The Good Lives Model (GLM): An Evaluation of GLM Operationalization in North American Treatment Programs

Gwenda M. Willis¹, Tony Ward², and Jill S. Levenson³

Abstract
The good lives model (GLM) has become an increasingly popular theoretical framework underpinning sex offender treatment programs, and preliminary research suggests that the GLM may enhance the efficacy of programs that adhere to the Risk, Need, and Responsivity (RNR) principles. However, this potential rests on the appropriate operationalization of the GLM in practice. Operationalized appropriately, the GLM aims to facilitate risk reduction alongside equipping clients with the tools to live personally meaningful and fulfilling lives. However, misguided operationalization of the GLM could result in ineffective treatment and ultimately higher rates of reoffending. This article presents findings from a multisite study exploring how the GLM has been operationalized and the degree to which the GLM has been integrated in a sample of 13 North American treatment programs. A comprehensive coding protocol was developed that included items related to program aims and client induction/orientation, assessment, intervention planning, intervention content, and intervention delivery. Each site was visited and items were rated through a review of program documentation, interviews with program directors/managers, and observations of treatment groups. Findings from inductive (how the GLM was operationalized) and deductive (the extent to which the GLM was integrated) analyses are presented and GLM consistent and inconsistent practices.

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are highlighted. The article concludes with suggestions for ways in which program responsiveness to the GLM could be enhanced.

**Keywords**
good lives model, sex offenders, offender rehabilitation

Enhancing the effectiveness of treatment programs for sexual offending is a central aim for researchers and practitioners whose work focuses on the tertiary prevention of sexual assault. Taken as a whole, research supports the efficacy of programs that adhere to the principles of Risk, Need, and Responsivity (RNR; Andrews & Bonta, 2010). In a recent meta-analysis, Hanson, Bourgon, Helmus, and Hodgson (2009) showed that greater adherence to the RNR principles was associated with larger reductions in sexual recidivism. Although GLM empirical research is in its infancy, preliminary research suggests that the efficacy of treatment might be further enhanced through integration of the good lives model (GLM; Laws & Ward, 2011; Ward & Maruna, 2007; Ward & Stewart, 2003) into sex offender treatment programs (e.g., Gannon, King, Miles, Lockerbie, & Willis, 2011; Simons, McCullar, & Tyler, 2006). The GLM is a strengths-based rehabilitation framework that has become increasingly popular with sex offender treatment providers (McGrath, Cumming, Burchard, Zeoli, & Ellerby, 2010). However, little is known about how the GLM is being operationalized in practice, nor the degree to which programs purporting its use actually adhere to its core principles. Operationalized appropriately, the GLM offers potential for improving outcomes of programs operating in accordance with the Risk, Need, and Responsivity (RNR) principles. Conversely, misguided application of the GLM could increase the very risk practitioners work to prevent and manage. In this article we present findings from an exploratory study investigating the current operationalization of the GLM in a sample of North American sex offender treatment programs.

**Program Fidelity to Rehabilitation Theory**

A solid theoretical grounding provides practitioners with a roadmap for applying evidence-based interventions at the appropriate times. It provides a structured approach to rehabilitation that makes sense to the practitioner, and most importantly, to the client. Working primarily from treatment theories (e.g., cognitive behavioral therapy) as opposed to rehabilitation theories makes it harder for practitioners to keep the reintegration “big picture” in mind and to grasp how the diverse elements of an offender’s intervention plan cohere. Evaluating program fidelity to theoretical frameworks comprises a central component of evaluating program integrity, or the degree to which a program is delivered as intended (Hollin, 1995). Large meta-analyses investigating the effectiveness of offender rehabilitation programs have consistently shown that
adherence to the RNR principles is associated with enhanced treatment effectiveness (e.g., Andrews & Dowden, 2005; Andrews, et al., 1990, Hanson, et al., 2009). Briefly, the Risk principle states that the dosage or intensity of interventions should match an offender’s risk level, such that intensive interventions are directed at high risk offenders and less intense (or no) interventions are aimed at lower risk offenders. The Need principle informs intervention targets, and more specifically that interventions should target criminogenic needs—or dynamic risk factors—which are the factors causally related to offending that, for a given individual, are changeable. Dynamic risk factors for sexual offending include deviant sexual interests and problems with general and sexual self-regulation (e.g., Hanson & Morton-Bourgon, 2005). Finally, the Responsivity principle informs the actual delivery of interventions to maximize their efficacy. Consideration is given to motivation, cognitive ability, learning style, culture, and other characteristics of individual offenders, and delivering treatment accordingly. The GLM is a strengths-based rehabilitation theory that builds on the RNR and has been operationalized in practice (e.g., Willis, Yates, Gannon, & Ward, 2013; Yates, Prescott, & Ward, 2010); however, no previous studies have explored program consistency to the GLM.

The Good Lives Model (GLM)

The GLM theory has been described extensively elsewhere (e.g., Laws & Ward, 2011; Ward & Maruna, 2007), thus only a brief description is provided here. The GLM was designed to augment the RNR and incorporates the dual aims of risk reduction and well-being enhancement. Using the GLM, a central focus of rehabilitation is on promoting pro-social attainment of primary human goods, broadly defined as: (a) life (including healthy living and functioning and basic survival); (b) knowledge (learning, knowing); (c) being good at, or excelling in work and hobbies/recreational pursuits; (d) personal choice and independence;1 (e) peace of mind (i.e., freedom from emotional turmoil and stress); (f) friendships and relationships (including intimate, family, and friend relationships); (g) experiencing a sense of community (i.e., belonging to a group); (h) spirituality (in the broad sense of having meaning and purpose in life); (i) happiness; and, (j) creativity (e.g., Ward & Gannon, 2006; Yates & Prescott, 2011a). Although it is assumed that all human beings seek to attain most, if not all primary goods, to some degree, the weightings or priorities given to specific primary goods reflect individuals’ particular values and life priorities. Instrumental or secondary goods represent the concrete means of achieving primary goods, or the activities people engage in to meet their overall goals in life. For example, the primary good of knowledge might be met through attending university, and the primary good of community might be met through belonging to and participation in a sports or cultural group.

Within the GLM, criminogenic needs are conceptualized as barriers toward attaining primary goods in pro-social ways. Criminogenic needs might reflect harmful secondary goods (e.g., relying on antisocial peers to achieve the good of friendships, abusing drugs to achieve peace of mind) or more general barriers to attainment of
primary goods (e.g., poor emotion regulation might block attainment of peace of mind; impulsivity might block attainment of personal choice and independence, being good at work and/or play). The GLM assumes that offending results from problems or flaws in the pursuit of primary goods, that is, flaws in an individual’s Good Life Plan. Importantly, these flaws relate to problems with secondary goods—the activities/means individuals use to achieve primary goods—and not the primary goods themselves (Ward & Gannon, 2006; Ward & Maruna, 2007). For example, an individual may seek out the primary good of relationships through sexual offending against a child. Additional problems or flaws in the pursuit of primary goods include a lack of scope in a GLP, in that an individual’s GLP may be overly narrow and neglect important goods; conflict between valued primary goods and/or the secondary goods (i.e., means) used to secure primary goods (i.e., the pursuit of one primary good lessens the chances of another good being secured); and a lack of internal and/or external capacity to attain primary goods in pro-social ways. Problems with capacity include criminogenic needs, for example poor problem-solving or affect regulation skills (problems with internal capacity), and a lack of pro-social associates and employment opportunities (problems with external capacity). In addition to reducing and/or managing risk to reoffend, treatment aims to assist clients to obtain primary goods in nonharmful ways and overcome flaws in their GLP. Practice implications of the GLM are outlined in the Method section, where we describe our approach to evaluating program consistency to the GLM.

Owing to its more recent development, the evidence basis for GLM-informed interventions is far less advanced than the RNR, however preliminary research suggests that the GLM may enhance outcomes of programs that adhere to the RNR principles (for a summary of relevant research, see Willis & Ward, in press). For example, Simons et al. (2006) found that offenders who received a GLM approach to treatment planning ($n = 96$) were more likely to complete treatment and remain in treatment longer compared with offenders who received RP-based treatment planning ($n = 100$). Pre- and posttreatment comparisons on a range of measures (including social skills, victim empathy, problem-solving, and coping skills) revealed that clients in the GLM group improved similarly, or better than, clients in the RP group.

**The Present Study**

Although the GLM has potential to enhance the effectiveness of sex offender treatment programs, this potential rests on the correct operationalization of the GLM in practice. Operationalized appropriately, the GLM aims to facilitate risk reduction alongside equipping clients with the tools to live personally meaningful and fulfilling lives. However, misguided operationalization of the GLM could result in ineffective treatment and ultimately higher rates of reoffending, for example through neglecting the RNR principles on which the GLM builds. How GLM related ideas have been operationalized, and the degree to which the GLM has been integrated in programs that purport to use the model, have not been evaluated. A recent survey of sex offender treatment providers found that one third of U.S. programs and half of Canadian programs
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for adult males report that they used the GLM as one of the three main theories informing their treatment approach (McGrath, et al., 2010). What this means, however, remains unknown. The aims of the present study were twofold: to explore how the GLM has been operationalized in a sample of North American treatment programs, and to systematically evaluate the degree to which the GLM has been integrated throughout such programs. Accordingly, the first aim was exploratory and data-driven (inductive), whereas the second aim took a deductive approach. In addition, the current study sought to investigate factors that helped and hindered programs from adopting a GLM approach. Given the exploratory nature of the study, no specific hypotheses were formulated.

**Method**

**Sample**

Treatment providers in the United States and Canada who reported using the GLM as a main theory informing their treatment approach were invited to participate in the current study. Potential participants were informed that the research aimed to explore how principles of the GLM had been operationalized in group-based treatment programs for adult male sex offenders. Given the exploratory nature of the current study, no further inclusionary criteria around how treatment providers had integrated the GLM were specified. To obtain a comparable sample of programs, juvenile programs and adapted programs (e.g., programs exclusively for clients with Learning Disabilities) were excluded. Programs were recruited between December 2010 and February 2011 via the Association for the Treatment of Sexual Abuser’s (ATSA) email list serve and through the researchers’ North American colleagues. The ATSA list serve is an electronic mailing list distributed to approximately 2000 ATSA members, primarily in North America (D. Prescott, personal communication, November 27, 2012). During the time period allocated for data collection, treatment providers from 27 programs expressed interest in participating in the study. Lengthy research approval processes meant that some of these programs could not be included (n = 10), and other programs did not meet inclusionary criteria because they were located outside the United States or Canada (n = 2), were juvenile programs (n = 1), or provided treatment exclusively to clients with a Learning Disability (n = 1). Thus, the final sample comprised of 13 treatment programs for adult males operating in prison (n = 6), community (n = 5), and civil commitment centre (n = 2) settings. The sample included 10 U.S.-based programs, and three Canadian programs. All of the Canadian programs were prison-based. A response rate could not be calculated because it was unknown how many programs advocating a GLM treatment approach were represented on the ATSA list serve.

**Measures**

**Semi-structured Interview.** A semi-structured interview containing 15 questions was constructed for use with program directors/managers to explore how the GLM was
conceptualized and operationalized, to identify factors that helped and hindered efforts to adopt a GLM approach, and to identify materials (e.g., therapist manuals, participant workbooks, client consent forms, etc.) required to evaluate the degree to which the GLM was integrated throughout each program.

**Coding Protocol.** A coding protocol was developed for the current study to evaluate the degree to which the GLM was integrated across five domains of a treatment program: overall aims and client induction/orientation, assessment, intervention planning, intervention content, and intervention delivery. The protocol contained 11 items, which described GLM consistent practice in each domain. A brief description of each item follows. An elaboration of GLM consistent practice across each domain is provided in Willis, Yates, Gannon, and Ward (2013).

**Program aims and orientation**

1. The aims of the treatment program include both risk reduction and well-being enhancement. These dual aims are integrated such that reducing risk is a fundamental step toward implementing a Good Life Plan. Program aims are communicated clearly to clients through the name of a program and any associated workbooks, treatment consent forms or contracts, and any other introductory material clients receive that describe the program.

**Client assessment**

2. Static and dynamic risk factors are routinely assessed using empirically supported measures such as the Static-99 (Hanson & Thornton, 1999) and Stable-2007 (Hanson, Harris, Scott, & Helmus, 2007).
3. Clients’ heavily weighted primary goods are identified through exploring clients’ future goals and priorities as well as goods evident in offending.
4. The full range of primary goods are assessed, including identifying the level of importance placed on each good, means used in the past and currently to attain the good (i.e., secondary goods), and any problems in capacity to attain the good.

**Intervention planning**

5. Individualized intervention plans are constructed for each client using information collected through assessment. Intervention plans revolve around the attainment of heavily weighted goods and reduction of risk. In practice this means that the majority of components of an intervention plan revolve around the prosocial attainment of clients’ valued goods (as opposed to program goals). Intervention plans show broad scope (e.g., containing vocational and educational components if relevant), are forward looking, and have elements intended to assist the client acquire the internal and external conditions necessary to
eventually implement their Good Life Plan (including addressing dynamic risk factors through evidence-based interventions). Intervention plans form the basis of a Good Life Plan produced at the end of the program.

Program content

6. Program components attend to goods promotion alongside risk reduction. All components/modules/assignments in a program are linked to the promotion of primary goods rather than simply the reduction of dynamic risk factors. More specifically, goals of each component/module/assignment are framed using approach goals (e.g., in treatment manuals, offender workbooks) and linked to the fulfillment of primary goods. The final component/module/assignment of a program involves clients consolidating their Good Life Plan (or equivalent).

7. Program content attends to the full range of primary goods, either through modules or assignments that explicitly target one or more primary goods (e.g., a relationship skills module designed to develop client capacity to satisfy the primary good of relatedness), or through the format of group sessions (e.g., using “claim time” or “check in” discussions at the beginning of group sessions to address primary goods not directly targeted by specific program components/modules).

8. Programs aim to promote clients’ social capital through attending to clients’ social ecology. Comprehensive discharge planning involving external people or agencies is a routine component in residential programs. In community-based programs attention to clients’ social ecology could be demonstrated through support meetings and assisting clients link in with services/activities consistent with their Good Life Plans.

Program delivery

9. Therapists approach clients in a manner that acknowledges their status as fellow human beings, of equal intrinsic value. Therapists’ attitudes and language around clients convey respect, and therapists display characteristics empirically associated with treatment change, specifically displays of warmth, empathy, praise, some directedness and no confrontation (Marshall, 2005; Marshall, et al., 2003). Displays of confrontation, hostility, labeling, reference to clients as simply bearers of risk, and/or disrespecting clients pursuing important values (e.g., shutting down a conversation relating to a client’s own pursuit of goods) are all inconsistent with a GLM approach. In the current study, therapist characteristics empirically associated with treatment change were rated using the same 5 point Likert-type scale used in Marshall et al. (2002): a score of 1 indicated that “the behavior did not occur,” 3 indicated that the behavior “usually occurred or the skill was displayed at an average level,” and 5 indicated that “the behavior occurred on all appropriate occasions or the skill was displayed at the excellent level” (p. 104).
10. The therapist seeks to collaborate with clients throughout the program (e.g., treatment goals collaboratively arrived at); and program delivery is transparent such that results of assessment procedures including psychometric testing and risk assessments are discussed with clients.

11. Intensity, content, and process of intervention delivery are individually tailored. The intensity and content of interventions are individually tailored according to each client’s intervention plan. For example, a client valuing relatedness who has poor interpersonal skills receives a higher intensity of interventions designed to satisfy this good compared with a client who doesn’t place as much emphasis on interpersonal relationships and/or has well-developed interpersonal skills. Clients only receive those interventions directly related to their intervention plan. For example, clients exhibiting no deviant sexual preferences don’t complete arousal reconditioning interventions. Finally, a tailored process refers to the systematic delivery of modules/interventions, such that clients are continually reminded how each module/intervention coheres with their unique intervention plan. In other words, a client’s intervention plan guides interventions received, rather than a manual.

Procedure

Information about the current study was posted to the ATSA list serve and distributed among the researchers’ North American colleagues. These initial postings included a brief description about the research and program eligibility criteria. Potential participants were advised that they would receive a written report from the researchers detailing program adherence to the GLM at the conclusion of the study. Treatment providers expressing interest in the research were asked to contact the first author for more detailed information. Research approval was sought from treatment providers continuing to express interest in the study and who were able to accommodate data collection in the allocated time frames.

The first author visited each program between March 2011 and July 2011. The length of program visits was informed by the frequency of group sessions, such that programs operating multiple groups per week could be visited in two days whereas programs with fewer groups required longer. Each visit began with an interview with the program director(s)/manager(s), using the semi-structured interview schedule described in the Method section. Given that recording devices were generally not permitted, the first author took notes during each interview, which were recorded verbatim as much as possible.

Materials identified through the semi-structured interview required to evaluate programs against each item of the coding protocol were reviewed, including program manuals, client workbooks, client assignments, treatment contracts, assessment templates, and treatment planning templates. When the researcher wished to clarify aspects of the program, a small sample of files of consenting clients was also reviewed. This was particularly useful for examples of treatment/intervention plans. Attempts were made to observe two group treatment sessions at each program, which was
possible at all but one program where one session was observed. Evidence for and against program consistency with each item of the coding protocol was recorded.

Two sets of data analyses were conducted. First, inductive thematic analyses were conducted on responses to selected questions of the semi-structured interview to identify overall themes for how the GLM was operationalized, and what helped and what hindered adoption of the GLM. Second, program consistency to the GLM was evaluated against the items described in the coding protocol. Based on the variance observed, an overall rating system was developed to rate the degree to which programs integrated the GLM throughout.

This research was conducted after review and approval by the Victoria University of Wellington Human Ethics Committee (a New Zealand Institutional Review Board equivalent), and relevant review bodies at each participating program.

Results

Results are divided into two sections: (i) current operationalization of the GLM in North American sex offender treatment programs, and factors considered to facilitate and impede adopting a GLM approach, and (ii) a description of the degree to which programs operated according to the items in the coding protocol.

Operationalization of the GLM and Factors Considered to Facilitate and Impede Adoption

Three sets of thematic analyses were conducted on program directors/managers’ responses to (i) how they had operationalized the GLM, (ii) what has helped in their efforts to implement the GLM, and (iii) what had hindered their efforts to implement the GLM. Thematic analyses followed the procedure outlined in Braun and Clark (2006). Consistent with the exploratory nature of these questions, each analysis was inductive (i.e., data-driven as opposed to deductive or theory driven); and semantic (as opposed to interpretative). The first author and a research assistant conducted each analysis independently and reached a consensus through discussion on the final themes, after which the prevalence of each theme across the sample was counted, and interrater reliability calculated. Findings for each thematic analysis follow.

Operationalization of the GLM. The first author identified 11 themes in directors’ responses to how they had operationalized the GLM, and the research assistant independently identified 15 themes. The additional themes identified by the research assistant could be collapsed into the themes identified by the first author, thus 11 themes were agreed upon by mutual consensus. A description of each theme and examples of directors’ responses fitting with each theme follows. Themes are described in order of prevalence, with the more prevalent themes described first.

1. Program framing. The aims of various program components (e.g., assignments, modules) were reframed under the auspices of the GLM through utilizing
approach goals instead of avoidant goals, and emphasizing coping over avoid-
ing. For example, one respondent reported that “treatment goals are framed as
approach goals.” Similarly another respondent noted that “the focus of the pro-
gram is on how to attain health, independence, inner peace, mastery, satisfac-
tion . . . rather than on what we want them to stop.”

2. Aftercare. The GLM was integrated through the addition of an extra phase or
module at the end of the program, or through amending existing final modules/
phases. To illustrate, one respondent reported that “phase three was added and
was specifically designed based on the GLM.” Other respondents described
replacing traditional Relapse Prevention plans with “Life Management plans.”
For example, one respondent reported that “Life management plans are the main
way we have incorporated the GLM.” Life management plans typically included
components of traditional RP plans (e.g., identification of warning signs, high
risk situations, and coping strategies), with the addition of a “Good Lives Plan,”
which required clients to identify how they were going to meet their needs (or
GLM primary goods) in healthy ways, and associated release plans.

3. GLM practice elements. The GLM was integrated through the inclusion of
GLM related assignments, exercises, or explicit discussion. For example, one
respondent described a “Good Life wheel assignment” in which clients rated
how satisfied they were in relation to each of the primary goods (referred to as
“domains”), and set goals in relation to domains they are least satisfied in.
Another respondent noted that “we have an explicit discussion on the GLM to
help clients to identify their needs and goals.”

4. Individual focus. Rather than adopting a one-size-fits-all philosophy, treatment
was tailored according to individual client needs. For example, one respondent
described the construction of “integrated care plans” for each client, which
were developed according to the treatment specific and broader needs (e.g.,
spiritual, recreational, vocational, etc.) of each client. Another respondent
reported that “individual [client] goals are developed alongside the manual
goals” for each treatment module.

5. Holistic focus. Program content addressed an array of client needs and in doing
so attended to noncrimogenic needs in addition to criminogenic needs. For
example, one respondent reported that their program had “adopted a holistic
model aimed at instilling positive values,” which was achieved through atten-
tion to sexuality, recreation, work, school, arts/crafts, and so on. The same
respondent stated that “staff are constantly trying to find ways to give more
options to [clients] . . . ” Another respondent reported that their program placed
a strong emphasis on “how to live a healthy life” and that “staff have always
believed in the importance of assisting clients live a healthy life, and finding
things to do instead [of offending].”

6. Positive and respectful form of delivery. Clients were approached as fellow
human beings, with dignity and respect; and therapists approached clients in a
positive manner. For example, one respondent noted that “our program adopts
a positive, motivational approach.” Similarly, another respondent reported that
their program aimed to “create a positive, fun environment which humanizes [clients] and gives them the opportunity to practice social skills as well as focus on important issues.”

7. **Adopted a strengths-based approach.** Therapists explicitly identified and reinforced client strengths. For example, one respondent noted that staff were “more intentional about clients identifying their strengths . . . ” Another respondent reported that at the end of each group session, participants were encouraged to praise a fellow group member for something they’re doing well.

8. **Greater emphasis on the social environment.** Efforts were made to create an environment outside the group room that fostered working toward treatment goals. For example, one responded reported that custodial staff received training in the philosophy of the program. Another respondent described bringing in outside people (including support people, volunteers, and professionals) for prerelease meetings.

9. **Focus on developing clients’ skills.** Skill development was emphasized over fixing and/or managing deficits and problems. For example, one respondent noted that “it’s about developing skills for clients to independently address vulnerabilities and develop strengths.” Another respondent reported that they focused on helping clients practice pro-social relationships in prison and take those skills back to the community.

10. **Program foundations.** The GLM was embedded in the foundations of the treatment program. For example, in one program the “Good Life” was introduced to clients at the outset of the program, and pictorially displayed as a lifestyle wheel, with primary goods grouped according to four areas—feeling good (satisfaction, inner peace, free of worry, and stress etc.), clear thinking/healthy decisions (clear and balanced thinking, healthy beliefs about the self, others, and the world), freedom and personal control (e.g., enjoy work and play, look after self, free of pain), and good relationships/support. Treatment targets (i.e., skills clients need to achieve these various Good Life elements) were mapped onto these four areas (i.e., problem-solving, affect regulation etc.). The “opposite life” was also pictorially represented with the same four segments (e.g., feelings = feel numb and empty, sad, unhappy, depressed etc.; freedom and personal control = can’t do what want to do, can’t work or keep a job, etc.). Clients were informed that treatment aims to move them away from the opposite life and toward the good life. Another program integrated the GLM in the program foundations through naming the program after the GLM, constructing their own manual that addressed GLM related ideas throughout, and displaying posters depicting elements of the GLM in group rooms.

11. **Fit with existing therapeutic orientation.** The GLM had several parallels with respondents’ approach to sex offender treatment prior to the development of the GLM. For example, one respondent noted that the GLM was “fitting with my therapeutic philosophy.” Another respondent reported that “it’s not really a GL program, I happened on it . . . it’s always been my orientation—looking at the whole person and dealing with all areas of need to help them make changes.”
Table 1 provides prevalence counts for each theme, and interrater reliability of prevalence counts. Interrater reliability was determined by (i) calculating the percentage of programs where the first author and a research assistant agreed on whether a theme was present or absent, and (ii) using Cohen’s κ. Cohen’s κ values ranged from 0.70 to 1.00, with an average of 0.93, demonstrating excellent reliability.

**Factors Supporting Adoption of a GLM Approach.** The first author identified seven themes in directors’ responses to factors supporting their adoption of a GLM framework. A research assistant independently identified five themes, of which one could be split to match the seven themes identified by the first author, thus seven themes were agreed upon. A description of each theme and examples of directors’ responses fitting with each theme follows. Themes are described in order of prevalence, with the more prevalent themes described first.

1. **Clients responsive.** Clients were better engaged in treatment following the introduction of GLM concepts. For example, various respondents indicated that “participants buy into it,” “clients respond well,” “the clients get it,” and “clients embrace the GLM approach.”

2. **Treatment staff responsive.** Treatment/therapy staff were responsive to a GLM approach. For example, respondents noted that “clinical staff are that way inclined,” “staff like it . . . because it sounds intuitive,” and “therapists buy into it.”

3. **Relevant literature.** Academic publications on the GLM and related areas (e.g., positive psychology) assisted in adopting a GLM approach. For example, one program noted that the Yates et al. (2010) book *Applying the Good Lives and Self-Regulation Models to Sex Offender Treatment: A Practical Guide for Clinicians* had been particularly useful, and another respondent indicated that “the positive psychology literature and Tony Ward’s papers” had assisted them.
4. **Professional community.** Conferences, email list serves, and relevant training assisted respondents integrate the GLM—for example, the annual ATSA conference and the ATSA list serve.

5. **Fit with existing therapeutic orientation.** The parallels between the GLM and other approaches used prior to its development promoted adoption of a GLM approach. For example, one respondent stated that the GLM’s emphasis on therapeutic process assisted them, “because we know that’s important.” Another respondent noted that the GLM helped clarify specifics of the four quadrants model through attending to each of the primary goods rather than four life domains. In this way the GLM helped clients recognize and articulate what was important in their lives.

6. **Support from program administration.** Program administration was supportive of treatment staff integrating the GLM. For example, one respondent reported that they had support from the Director of Prisons and Deputy Director of Prisons. Another respondent noted that the “[administrative body] are generally supportive because they don’t have the knowledge I do . . . and therefore support whatever I recommend.”

7. **External support.** Key stakeholders external to the program adopted a similar approach and/or treatment staff had actively engaged external people in their program philosophy. For example, one respondent reported that Probation and Parole officers they worked with “have the same philosophy when it comes to wanting to help clients live a better life.” Another respondent described “bringing in the people you don’t want there,” including Police and prosecutors.

Table 2 provides prevalence counts for each theme, and interrater reliability of prevalence counts. Interrater reliability was determined by (i) calculating the percentage of programs where the first author and a research assistant agreed on whether a

<table>
<thead>
<tr>
<th>Theme</th>
<th>Prevalence (N = 13)</th>
<th>Interrater Reliability (% Agreement)</th>
<th>Interrater Reliability (Cohen’s κ)</th>
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<tbody>
<tr>
<td>Clients responsive</td>
<td>9 (69%)</td>
<td>13/13 (100%)</td>
<td>1.00</td>
</tr>
<tr>
<td>Treatment staff responsive</td>
<td>5 (38%)</td>
<td>12/13 (92%)</td>
<td>0.83</td>
</tr>
<tr>
<td>Literature</td>
<td>4 (31%)</td>
<td>13/13 (100%)</td>
<td>1.00</td>
</tr>
<tr>
<td>Professional community</td>
<td>4 (31%)</td>
<td>13/13 (100%)</td>
<td>1.00</td>
</tr>
<tr>
<td>Fit with existing therapeutic orientation</td>
<td>4 (31%)</td>
<td>12/13 (92%)</td>
<td>0.83</td>
</tr>
<tr>
<td>Support from program administration</td>
<td>3 (23%)</td>
<td>13/13 (100%)</td>
<td>1.00</td>
</tr>
<tr>
<td>External support</td>
<td>3 (23%)</td>
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<td>1.00</td>
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theme was present or absent, and (ii) using Cohen’s $\kappa$. Cohen’s $\kappa$ values ranged from 0.83 to 1.00, with an average of 0.95, demonstrating excellent reliability.

**Factors Hindering Adoption of a GLM Approach.** The first author and research assistant both identified the same six themes in directors’ responses to factors that hindered their adoption of a GLM approach. A description of each theme and examples of directors’ responses fitting with each theme follows. Themes are described in order of prevalence, with the more prevalent themes described first.

1. **Policy and law.** Policy and law surrounding sex offender management created barriers for adopting a GLM approach. Several respondents indicated that parole and probation requirements were not conducive to a GLM approach—for example, one respondent reported that Parole and Probation Officers “have the final say and take a hard approach.” Another respondent reported that the legislature was very punitive and against GLM ideas, stating that “they’re non-treatment oriented and don’t like to see sex offenders released.” Other respondents gave specific examples, such as “laws—primarily housing” were a hindrance.

2. **Lack of resources.** A lack of resources and staffing created barriers to adopting a GLM approach. One respondent commented on the lack of written treatment manuals, and another respondent reported that constructing extensive treatment plans was difficult due to staffing and time constraints.

3. **Punitive societal attitudes toward sex offenders.** Negative societal attitudes toward sex offenders created barriers toward adopting a GLM approach. For example, one respondent indicated that “negative societal attitudes” hindered what they could do, and that “some of the custody staff also have negative attitudes.” Another respondent reported that “there’s a belief out there that these clients are unchangeable.”

4. **Community barriers.** Outside the barriers imposed by policy and law, additional community barriers hindered the adoption of a GLM approach. For example, one respondent commented on the lack of community-based mental health and social services. Other respondents described problems clients experience finding employment.

5. **Program administration.** While some respondents indicated that program administration supported their attempts to integrate the GLM, some respondents reported program administration as a barrier. For example, one respondent reported that “the only occasional barrier is my own senior management.” Another respondent stated that she’s faced with management telling her “there’s not enough evidence yet” for applying the GLM.

6. **Knowledge of the GLM.** Confusion around GLM concepts and GLM terminology hindered its application. For example, one respondent stated that “the GLM terminology is sometimes a hindrance but this is overcome by adapting it.” Another respondent reported that the GLM was “confusing to some staff,” and made specific reference to the etiological assumptions of the GLM.
Table 3 provides prevalence counts for each theme, and interrater reliability of prevalence counts. Interrater reliability was determined by (i) calculating the percentage of programs where the first author and a research assistant agreed on whether a theme was present or absent, and (ii) using Cohen’s κ. Raters reached 100 percent agreement (Cohen’s κ = 1.00) for the presence versus absence of themes in relation to factors that hindered adoption of the GLM.

Program Consistency With the GLM

Next we summarize findings in relation to the degree to which the GLM was integrated across programs according to the items described in the coding protocol (refer to the Method section). Due to the minimal variance observed in relation to specific items, program consistency to the GLM is described in terms of the five domains in the coding protocol: program aims and orientation, client assessment, intervention planning, intervention content, and intervention delivery.

Program Aims and Orientation. With one exception, all programs communicated the dual aims of risk reduction and well-being enhancement to clients at the beginning of the program. This was evident in treatment providers’ responses in the semi-structured interview, program names, and sometimes through formal program materials. In the only program that did not communicate the dual aims of risk reduction and well-being enhancement at the beginning of the program, the latter aim was reserved for the final phase of the program. The final phase was considered a “privilege” for clients who successfully completed the earlier two phases, which were risk reduction and risk management in orientation.

Client Assessment. Assessment practices at most (n = 8) programs included a standardized assessment of static and dynamic risk factors and assessment of psychosocial history. All programs used a static risk assessment tool, with the most popular being the Static-99. Ten programs used a dynamic risk assessment tool, with the most popular being the Stable-2007. Primary goods implicated in offending were assessed to some
extent in the pretreatment assessment phase of one program through a series of worksheets. These worksheets oriented clients to consider the primary goods important to them in the 12 months leading up to their offending. In another program, the aim of the initial program phase was for clients to develop an understanding of their good lives conception in terms of their most valued primary goods currently, and goods implicated in offending were explored in a later phase.

**Intervention Planning.** Most programs adopted a collaborative approach to intervention planning whereby client input was explicitly sought in the construction of intervention plans \((n = 7)\). Typically this occurred in a post-assessment individual session during which clients’ goals for treatment were elicited. Three programs used a generic treatment plan for each client but included space for clients to add their own goals if they wanted to do so, and one program used individualized treatment plans based on the results of dynamic risk assessment (and included space for clients to add their own goals). Intervention planning was absent from the remaining two programs.

**Intervention Content.** Strengths-based treatment manuals or guides were evident in \(n = 8\) programs, in which the aims of each treatment component were approach-oriented and often linked to one or more primary goods. W. L. Marshall et al.’s approach (e.g., Marshall, Marshall, Serran, & O’Brien, 2011) formed the basis for program content in several of these programs. Two programs used RP-based workbooks as an auxiliary to process-oriented therapy with no formal manual or guide (i.e., clients completed workbook material for homework, and the therapist decided what was presented to group), and the remaining three programs explicitly followed RP-based manuals and incorporated a GLM component in the final phase/module of treatment. Most programs described minimal formal links with clients’ support people or external agencies beyond the referral source (e.g., probation/parole) due to resourcing and funding constraints, with two exceptions. One community-based program provided “supervisor training” to clients’ support people, including sharing the client’s future plans for managing risk and attaining pro-social goals; and one prison-based program included community transition meetings modeled on Hover and Shilling’s (2010) approach.

**Intervention Delivery.** Positive therapist characteristics were observed at all programs, however some characteristics were more prevalent than others. Displays of warmth were evident in all group observations (i.e., score of 3 or above on the 5 point Likert-type scale described in the coding protocol), while displays of empathy were less prevalent, observed in approximately half \((12/25)\) of the groups observed. Displays of praise and some directedness were observed in most group observations. Negative therapist characteristics, specifically displays of confrontation, were observed in three group observations at three different programs. The degree of collaboration between therapist and clients across group observations varied considerably. In some groups, sessions had a classroom-like feel and the therapist took on a teacher role, whereas in other programs the therapist took on the role of a guide and worked collaboratively.
Table 4. Examples of GLM Consistent and Inconsistent Practices.

<table>
<thead>
<tr>
<th>Program Domain</th>
<th>Consistent With the GLM</th>
<th>Inconsistent With the GLM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program aims and orientation</td>
<td>• Clear communication of the dual aims of risk reduction and well-being enhancement</td>
<td>• Avoidant-goal oriented treatment contracts</td>
</tr>
<tr>
<td>Assessment</td>
<td>• Comprehensive assessment practices canvassing a range of GLM primary goods</td>
<td>• Minimal assessing of clients' prioritized goods</td>
</tr>
<tr>
<td>Intervention planning</td>
<td>• Individualized treatment/intervention plans for each client</td>
<td>• Generic treatment plans</td>
</tr>
<tr>
<td>Program content</td>
<td>• Self management plans incorporating the GLM</td>
<td>• Overly heavy emphasis on accepting responsibility for offending</td>
</tr>
<tr>
<td></td>
<td>• GLM-based assignments</td>
<td>• Overly heavy emphasis on RP</td>
</tr>
<tr>
<td></td>
<td>• Linking program modules to attainment of primary goods</td>
<td></td>
</tr>
<tr>
<td>Program delivery</td>
<td>• Positive therapist characteristics</td>
<td>• Rigid use of manuals</td>
</tr>
<tr>
<td></td>
<td>• Collaboration with clients</td>
<td>• Classroom-style delivery</td>
</tr>
<tr>
<td></td>
<td>• Attention to individual client goals</td>
<td>• Displays of confrontation</td>
</tr>
</tbody>
</table>

with clients. Similarly, the degree to which treatment components were tailored to individual clients varied substantially between group observations. In some groups, minimal or no tailoring at all was observed and therapists appeared to assume a didactic role and closely follow a manual, at times reading directly from the manual. In other groups, greater tailoring of intervention delivery to client goals was observed, where the relationship between module content and process appeared seamlessly integrated.

Specific examples of GLM consistent and inconsistent practices within each domain are provided in Table 4. It is noted that these examples aren’t all unique to the GLM (e.g., use of positive therapist characteristics, assessment of dynamic risk), given that the GLM was designed to augment the RNR and therefore incorporates the major RNR principles within a broader strength-based framework (see Ward, Yates, & Willis, 2012). One of the more striking inconsistencies with a GLM approach was the use, in some programs, of avoidant-goal oriented treatment contracts which clients were required to sign before commencing treatment. These contained a list of behaviors in which clients were prohibited from engaging in throughout treatment, for example, use of alcohol or drugs, being on premises that sell alcohol, use of pornography, and contact with other group members outside of group times. Such contracts were inconsistent with the GLM because of their avoidant-goal framing and because
clients were forced to sign them without a clear understanding of their function and link with treatment aims.

**Overall Program Consistency with the GLM**

Following site visits, a quantitative rating scheme was designed to rate each program’s overall consistency with the GLM, based on the variance observed. Ratings ranged from 1 to 3, with 1 indicating weak consistency to the GLM and 3 indicating greater consistency to the GLM. More specifically, a rating of 1 indicated that integration of the GLM was minimal and typically amounted to an addition to a predominantly risk management or RP-based framework. For example, programs might have added an additional component such as construction of a Good Life Plan at the end of the program. Links between the added component and other program components were either weak or absent. Program directors/managers might have described their program as promoting client well-being alongside managing risk, however program content and delivery were generally inconsistent with these aims. A rating of 2 indicated some responsiveness to the GLM, however integration remained largely additive to an existing risk management or RP-based framework. A score of 2 reflected greater incorporation of GLM principles than a score of 1 in that GLM principles were integrated throughout the program. More specifically, consistent evidence showed that the GLM helped inform program delivery. More often than not, a GLM “spirit” was evident, as evidenced by respectful and positive therapeutic relationships, tailoring the delivery of treatment to each individual client (rather than rigidly following a manual), promoting clients’ pursuit of pro-social goals, and the like. Some attempts may have been made to integrate the GLM into program content, however the majority of program components were problem focused and not linked to the acquisition of primary goods. For example, therapists might have relied on RP-based manuals but used these as auxiliaries to process-oriented therapy, which attended to goods fulfillment. A score of 3 reflected greater incorporation of GLM principles than a score of 2 in that the GLM was explicitly integrated into program content (e.g., through assignments attending to primary and secondary goods). Overall, program delivery and content were responsive to the GLM. In programs rated as 3 a majority of program components used approach goals and were linked to fulfillment of primary goods; and the program emphasized the importance of developing a Good Life Plan (or equivalent).

A research assistant made independent ratings based on a randomly selected sample of $n = 6$ programs to calculate interrater-reliability of GLM responsiveness ratings. Raters reached 100 percent agreement, indicating excellent interrater reliability. Table 5 provides overall ratings for programs in the United States and Canada, and the sample as a whole. Eleven of the 13 programs received a rating of two or higher. All Canadian programs received a three, together with one community-based U.S. program. Comparisons were not made between programs operating in different settings (community, prison, and civil commitment centers) given the small sample size, and the fact that all Canadian programs in the sample were prison-based.
The current study aimed to explore how the GLM has been operationalized in North American treatment programs, and the degree to which the GLM was integrated throughout such programs. In addition, findings from the current study clarified what factors helped program directors to adopt the GLM and, conversely, which factors made it harder to implement the model in North American sex offending treatment programs. The data were rich and we do not have the space to discuss all the relevant findings in this section. Instead, our intention is to focus on the most pressing issues from policy and practice perspectives. Thus, in this section, we concentrate on the overall findings concerning the operationalization of the GLM, followed by a summary of facilitative and obstructive factors associated with the implementation of this strength-based rehabilitation framework. The discussion section concludes with some suggestions from the authors on ways in that program responsiveness to the GLM can be enhanced.

Findings from both inductive and deductive analyses showed that operationalization of the GLM was typically at the level of intervention delivery (as opposed to assessment and treatment planning), and/or the addition of an extra module or component. More specifically, it was common for treatment providers to report a greater emphasis on approach goals rather than avoidant goals, as well as the integration of GLM concepts into self management or relapse prevention plans at the conclusion of a program. Such findings are consistent with empirical evidence documenting support for the use of approach versus avoidant goals (Mann, Webster, Schofield, & Marshall, 2004), and the importance of carefully planned reentry and reintegration (e.g., Scoones, Willis, & Grace, 2012; Willis & Grace, 2008, 2009). Encouragingly, positive therapist characteristics were frequently observed, again consistent with research evidence documenting their importance in facilitating treatment change (e.g., Marshall, et al., 2002; Marshall, et al., 2003). Although the use of approach goals, an emphasis on reentry and reintegration, and displays of positive therapist characteristics are not unique to the GLM, the GLM provides a coherent and overarching theoretical framework that promotes such features. In other words, these features are natural bi-products of the correct operationalization of the GLM in practice. One of the desired functions of a rehabilitation theory is to provide a conceptual map of an offender’s rehabilitation and reintegration journey and thus to highlight the resources necessary to increase the chances of successful rehabilitation and reintegration. Because of its strength-based

<table>
<thead>
<tr>
<th>Score</th>
<th>U.S. Programs (n = 10)</th>
<th>Canadian Programs (n = 3)</th>
<th>Total (N = 13)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2 (20%)</td>
<td>0 (0%)</td>
<td>2 (15%)</td>
</tr>
<tr>
<td>2</td>
<td>7 (70%)</td>
<td>0 (0%)</td>
<td>7 (54%)</td>
</tr>
<tr>
<td>3</td>
<td>1 (10%)</td>
<td>3 (100%)</td>
<td>4 (31%)</td>
</tr>
</tbody>
</table>

Discussion

The current study aimed to explore how the GLM has been operationalized in North American treatment programs, and the degree to which the GLM was integrated throughout such programs. In addition, findings from the current study clarified what factors helped program directors to adopt the GLM and, conversely, which factors made it harder to implement the model in North American sex offending treatment programs. The data were rich and we do not have the space to discuss all the relevant findings in this section. Instead, our intention is to focus on the most pressing issues from policy and practice perspectives. Thus, in this section, we concentrate on the overall findings concerning the operationalization of the GLM, followed by a summary of facilitative and obstructive factors associated with the implementation of this strength-based rehabilitation framework. The discussion section concludes with some suggestions from the authors on ways in that program responsiveness to the GLM can be enhanced.

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orientation and ability to easily incorporate content and process variables the GLM can assist therapists to work in ways that engage clients in the difficult process of lifestyle and personal change.

The factor most frequently reported as supporting adoption of the GLM was that clients were particularly responsive to the application of the model. This finding is consistent with preliminary research on outcomes of GLM-derived programs suggesting that the GLM can enhance client engagement in treatment. For example, Simons et al. (2006) found higher rates of treatment completion using the GLM compared with RP, and Gannon et al. (2011) implemented a GLM approach with mentally disordered sex offenders and found that notwithstanding their complex mental health needs, all clients completed the program in its entirety. Not surprisingly, the most frequent factor reported to impede adoption of the GLM was policy and law. It is well-documented that U.S. sex offender registration and notification policies impede successful reintegration by creating obstacles to stable employment, housing, and social support (Levenson & Cotter, 2005a; Levenson, D’Amora, & Hern, 2007; Mercado, Alvarez, & Levenson, 2008; Tewksbury, 2005). Treatment occurs in an environmental context, and despite the strengths of the GLM approach, clients may have difficulty, despite their best efforts, overcoming reentry obstacles. Increasingly restrictive sex offender management policies might help explain why Canadian programs integrated the GLM to a greater extent than their U.S. counterparts; however, Canadian programs also reported policy and law as a hindrance. A lack of resources was also mentioned as a hindering factor, however we note that several resources have recently become available including a clinician guide (Yates, et al., 2010), client workbook (Yates & Prescott, 2011b), and more general guidelines for integrating the GLM with the RNR (Willis, et al., 2013). Negative community attitudes were viewed as a barrier to integrating the GLM approach, and can be seen as an obstacle to sex offender treatment in general (Willis, Levenson, & Ward, 2010).

Enhancing program consistency with the GLM requires using it as a comprehensive theoretical framework to guide interventions throughout the entirety of a program, starting with the pretreatment assessment phase. In addition to assessment of risk, criminogenic needs, and responsivity factors a crucial task of assessment is to identify offenders’ core commitments and strengths—or their heavily weighted primary goods and associated secondary goods. In the GLM, individuals’ core commitments shape the kind of person they are and wish to become; they provide a sense of meaning and purpose. In GLM guided sex offender treatment core commitments and the psychological and social resources necessary to effectively realize them in everyday life are factored into an intervention plan. More specifically, one of the major functions of a GLM-derived intervention plan is to spell out what internal and external conditions need to be in place for individuals to increase their chances of achieving pro-social and personally fulfilling lives. In this process, risk factors are targeted in the course of building strengths and capacities to help offenders achieve their goals. Every aspect of an intervention plan is linked back to offenders’ good lives intervention plans (and thus to their heavily weighted goods) and it functions as a unifying roadmap.
for all practitioners working with an offender, be they therapists, vocational teachers, or custodial staff. It must be acknowledged that many sex offenders find their coping skills challenged by reentry obstacles and limited opportunities for productive and civic engagement, underscoring the importance of considering contextual factors in the construction of Good Lives-based intervention plans. GLM principles can assist clients to develop an enhanced repertoire of coping strategies for dealing with the social isolation and limitations present when facing life as a registered sex offender, and to help them meet their emotional needs in more healthy, adaptive, nonharmful ways.

In our view, adding a GLM module toward the completion of a program is too late and may simply amount to therapy as usual, with a positive twist at the end. A risk is that the benefits of a comprehensive GLM approach will be lost and the intervention plan itself may suffer from a lack of clarity and logic. It is unlikely that the treatment plan will be based on an offender’s core commitments and stipulate what internal and external capabilities are required to effectively achieve them. Rather, what is probable is that targeting of criminogenic needs will dominate the early and middle treatment phases and the GLM component will simply be tacked on to the end. The mixture of avoidance and later approach goals may prove confusing and there will be a failure to capitalize on the motivational benefits of aligning intervention with lifestyle variables offenders find meaningful and worth investing in. Thus, a worry with adding the GLM at the end is losing clients who might have otherwise engaged if treatment had been more closely aligned with their interests, strengths, and core commitments.

With the study’s results in mind we would like to make a few suggestions for enhancing program consistency to the GLM throughout each phase of a treatment program. In the initial assessment phase, the dual aims of rehabilitation should be communicated clearly in any introductory materials and consent forms. Furthermore, the assessment of primary goods should be undertaken with a clinical interview, for which a semi-structured interview protocol is available (Yates, Kingston, & Ward, 2009). A semi-structured method for obtaining information on primary goods and their pursuit ensures a systematic and comprehensive assessment and therefore assists practitioners to avoid the mistake of premature closure during assessment. Following assessment, practitioners should construct individual intervention plans that have at their centers individuals’ most heavily weighted goods and an outline of strategies intended to achieve them within environments they are currently living in or the ones they are most likely to be released into. Individualized good lives interventions plans can easily be utilized within a group treatment format or within individual therapy. They also have the distinct advantage of being easily translated into the posttreatment phase of the reintegration process as they are essentially plans for living. The inclusion of vocational, educational, community, spiritual and other desistance elements extends the scope of a Good Lives Plan beyond what happens during the treatment phase of an intervention plan.

A limitation of the current study was its reliance on a short site visit to evaluate how the GLM was operationalized and the degree to which GLM ideas were integrated throughout each program. Nevertheless, the multimodal approach of interviewing
program directors/managers, reviewing program documentation, and observing treatment groups enhances confidence in the reliability of the study’s findings. The translation of theory into good practice is an iterative and complex process that requires a sound knowledge base, ethical sensitivity, and considerable clinical skill. The GLM is a relatively new theory of offender rehabilitation and it is encouraging to see its application to the treatment of sex offenders in so many North American treatment programs. Although this study has revealed some areas of weakness in the implementation of the GLM, the majority of programs examined appeared to effectively use the model to create positive, motivationally engaging, and risk reducing therapeutic approaches. Whether sex offending treatment programs informed by the GLM turn out to be more effective than those based on traditional models is far from clear. But from our perspective, the integration of strength-oriented treatment with risk-management strategies represents an exciting innovation, and one that it is well worth evaluating further.

Note
1. Purvis (2010) has suggested separating this primary human good into two separate primary goods to differentiate excellence in work and excellence in hobbies/recreational pursuits.

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