk that sexual offenders pose to the community (Human Rights Watch, 2007).

In this review, we examine two prominent models of offender treatment intervention—the Risk/Needs/Responsivity (RNR) model put forward by Andrews and Bonta (2007) and the Good Lives Model (GLM) as described by Ward et al. (Ward, 2006; Ward & Gannon, 2006; Ward & Stewart, 2003) and as integrated with the Self-Regulation Model (SRM—Ward & Hudson, 1998; Ward, Yates, & Long, 2006; Yates & Ward, 2008). Recent reviews have illuminated the value of each, but have suggested that further consideration is required regarding theoretical underpinnings; particularly, of the RNR model (Ward, Melser, & Yates, 2007). We suggest that an integration of the two models is easily accomplished, and contend that the development and implementation of an integrated strategy would further assist in reducing offender recidivism, while increasing offender self-efficacy, re-integration potential, and community safety.

1. Effective correctional interventions

In answer to the "nothing works" dilemma raised by Martinson (1974), the correctional treatment literature turned its attention to developing best practice models supported by empirical evidence. Andrews, Bonta, and their associates were at the vanguard of the new "what works?" zeitgeist that swept through the corrections literature in the 1990s. In their seminal work "The Psychology of Criminal Conduct", originally published in 1994, Andrews and Bonta (2007) argued that traditional models of sanction and punishment did little to reduce re-offending. Reduced recidivism could only be achieved through the application of human service—correctional programming. Andrews and Bonta further argued that there are relatively simple rules that, if followed, will maximize the benefit of such correctional programming. This perspective has since become known as the RNR model—risk, needs, responsivity—and has gained considerable favor and empirical support in correctional research and practice. Indeed, it has been regarded as the "premier treatment model for offenders" (Ward et al., 2007).

1.1. The risk principle

Simply put, the risk principle decrees that the intensity of correctional interventions must be attendant to the level of risk posed by the offender. Higher risk offenders should receive more intensive interventions, while low risk offenders should be offered lower intensity programs, if any programming at all. Andrews and Bonta's (2007, orig. 1994) research showed that mismatching risk and intensity led to increased offending. Interestingly, this did not apply solely to high risk offenders under-programmed by lower intensity interventions (i.e., those who received a lower than required intensity level); destabilization caused by overprogramming low risk offenders also led to increased recidivism.

1.2. The need principle

The need principle states that treatment programming offered to offenders must principally target those problem areas most related to offending. Termed "criminogenic needs", these problem areas include those demonstrated by research to be linked to offending, and particularly in regard to an individual case. It is these factors that must be targeted in treatment in order to reduce risk for re-offending. Accordingly, for example, sexual offenders require treatment specific to sexual behavior difficulties while alcoholics require substance abuse treatment. Although some secondary gain may be achieved by offering treatment in ancillary domains, recidivism is only decreased by specifically focusing on criminogenic need areas. This principle pointedly targets the oft-observed tendency to offer general, insight-oriented counseling or psychotherapy to offenders, without specific focus on those lifestyle areas that led to offending. In short, treatment must clearly address criminogenic needs in order to be effective.

1.3. The responsivity principle

The responsivity principle requires treatment providers to consider participant characteristics and idiosyncrasies in designing treatment plans and implementing interventions. Issues of cognitive ability, motivation, maturity, and the individual's personal and interpersonal circumstances are among the domains in need of consideration. Treatment plans and methods must be tailored to such issues in order to be most effective. Failure to ensure adequate client motivation for participation or change more often than not results in a failure to achieve maximal gain via programming (Barrett, Wilson, & Long, 2003).

2. Support for the RNR model

The research literature regarding the application of the RNR model of effective correctional interventions includes several meta-analyses. In addition to Andrews and Bonta's (2007) original work, later research (Dowden & Andrews, 1999a,b, 2000, 2003) showed clearly that sanctions alone are unlikely to reduce recidivism. Adherence to the RNR model has clearly been shown in these studies to significantly decrease future offending, particularly when placed in a framework which also attended to environmental and social considerations. In particular, programs which sought to limit antisocial peer affiliation while promoting pro-social values and attitudes were most likely to see decreased antisociality, generally. Warm, supportive, family and friendly support has also been shown to increase rehabilitative success in the community (Wilson, 2007; Wilson, Picheca, & Prinzo, 2005; Wilson, Cortoni, & Vermani, 2007). However, the latter has not been a primary focus of the RNR model, and this is potentially where some of the criticism against it has originated.

While the majority of Andrews and Bonta's work has focused on offenders in general, Hanson (2006) recently demonstrated that these principles also apply to sexual offenders. In his study, Hanson found that adherence to the RNR principles was associated with reduced sexual recidivism, with the most significant effect being found among treatment programs that adhered to all three principles. This important meta-analysis provides evidence for the use of the RNR model in reducing re-offending among sexual offenders, specifically. Simply put, there is good reason to believe that successes achieved in applying sound social learning findings in a multidimensional, cognitive-behavioral framework will be observed every bit as much with sexual offenders as with offenders in general.

3. Problems in the RNR model

A principal criticism of the RNR model has been that its focus on criminogenic needs is a *necessary* but not *sufficient* condition for effective treatment (Ward & Gannon, 2006; Ward et al., 2007, emphasis added). Although it provides a framework for the preparation and evaluation of "effective" programs, the RNR model does not necessarily assist clinicians in choosing intervention styles that best engage offenders in therapy. In particular, knowing or asserting that a focus on risk reduction is important does not necessarily ensure that offenders will be motivated to engage in treatment to that end. Given that lack of motivation is an important responsivity factor in treatment, and that research clearly indicates that individuals who do not complete treatment re-offend at higher rates than those who

complete treatment (Hanson & Bussière, 1998), it is evident that the field cannot afford to ignore interventions designed to better attend to offender responsivity concerns. Furthermore, research in various clinical domains clearly indicates that effective therapist characteristics and behaviors, such as empathy, respect, warmth, and the use of positive reinforcement, are essential to treatment effectiveness, accounting for significant portions of the variance in outcome (Marshall, Anderson, & Fernandez, 1999; Marshall et al., 2003; Marshall, Marshall, Serran, & Fernandez, 2006; Marshall et al., 2002). It is argued, therefore, that it is essential that treatment go beyond the RNR approach if it is to be maximally effective, and that the RNR model's sole focus on risk management does not provide therapists with sufficient tools to engage and work with offenders in therapy, nor to provide offenders with sufficient motivation to engage in the treatment process (Mann, Webster, Schofield, & Marshall, 2004).

Additionally, criticism has suggested that the RNR model tends to "pigeon-hole" offenders into risk categories and, subsequently, treatment streams, without fully attending to critical individual needs. In essence, the RNR model sometimes has difficulty keeping offender responsivity concerns in focus (Ward et al., 2007). In practice, attention to responsivity factors tends to focus predominantly (and inadequately) on offender motivation, to the detriment of other responsivity concerns. From a purely practical standpoint, we have frequently observed that treatment offered to offenders in correctional settings sets out with the best of "responsivity intentions". However, these intentions often go by the wayside as administrative concerns and individual offender quirks are encountered. As such, some of the best responsivity-sensitive interventions are those offered by non-correctional enterprises, for example, Circles of Support and Accountability (COSA—Wilson, 2007; Wilson et al., 2005, 2007), a volunteer-driven approach to supporting high-risk sexual offenders released without formal supervision or treatment. Such an approach also demonstrates how intervention can focus on criminogenic needs (in this case, positive social influences; Hanson, Harris, Scott, & Helmus, 2007) while going beyond this focus in order to address offender responsivity and personal needs. Furthermore, such an approach has been effective in reducing sexual, violent, and other recidivism—significantly so, in comparison to matched control subjects (Wilson et al., 2005). Interestingly, in his meta-analysis of the applicability of the RNR model to various sexual offender interventions, Hanson (2006) noted that the community-based, volunteer-driven COSA project exceeded the threshold to be considered an "effective intervention".

4. Self-regulation and Good Lives Models

Over the past two decades, treatment approaches with sexual offenders have tended to derive from, and reinforce, a punitive, rather than positive, approach to sexual offenders (Ward & Stewart, 2003; Yates, 2004). The still-popular relapse prevention model (Laws, 1989; Pithers, 1990) holds that sexual offending is generally the result of maladaptive problem-solving applied to a negative emotional state, exacerbated by high-risk situational variables (e.g., substance abuse, victim access, deviant fantasies). In contrast, recent advances in sexual offender treatment, specifically the application of self-regulation theory (i.e., Self-Regulation/Pathways Model—Ward & Hudson, 1998), have proposed that individuals follow different offense pathways, including some which begin with positive emotional states. This model acknowledges and better incorporates the multiple and diverse factors that lead to offending, with treatment adjusted accordingly (Yates, 2005, 2007; Yates & Ward, 2008).

In tandem with the recent switch from relapse prevention-based treatment to the self-regulation model, new conceptual formulations of sexual offender specific treatment have recommended utilization of a "Good Lives Model" (GLM) as a broad rehabilitative framework (Ward, 2002; Ward & Stewart, 2003), and the development of an integrated Good Lives/Self-Regulation approach (Ward et al., 2006; Yates & Ward, 2008). In many respects, this represents a return of sorts to elements of Self Psychology (Kohut, 1971), in which clients are encouraged to develop a conscious, reflective personality. Having a better sense of themselves as people will assist offenders in developing a more realistic moral structure and increased interpersonal capacity, ultimately leading to reductions in risk for maladaptive behavior.

In the Good Lives Model, individuals are regarded as active, goal-seeking beings who seek to acquire fundamental primary human goods—actions, experiences, and activities that are intrinsically beneficial to their individual well-being and that are sought for their own sake (Ward & Gannon, 2006; Ward & Stewart, 2003). Examples of primary human goods include relatedness/intimacy, agency/autonomy, and emotional equilibrium, and all humans seek to attain these (Ward, 2002; Ward & Stewart, 2003). Among sexual offenders, risk factors and criminogenic needs may then be seen as symptoms or markers of ineffective or inappropriate strategies employed to achieve these goods or goals. For example, an offender may desire intimacy, but turn to children to meet this need. Essentially, criminal behavior results from problematic methods used to achieve goals, and not from the goals themselves. The aim in treatment is, therefore, not to change the goal (intimacy), but to target the methods the individual uses to achieve the goal (achieving "intimacy" with children). Thus, in treatment, the individual is assisted to identify important goals and to develop the capacity to attain these in non-offending ways (Ward et al., 2006; Yates & Ward, 2008).

The progenitors of the Good Lives Model believe that adding a GLM focus to sexual offender specific treatment will contribute to the reduction of risk and, ultimately, to the protection of society (Ward & Stewart, 2003). Importantly, this approach holds greater promise of motivating offenders to change their behavior by increasing engagement with treatment via increased attention to responsivity needs and a stronger therapeutic alliance (Ward & Stewart, 2003), an approach that is consistent with both the responsivity principle (Andrews & Bonta, 2007), discussed above, and with effective clinical practice (Marshall et al., 1999). In fact, a recent study found that taking a GLM focus to treatment resulted in significantly higher rates of treatment engagement and completion, significantly lower rates of attrition, higher levels of motivation, and greater within-treatment change in areas such as coping skills, as compared to treatment using the standard RP model (Simons, McCullar, & Tyler, 2008).

In the integrated GLM/SRM model (Ward et al., 2006; Yates & Ward, 2008), treatment of sexual offenders should begin by identifying the individual's overarching life goals (i.e., those things the individual values and that form his personal identity), the primary goods implicated in sexual offending, self-regulation capacity, and internal and external barriers and opportunities to attaining goals. This understanding, in conjunction with an understanding of criminogenic needs, leads to the development of a full conceptualization of the individual as a whole, rather than simply as a constellation of risk factors (Yates & Ward, 2008). This is done so that, through treatment, the individual may work toward both personal fulfillment, the achievement of a balanced, self-determined lifestyle (see Curtiss & Warren, 1973), and management of risk to re-offend. Therefore, within this overarching framework, the focus is not only upon reducing risk to re-offend and targeting criminogenic needs, but also on enhancing the offender's capacity to improve his life. In order to achieve this goal, the focus on general welfare therefore becomes almost as important as the focus on inappropriate sexuality (see Wilson, 2007; Wilson et al., 2005; Wilson, Cortoni, Picheca et al., 2007). Treatment is then tailored accordingly to each individual, and aims to both inculcate required skills to address criminogenic needs (using cognitive-behavioral methods), and to develop a "Good Lives Plan"—a plan for living in which the individual is able to fashion a new narrative identity and to actively work toward achieving important goals in life (Yates & Ward, 2008).

Implicit in the GLM is an understanding that sexually inappropriate behavior derives from a complex interaction of offender specific and

environmental factors which spans biological, psychological, and social realms (Ward & Gannon, 2006). Although refraining from engaging in sexually inappropriate behavior is the ultimate goal, the path to reduced risk will necessarily include attention to such important lifestyle domains as "self", "family", "community", "employment", and "leisure". Accordingly, comprehensive treatment programming for persons who have sexually offended must incorporate interventions tailored to address these other areas, including focusing on such domains as substance abuse, anger and emotions management, family and friendly support networks, basic job readiness, and problem-solving skills development, among others.

The GLM fits well with the self-regulation model of offending, specifically, and with the cognitive-behavioral approach to treatment, generally. The focus of treatment based on these models involves the delineation of prosocial goals and strategies to achieve these goals, rather than solely avoiding problematic or high-risk situations (Yates, 2005, 2007). This is particularly important, since such approach goals are more easily attained than are avoidance goals, and are more likely to be maintained in times of stress and crisis than are avoidance goals, which are associated with psychological deterioration during such times (Mann, 1998; Mann & Shingler, 2001). In addition, identification of existing strengths and reinforcement of new skills, essential to treatment (Hanson, 1996), is also facilitated by this approach. In short, this approach utilizes the RNR model, but enhances intervention to focus on the individual as a whole person and aims to assist the offender to attain that degree of psychological well-being expected to assist in risk reduction. This approach also allows treatment to more effectively address responsivity and to better incorporate effective clinical strategies in intervention.

5. Integrating RNR and GLM to maximize treatment gain and reduce recidivism

There has been recent debate in the literature as to whether RNR and GLM might be at odds. Ward et al. (Ward, 2006; Ward et al., 2007) have suggested that the RNR model is too narrow and that it has failed to adopt a positive or constructive approach to treatment. Essentially, the argument is that RNR focuses too much on addressing risk for failure and not enough on increasing the well-being of treatment participants. Ward (2006, p. 112) further suggests that it is "necessary to broaden the scope of correctional interventions to take into account the promotion of human goods". As noted above, these goods are associated with general well-being, and the sort of balanced, self-determinism argued in the life skills model (Curtiss & Warren, 1973).

The literature regarding the RNR model clearly demonstrates its utility and effectiveness in reducing risk. To paraphrase Abracen and Looman (2005), we have moved beyond the question of "What works?" into the realm of "What works best?". We are always compelled to look for ways to maximize reductions in re-offending. It would seem that an integration of RNR and the GLM might assist us in achieving those additional reductions in recidivism by focusing on problem areas and offering interventions commensurate with risk and need, while ensuring consumer buy-in and attending to the overall well-being and pro-social functioning of offenders. This would seem to be an admirable treatment goal.

Because the GLM, and to some extent the SRM, are in their relative infancy with respect to their application to intervention, less direct research support is available than currently exists for the RNR. However, research to date has provided validation for the self-regulation model and its attendant pathways (Bickley & Beech, 2002, 2003; Keeling, Rose, & Beech, 2006; Proulx, Perreault, & Ouimet, 1999; Ward, Louden, Hudson, & Marshall, 1995; Webster, 2005) and its relationship to static and dynamic risk factors among sexual offenders (Yates & Kingston, 2006; Yates, Kingston, & Hall, 2003). Research also supports the utilization of the GLM in treatment, as described above, with respect to treatment gain and increased treatment engagement (Simons et al., 2008), as well for the relationship between the development of a new narrative or personal identity and desistance from crime among offenders generally (Maruna, 2001).

In offering comprehensive treatment programming to persons who have sexually offended, there are several considerations that must be taken into account. First, there are greater stakes at hand in regard to these clients and the risk they pose, in comparison to the risk posed by many other types of offenders. Sexual offenders released to the community are held to a much higher standard and, indeed, most citizens hold that even one sexual recidivist is too many. Consequently, there is a tendency to advocate longer sentences and more stringent controls for sexual offenders. To reiterate, the literature (Hanson & Bussière, 1998; Hanson & Morton-Bourgon, 2004) is clear that sexual re-offending is the result of a complex interaction of offender specific and environmental factors which span biological, psychological, and social realms. As such, simply focusing on issues of containment, without attending to offenders as whole beings, will ultimately fail to maximize reduction of risk to the community.

To truly address risk for sexual offending, we must attend to skill deficits and psychological needs in a number of domains. First, intensity of treatment must be in line with the level of risk posed by the offender (see Abracen, Looman, Mailloux, Serin, & Malcolm, 2003; Hanson & Yates, 2004; Mailloux et al., 2003; Marshall & Yates, 2005). Second, programming must specifically address the various lifestyle areas identified during assessment and ongoing intervention as contributing to risk. We must remember that sexual offending is a multi-faceted problem, with problematic behavior and attitudes existing in a number of domains. Thus, for example, simply focusing on inappropriate acquisition of intimacy is unlikely to truly address risk overall. In keeping with the need principle of the RNR model, our principal concern in treating sexual offenders must be the risk of future sexual offending, as that is the area that puts them most at odds with society. Current literature, reviewed here, strongly suggests that comprehensive approaches are most likely to be effective in the risk of re-offending. Indeed, the literature is replete with evidence that sexual offense risk is mediated by such concerns as alcohol and substance abuse, poor problem-solving skills, dysregulation of emotion, self-regulation deficits, mental health difficulties, and other treatment-complicating factors. In order to truly address the totality of risk, we must consider all of these areas, and do so in a manner that treats the whole person and that aims to increase psychological well-being.

In addition to paying attention to the two aspects of the RNR model that are traditionally emphasized, it is clear that treatment programming must *truly attend* to issues of responsivity in attempting to maximize gains and overall reintegration potential. In offering effective interventions, consideration of treatment readiness (Cullen & Wilson, 2003) is a necessity, as is attention to approaches that seek to engage clients, rather than simply require that they "do what we want them to" (see Marshall, Thornton, Marshall, Fernandez, & Mann, 2001). Further, it is clear that we must do more to engage those we want to change in the process of change, which will require consistent effort to gauge how offenders are "doing" in treatment, as "whole" persons. It is incumbent on treatment providers to remember that offenders in treatment must have something to work toward, in terms of future planning. As lofty a goal as it may be, treatment providers must assist offenders in recognizing not only their difficulties and problem areas, but also their strengths and goals so that they can ultimately achieve well-being and the sort of balanced, self-determined lifestyle promoted by the Good Lives Model.

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