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Konrad Adenauer Foundation

Freedom, justice, and solidarity are the basic principles underlying the work of the Konrad-Adenauer-Stiftung (KAS). KAS is a political foundation, closely associated with the Christian Democratic Union of Germany (CDU). In our European and international cooperation efforts, we work for people to be able to live self-determined lives in freedom and dignity. We make a contribution underpinned by values to help Germany to meet its growing responsibilities throughout the world. By bringing people together who embrace their responsibilities in society, we develop active networks in the political and economic spheres as well as in society itself.

Regain Trust

REGAIN TRUST is a Namibian NGO active in the field of gender-based violence prevention. All our activities are dedicated to decreasing gender-based violence rates in Namibia. We are doing research and awareness campaigns to inform citizens about gender-based violence issues in Namibia. Other activities include empowerment programs, psychological counselling for survivors of abuse, and the promotion of psycho-logical therapy for sex offenders.

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The methods described within this book are not intended to be a definitive set of instructions for sex offender treatment in Namibia. There may be other methods and materials to accomplish similar end results.

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List of Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
EU	European Union
FIT	Feedback-Informed Treatment
GBV	Gender Based Violence
GLM	Good Lives Model
GPO	Government Publishing Officer
GSRS	Group Session Rating Scale
HIV	Human Immune Virus
ICPA	International Corrections and Prison Association
KAS	Konrad-Adenauer-Stiftung
LAC	Legal Assistance Centre
NAMPOL	Namibian Police
NCS	Namibian Correctional Service
ORS	Outcome Rating Scale
PACI-O	Personal Aspirations and Concerns Inventory for Offenders
PCIO	Personal Concerns Inventory for Offenders
PST	Problem Solving Therapy
RCT	Randomized Clinical Trial
SADC	Southern African Development Community
SAMHSA	Substance Abuse and Mental Health Service Administration
SRM	Self - Regulation Model
SRS	Session Rating Scale
TLS	Thinking & Living Skills
WHO	World Health Organization

Foreword Konrad Adenauer Stiftung

Freedom, justice and solidarity are the basic principles underlying the work of the Konrad-Adenauer-Stiftung (KAS). By bringing people together who embrace their responsibilities in society, we develop active networks in the political and economic spheres as well as in society itself.

Namibia has one of the highest rates of Gender Based Violence (GBV) in the entire Southern African Development Community (SADC) region. Our aim is to empower women in need to become independent and to sustain themselves and their children in a better way. The greatest challenge in reducing GBV is to find the reason for it and to find strategies to prevent GBV in future. Due to the reason that KAS wants to protect female victims we found it crucial to support the sex offender treatment program to decrease relapse rate of offenders when back into community. We need reintegration to protect survivors of future abuse.

Therefore a strategy must be implemented how perpetrators of sexual offence can be successfully re- integrated into Namibian society again. In our initial survey of these men's motivation for treatment, we found out that they wanted any opportunity they could have for treatment that would help them live a better life after release from prison. This fact often goes unnoticed. Prison inmates are very often grateful for the chance to learn ways to prevent further crime. There has been value in bringing the very best and most advanced treatment into the prison in Rundu as a start to decrease GBV incidents.

This topic does not only have high relevance in Namibia. The sexual assaults in Cologne, Germany, where around 500 women got sexual harassed on New Year's Eve 2015 brought up a new sensible discussion. Why are women not as respected as men in our society? Are there cultural differences that lead to sexual abuse? Why do certain groups in certain countries don't respect the sexual self-determination among women? How can we deal with sexual offenders in correctional services? Regarding these questions, this study also has new political relevance and importance for the discussions in Germany and Namibia and for the question of how to protect the victims and how to deal with sexual offenders.

KAS Namibia-Angola

Preamble

Mirjam Nampweya, Namibian Correctional Service (NCS)

Article 1 of the 1993 United Nations Declaration on the Elimination of Violence against Women, defined gender-based violence (GBV) as “Any act of gender-based violence that results in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or in private life”.

Although this definition implies that victims of GBV are solely females, however evidence states that there are male victims of GBV as well. The fact is that female victims are more affected than male victims, as one in three women suffer from these types of violence, while only o1 in 20 men are victims. Despite such statistics, one should understand that the definition of GBV is inclusive of all gender.

Regrettably, in 2004, Yanyi K. Djamba and Sitawa R. Kimuna pointed to the fact that GBV is the most common universal social problem yet the least recognized human rights violation. Western society is a step ahead in its effort to develop preventative strategies through evidence-based research. Africa is lagging behind in research, more so on this very topic, perhaps because it is deeply steeped in a patriarchal ideology.

In spite of this limitation, a few African countries have made some progress in research. Many of their efforts go on in vain as countries fail to implement recommendations from these studies or put the findings to use. Research can influence practice through evidence-based approaches. Frank Porporino emphasized this point when he presented on Research and Development at the 17th International Corrections and Prison Association (ICPA) annual conference in Melbourne, Australia. He clearly suggested that research provides a way to develop new ideas that should then be translated into practice. Therefore, findings of this pilot sex offender program study in Namibia should not fall flat. These findings should inform intervention strategies aimed at reducing the alarming statistics and nature of GBV, specifically that of rape and other sex-related violence against women and children as evident in this publication.

In Namibia, a sexual act is defined in the Combating of Rape Act, Act No. 8 of 2000 as:

(1) Rape is committed if there is
(a) The insertion (to even the slightest degree) of the penis of a person into the vagina or anus or mouth of another person; or
(b) The insertion of any other part of the body of a person or of any part of the body of an animal or of any object into the vagina or anus of another person, except where such insertion of any part of the body (other than the penis) of a person or of any object into the vagina or anus of another person is, consistent with sound medical practices; carried out for proper medical purposes; or (c) cunnilingus or any other form of genital stimulation

(2) Rape is deemed to have been committed if
(a) Any person intentionally commit a sexual act under coercive circumstances or

(b) Causes another person to commit a sexual act with the perpetrator or with a third person.

Therefore, sex offences in Namibia include rape, as defined in the Combating of Rape Act No 8. of 2000, child molestation, possession of child pornography, soliciting of minors through the internet, sexual assault and incest. An offender convicted of the above acts is said to be a sex offender in the Namibian Criminal Justice system.

During the Second National Conference on Gender Based Violence in 2014, it was again stressed that sex-related offences are rife in the country. At the same conference, it was a shock to hear from Mr. Charles Sibolile from the Namibia Police Force that more than 4502 sex-related crimes were reported between 2011 and 2013, and 3247 of them were rape cases. At the same time, another shock came while analysing the study, undertaken together with Mr. William Chiremba, around the same time in 2014. This revealed that of the 438 offenders convicted of sex offences in our correctional facilities in June, 2014, 431 of the sex offender population were rape cases committed by male offenders who were either relatives or intimate partners and the survivors were solely children and women. Of course, these are the reported cases, and as we all know, most of these cases go unreported. The real statistics are probably much higher.

In light of the above forecast of sex offences in the country, Vision 2030 states that Namibia aims to be "A prosperous and industrialized nation, developed by her human resources, enjoying peace, harmony and political stability." This vision was divided into four main goals to be addressed as a way to assure its realization namely:

- Prosperity
- Interpersonal Harmony
- Peace
- Political Stability

Henceforth, reducing cases of sexual offences which affect mostly women and children would, in part, entail developing and strengthening rehabilitation and reintegration programs tailored towards sex offenders, as this will speak directly to the third goal of Vision 2030 that of peace. Peace was further expanded to emphasize a nation free from violence and crime.

In U.S. the Government Publishing Office (GOP), John Kerry stated in his article on GBV in 2015 that ″approximately one in three women across the globe is physically or sexually abused during her lifetime; many at the hands of an intimate partner… violence against women creates and maintains poverty. GBV threatens peace." Therefore, for the Namibian nation to live in peace by 2030, it needs to address the issue of sexual violence. In part, this means deterring perpetrators of sexual violence from re-offending altogether. An important piece of this will be developing specific sex offender rehabilitative programs and effective supervision and monitoring strategies that help reintegrate them successfully in our communities. Whereas rehabilitation is not a strange word in the Namibian Correctional Service (NCS) as it forms part of the main responsibility of the department under the Ministry of Safety and Security, it poses some of the biggest challenges in our system.

The Namibian Correctional Service conducts risk and need assessments to determine the best ways to rehabilitate offenders and provides several means to help them become productive citizens through programs such as education, vocational training, evidenced-based programs for substance abuse and cognitive restructuring. However, these programs are not yet available to all offenders who need them, mainly due to the lack of resources. The greatest challenge the correctional system has encountered since implementing the notion of rehabilitating offenders is developing a properly focused sex offender program. Despite the fact that general rehabilitative programs do benefit our sex offender population to an extent, offering them a program specifically developed for them will provide an even better outcome in reliably reducing their chances of recidivism. There has been some progress in the development and establishment of a sex offender program. The first step has been gathering data needed to develop a complex sex offender program in the Namibian Correctional Service with the help of a well-recognized Canadian consultant who has extensive knowledge on rehabilitative programs. Second, Regain Trust has begun piloting a study focused on a sex offender program, which has helped to streamline the type of factors to consider in implementing a successful program for sex offenders. With these findings, the Namibian Correctional Service (NCS) can build an in-depth understanding of how to tailor a sex offender program specifically for our population, which considers the cultural aspects from an African perspective.

The Namibian Correctional Service (NCS) hopes the result of this pilot study will evoke useful debates geared towards implementing preventative, rehabilitative and deterrence strategies aimed at reducing not only rape or sexual violence, but at reducing GBV in general.

Lastly, in my private capacity, I would like to state what eventually motivated me to put my two cents' contribution to this publication is these bible verses:

"All hard work brings a profit, but mere talk leads only to poverty." (Proverbs 14: 23)

"My people are destroyed from lack of knowledge." (Hosea 4:6)

"For nothing is impossible with him." (Luke 1:37)

The first two verses reminded me that change starts with me, in other words, reducing GBV starts with me, that talking and wanting change should be followed by action. It starts with the attempt to share my knowledge and understanding on this topic with whoever is willing to learn and be encouraged to take a step in preventing harm. It is with knowledge that we can better understand these crimes and devise effective ways to reduce them. The last verse took me back to how everything I have ever achieved was because of my Lord. How He works through me is amazing. I am thus a firm believer that nothing is impossible with God. I believe that He gave me this chance, as He knew that with His help I could touch someone's heart with these few words and encourage them to take one step in reducing sexual offences. This publication will enlighten you, make you cry, and make you see the extent of sexual violence in our country. Take time not just to be a spectator, but to let this book touch you and compel you to act.

Introduction

According to a World Health Organization's (WHO) study from 2005 a third of Namibian women have already experienced intimate partner violence (World Health Organization, 2005, p.243-245). Although Namibia has already one of the highest rates of gender-based violence rates in the entire Southern African Development Community region (Tjitemisa, 2014), NAMPOL Deputy Commissioner Edwin Kanguatjivi pointed out that the total number of gender-based violence (GBV) cases still tends to increase (Kazondovi, 2013). A tailored sex offender treatment program is therefore deemed necessary to decrease sexual violence and violence against women in Namibia.

At the moment such a program does not exist in Namibia. In previous years sex offender did not benefit from any form of treatment. Recently some were integrated into newly established general rehabilitation programs. Nevertheless these general programs carried out under the Namibian Correctional Service (NCS) do not fully serve to the needs of Namibian sex offender population, nor do they reduce recidivism rates to a satisfactory extend. In order to establish a need-tailored program, two mentionable pre-efforts were after 2010 carried out under the Namibian Correctional Service (NCS). A first analysis of the Namibian sex offender population and the present pilot study.

A sex offender treatment program is crucial to decrease relapse rate of offenders when they are released back into community. The Namibian Correctional Service (NCS) is very much aware of this and stresses the need for suitable programs. A balanced and culture-tailored sex offender treatment program can decrease gender-based violence and rape rates and prevent HIV-infections.

The Good Lives Model (GLM; Ward & Gannon, 2006; Ward & Stewart, 2003) offers real promise for putting sex offenders back on the path towards a productive and harm-free mindset. The GLM is a strengths-based approach to rehabilitation that augments the risk, need and responsivity principles of effective intervention in correctional settings (Andrews & Bonta, 2010). It focuses on assisting clients to develop and implement meaningful plans for their life that make harmful sexual behaviour undesirable and unnecessary. Preliminary research suggests that the GLM can enhance client engagement in treatment and reduce the number of people who leave treatment programs before completion (e.g., Simons, McCullar, & Tyler, 2006), a factor frequently associated with higher recidivism rates (Hanson, et al., 2002; Olver, Stockdale, & Wormith, 2011).

A study at the Elizabeth Nepemba correctional facility in Rundu documented the results of a six-month pilot program following 40 sex offenders. The aim of the program was to adapt sex offender treatment methods common in the Western Hemisphere to the African-Namibian cultural setting, since literature and sex offender treatment programs for the African continent, especially for Namibia are rather limited.

The sample group was composed of 40 sex offenders, clustered in four risk groups. All offenders ranged in age from 20 to 30 years and had committed rape on a female Namibian citizen above the age of 12. The treatment (group and individual sessions) was carried out by four program officers at the Elizabeth Nepemba facility.
The total program included five phases. The first two were identification and clustering

phases to evaluate clients. The final three phases treated the major issues at stake identified earlier, namely:

A. Problem solving capacities
B. Relationship capacities
C. Sex drive

The outcome of each phase and overall results will be presented in the following chapters. Please keep in mind that this book is not intended for only a scientific readership, and therefore writing style was tailored and adapted for a broader understanding.

References

Andrews, D. A., & Bonta, J. (2010). The psychology of criminal conduct (5th ed.). Cincinnati, OH: Anderson Publishing.

Hanson, R. K., Gordon, A., Harris, A. J. R., Marques, J. K., Murphy, W., Quinsey, V. L., et al. (2002). First report of the collaborative outcome data project on the effectiveness of psychological treatment for sex offenders. Sexual Abuse: A Journal of Research and Treatment, 14, 169-194. doi: 10.1177/107906320201400207

Kazondovi, K. (2013) 'Namibia: Domestic Violence Cases Alarming'. All Africa [Online] 26 June. Available at http://allafrica.com/stories/201306261037.html [Accessed 15 May 2015].

Simons, D. A., McCullar, B., & Tyler, C. (2006). Evaluation of the Good Lives Model approach to treatment planning. Paper presented at the 25th Annual Association for the Treatment of Sexual Abusers Research and Treatment Conference, Chicago, Illinois.

Tjitemisa, T. (2014) 'Seminar to devise ways to mitigate GBV'. New Era [Online] 4 June. Available at www.newera.com.na/2014/06/04/seminar-devise-ways-mitigate-gbv/ [Accessed 10 May 2015].

Oliver, M. E., Stockdale, K. C., & Wormith, J. S. (2011). A meta-analysis of predictors of offender treatment attrition and its relationship to recidivism. Journal of Consulting and Clinical Psychology, 79, 6-21. doi: 10.1037/a0022200

Ward, T & Gannon, T. A. (2006). Rehabilitation, etiology, and self-regulation: The comprehensive good lives model of treatment for sexual offenders. Aggression and Violent Behavior, 11, 77-94. doi: 10.1016/j.avb.2005.06.001

Ward, T. & Stewart, C. A. (2003). The treatment of sex offenders: Risk management and good lives. Professional Psychology: Research and Practice, 34, 353-360. doi: 10.1037/0735-7028.34.4.353

World Health Organization (2005). WHO Multi-country Study on Women´s Health and Domestic Violence against Women. Initial results on prevalence, health outcomes and women´s responses. Geneva: WHO.

1. Situation in Namibia

Domestic violence and rape rates. Gender-based violence is a major issue in Namibia. Despite years of the problem being prominent in daily newspaper coverage, the issue becomes increasingly severe. Concerning a 2005 WHO study nearly a third of Namibian women (31%) experienced intimate partner violence, committed by either a husband or boyfriend, 17% experienced sexual violence. In total, 38% suffered from intimate partner or sexual violence (World Health Organization, 2005, p.243-245). Recent surveys do not indicate a positive shift either. According to a statement of the Namibian Police (NAMPOL) 10.000 gender-based violence cases have been reported in the last three years, based on the early 2016 data (New Era, 15 February 2016).

On average, 1100 to 1200 rape cases are reported each year. Over a third of all charges are issued by women under the age of 18 (Legal Assistance Centre, 2006, p. IV; 2013, p.4). It is crucial to mention that rape is one of the most underreported crime in Namibia. The actual figure will certainly be much higher.

These high crime rates stress the importance of a national sex offender reintegration program to prevent recidivism and to decrease high rape rates in Namibia.

Sex offender reintegration in Namibia. Sex offender rehabilitative programs are not extensively developed on the African continent and are not implemented in Namibia yet. The responsible departments acknowledged that a successful reintegration program is urgently needed, not only to decrease crime and gender-based violence rates but also to meet the national targets. Officials agreed that a successful sex offender rehabilitation program is crucial because it provides the chance to enhance community safety and citizens' life quality in Namibia.

The Namibian Correctional Service (NCS) in line with the Ministry of Safety and Security (MSS) is very much aware of these challenges and has already undertaken efforts to develop and provide suitable solutions. The NCS has already implemented certain rehabilitative programs for perpetrators of other types of crime, which may extend to sex offenders as well. Further data sets have been gathered to prepare the baseline to develop a future sex offender program.

Today, it is crucial to build upon these findings and go a step further. These findings shall provide deep understanding to the NCS to create and implement a tailored sex offender treatment program that takes Namibian culture and mindset into account. The methodical and theoretical approach presented in the following chapter, is a first step toward that effort.

References

Legal Assistance Centre (2013). Gender research & advocacy project [Online] Available at http://www.lac.org.na/projects/grap/grapaddressinggbv.html [Accessed 19 June 2015].

Legal Assistance Centre, LAC (2006) Rape in Namibia, An assessment of the Operation of the Combating of Rape Act 8 of 2000. Windhoek: LAC.

New Era, NE. (2016) '10 000 GBV cases reported in three years'. New Era. [Online] 15/ February. Available at <https://www.newera.com.na/2016/02/15/10-000-gbv-cases-reported-years/> [Accessed 01/ March].

World Health Organization, WHO (2005). WHO multi-country study on women´s health and domestic violence against women. Initial results on prevalence, health outcomes and women´s responses. Geneva: WHO.

2. Treating Convicted Sex Offenders in Namibia

A Pilot Program Using the Good Lives Model and Feedback-Informed Treatment

David S. Prescott, LICSW

Introduction

Sex, sexual misconduct, and sexual violence have been difficult to understand and have often disturbed and outraged society since people first started talking about their lives. For many years, across many societies, it was common for people to be punished for crimes and shunned for other problem behaviours. It is only in the past 30 years that society has developed a better understanding of what works in helping people rebuild their lives after their sexual behaviour has caused harm to others. In the end, many professionals have concluded that the safest way forward for a person who has caused sexual harm is for them to be stable, to be occupied with a job or studies, to have supportive people to whom they are accountable, to have no desire to harm others, and to have everything to lose by repeating their past behaviours.

Historically, many nations have been uncertain how best to address the problem of sexual abuse. Prosecution can be a difficult task, and specialized knowledge about rehabilitation is still very new. Societies therefore have questions to consider:

1. Do we want this person to reoffend or not?
2. Assuming the answer is no, what works to reduce his risk?
3. How can society ensure the safety and wellbeing of those around the offender (i.e. victims, family members, and the community)?
4. On the other hand, what sorts of things don't work?
5. Finally, what are the qualities of professionals that are most likely to result in reduced risk?

Ultimately, recent studies in criminology and psychology, including with violent men, have made clear:

- On its own, punishing people does not reduce their risk for reoffence (Smith, Goggin, & Gendreau, 2002). This fact has received so much study that it is no longer controversial.
- Sex offenders who complete treatment programs reoffend at lower rates than those who do not enter treatment or are unable to complete treatment.
- The most effective sexual offender treatment providers are warm, empathic, rewarding and directive (Marshall, 2005)
- Poorly administered treatment can replicate the dynamics of abusive relationships. For example, clients in treatment who simply follow their therapists' orders are reenacting power-based relationships similar to intimate-partner violence (Shamai & Buchbinder, 2010).
- People tend to change more in response to what they hear themselves say than in response to what others say to them (Bem, 1972).

- Although many people start to make changes to their lives because of outside factors, they typically find their own internal reasons for change along the way (Deci & Ryan, 2002).

Historical Foundations

Early texts on treating people who have sexually abused emphasized overtly directive approaches to treatment. For example, in a highly influential 1988 book, Anna Salter stated that "… (T)he process of treating child sex offenders is heavily weighted in the direction of confrontation. Treatment requires continual confrontations" (p. 93). Examples include the following statements:

- No, I do not trust you, and you would be pretty foolish to trust yourself.
- Give me a break. What do you mean one drink can't do any harm? Drinking is a parole violation, and you seem to be making a serious attempt at getting yourself back in jail (p. 93).

Salter points out however, that "Confrontation does not have to involve hostility and it must not if it is to be therapeutic… the task in treatment is not only to confront, it is to hold the offender with one through the confrontation, and to come out the other side with the message clear but the rapport intact" (pp. 93-4). Where the line falls between confrontation and hostility is not entirely clear. What is clear, however, is that subsequent findings have cast confrontational approaches into a much less favourable light (Marshall, 2005; Parhar, Wormith, Derkzen, & Beauregard, 2008). In fact, in an influential article regarding addictive behaviour, White and Miller (2007) stated:

"There are now numerous evidence-based alternatives to confrontational counselling, and clinical studies show that more effective substance abuse counsellors are those who practice with an empathic, supportive style. It is time to accept that the harsh confrontational practices of the past are generally ineffective, potentially harmful, and professionally inappropriate."

Of course, the ultimate proof of any effectiveness in the treatment of sexual aggression is in re-offence rates. A 1998 meta-analysis found that sexual offenders who drop out or otherwise fail to complete treatment are at elevated risk for re-offense (Hanson & Bussière, 1998). A decade later, meta-analytic study found that programs adhering to sound correctional practices produce better outcomes (Hanson, Bourgon, Helmus, & Hodgson, 2009). Still, researchers question whether results say more about the clients completing the programme or the effects of treatment (Hanson, Gordon, Harris, et al., 2002). Further, given the questionable condition of the comparison groups, only limited conclusions are possible.

Most recently, investigators have emphasized the need for high-quality research in this area; in particular, randomized clinical trials (e.g., Långström, Enebrink, Laurén, et al., 2013). One such study that has helped influence the field was a long-awaited randomized clinical trial (RCT) led by Janice Marques (Marques, Wiederanders, Day, et al., 2005). Interestingly, it found no difference between those who completed the

treatment program and those in the control group. However, the authors concluded that those treatment participants who "got it" and meaningfully completed their treatment goals really did reoffend at lower rates.

The Marques et al. study sparked considerable debate, serving as a source of optimism for some, but leading others to question the efficacy of treatment for sexual aggression. Marshall and Marshall (2007) argued that RCTs are not the final word in scientific evidence. A host of others (e.g., Seto, Marques, Harris, et. al., 2008) disagreed, with a net effect that it can be easy to forget that clients who complete programs do in fact reoffend at lower rates, but that the highest quality studies are unable to find a treatment effect or identify what the active ingredients in treatment actually are, except that those who "get it" and achieve their goals do better than those who simply show up.

The most recent sexual offender treatment outcome meta-analysis (Hanson, Bourgon, Helmus, & Hodgson, 2009) found that programs adhering to the effective correctional principles (i.e. those of risk, need, and responsivity) have the greatest effect on sexual re-offence. Also known as the risk-need-responsivity model, these principles, summarized by Andrews & Bonta (2010), have explained the success and failure of numerous criminological interventions. Simply put, the risk principle holds that the majority of treatment resources should be allocated towards those who pose the highest risk. The need principle holds that interventions should focus on treatment goals demonstrated to be related to criminal re-offence. The responsivity principle holds that interventions should be tailored to the individual characteristics of each client. This last principle can sometimes be the most confusing and challenging for programs to achieve. At its most basic level, the responsivity principle includes efforts to ensure that the client is capable of responding to an intervention (e.g., matching treatment to cognitive abilities). At a more challenging level, responsivity involves efforts to understand motivation to change and what problems may constitute barriers to meaningful engagement in treatment.

The question remains: What about those people who do complete treatment programs? Should our research and practice efforts be focused on creating what Marques and colleagues referred to as those who "got it"? Elsewhere, Prescott and Levenson (2009) have asked whether our field is actually asking the right questions. For example, beyond "does treatment work?" there are concerns regarding with whom it works, under what conditions, with what kinds of providers, etc. More recently, Prescott (2011) suggested shifting the focus of clinical and research efforts to understanding what transforms reluctant clients into willing partners in treatment programs. That is, what can professionals do to create programs for clients who may be at risk for refusing treatment or dropping out to "get it" and make meaningful changes? Whatever the case, it's important to remember that treatment attrition is a serious problem in all of criminology. Olver, Stockdale, and Wormith (2011) found an overall attrition rate of 27.1 percent and concluded that:

> "The clients who stand to benefit the most from treatment (i.e., high-risk, high-needs) are the least likely to complete it. Offender treatment attrition can be managed and clients can be retained through an awareness of, and attention to, key predictors of attrition and adherence to responsivity considerations (p. 6)."

This should come as no surprise and recalls other important findings that have attracted little attention. For example, Parhar, Wormith, Derkzen, and Beauregard (2008) found that coercive methods of correctional treatment are less successful than voluntary, invested participation. This may be at least partially explained by self determination theory, which holds in part that many change efforts begin with extrinsic motivation (e.g., being mandated into treatment) and evolve into clients discovering their own intrinsic motivations for building and maintaining change.

To summarize to this point, early approaches to treating sexual aggression were frequently of a harsh, confrontational nature despite any supporting research evidence. Research has focused more on the qualities of effective treatment programs (e.g., Hanson et al., 2009) but far less on the qualities of effective professionals (Marshall, 2005). Further, it seems that we know more about how programs can improve (for example, through the use of measures such as the Corrections Program Assessment Inventory; Gendreau & Andrews, 2001) than how professionals can improve their own effectiveness at helping their clients become successful.

A key question resulting from these finding is under what conditions professionals would want to use harsh confrontational techniques when it is likely more effective to guide clients toward confronting themselves.

Treatment for People Who Have Caused Sexual Harm

The most recent large-scale sexual offender treatment outcome meta-analysis by Hanson, Bourgon, Helmus, and Hodgson (2009) may not have attracted the level of attention that it deserved. Beyond simply asking the question “does treatment work,” the authors investigated the qualities of effective programs and found that those adhering to the effective correctional principles (i.e. those of risk, need, and responsivity) have the greatest effect on sexual re-offence. Also known as the risk-need-responsivity model (RNR), these principles, summarized by Andrews & Bonta (2010), have explained the success and failure of numerous criminological interventions. Simply put, the risk principle holds that the majority of treatment resources should be allocated towards those who pose the highest risk. The need principle holds that interventions should focus on treatment goals demonstrated to be related to criminal re-offence. The responsivity principle holds that interventions should be tailored to the individual characteristics of each client.

The responsivity principle can sometimes be the most confusing and challenging for programs to master (e.g., Prescott & Miller, in press; Prescott & Wilson, 2013). At its most basic level, the responsivity principle includes efforts to ensure that the client is capable of responding to an intervention (e.g., matching treatment to cognitive abilities). At a more challenging level, responsivity involves efforts by the professional to understand each client’s motivation to change and what barriers may prevent meaningful treatment participation.

Fundamental questions remain unanswered. What do we know about people who have sexually abused and are able to complete treatment programs successfully? Should

our research and practice efforts be focused on creating what Marques and colleagues referred to as those who "got it"? Beyond "does treatment work?" there are concerns regarding with whom it works, under what conditions, with what kinds of providers, etc. (Prescott & Levenson, 2009). More recently, Prescott (2011) suggested shifting the focus of clinical and research efforts to understanding what transforms reluctant clients into willing partners in treatment programs. That is, what can professionals do to create programs for clients who may be at risk for refusing treatment or dropping out to "get it" and make meaningful changes?

People convicted for sex crimes frequently present with barriers to immediate treatment engagement (Mann, 2009). The very nature of the material covered in these programs (e.g., offence disclosure, exploring the impact of one's actions on others) increases the risk of attrition, especially among those who would see the most benefit from treatment (Olver et al., 2011). Ultimately, the challenge for treatment providers is to create an environment in which change is possible; where treatment is tailored to each client's abilities; and where there is agreement on the nature of the relationship, the goals and tasks of treatment, and accommodation of strong client preferences wherever possible (Bordin, 1979; Duncan, Miller, Wampold, & Hubble, 2010; Nor-cross, 2011).

The observations of Olver et al. (2011) call to mind other important but overlooked findings. For example, White and Miller (2007) observed that harsh confrontational approached were ineffective in treating addictions, while a meta-analysis by Karen Parhar and her colleagues found that coercive methods of correctional treatment are less successful than voluntary, invested participation (Parhar, Wormith, Derkzen, & Beauregard, 2008). This fact may be explained at least partially by self-determination theory, which holds in part that many change efforts begin with extrinsic motivation (e.g., being mandated into treatment) and evolve into clients discovering their own intrinsic motivations for building and maintaining change.

Summarizing to this point, early approaches towards treating sexual aggression were frequently of a harsh, confrontational nature despite any supporting research evidence. Research has focused more on the qualities of effective treatment programs (e.g., Hanson et al., 2009) but far less on the qualities of effective professionals (Marshall, 2005). Further, it seems that we know more about how programs can improve (for example, through the use of measures such as the Corrections Program Assessment Inventory; Gendreau & Andrews, 2001) than how professionals can improve their own effectiveness at helping their clients to succeed.

Certainly, focusing more on treatment program components than on therapeutic processes made sense at a time when little was known about what works in the treatment of people who have sexually abused. However, decades of research has shown that there can be more variability among therapists than there is between treatment models (Wampold & Brown, 2005). Indeed, Steven Walfish and his colleagues surveyed therapists in all 50 of the United States and found that, in common with other professions, the average clinician rates their performance and clinical skills at the 80th percentile. 25% rate themselves at the 90th percentile, and none rated themselves as below average (Walfish et al., 2012). The authors also found that "clinicians tended to overestimate their rates of client improvement and underestimate their rates of client deterioration" (p. 632).

The good news in this study is that therapists want to excel at their work. The bad news may be what other studies have found: that the least competent therapists often believe themselves to be among the most competent (Hiatt & Har-grave, 1995).

So why focus on motivation and why now? Over and above the identified challenges in reducing the harm of sexual abuse, there are several simple facts: Despite the work yet to be done, risk assessment has improved dramatically during the past 20 years (Hanson & Morton-Bourgon, 2005). The same is true of empirically based treatment targets (e.g., Hanson & Bussière, 1998). Many programs have taken to heart the principles of risk, need, and responsivity. It is now time to focus more effort on the responsivity principle. Beyond ensuring that treatment materials are understandable to clients, professionals can be most effective when they ensure that their clients find treatment meaningful – that there is something in it for them – and that they feel heard, understood, and respected (Prescott & Miller, in press).

Good Lives Model

The Good Lives Model (GLM; Ward & Gannon, 2006; Ward & Stewart, 2003) has become increasingly popular in sexual offending treatment programs (McGrath, Cumming, Burchard, Zeoli, & Ellerby, 2010) and is used in diverse areas around the world. The GLM is a strengths-based approach to rehabilitation that augments the risk, need and responsivity principles of effective intervention in correctional settings (Andrews & Bonta, 2010). It focuses on assisting clients to develop and implement meaningful plans for their life that make harmful sexual behaviour undesirable and unnecessary. Preliminary research suggests that the GLM can enhance client engagement in treatment and reduce the number of people who leave treatment programs before completion (e.g., Simons, McCullar, & Tyler, 2006), a factor well known to be associated with higher recidivism rates (Hanson, et al., 2002; Olver et al., 2011).

A central assumption of the GLM is that harmful sexual behaviour results from problems in the way an individual seeks to attain primary human goods. Primary human goods are certain states of mind, outcomes, and experiences that are important for all humans to have in their lives. Examples of primary human goods include happiness, relationships/ friendships, and experiencing competence in work and leisure activities. Examples of how they might have a role in harmful sexual behaviour might include:

- A person who lacks the skills to develop relationships with women of his own age might turn to teenage girls in the belief that it is his only way of having states of happiness and pleasure. He might also imagine that this is the closest thing to a satisfying sexual relationship with another person that he will ever have.

- A man who sexually assaults a woman might believe it is the only way that he will maintain control over his relationship and attain a state of calm. He may also believe that his mission and purpose in life is to be a strong man, and this means having dominance over women.

- A man who is sexually attracted to people who are much younger than he is may

believe that no one his own age could ever be attracted to him. Because he believes he will never be desirable to other adults, he also spends his leisure time in hobbies that are oriented to young people, such as video games.

Identifying the primary goods that are most important to clients and those that are implicated in the offence process, is a fundamental part of assessment. This is because treatment explicitly aims to assist clients to attain these primary goods in personally meaningful, rewarding, and non-harmful ways in addition to addressing reoffence risk (Ward, Yates, & Long, 2006; Yates, Prescott, & Ward, 2010; Yates & Ward, 2008). One way to assess which primary goods are more and less important to a client can be to use the scaling questions that are commonly used in motivational interviewing. For example:

> On a scale of zero to ten, how important is having satisfying relationships to you? And on the same scale of zero to ten, how confident are you that you can have satisfying relationships?

Following motivational interviewing principles, the professional can then elicit statements that reflect the client's desire, ability, reason, or need to change by asking questions such as why the client did not rate himself lower.

The GLM views risk factors for continued sexual behaviour problems as obstacles that block or otherwise act as barriers to healthy and non-harmful attainment of primary human goods. Therapists using the GLM directly target these risk factors in treatment as a very important step towards assisting clients to attain primary goods in their lives. In this way, clients become invested in the treatment process because treatment explicitly aims to help them live a fulfilling life – one that is satisfying to them – in addition to reducing and managing risk. As Ward, Mann, & Gannon (2007) suggest, "…offenders want better lives not simply the promise of less harmful ones" (p. 106). It is beyond the scope of this chapter to describe the GLM theory and its development in detail. Key developments in recent years include its alignment with desistance theory and research (Laws & Ward, 2011) and integration with the Self-Regulation Model – Revised (SRM-R; Yates, et al., 2010; Yates & Ward, 2008). Several journal articles, books, book chapters, and guides for implementation are available to provide comprehensive descriptions of the GLM theory, including these recent developments (Laws & Ward, 2011; Ward & Maruna, 2007; Ward, Yates, & Willis, 2012; Willis & Yates, in press; Yates, et al., 2010).

Of course, a problem with the idea of "primary goods" in the development of the GLM has been that a "good" is not necessarily the same as a "goal." Primary goods are states of being that all people seek to attain. Goals can take many forms. For example, many people have long-term goals that one seeks across a lifetime ("I want to be the best person I can be"), while others are more tangible ("I want to travel the world") and others are more directly measurable ("I want my wife to be happy in our marriage"). For this reason, Yates & Prescott defined common life goals that are based explicitly on the primary human goods outlined in earlier writings (Yates & Prescott, 2011a). The hope has been to make the GLM increasingly accessible to practitioners and to promote a positive approach to treatment and the change process itself. After all, treatment programs for sexual behaviour problems have historically been a challenging environment for all involved (Marshall, 2005; Prescott, 2013).

Primary Human Goods / Common Life Goals

The GLM primary human goods were identified through an extensive review and synthesis of psychological, social, biological, and anthropological research (Ward & Stewart, 2003). Initial descriptions of the GLM proposed 10 primary human goods, while Purvis (2010) has suggested the separation of one of the initially proposed primary goods into two separate primary goods, suggesting the possibility of 11 primary human goods. In addition, the terminology associated with these goods has been explicitly revised (Yates & Prescott, 2011a) in order to be more accessible to clinicians and clients, and to reflect common life goals in order to emphasize the importance of the goods to all individuals. These "Common Life Goals" include:

- Life: Living and Surviving
- Knowledge: Learning and Knowing
- Being Good at Work and Play
- Personal Choice and Independence
- Peace of Mind
- Relationships and Friendships
- Community: Being Part of a Group
- States of Happiness and Pleasure
- Spirituality: Having Meaning in Life
- Creativity (having new experiences)

Importantly, the common life goals represent changes to the labels of the original primary human goods, but not to their original definitions, based on the authors' experience and feedback from clinicians and clients that the use of goal-based language is more accessible to clients and practitioners and that revision to terminology was required for implementation in practice. What is crucial is clinicians' ability to convey the meaning to clients in a manner that engages them in treatment, for clients to be able to relate important constructs to their own lives and experiences, and to differentiate between secondary or instrumental goods and the underlying primary goods or common life goals they seek to attain via these specific activities. When asking clients about their life goals and valued activities, clients typically respond at the level of secondary goods, from which the underlying primary goods or common life goals must be inferred upon exploration (a semi-structured interview protocol is also available; see Yates, Kingston, & Ward, 2009). That is, a secondary good could indicate importance placed on any number of primary goods and assessment is required to determine which life goal is being sought. For example, creating Aboriginal art might reflect numerous underlying primary goods/ common life goals, including creativity, being good at work, being good at play, peace of mind, spirituality, belonging to a group, and community. Only through exploration of what the Aboriginal art means to the client can the underlying primary goods or common life goals be identified. Using a different example, a client might have an extensive history of theft, an instrumental/secondary good which could indicate attempts to achieve the common life goals of life (e.g., stealing money to pay rent), happiness (e.g., enjoying the risk-taking element of stealing), personal choice and independence (e.g., being financially independent), community (e.g., belonging to a gang), or any combination of these. Without exploring what the client gains from theft, the clinician could erroneously conclude that the client is simply antisocial, resulting in an incomplete treatment approach to this behaviour.

The common life goal terminology was designed to provide a concrete and more accessible language to convey primary human goods. It is acknowledged that jurisdictional and cultural differences might warrant subtle changes to the labels provided. In a recent small-scale study in Australia which used the common life goal terminology, this terminology was found to be generally well understood; however, clients indicated that "being good at play" was better understood as "being good at hobbies and leisure activities;" and "life: living and surviving" was better understood as "physical wellbeing and safety" (Willis & Yates, 2012). Whatever labels are used, it is crucial that each client's valued common life goals and the goals implicated in offending are identified at the point of assessment, that treatment is designed around these goals and their relationships to offending, and that clients understand these and are able to apply them during treatment and to their lives in general. Using the GLM, each client's treatment or intervention plan is centred on these common life goals (see Willis, Yates, et al., in press), which forms the basis of a future-oriented good life plan (GLP). GLPs contain a detailed set of plans for achieving valued common life goals in personally meaningful ways that are incompatible with future offending.

Treatment Approaches

Critical to using the GLM and in keeping with the needs principle of effective correctional interventions (Andrews & Bonta, 2010) is the assessment of criminogenic needs. The key difference in using the GLM is how criminogenic needs are understood, included, and addressed within the overarching framework of a treatment program and the emphasis on each client's GLP (for details see Willis, Yates, & Levenson, in press; Yates & Prescott, 2011b; Yates, et al., 2010; Yates & Ward, 2008). The aims of each treatment component or module are framed using approach goals, as opposed to solely avoidant goals, and are linked to the fulfilment of common life goals. For example, a module addressing relationships would focus on how to seek out and establish satisfying relationships rather than a focus on overcoming intimacy deficits and avoiding problematic relationships. For the Namibian experience, common areas of treatment focus included:

1. Problem solving capacities
2. Relationship capacities
3. Sex drive

To review, treatment aims to assist clients to attain common life goals in pro-social, non-offending ways, while simultaneously targeting risk reduction. Addressing criminogenic needs is a crucial step in working towards these dual aims. For example, consider a client who places high importance on the common life goals of relationships, peace of mind, and personal choice and independence, yet has marked emotion regulation problems and intimacy deficits (both dynamic risk factors; see Hanson, Harris, Scott, & Helmus, 2007; Hanson & Morton-Bourgon, 2005). Using the GLM, treatment goals centre on developing skills to attain the client's valued common life goals, which will necessarily include developing effective emotion regulation and intimacy skills to both manage risk and to enable the client to attain these goals via non-harmful means. By contrast, in a traditional risk-based program, addressing emotion regulation problems and intimacy deficits would occur in the absence of any link to a client's priorities and goals in life and

would typically be focused on avoiding situations in which these problems arise and/or on developing and rehearsing strategies to simply cope with these states when they occur as a risk reduction strategy.

Table 1 illustrates a good life plan. Rather than a focus solely on risk factors, high-risk situations, warning signs, and coping strategies, this plan centres on clients' valued common life goals and their relationships to offending, risk factors, and self regulation failure.

Table - Good Lives Plan - template.

Common Life Goals Desired	Tasks Towards This Goal	What Progress Will Look Like To Me and Others	Barriers to Accomplish This Goal	Signs That Things Are Going Wrong	Plan for Managing Things That Go Wrong
Life: Living and Surviving					
Knowledge: Learning and Knowing					
Being Good at Play					
Being Good at Work					
Personal Choice and Independence					
Peace of Mind					
Relationships and Friendships					
Community: Being Part of a Group					
Spirituality: Having Meaning in Life					
Happiness					
Creativity					

Table 1 - GLM, adapted from Yates, Prescott, & Ward, 2010.

Feedback-Informed Treatment

In order to ensure that treatment made sense and was meaningful to the inmates at Rundu, it was necessary to solicit their views on it. An emerging body of research indicates that incorporating formal feedback regarding progress and engagement into treatment services builds responsivity while simultaneously improving outcome and retention (Lambert, 2010). Briefly, Feedback-Informed Treatment (FIT) has been integrated successfully into both mental health and substance abuse programs, serving both voluntary and mandated clients, in agencies and systems of care around the world (Bertolino & Miller, 2012). Multiple, randomized clinical trials demonstrate that adding FIT to existing treatment services as much as double the effectiveness of the care provided, and reduces attrition and deterioration rates by 50% and 33%, respectively (Miller, Hubble, Chow & Seidel (2013).

In practice, FIT involves administering two scales over the course of treatment; one measures the quality of the therapeutic relationship, the other assesses progress or outcome. Over 1,100 studies have made clear the importance of the therapeutic relationship to treatment outcome (Duncan, Miller, Wampold, & Hubble, 2010). Indeed, in an era that emphasizes evidence-based practice, the therapeutic relationship is the most evidence-based concept in psychotherapy research (Miller & Bargmann, 2011). Understanding changes in the relationship can help ensure that clients are meaningfully engaged in change efforts, assist treatment providers in adjusting their strategies to meet each client's needs (thereby adhering to the responsivity principle), and act as an early warning system for treatment deterioration and failure. At the same time, research has demonstrated that changes in a person's individual, relational, and social functioning are strong predictors of successful therapeutic work (Miller & Bargmann, 2011; Miller, Duncan, & Hubble, 2004).

To date, research shows that access to real time feedback regarding progress and engagement provides clinicians with an opportunity to adjust services in a way that enhances individual client responsivity and achievement of treatment goals (e.g., decreased reoffending). The same body of evidence documents that FIT promotes professional development, resulting in measurable improvements in individual provider responsivity and effectiveness (Miller, Hubble, Chow, & Seidel, 2015). In 2013, FIT was deemed an evidence-based practice by the Substance Abuse and Mental Health Service Administration (SAMHSA) and listed on the National Registry of Evidence Based Practices and Programs (see www.nrepp.samhsa.gov/ViewIntervention.aspx?id=249).

In the Rundu application, we used the Session Rating Scale (SRS [Miller, Duncan, & Johnson, 2000]) and the Outcome Rating Scale (ORS [Miller, & Duncan, 2000]). The SRS measures the working alliance, including how much the inmate agrees with the goals and tasks of treatment and how well he feels heard, understood, and respected. The ORS measures the inmate's perceived functioning at an individual level and within close friendships and acquaintanceships. Both scales are brief, self report instruments that have been tested in numerous studies and shown to have solid reliability and validity (Miller & Schuckard, 2013). Most importantly perhaps, available evidence indicates that routine use of the ORS and SRS is high compared to other, longer measures (99% versus 25% at one year [Miller, Duncan, Brown, Sparks, & Claud, 2003]).

Administering and scoring the measures is simple and straightforward. The ORS is administered at the beginning of the session. The scale asks consumers of therapeutic services to think back over the prior week (or since the last visit) and place a mark (or "x") on four different lines, each representing a different area of functioning (e.g., individual, interpersonal, social, and overall wellbeing).The SRS, by contrast, is completed at the end of each visit. Here again, the client places a mark on four different lines, each corresponding to a different and important quality of the therapeutic alliance (e.g., relationship, goals and tasks, approach and method, and overall). On both measures, the lines are ten centimetres in length. Scoring is a simple matter of determining the distance in centimetres (to the nearest millimetre) between the left pole and the client's mark on each individual item and then adding the four numbers together to obtain the total score. The staff in the Rundu prison found that the feedback they received was invaluable in helping them adjust treatment to make the experience more meaningful and therefore more effective – to the inmates.

References

Andrews, D. A., & Bonta, J. (2010). The psychology of criminal conduct (5th ed.). Cincinnati, OH: Anderson Publishing.

Bem, D.J. (1972). Self-perception theory. In L. Berkowitz (Ed.), Advances in experimental social psychology, volume 6, 2–62. New York: Academic Press.

Bertolino, B & Miller, S. (Eds.) (2012): ICCE Manuals on Feedback Informed Treatment (Volumes 1-6). Chicago, IL: The International Center for Clinical Excellence.

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. Psychotherapy: Theory, Research & Practice, 16, 252-260.

Deci, E., & Ryan, R. (Eds.), (2002). Handbook of self-determination research. Rochester, NY: University of Rochester Press.

Duncan, B., Miller, S.D., Wampold, B., & Hubble, M., (2010). The heart and soul of change, second edition: Delivering what works in therapy. Washington, DC: American Psychological Association.

Gendreau, P., & Andrews, D.A. (2001). Correctional Program Assessment Inventory. Author.

Hanson, R. K., Bourgon, G., Helmus, L., & Hodgson, S. (2009). The principles of effective correctional treatment also apply to sexual offenders: A meta-analysis. Criminal Justice and Behavior, 36, 865-891.

Hanson, R. K., & Bussière, M. T. (1998). Predicting relapse: A meta-analysis of sexual offender recidivism studies. Journal of Consulting and Clinical Psychology, 66(2), 348-362.

Hanson, R. K., Gordon, A., Harris, A. J. R., Marques, J. K., Murphy, W., Quinsey, V. L., et al. (2002). First report of the collaborative outcome data project on the effectiveness of psychological treatment for sex offenders. Sexual Abuse: A Journal of Research and Treatment, 14, 169-194. doi: 10.1177/107906320201400207

Hanson, R. K., Harris, A. J. R., Scott, T., & Helmus, L. (2007). Assessing the risk of sexual offenders on community supervision: The Dynamic Supervision Project. Ottawa: Public Safety Canada.

Hanson, R. K., & Morton-Bourgon, K. E. (2005). The characteristics of persistent sexual offenders: A meta-analysis of recidivism studies. Journal of Consulting and Clinical Psychology, 73, 1154-1163. doi: 10.1037/0022-006X.73.6.1154.

Hiatt, D. & Hargrave, G. E. (1995). The Characteristics of Highly Effective Therapists in Managed Behavioral Provider Networks. Behavioral Healthcare Tomorrow, 4, 19–22.

Lambert, M. (2010). Prevention of treatment failure: The use of measuring, monitoring, and feedback in clinical practice. Washington, DC: American Psychological Association.

Långström, N., Enebrink, P., Laurén, E.-M., Lindblom, J., Werkö, S., & Hanson, R. K. (2013). Preventing sexual abusers of children from reoffending: systematic review of medical and psychological interventions. BMJ : British Medical Journal, 347, f4630. http://doi.org/10.1136/bmj.f4630

Laws, D. R., & Ward, T. (2011). Desistance and sex offending: Alternatives to throwing away the keys. New York, NY: Guilford Press.

Mann, R (2009) Getting the context right for sex offender treatment, in Prescott, D. (ed.) Building motivation for change in sexual offenders, Brandon, VA, US: Safer Society Press.

Marques, J. K., Wiederanders, M., Day, D. M., Nelson, C., & van Ommeren, A. (2005). Effects of a relapse prevention program on sexual recidivism: Final results from California's Sex Offender Treatment and Evaluation Project (SOTEP). Sexual Abuse: A Journal of Research & Treatment, 17, 79-107.

Marshall, W. L. (2005). Therapist Style in Sexual Offender Treatment: Influence on Indices of Change. Sexual Abuse: Journal of Research and Treatment, 17, 109-116. doi: 10.1177/107906320501700202.

Marshall, W. L. & Marshall, L. E. (2007). The utility of the Random Controlled Trial for evaluating sexual offender treatment: The gold standard or an inappropriate strategy? Sexual Abuse: A Journal of Research and Treatment, 19, 175-191.

McGrath, R. J., Cumming, G., Burchard, B., Zeoli, S., & Ellerby, L. (2010). Current practices and emerging trends in sexual abuser management: The Safer Society 2009 North American survey. Brandon, Vermont: Safer Society Press.

Miller, S.D. & Bargmann, S. (2011). Feedback Informed Treatment (FIT): Improving outcome with male clients on man at a time. In J.A. Ashfield & M. Groth (Eds.), Doing psychotherapy with men. Create Space Independent Publishing Plat-form.

Miller, S.D., & Duncan, B. (2000). The Outcome Rating Scale. Chicago, Illinois: International Center for Clinical Excellence.

Miller, S.D., Duncan, B.L., Brown, J., Sparks, J., & Claud, D. (2003). The outcome rating scale: A preliminary study of reliability, validity, and feasibility of a brief visual analog measure. Journal of Brief Therapy, 2, 91-100.

Miller, S.D., Duncan, B., & Hubble, M. (2004). Beyond integration: The triumph of outcome over process in clinical practice. Psychotherapy in Australia, 10, 2-19.

Miller, S.D., Duncan, B.L., & Johnson, L.J. (2000). The Session Rating Scale. Chicago, Illinois: International Center for Clinical Excellence.

Miller, S. D., Hubble, M., Chow, D. L., & Seidel, J. A. (2013). The outcome of psychotherapy: yesterday, today, and tomorrow. Psychotherapy, 50(1), 88–97. doi:10.1037/a0031097

Miller, S. D., Hubble, M. A., Chow, D. L., & Seidel, J. A. (2015). Beyond measures and monitoring: Realizing the potential of feedback-informed treatment. Psychotherapy, 52(4), Dec 2015, 449-457.

Miller, S.D., & Schuckard, E. (2013). Psychometrics of the ORS and SRS: Results from RCT's and meta-analyses of routine outcome monitoring and feedback. Retrieved from http://scottdmiller.com/uncategorized/resources-on-feedback-informed-treatment-training-research/

Norcross, J. (2011). Psychotherapy relationships that work (2nd ed.). New York: Oxford University Press.

Olver, M. E., Stockdale, K. C., & Wormith, J. S. (2011). A meta-analysis of predictors of offender treatment attrition and its relationship to recidivism. Journal of Consulting and Clinical Psychology, 79, 6-21. doi: 10.1037/a0022200

Parhar, K. K., Wormith, J. S., Derkzen, D. M., & Beauregard, A. M. (2008). Offender co-ercion in treatment: A meta-analysis of effectiveness. Criminal Justice and Behavior, 35, 1109 – 1135.

Prescott, D.S. (2011, winter). Creating willing partners: Meaningful engagement of offenders in change. The ATSA Forum Newsletter.

Prescott, D. S. (2013). Motivational interviewing: An update for professionals working with people who have sexually abused. The Forum, Newsletter of the Association for the Treatment of Sexual Abusers (ATSA), 25, 1-9.

Prescott, D.S., & Levenson, J.S. (2009, summer). To treat or not to treat: What are the questions? Considering the Effectiveness of Sexual Offender Treatment. The ATSA Forum Newsletter.

Prescott, D.S. & Miller, S.D. (in press). Improving outcomes one client at a time: Feedback-informed treatment with adults who have sexually abused. In B. Schwartz (Ed.). The sex offender, volume 8. Kingston, NJ: Civic Research Press.

Prescott, D., & Wilson, R.J. (2013). Awakening Motivation for Difficult Changes, Holyoke, MA: NEARI Press.

Purvis, M. (2010). Seeking a Good Life: Human Goods and Sexual Offending. Germany: Lambert Academic Press.

Salter, A. (1988). Treating child sex offenders and victims. Thousand Oaks, CA: Sage Publishing.

Seto, M.C., Marques, J.K., Harris, G.T., Chaffin, M., Lalumière, M.L., Miner, M.H., Berliner, L., Rice, M.E., Lieb, R., & Quinsey, V.L. (2008). Sexual Abuse: A Journal of Research and Treatment, 20, 247-255.

Shamai, M., & Buchbinder, E. (2010). Control of the self: Partner-violent men's experience of therapy. Journal of Interpersonal Violence, 25, 1338-1362.

Simons, D. A., McCullar, B., & Tyler, C. (2006). Evaluation of the Good Lives Model approach to treatment planning. Paper presented at the 25th Annual Association for the Treatment of Sexual Abusers Research and Treatment Conference, Chicago, Illinois.

Smith, P., Goggin, C., & Gendreau, P. (2002). The effects of prison sentences and intermediate sanctions on recidivism: General effects and individual differences. (User Report 2002-01). Ottawa: Solicitor General Canada.

Simons, D. A., McCullar, B., & Tyler, C. (2006). Evaluation of the Good Lives Model approach to treatment planning. Paper presented at the 25th Annual Association for the Treatment of Sexual Abusers Research and Treatment Conference, Chicago, Illinois.

Walfish, S., McAlister, B., O'Donnell, P., & Lambert, M. J. (2012). An investigation of self-assessment bias in mental health providers. Psychological Reports, 110, 639–644.

Wampold, B. E., & Brown, G. S. J. (2005). Estimating variability in outcomes attributable to therapists: a naturalistic study of outcomes in managed care. Journal of Consulting and Clinical Psychology, 73(5), 914–923. doi:10.1037/0022-006X.73.5.914

Ward, T. (2002). Good lives and the rehabilitation of offenders: promises and problems. Aggression and Violent Behavior, 7, 513-528. doi: 10.1016/S1359-1789(01)00076-3

Ward, T., & Gannon, T. A. (2006). Rehabilitation, etiology, and self-regulation: The comprehensive good lives model of treatment for sexual offenders. Aggression and Violent Behavior, 11, 77-94. doi: 10.1016/j.avb.2005.06.001

Ward, T., Mann, R. E., & Gannon, T. A. (2007). The good lives model of offender rehabilitation: Clinical implications. Aggression and Violent Behavior, 12, 87-107. doi: 10.1016/j.avb.2006.03.004

Ward, T., & Maruna, S. (2007). Rehabilitation: Beyond the risk assessment paradigm. London, UK: Routledge.

Ward, T., & Stewart, C. A. (2003). The treatment of sex offenders: Risk management and good lives. Professional Psychology: Research and Practice, 34, 353-360. doi: 10.1037/0735-7028.34.4.353

Ward, T., Yates, P. M., & Long, C. A. (2006). The Self-Regulation Model of the Offence and Relapse Process, Volume II: Treatment. Victoria, BC: Pacific Psychological Assessment Corporation. Available at www.pacific-psych.com.

Ward, T., Yates, P. M., & Willis, G. M. (2012). The Good Lives Model and the Risk Need Responsivity Model: A critical response to Andrews, Bonta, and Wormith (2011). Criminal Justice and Behavior, 39, 94-110. doi: 10.1177/0093854811426085

White, W. & Miller, W. (2007). The use of confrontation in addiction treatment: History, science and time for change. Counselor, 8(4), 12-30. Retrieved October 6, 2013 from www.williamwhitepapers.com/pr/2007ConfrontationinAddictionTreatment.pdf.

Willis, G. M., Ward, T., & Levenson, J. S. (in press). The Good Lives Model (GLM): An evaluation of GLM operationalization in North American treatment programs. Sexual Abuse: A Journal of Research & Treatment.

Willis, G. M., & Yates, P. (2012). Assessing attainment of GLM primary goods. Paper presented at the 31st Annual Conference of the Association for the Treatment of Sexual Abusers, Denver, CO.

Willis, G. M., & Yates, P. M. (in press). Strengths-based theories and sexual offending. In T. Ward & T. Beech (Eds.), Theories of Sexual Offending. West Sussex, UK: Wiley-Blackwell.

Yates, P. M., Kingston, D. A., & Ward, T. (2009). The Self-Regulation Model of the offence and re-offence process: A guide to assessment and treatment planning using the integrated Good Lives / Self-Regulation Model of sexual offending. Victoria, BC: Pacific Psychological Assessment Corporation.

Yates, P. M., & Prescott, D. S. (2011a). Applying the Good Lives Model to clinical practice: Redefining primary human goods. Newsletter of the National Organisation for the Treatment of Abusers (NOTA) (http://www.nota.co.uk/), 68, December 2011.

Yates, P. M., & Prescott, D. S. (2011b). Building a better life: A good lives and self-regulation workbook. Brandon, VT: Safer Society Press.

Yates, P. M., Prescott, D. S., & Ward, T. (2010). Applying the Good Lives and Self Regulation Models to sex offender treatment: a practical guide for clinicians. Brandon, VT: Safer Society Press.

Yates, P. M., & Ward, T. (2008). Good lives, self-regulation, and risk management: An integrated model of sexual offender assessment and treatment. Sexual Abuse in Australia and New Zealand: An Interdisciplinary Journal, 1, 3-20.

3. Methodology

3.1 Sample Description

Forty sex-offenders at the Elisabeth Nepemba correctional facility in Rundu participated in the pilot study. All offenders had been convicted of rape against victims over the age of 12. The sample group was split into the treatment group (20 inmates) and the control group (20 inmates).

Average Age	26 years
Average Prison Sentence	12 years
Remaining Prison Sentence	6 years

Table 2 - Sample description.

The treatment group (20 inmates) was composed of 4 different risk groups:

1. High risk group (4 inmates)
2. Medium risk group (5 inmates)
3. Medium risk group, participating the TLS* program (5 inmates)
4. Low risk group (6 inmates)

*The Thinking and Living Skills for Re-Integration (TLS) program is a program targeting all types of offenders to prepare for release.

The risk group diversification serves to analyse the treatment outcome in more detail.

Note: The abbreviations M1, S2 or C2C are codings for inmates chosen to protect the identity of study participants.

3.2 Data Evaluation Instruments

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Risk. Prior to the therapy, the risk of recidivism was assessed for all offenders with the established assessment instruments Static-99 (Hanson & Thornton, 1999), Stable-2007 (Hanson, Harris, Scott, & Helmus, 2007) and Acute-2007 (Hanson et al., 2007).

The Static-99 is based on 10 static or unchangeable factors, e.g. prior convictions and victim characteristics. The scoring manual defines how to score each item with 0 to 3 points (Harris, Phenix, Hanson, & Thornton, 2010). All individual item scores add up to a total risk score that leads to placement in one of the following risk categories: Low, Moderate-Low, Moderate-High, and High (Hanson & Thornton, 1999).

The predictive power of sexual and violent recidivism for sexual offenders is well documented for the Static-99 (Eher et al., 2013; Hanson et al., 2007). On the basis of a meta-analyses, Hanson and Morton-Bourgon (2007) found a moderate accuracy in the prediction of sexual recidivism in diverse samples from North America and Europe (d. = .70, 95% C.I. of .64 to .75). The Static-99 is, therefore, far more accurate than unstructured professional judgment (d. = .43, 95% C.I. of .28 to .58; Hanson & Morton-Bourgon, 2007).

The Stable-2007 questionnaire can be used in combination with the Static-99. It is based on stable risk factors, which include offender characteristics that are related to recidivism and capable of changing over months or years (Hanson et al., 2007). The 13 factors are assessed using three-point ratings scales “0 – no problem”, “1 – some concern/slight problem” and “2 – present/definite concern”. The ratings add up to produce a total score. Using the cut-offs from the scoring manual, the total score defines three nominal need categories: Low, Moderate, and High.

The design study (N = 997) showed with .80, a reliable internal consistency (alpha) of the 13 Stable-2007 items and a good predictive validity (AUC = .76; CI [.59-.74]; Hanson et al., 2007). Further studies confirmed the predictive accuracy (Rettenberger, Matthes, Schilling, & Eher, 2011).

Rules for combining static and stable factors.

Static-99 category	Stable-2007 need category	Static/Stable priority rating
Low	Low Moderate High	Low Low Moderate-low
Moderate-low	Low Moderate High	Low Moderate-low Moderate-high
Moderate-high	Low Moderate High	Moderate-low Moderate-high High
High	Low Moderate High	High High Very-high

Table 3 - Rules for combining static and stable factors.

The Acute-2007 questionnaire (Hanson, 2007) rates the current short term risk of reoffending. It contains seven acute dynamic factors that can change over a period of weeks or days. Four of them are significantly related to sexual recidivism (Hanson et al., 2007). When combined with the Static-99 and Stable-2007 the Acute-2007 adds incremental validity to the prediction of recidivism rates (Hanson et al., 2007).

Therefore, a set of decision rules was constructed to combine static, stable and acute factors into three priority levels (see Table 2). The static/stable/acute high priority offenders are about four times more likely to reoffend than the low priority offenders (Hanson et al., 2007; Rettenberger et al., 2011).

Rules for combining static, stable and acute risk factors.

Static/Stable-2007 priority cate-gory	Acute score	Priority level
Low	Low Moderate High	Low Low Moderate
Moderate-low or Moderate-high	Low Moderate High	Low Moderate High
Moderate-high	Low Moderate High	Moderate-low Moderate-high High
High or Very high Low	Low Moderate High	Moderate High High

Table 4 - Rules for combining static, stable and acute risk factors.

Motivation. Prior to intervention and treatment, the offenders' motivation for treatment and behaviour change was assessed using the Personal Aspirations and Concerns Inventory (PACI-O). The PACI-O is based on the scales of the Personal Concerns Inventory (PCI; Cox & Klinger, 2000), which was developed to assess the motivation to change in people with addictive behaviours (Cox & Klinger, 2004, S. 148). The PCI questionnaire contains of 11 life areas. Participants set a personal goal for each life area and rate each of these goals on the following rating scales from 0 to 10: Importance, How likely, Control, What to do, Happiness, Unhappiness, Commitment, When happen, Alcohol help, Alcohol hinder (Cox & Klinger, 2004; S. 149).

Based on the work of Sellen, McMurran, Cox, Theodosi, and Klinger (2006) Campel adapted the PCI for use with imprisoned sexual offenders. To make it more feasible, the questionnaire was reduced to seven life areas. Along with other changes, scales for "Prison helping" and "Reoffending helping" were added (Campbell, 2009) to capture the living situation of imprisoned offenders.

Campbell identified a three-factor structure for the PACI-O that describes the structure and strength of motivation. Only one factor – adaptive motivation - showed sufficient psychometrically properties. Adaptive motivation is associated with an expectation of success, strong commitment, and emotional engagement (Fadardi, Azad, & Nemati, 2010).

With 0.67 the alpha level of the adaptive motivation factor, including all PACI-O scales, was below the acceptable cut-off point of 0.70. The reduction of the PACI-O scales to the original PCI scales raised Cronbachs alpha to 0.72 (Campbell, 2009). This is concordant with results from other studies that show the reliability and validity of the PCI scales for different populations (Fadardi et al., 2010; Fadardi & Cox, 2008). Therefore, this study is using the PCI scales only to calculate adaptive motivation: Importance, Likelihood, Control, Achievability, Happiness, and Commitment.

Adaptive motivation is calculated by totalling the means of the rating scales. This gives a potential raw score of between 0 and 60. To produce a 0-10 scale, the score was divided by the number of scales (Campbell, 2009).

Feedback. To evaluate therapy progress, the offenders gave feedback using two different ultra-brief measures. One of them is the Outcome Rating Scale (ORS; Miller & Duncan, 2003) that assesses the success of therapy using only four items in an visual analogue format: Overall (general sense of wellbeing), Individual (personal sense of wellbeing), Interpersonal (family, close relationships), and Social (work, school, friendships). The participants are asked to think about their situation during the last weeks and place a hash mark on the corresponding 10 cm line, with low estimates to the left and high to the right.

Despite its brevity, the ORS shows solid psychometric properties: The internal consistency of the ORS has been demonstrated in previous studies (alpha=.93, test-re-test, r=.66; Miller et al., 2003). The overall correlation between the ORS and the Outcome Questionnaire 45.2, a 45-item scale to measure therapy outcome, is .59 and therefore provides a moderate indication of concurrent validity (Miller & Duncan, 2003).

The second measure is the Program Evaluation Scale, designed for all treatment phases – Problem Solving Capacity, Relationship Capacity, Sex Drive – aligned to the methods and structure of the ORS.

The third measure to evaluate therapy progress is the Group Session Rating Scale (GSRS; Duncan & Miller, 2007), an ultra-brief alliance measure for group therapy. The GSRS was adapted from the Session Rating Scale (SRS; Duncan et al., 2003) that is used in individual therapy. The four items are presented as bipolar anchors requiring a response on the 10-centimeter line similar to the ORS measure. The items assess the following areas: the relationship to the leader and the group, therapy goals and topics, the acceptance of the approach and method used in the group and a sense of overall fit and wellbeing (B. L. Duncan & Miller, 2007).

The internal consistency of the GSRS is good, as Cronbach alphas ranged from .86 to .90 over the four sessions. Previous studies also showed medium-to-large effects for the correlation coefficients between the GSRS and established alliance rating scales (Quirk, Miller, Duncan, & Owen, 2013).

ORS and GSRS are self-report scales. They were handed out to the participants four times at the end of an intervention phase. Measuring the marks made by the participant and summing the millimetre lengths on each of the four lines obtain ORS and GSRS scores. Scores are summed out of a total possible score of 40 (Janse, Boezen-Hilberdink, van Dijk, Verbraak, & Hutschemaekers, 2014).

References

Campbell, J. A. (2009). Measuring and enhancing offenders' motivation for treatment and change. Cardiff Metropolitan University.

Cox, W. M., & Klinger, E. (Eds.). (2004). Handbook of motivational counselling: Concepts, approaches, and assessment. John Wiley & Sons.

Duncan, B. L., & Miller, S. D. (2007). Group Session Rating Scale (GSRS).

Duncan, B., Miller, S., Sparks, J., Claud, D. a., Reynolds, L. R., Brown, J., & Johnson, L. D. (2003). The Session Rating Scale: Preliminary psychometric properties of a "working" alliance measure. Journal of Brief Therapy, 3, 3–12.

Eher, R., Rettenberger, M., Gaunersdorfer, K., Haubner-MacLean, T., Matthes, A., Schilling, F., & Mokros, A. (2013). Über die Treffsicherheit der standardisierten Risikoeinschätzungsverfahren Static-99 und Stable-2007 bei aus einer Sicherungsmaßnahme entlassenen Sexualstraftätern. Forensische Psychiatrie, Psychologie, Kriminologie, 7, 264–272. http://doi.org/10.1007/s11757-013-0212-9

Fadardi, J. S., Azad, H., & Nemati, A. (2010). The relationship between resilience, motivational structure, and substance use. Procedia - Social and Behavioral Sciences, 5, 1956–1960. http://doi.org/10.1016/j.sbspro.2010.07.395

Fadardi, J. S., & Cox, W. M. (2008). Alcohol-attentional bias and motivational structure as independent predictors of social drinkers' alcohol consumption. Drug and Alcohol Dependence, 97, 247–256. http://doi.org/10.1016/j.drugalcdep.2008.03.027

Hanson, R. K., Harris, A. J. R., Scott, T.-L., & Helmus, L. (2007). Assessing the risk of sexual offenders on community supervision: The Dynamic Supervision Project.

Hanson, R. K., & Morton-Bourgon, K. E. (2007). The accuracy of recidivism risk assessments for sexual offenders: a meta-analysis. Corrections user report: 2007-1 (Vol. 21). Ottawa.

Hanson, R. K., & Thornton, D. (1999). Static-99: Improving actuarial risk assessments for sex offenders. User Report 99-02. Ottawa.

Hanson, R. K., & Thornton, D. (2000). Improving risk assessments for sex offenders: a comparison of three actuarial scales. Law and Human Behavior, 24.

Harris, A., Phenix, A., Hanson, R. K., & Thornton, D. (2010). STATIC-99 Coding Rules, Revised - 2003.

Janse, P., Boezen-Hilberdink, L., van Dijk, M. K., Verbraak, M. J. P. M., & Hutschemaekers, G. J. M. (2014). Measuring Feedback From Clients. European Journal of Psychological Assessment, 30, 86–92. http://doi.org/10.1027/1015-5759/a000172

Miller, S. D., & Duncan, B. L. (2003). The Outcome Rating Scale: A preliminary study of the reliability, validity, and feasibility of a brief visual analog measure. Journal of Brief Therapy, 2, 91–100.

Quirk, K., Miller, S., Duncan, B., & Owen, J. (2013). Group Session Rating Scale: Preliminary psychometrics in substance abuse group interventions. Counselling & Psychotherapy Research, 13, 194–200. http://doi.org/10.1080/14733145.2012.744425

Rettenberger, M., Matthes, A., Schilling, F., & Eher, R. (2011). Die Validität dynamischveränderbarer Risikofaktoren bei der Vorhersage einschlägiger Rückfälle pädosexueller Straftäter: Eine Studie über Stable-2000 und Stable-2007. Forensische Psychiatrie, Psychologie, Kriminologie, 5, 45–53. http://doi.org/10.1007/s11757-010-0086-z

4. Program Design

The pilot treatment program was structured into 5 phases.

Phase	Instruments
Phase 1	Static-99 , PACI-O
Phase 2	Stable 2007, Tables of Goods, GSRS, ORS, Acute-2007 (Treatment Group)
Phase 3 Problem Solving Capacity	Acute-2007 (Control Group), Evaluation Treatment Phase (Assessor and participant), GSRS, ORS (Control and Treatment Group), Monthly Program Report, Problem Solving Report
Phase 4 Relationship Capacity	Evaluation Treatment Phase (Assessor and participant), GSRS, ORS (Control and Treatment Group), Monthly Program Report, Problem Solving Report, Drawing Exercise
Phase 5 Sex Drive	Evaluation Treatment Phase (Assessor and participant), GSRS, ORS (Control and Treatment Group), Monthly Program Report, Problem Solving Report, Letter to Victim

Table 5 - Program design

Phases 1 and 2 included the risk and motivational assessment for the treatment and control group clustering.

Phases 3 to 5 covered treatment based on the main problems identified in the prior phases related to problem solving capacity, relationship capacity, and sex drive. The timeframe for each phase was approximately one month. Each treatment phase had a group and individual therapy ratio of 4:1.

Phase 1

Phase 1 was dedicated to defining the treatment and control group's participants' set-up.

Motivation PACI-O

The PACI-O was chosen and used to:
- Enhance motivation of participants
- Level motivation to positively influence the treatment outcome
- Test language abilities to meet the program officer's skills and capacities and to determine the size of treatment group
- Identify main problem categories which were attended to in post phases 3,4,5

Static-99

The Static-99 served to:
- Do the risk group clustering for treatment and evaluate risk factor's impact on treatment

- Evaluate language abilities to choose treatment group participants based on the program officer's language abilities

Note: Originally, the Static-99 clustering is based on criminal record data from the court and police, but were not available in the Namibian setting. Therefore, experienced correctional facility program officers carried out personal interviews towards the same end.

After the end of phase 1, the treatment and control groups were defined. The Namibian Correctional Service (NCS) settings and structures were taken into account so that inmates of different prison units were not allowed to meet during treatment.

Phase 2

After groups were defined, phase 2 served to prepare the treatment and to facilitate group building. Participants were introduced and got to know each other through trust-building measures between group members and program officers. Participants were given information about the program's content, structure, and aims, as well as answers to open questions. The Good Lives Model (GLM) was presented. Goals were roughly defined and discussed. Several exercises (for instance exercise 1) were conducted to foster treatment motivation and to prepare inmates for the treatment's content.

Acute-2007

The Acute-2007 tool:
- Was applied within treatment and control group before and after treatment to evaluate the program's outcome and impact of treatment
- Served to measure linguistic skills and enhanced trust-building between the program officer and inmates
- Defined in more detail the content of the treatment phases (see phase 3,4,5)

Note: Such psychological treatment is normally spread over a minimum two-year timeframe. The program's treatment phase conducted a shortened treatment period to explore the Namibian set-up and cultural differences in order to tailor a larger future treatment program more precisely to Namibian needs.

Conclusion for treatment phases

The experiences from the prior preparation served to tailor the treatment's structure and content. In summary, the three major points influencing the treatment design were following:

Illiteracy rate. The unexpected high illiteracy rate posed difficulties in conveying the program's content adequately. The content was redesigned using:
- Less text work in classes and for homework
- More image-based material, such as videos and pictures

- Less content for the same timeframe

Limited receptiveness. The participants limited receptiveness to absorb new content and limited ability to memorize old topics led to:

- Shortened treatment sessions and less content during single sessions
- The use of role-playing techniques that helped participants to visualize content and thereby to enhance memorization
- The use of fishbowl techniques to enhance participants' engagement to achieve higher treatment effect

The Namibian Correctional Service (NCS) settings. The structure of the Namibian Correctional Service altered the program' in three areas.

- **Risk group composition.** Inmates assigned to different program risk groups did not necessarily meet the correctional facility's risk composition. For instance inmates with a high risk score under sex offending terms, might have been in a lower correctional facility risk class. Inmates from different correctional facility risk clusters are not allowed to mix or meet during treatment. In the group composition, both requirements had to be met.
- **Language and literacy skills.** Due to the lack of program officers' language diversity, only inmates with a certain level of literacy and sufficient English and Afrikaans skills could enter the program.
- **Training of the program officer.** One program officer had not passed the full NCS's training yet, so higher risk groups were assigned to program officers with more experience and knowledge, while lower risk groups had to be formed according to the officers' level of education.

Based on these findings, the final group structure and treatment content were adjusted and elaborated so the treatment phase could begin.

Treatment phases. All treatment phases followed a similar pattern to achieve a certain level of participant's knowledge in structure and content of instruments in order to meet the shortages identified in prior phases (e.g. limited receptiveness).
All phases contained a:

- Problem solving worksheet
- Tailored evaluation of treatment phase for participants and assessors
- ORS
- GSRS
- Monthly program report

The problem-solving sheet. The problem-solving sheet constituted the centre of each treatment phase. A different version was used for all phases to achieve simplicity and practicality.

Please see below as filled sample from an inmate of the medium risk group.

3rd of September 2015

How can we solve problems?

Based on a "A five-step model of the problem – solving process."
Name: C1

Write down your chosen problem: Drug and alcohol abuse

1. **Orienting to the problem: Which negative beliefs about your abilities and (yours'/others') willingness to solve problem do you have?**
   - I couldn't stay or live without taking drugs and alcohol.
   - It was very difficult for me to buy something else.
   - I didn't have a limit on taking drugs and alcohol.

2. **Defining and formulating the problem.**
   a. **Who does it involve?**
   - Myself
   - Family
   - Children
   - Friends

   b. **Where and when does your problem occur?**
   - Almost everyday
   - Clubs
   - Shebeens
   - Bars
   - Drug dealer's places

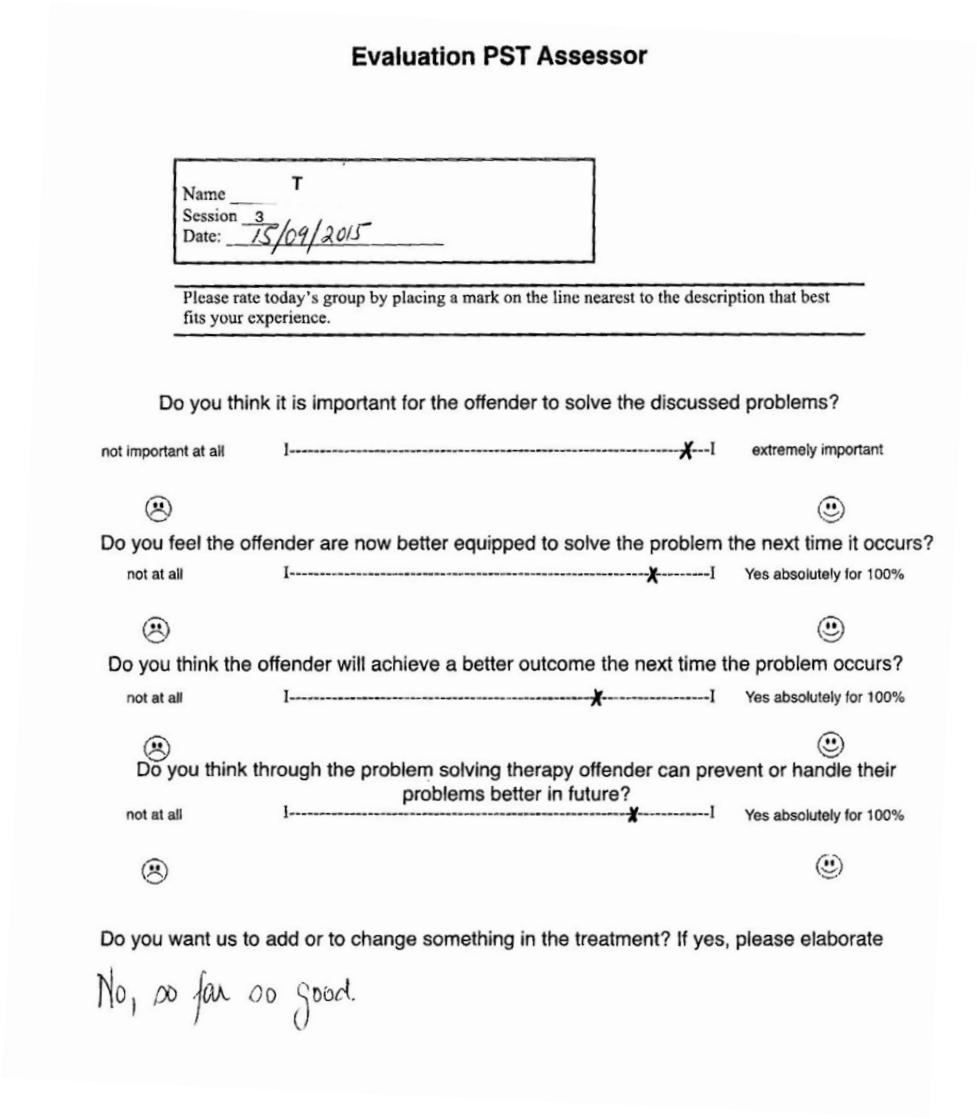
   c. **What are the specific facts of your problem?**
   - Lack of self-control
   - A lot of bad friends or people around me
   - Personal weakness
   - Self-devotion

3. **Generate as many alternative solutions to your problem**
   - Consulting a social worker
   - Try to start limiting my drug and alcohol use
   - Staying sober
   - Staying away from alcoholic friends
   - Less visit to drinking places

4. **What obstacles must you overcome to solve your problem?**
   - Personal weakness (I can't say no)
   - Bad influence of friends (peer pressure)
   - Lack of skills (don't know how to stop)
   - Failure to overcome addiction (temptation)

Graphic 1 - Example of problem solving worksheet.

Evaluation of treatment phase.
Next to the ORS and GSRS, an evaluation regarding the treatment phase's content and success was constantly done. The aim was to track detailed results and information regarding participants' and assessors' satisfaction.



Evaluation PST Assessor

Name T
Session 3
Date: 15/09/2015

Please rate today's group by placing a mark on the line nearest to the description that best fits your experience.

Do you think it is important for the offender to solve the discussed problems?

not important at all I----------X---I extremely important

Do you feel the offender are now better equipped to solve the problem the next time it occurs?

not at all I----------X--------I Yes absolutely for 100%

Do you think the offender will achieve a better outcome the next time the problem occurs?

not at all I----------X----------I Yes absolutely for 100%

Do you think through the problem solving therapy offender can prevent or handle their problems better in future?

not at all I----------X----------I Yes absolutely for 100%

Do you want us to add or to change something in the treatment? If yes, please elaborate

No, so far so good.

Picture 1 - Example evaluation sheet.

Monthly program report. The program report was used to alter future phases based on the feedback given, to monitor assessor's satisfaction and concerns in detail, and to asses inmates' individual development and personal difficulties during treatment process.

Monthly Program Report Name of assessor: S				
Session	**Challenges**	**Recommendations**	**Strengths**	**Document sent (Number of forms)**
1	Some offenders were struggling to identify problems.	Treatment Manual to be given to offenders before the start of the sessions, so that it can serve as a precourse information pack	Existence of human re-sources to develop the desired treatment manual.	
2	Some offenders found it too difficult to follow the steps of problem solving therapy.	Treatment Manual to be developed.	All of them have back-ground Information from the Thinking and Living Skills Programme. It helped them.	5 Forms
3	Some offenders were not comfortable role-playing their selected permanent alternative.	Sex offenders to be accommodated in one block, so that they can help each other on homework assignments.	Within the group there were those who were self-motivated and helped others to believe in themselves	5 X GSRS 5 X ORS 5 X PST

Table 6 - Monthly Program Report, Phase 3, Sex Offender Program.

Phase 3 - Problem-Solving Capacity

Phase 3 was dedicated to enhance participants' problem solving capacity. Inmates explored using wrong tools and behaviour patterns to solve identified problems. For instance, alcohol and drugs were used to overcome loneliness, to acquire friendship, or to forget about unemployment and family quarrels. In a structured approach, wrong problem-solving patterns were identified and alternatives discussed, chosen, and exercised.

Problem solving therapy (PST)

A. Today we speak about "problems"

1. (violent) arguments / fights with others
2. mismanagement of money / economical dependence
3. unemployment / lack of vocational training
4. negative peer pressure / "false" friends / bad community relations / fear of rejection / unsatisfying relations with women
5. drug and alcohol abuse
6. poor relations with / within family

You will see videos, pictures of problem situations now.

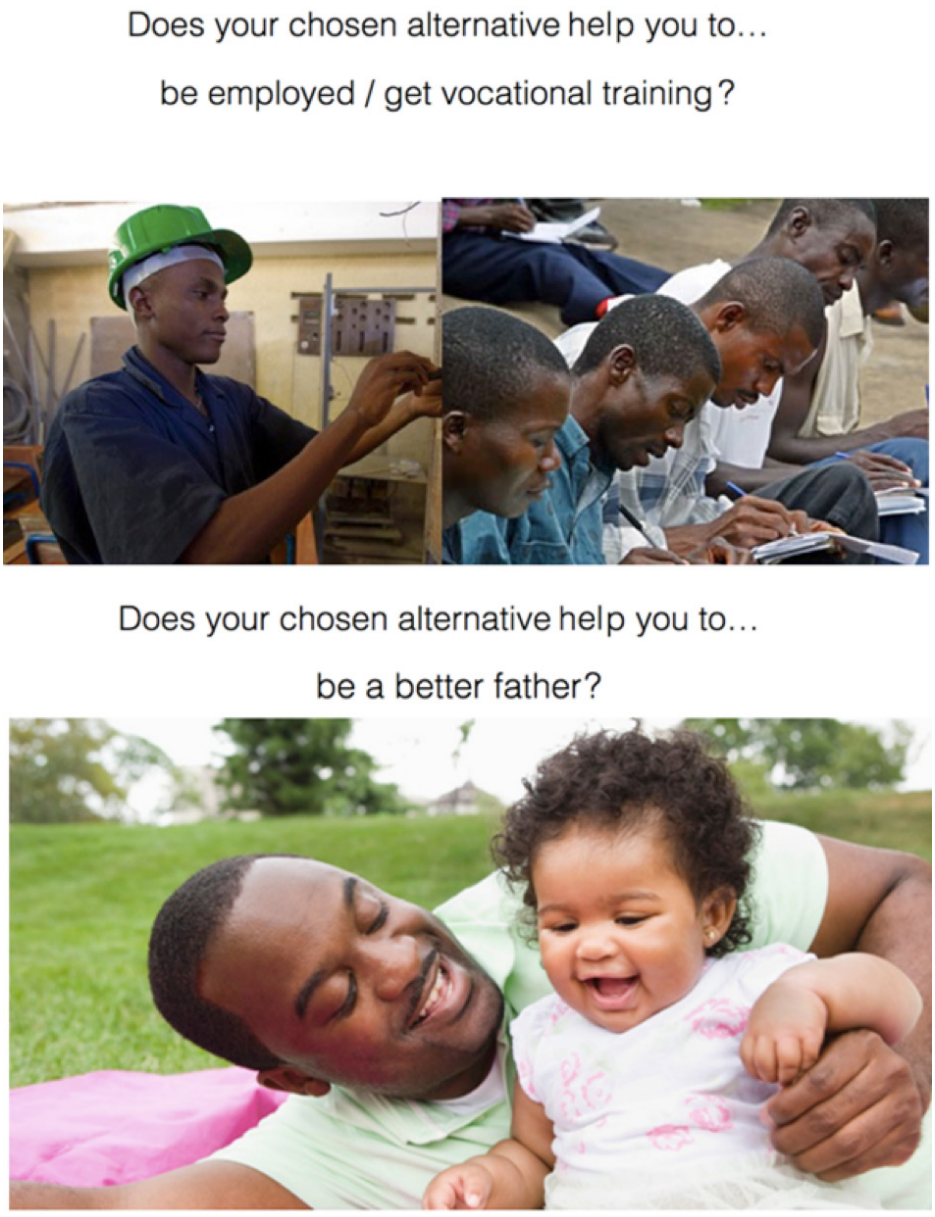
Picture 2 - Abstract of content, phase 3.

Phase 4 - Relationship Capacity

The second major issue identified in the preparation phases was the capacity to build a relationship with a lover that is lasting, respectful and satisfying for both partners. This phase was composed of group work, small assignments, individual counselling, and different discussion techniques. In a group work setting, the phase's topic was explored mutually.

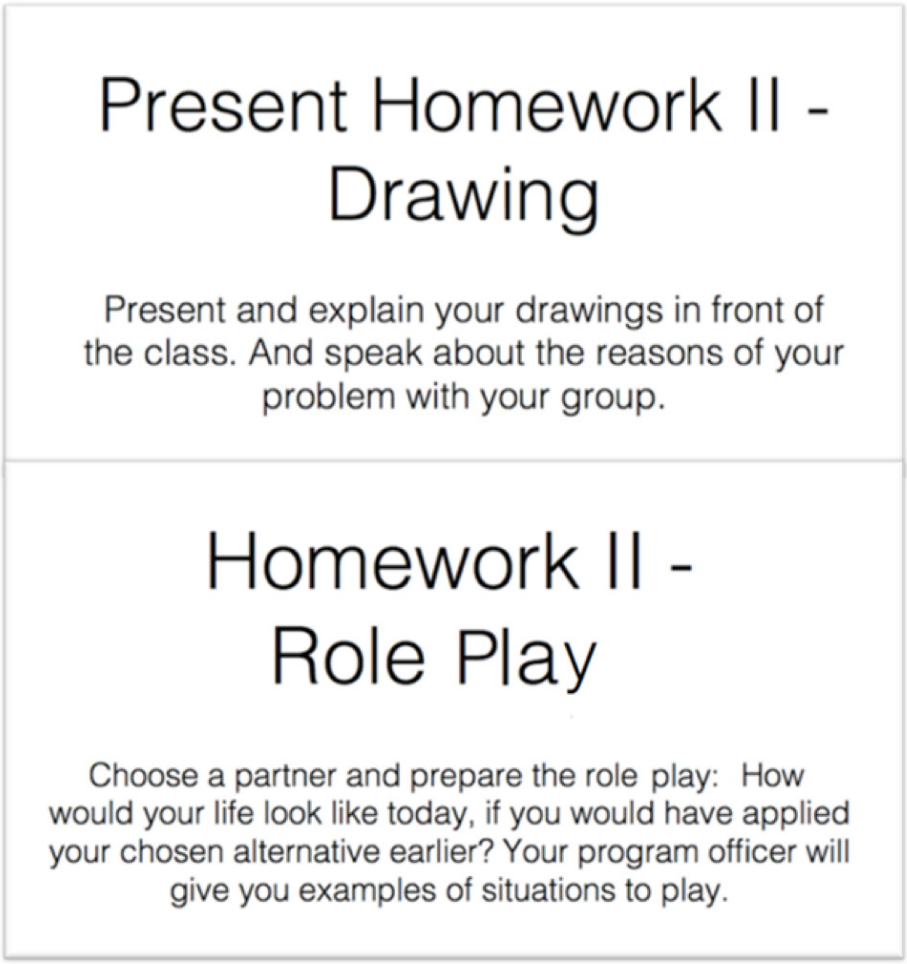
Picture 3 - First session, introduction of phase's content.

In a holistic approach, all chosen alternatives to tackle the identified problem were weighed against each other considering their compatibility with other identified critical areas. The aim was to make the chosen alternative compatible with reality in communities, suitable to tackle other concerns, and thus more stable and lasting.



Picture 4 - Elaborating alternatives.

All treatment phases were composed of different discussion techniques and communication models to tackle the shortcomings identified in the preparation phases.



Picture 5 - Different communication techniques.

Homeworks were used to make therapy content more lasting and intense to enhance treatment's success. Different narrative and artistic techniques, likewise role plays or drawings of scenes, were explored to reach deeper understanding of treatment content.

Phase 5 - Sex Drive

The identified problem – managing personal sex drive – was chosen to be the last element of treatment, after trust between group members and program officers was established and deepened. Different problem areas were identified during preparation phase 1 and 2. Below an overview about the six problem areas, which were discussed during the phase “Sex Drive”. Treatment material was again presented in a highly visualised form to inmates in order to make content more understandable and appealing.

1. Illegal or unusual sexual interests
2. Sexual interest in children
3. Sexual interest in forced sex or rape
4. Sexual impulsivity
5. Sexual preoccupation
6. Using sex to cope with stress.

Picture 6 - Overview of topics, phase 5.

Picture 7 - Material used for group discussion.

Similar to the other treatment phases, assessors got detailed material to guide group discussions along with vivid material to prompt discussion of various topics.

Further assessors got clear guidelines about each treatment phase to ensure all content is mentioned fully and presented clearly. Below an assessor's guideline sample for the area of "sexual interest in forced sex or rape" from phase "sex drive". The sample's questions are linked to the above picture.

Category: Sexual Interest in forced sex or rape

1. Describe the picture	1. Group work (describe colours, persons (their emotions, feeling) and surroundings. YOU: How would you feel if you would be that WOMAN in the picture?
2. Which problem is stated?	2. Some people enjoy the forceful aspects of sexual assaults as much or more than the sex itself. People who have a sexual preference for forced sex or rape, would rather, if given the choice, have sexual relationship that involve force than consensual sex.
3. Positive and negative consequences for the person in the picture (3.1) and the person (en)acting (3.2)	3.1 WOMEN IN THE PICTURE Positive: N/A Negative: She feels fear, pain, gets traumatized, can get psychological problems like an eating disorder and problems trusting others. 3.2 THE MAN ENACTING Positive: He may feels the sense of power and control that he wants in a relationship. Negative: Punishment through survivor itself, her children, family, or government (by imprisonment)
4. Can it lead to offending?	4. When people have these preferences, they may enjoy the other person's suffering, humiliation, or fear. These people are at risk of offending because they are not able to have consensual sex.

Table 7 - Assessor's guide for content discussions.

Again, different treatment tools were used to understand participants' mind-set and capacities, as well as to identify the level of empathy and consciousness of guilt for the index offence. Homework like "The Letter to your Victim" was used to go again through details of the index offence and to create empathy with the survivors feelings and awareness on the impacts and consequences of the inmate's actions.

Homework: Letter to your Victim.

We discussed your solutions. Now we want to speak about your offence. We want you to write a letter to your victim of your index offence.

Graphic 2 - Letter to survivor.

The treatment ended, similar to the other phases, with an individual session to touch deeper on certain problems and to discuss certain content in a more private setting. These settings allowed inmates to speak about problems they were not confident with during group therapy with the program officer.

Individual sessions

Use individual session 30 min – 60 min to speak with your program officer alone about your worksheet and letter to victim.

Graphic 3 - Assessor's guideline for individual sessions.

5. Findings

The following section will present the main findings linked to each of the instruments.

As mentioned earlier, psychological treatment is normally spread over a two-year timeframe. The program's treatment phase conducted a shortened pilot program to explore the Namibian set-up and cultural differences, in order to tailor the larger treatment program to meet the specific needs of Namibian clients. Despite the shorter timeframe, measurements indicated positive results and development.

5.1 STATIC-99

Both treatment and control groups were composed of four different risk cluster (see table below). In the composition of the treatment groups, the prison's set up had to be respected in that inmates of different prison units are not allowed to mix or to have contact. The mixed risk group (TLS) was composed of inmates with low to moderate risk factors, all of whom participated in the TLS program described earlier.

Risk Group	Static-99 Risk Category
High Risk Group (T)	mainly moderate – high
Medium Risk Group (C)	mainly moderate – low
Low Risk Group (M)	low
Mixed Risk Group in treatment (S)	low to moderate – low

Table 8 - Risk group structure according to Static-99.

Based on Harris, A., Phenix, A., Hanson, R.K. & Thornton, D. (2010). STATIC-99 Coding Rules, Revised – 2003.

5.2 Stable-2007

Based on the Stable-2007 evaluation, both groups were clustered into the following structure.

Risk Group	Stable-2007 Risk Category
High Risk Group (T)	mainly high
Medium Risk Group (C)	mainly moderate
Low Risk Group (M)	mainly low – moderate
Mixed Risk Group in treatment (S)	mainly moderate

Table 9 - Risk group structure according to Stable-2007.

Based on Hanson, R.K., Harris, A.J.R., Scott, T.L., & Helmus, L. (2007). Assessing the risk of sexual offenders on community supervision: The Dynamic Supervision Project.

The results of Static-99 and Stable-2007 corresponded. Of note is that one offender (M6) from the low risk group was rated low in Static-99 and moderate-high in Stable-2007. Normally the Static-99 rating is based on court and police data. Since this information was not available, assessments were based on interviews with the offender rather than criminal history records.

Offenders reasoning for committing rape. The Stable-2007 data gave an overview about the offender's reasoning for committing the index offence. Alcohol abuse and sex drive control (sexual satisfaction) were main reasons. Both elements were major components of the later treatment.

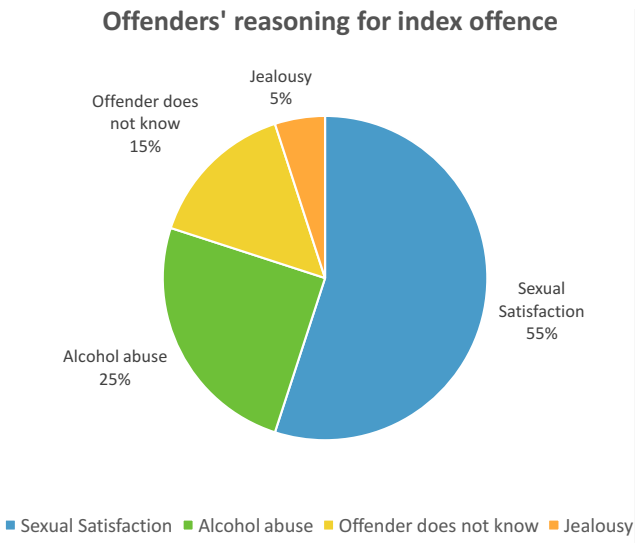


Chart 1 - Offenders' reasonings.

Next to the offender's reasonings above the below causes triggered according to inmates the index-offence as well:

On the question how easy it is for you to make friends: "When you buy alcohol, people start becoming close to you." (Offender M1)

"I gave in to the sexual urge" - after complainant 'seduced' him. (Offender C2)

"I had the urge to have sex and seeing that I couldn't find my girlfriend who lived in the same house (as the survivor), I ended up having sex with that girl." (Offender C4)

"I did it out of the reason, because the girl was seeing another guy, while I was still in love with her." (Offender M5)

To conclude sex drive, wrong gender constructs and assumptions about relationships led to the index offence. Treatment addressing both components is crucial.

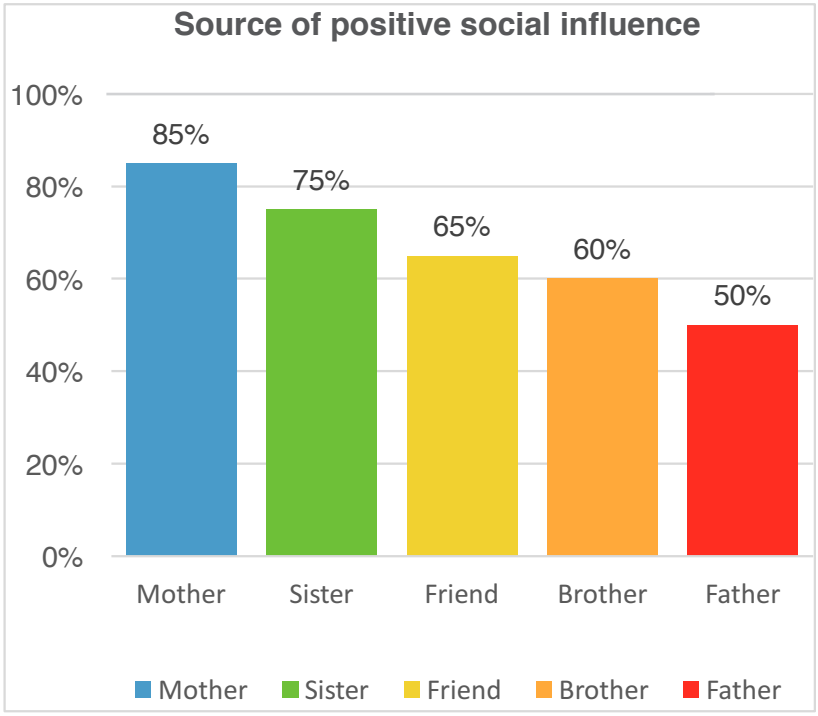


Chart 2 - Significant social influences on inmates.

Significant social influences. Different social influences on the inmates affecting the index offence (positively/negatively) were as well elaborated. Major sources of positive influence on inmates turned out to be mostly female household members, especially mothers and sisters.

1. 85% of all participants named their mother as their major source of positive influence before and during imprisonment. The influence of the mother was rated to 100% positive.
2. Other female family members, like sisters or female friends, were identified to be major sources of positive influence, as well.

Supporting and reintegrative programs after arrest should take the positive social influence of female family and household members into consideration and best, integrate these members into therapy. The positive influence of the mother and female siblings is crucial to consider in treatment especially after release.

"No one cares for me. I don't have any help from family and friends." (Offender T1C)

Nevertheless, a number of participants identified broken family settings and negative roles models. Treatment should help offenders identify and master the tools necessary to handle these influences adequately, in order to prevent relapse after release.
In summary, the Stable-2007 revealed some fundamental issues, for instance in regard to offenders' family settings, which influenced and altered treatment phase.

Main problems identified from Stable-2007 assessment for treatment phase.

Problem Solving Capacity

The Stable-2007 stated:
- Higher Likelihood to Perform Impulsive Acts: Majority of treatment group stated that they regularly or sometimes do something on impulse and then wonder why they did it (for instance get into a fight, steal something, or drive too fast).
- Poor Cognitive Problem Solving Skills: Inmates stated problems, such as rejection by community, financial problems, and bad friends as the major challenges facing them if they were granted parole. Further 65% of treatment group members stated having problem with money/managing money.
- Negative Emotionality/Hostility: 40% stated that there are situations and times, when they can't take it anymore; indirectly expressing poor problem solving skills.

Relationship Capacity

The Stable-2007 further identified, (that):
- Based on the Static-99 assessment, a vast majority never lived with an intimate partner for more than two years, indicating weak capacities to live an intimate, lasting relationship.
- In case inmate was in an intimate relationship, he often faced different severe problems keeping the relationship alive.
- Certain hostilities against women were indicated. For instance, the majority of inmates had the impression that "women would sometimes say things just to get men in trouble."
- According to certain sample group members "women are an obstacle for achieving a healthy life." (Offender S1). Several offenders stated they were "seduced by women" (Offender M3) and therefore constantly searched their close company.

- A negative emotionality/hostility: Another factor feeding into unstable relationships, is a negative emotionality. 45% of the treatment group participants stated that they feel that people are “just out there to get you”, and 80% stated, “that they deserve better than they have gotten in life”.

Sex Drive

- Certain inmates had a high fluctuation and high number of sexual partners over their lifetime, sometimes ranging over to 80 different sexual partner, indicating a strong lack of control over own sex drive.

High number of different sexual partner and hostility towards women were mainly identified in medium and high risk group. Likewise offender S4 stated about the complainant of the index offence “I was just enjoying myself, because she served as a substitute for my girlfriend.” Further inmates of all risk groups stated high frequencies of sexual thoughts during the course of the day.

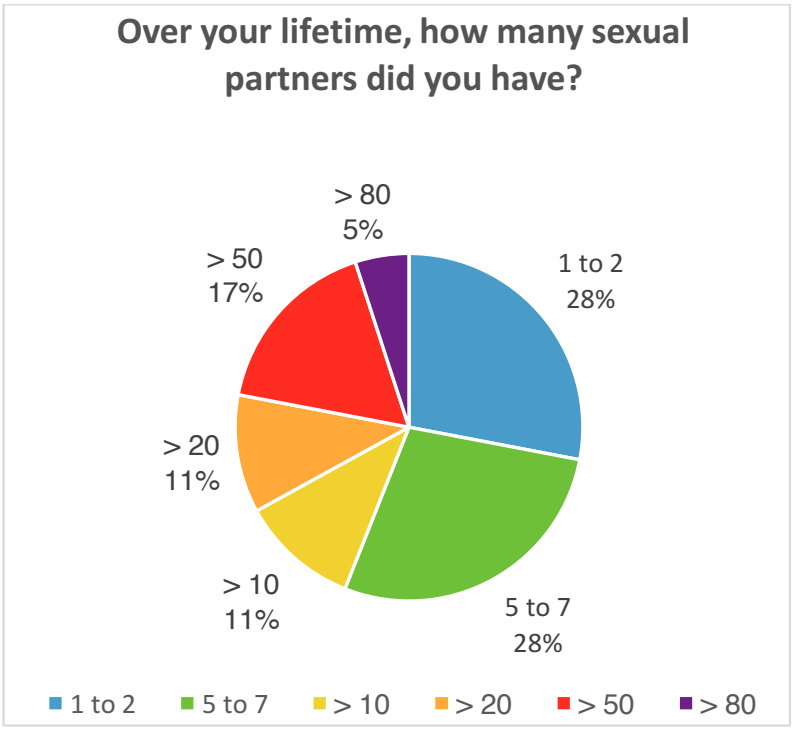


Chart 3 - Number of sexual partners.

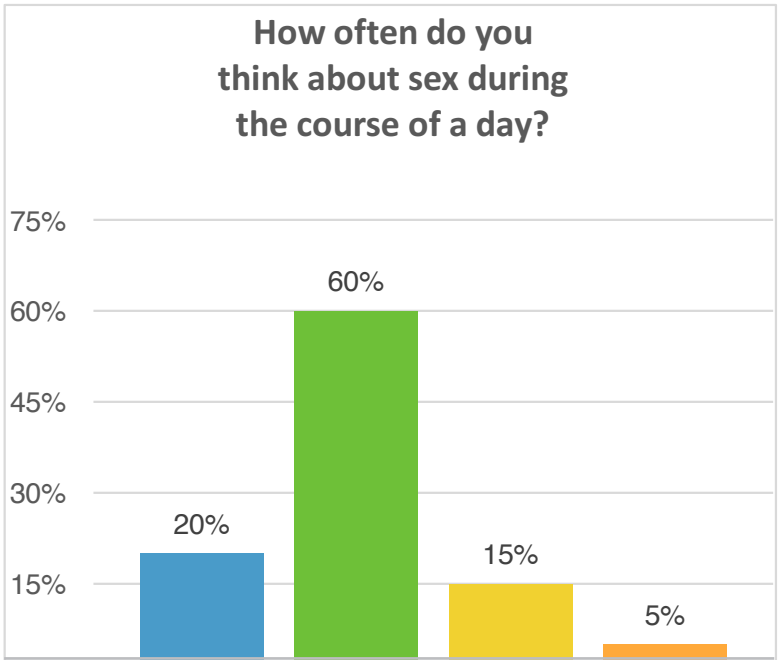


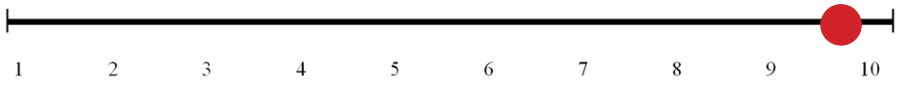
Chart 4 - Thinking on sex during the course of the day.

5.3 PACI-O

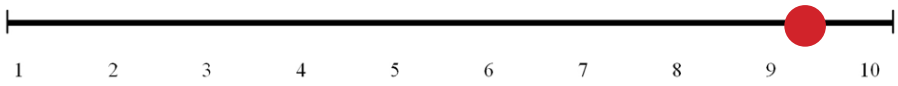
The motivational analysis revealed that motivation of all participants to change and to achieve chosen life goals is in general high (on a scale of 1 to 10 with highest motivation indication being 10). Motivational reasonings differed, offender M1 for instance stated “Back to prison ? - I can waste a lot of my time”, revealing a high motivation to stay out of prison after release.

The low-risk group had the highest level of motivation, whereas the high-risk group had the lowest motivational level. The data between the medium risk group and the (low and medium) risk group (already receiving treatment) did not differ much.

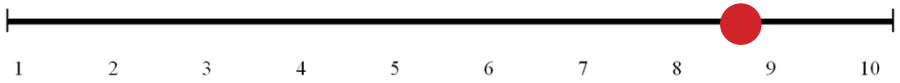
Low-Risk Group (M) Ø – 9.6



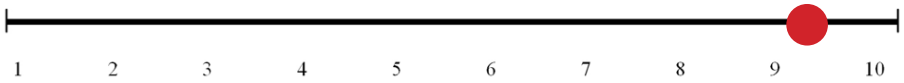
Medium-Risk Group (C) Ø – 9.2



High Risk Group (T) Ø – 8.7

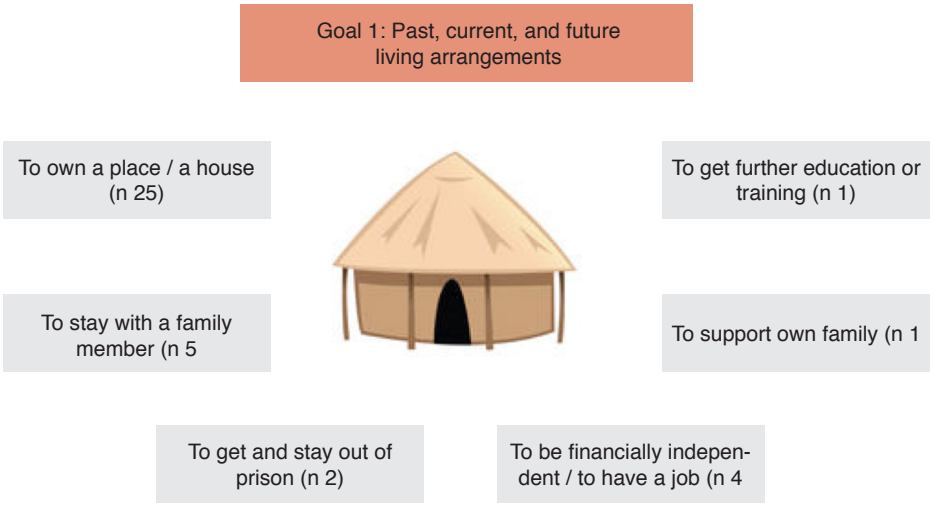


Low and Medium Mixed TLS Risk Group (S) – Ø 9.3



Graphic 4 - PACI-O results.

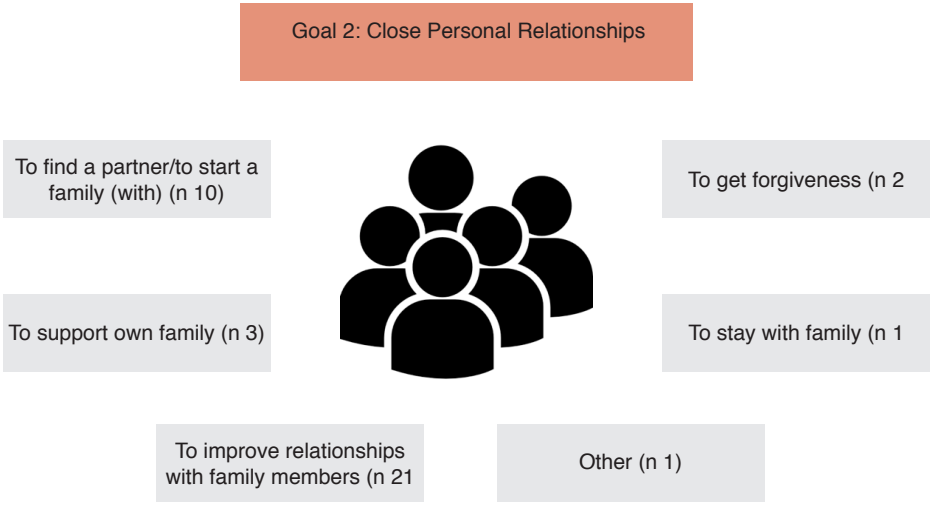
Participants were asked to identify motivational goals for six different areas of life. The clustered answers are presented below.



Graphic 5 - PACI-O Goal 1.

Main goal after release was to own a house / place to live, with big distance, followed by the aim to be reunited with family and to be financially independent. Achievement of life goals is linked to decreased likelihood of relapse.

The second cluster are life goals geared around close personal relationships, whose achievement is as well strongly linked to reduced probability of reoffending. Majority of inmates are seeking to enhance relationships with family members and to live in a stable partnership.

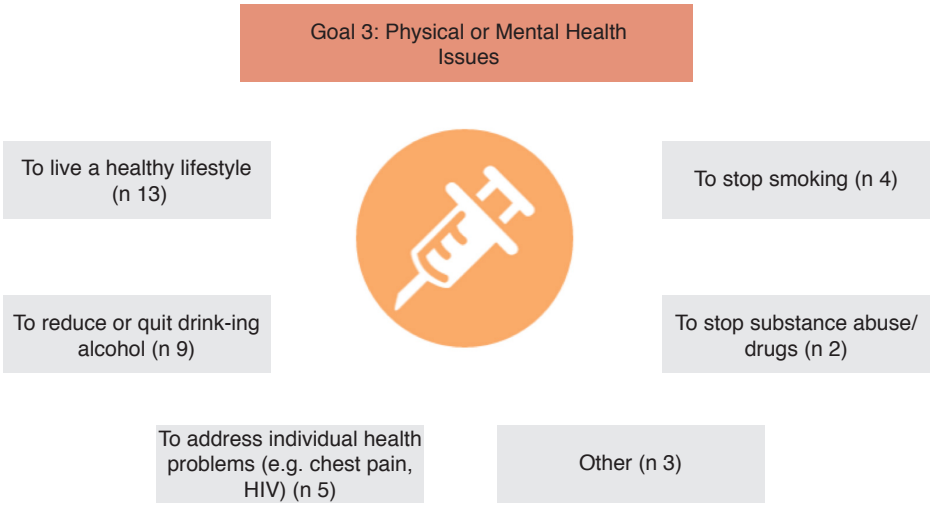


Graphic 6 - PACI-O Goal 2.

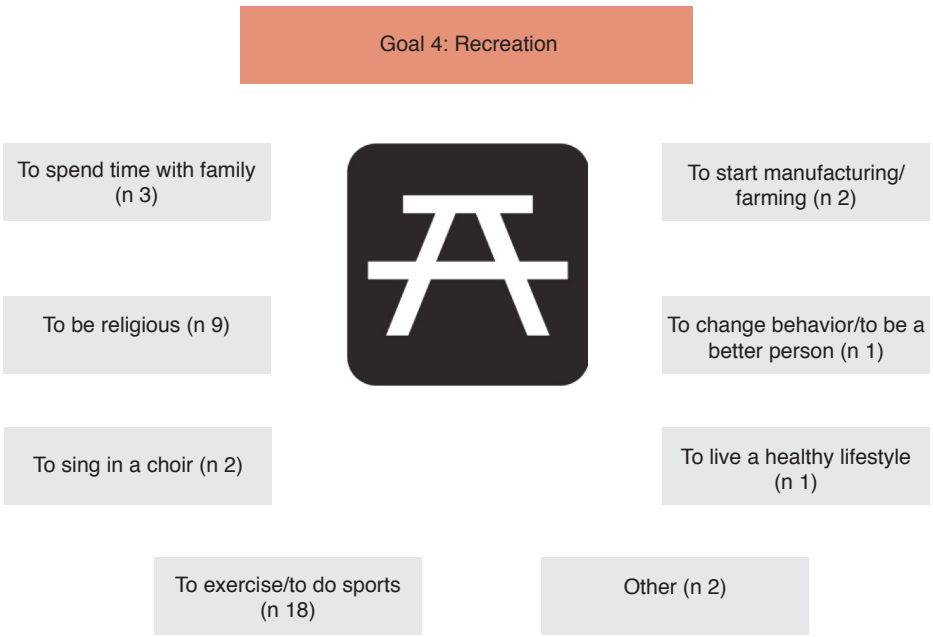
The major goal was the establishment of a home for themselves and their families as a basic need for the achievement of other objectives. Further already at the beginning of treatment, the need to improve personal relationships with family or lover was paramount.

A balanced life style is enhancing psychological well-being. According to the Good Lives Model (GLM), the attainment of good physical and mental health conditions are factors featuring a holistic stability of inmates after release. Main objectives targeted by the sample group were “to do sports”, “to be religious”, “to live a healthy lifestyle” and “to reduce substance abuse”, in order to increase possibility to live a crimefree life. In a nutshell, substance abuse and health risk linked to HIV infections were identified as crucial - “Alcohol is a door to problems” (M6C). Offender S3 stated during therapy “I learn that being without alcohol doesn’t make me sick” and T3 mentioned regarding his drug abuse, “If I had stayed outside prison I don’t know if I could have stopped”, assessing his term in prison as clearly beneficial.

Religion played an unexpected role in inmates’ life goals. The majority confessed to be strong believers and aimed to be better Christians. Offender C4C stated “It is against my religion to be in prison for a second time”. Life goals further stated the high need for employment and further education to maintain and achieve stability in life.



Graphic 7 - PACI-O Goal 3.



Graphic 8 - PACI-O Goal 4.

Goal 5: Self-Change and Personal Improvement

To control anger (n 12)

To be a better person (n 10)

To live crime free (n 8)

To improve relationships with family (n 2)

Learn to love others (n 2)

Other (n 2)

To become a hard worker (n 2)

Graphic 9 - PACI-O Goal 5.

Goal 6: Employment, Training and Financial Situation

To get further education or train-ing (n 21)

To find a job (n 12)

To improve financial situation (n 4)

Other (n 1)

Graphic 10 - PACI-O Goal 6.

PACI-O overall goals (in descending order).

Goal	n
To own a place or a house	25
To get further education or training	22
To improve relationships with family/family member	21
To exercise/do sports	18
To live a healthy lifestyle	14
To control anger	12
To find a job	12
To change behaviour/be a better person	11
To find a partner/to start a family	10
To reduce or quit drinking alcohol	9
To be religious	9
To live a crime free life	8
Other	9
To stay with a family member	6
To address individual health problems (e.g. chest pain, HIV)	5
To be financially independent/to have a job	4
To support own family	4
To stop smoking	4
To improve financial situation	4
To spend time with family	3
To get and stay out of prison	2
To get forgiveness	2
To stop substance abuse/drugs	2
To adjust to prison/accept sentence	2
To start manufacturing/farming	2
To sing in a choir	2
To become a hard worker	2
To improve relationships with family members	2
To learn to love others	2
Sum	228

Table 10 - PACI-O overall goals.

Several goals stretched across different categories…

Improved family relations
Financial success
Personal improvement
Healthy lifestyle

Table 11 - PACI-O re-occurring goals.

1. Family Relations - to improve relationships / stay / support with family/family member
2. Financial success - to be financially independent / to have a job / further training
3. Personal improvement - to be a better person / stay out of prison / be religious / control anger
4. To live a healthy lifestyle

… and were identified to be of major importance for inmates. In a holistic approach, treatment aimed in every mutual elaborated problem solution alternative to meet and to achieve the identified four overall goals through altered behaviour.

5.4 Exercise. How important is change for me?

Based on the PACI-O findings, participants went through exercises to identify the importance of personal change.

How important is change for me?
Risk Groups (M,C,T,S) Ø – 9.9

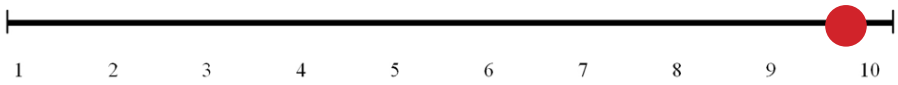


Chart 5 - How important is change for me?

Likewise, the PACI-O results measuring the motivation for change were very high with 18 out of 20 participants assigning it the maximum score of 10. In total, the treatment group indicated a high motivation to change and to participate in treatment.

Main reasons for change. Participants main reasons to introduce change were the following (descending order).

Reason	n
Be a better person	12
Support family	10
Learn from mistakes	9
Enhance social life	7
Better relationships with women	7
Better friendships	5
Win back trust of community	5
Be employed	5
Respect for others	4

Table 12 - Main reasons for change.

Individual wellbeing and enhanced family relations composed the two main motivators for change. Majority of inmates indicated a strong and high willingness to change.

Real willingness to change	n = 19

Table 13 - Willingness for change.

5.5 Problem Solving Sheets

The problem-solving sheet taught participants to identify problems that have led to the index offence and how to elaborate a permanent alternative solution to reach life goals in a better and legal pattern.

Main problem areas. The following problems leading to the index offence were identified (top down) during each specific treatment phase.

Phase 3 "Problem Solving Capacity"	Phase 4 "Relationship Stability"	Phase 5 "Sex Drive"
Substance abuse	Substance abuse	Sex as stress relief
Unemployment	Faithfulness issues with partner	Sexual preoccupation
Lack of qualification	Poor family relationships	Sexual agression
Financial problems	Agressions	Paedophilia
Agression	Financial problems	
Poor family relationships	Sexual issues	
	HIV	

Table 14 - Main areas of problems.

Substance abuse, financial problems linked to unemployment, aggression, and poor family relationships were the main problems identified by the participants (in phases 3 and 4) as having triggered their index offence.

Negative beliefs to solve problems. Participants identified several obstacles preventing them from achieving a solution or a better behavioural pattern to solve their problems.

Phase 3 "Problem Solving Capacity"	Phase 4 "Relationship Stability"	Phase 5 "Sex Drive"
Drug/Alcohol abuse	Drug/Alcohol abuse	Sex drive (as stress relieve)
Low education	Polygamy	Polygamy
Mismanagement of money		
Poverty/unemployment		
Unable to report women		
No control over temper		
Lack of family support		

Table 15 - Negative beliefs to solve problems.

Clustered drug/alcohol abuse and polygamy were constantly defined as participants' main concerns with regard to tackling their individual problems. Both obstacles received additional focus during treatment.

Alcohol. Participants' assumptions regarding alcohol use were, that it is needed to keep friends and women or to overcome problems in a better way.

"I cannot live without alcohol, I will lose all my friends." (S3)

"In my belief, when I'm drunk I'm man enough." (C1)

Culture - Polygamy. Certain participants favoured polygamy as their preferred form of relationship. Reasons included limited satisfaction, fun, or pleasure in a monogamous relationship.

"Sex with one woman is boring." (M2)

Culture - Being unable to report women. Participants identified cultural limits pressing them into certain male stereotypes nurturing the index offence.

"A man can't report to the police if he is beaten by women. A man can't cry. A man can't cook. A man can't be controlled by women." (M5)

Poverty. Poverty was seen as a major influential factor in reaching certain educational objectives or employment goals.

"I am born to be poor and education is only for rich people." (S1)

Sex Drive. During the problem sheet exercises, it appeared to be clear that sex drive comprised major obstacles to achieve individual life goals.
"I believe that sexuality in children can reduce stress, anger, and emotional desire." (T1)

Whom does the problem involve? In order to adapt the treatment to participants' familiar situation, they were asked to mention other individuals involved in their identified problem.

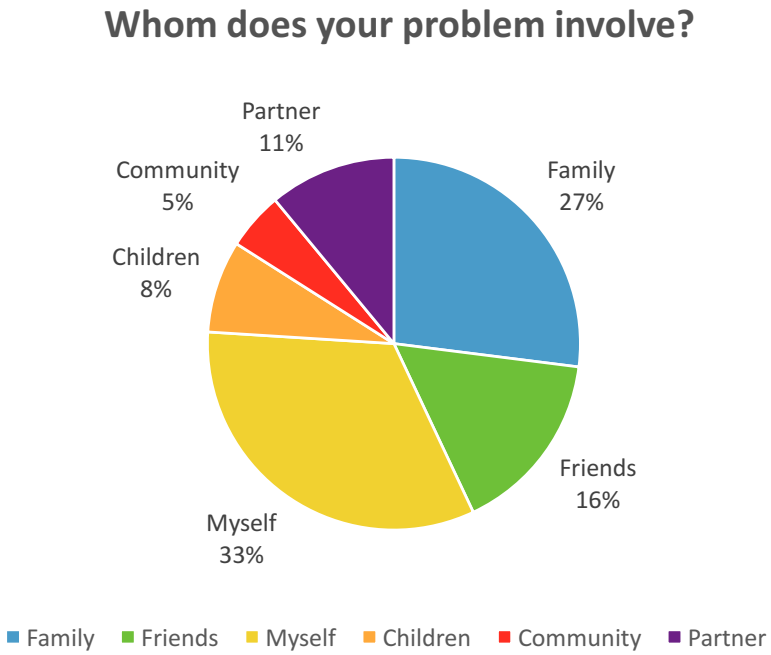


Chart 6 - Whom does problem involve?

Apart from the perpetrator himself, again family members and certain friends were mainly identified as triggers supporting the index offence. For instance offender M4 stated that "In order to fit in with my friends I needed to have more than one girlfriend." Often these assumptions were linked with low self-esteem. "I am unable to propose to a lady, because I know that the answer will always be no." (M1)

Family and Friends. Often inmates do not have a supportive network, which is important to prevent relapse. "I don't have anyone to support me, because my family is very poor" (Offender T1). This knowledge is important for later treatment. When an offender is on parole, family and friends have to be involved in accompanying measures as far as possible, and certain community/cultural beliefs must be strongly addressed during later treatment.

Community / Cultural beliefs. Especially monetary and health issues were incorporated and discussed based on inmates assumptions. T3 for instance thought that, "I must give people money in order for them to see me" and several other inmates, especially in the higher risk group had the impression that "Real men have to die of HIV" (Offender S1).

When does it occur? Certain times and venues have to be given additional consideration during therapy, since they present higher likelihood for re-offending. Without treatment "when out of prison" equated with a high risk of reoffending.

Phase 1 - Problem-Solving Capacity

When does it occur?	n=14
Month end/when money available	5
Every day	4
When out of prison	3
When drunk	1
When seeking job	1

Table 16 - Problem-Solving Capacity.

Phase 2 and 3 combined - Relationship Capacity and Sex Drive

When does it occur?	n=35
Stressed	9
Lonely	6
Under the influence of alcohol/drugs	4
During arguments	4
When need for sex	3
When disappointed/worried	3
Bored	2
Others	4

Table 17 - Relationship Capacity and Sex Drive.

"I have to stay away from women's company, especially women who wear clothing that is a temptation" (Offender S3). During the later phases especially, certain mood stages significantly influenced the occurrence of the problem. Providing tools to handle negative moods and sexual feelings adequately composes a crucial point in more in-depth treatment.

Permanent alternative (over all phases). Together group participants and program officers elaborated on permanent alternatives to achieve identified life goals. In exercises (limited to the prison setting), the adherence to the solutions was trained.

When does it occur?	n=59
Limit alcohol & drug abuse	15
Seek counselling & professional help incl. TLS	16
Employment (Start work project, any productive activity, find a job)	14
Be more committed to a partner/monogamy	10
Higher education	2
Enhance family situation	2

Table 18 - Permanent alternatives (over all phases).

Outcome of the chosen alternative. Participants were asked about the outcome if they had chosen and stuck to the identified behaviour pattern earlier in life. All participants forecasted a positive outcome if they followed the new alternative to solve identified problems, which reinforced commitment and motivation during treatment. In detail, the new outlook has included:

- Good relationship/marriage (being able to marry, being a better partner) n=17
- Better familiar relations (being a better father, husband, son) n=13
- Gain respect (from family and community) n=4

Examples for individual alternatives were for instance:
- “Stop buying things for women in exchange for sexual favours.” (S5)
- “I want to be a good person and respect women” (M2)
- “I need to understand the difference between sex and love.” (S1)

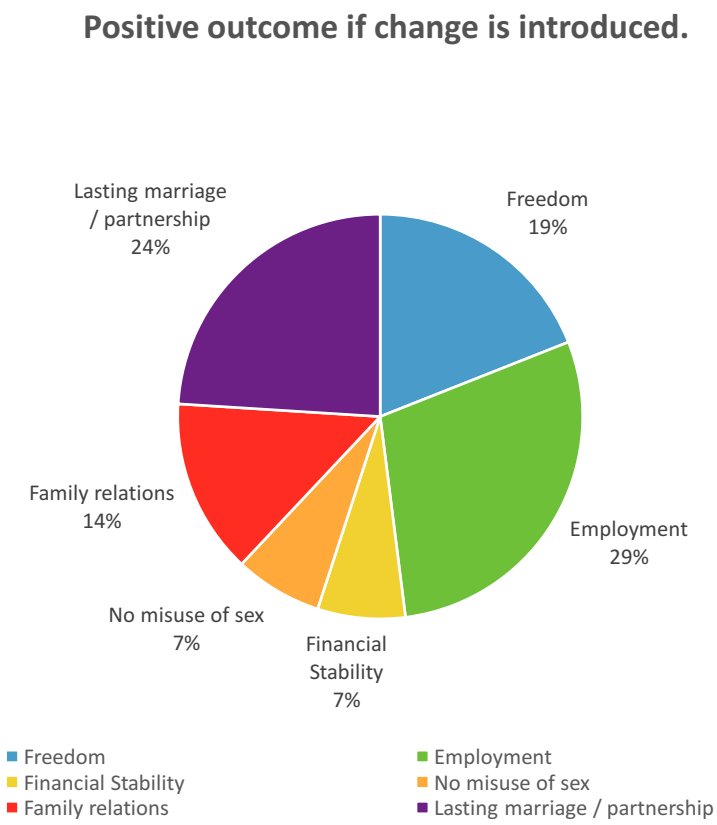


Chart 7 - Outcome of chosen alternative.

Inmates identified positive outcome and consequences if changed personal behavioural patterns are to be introduced. Positive outcomes touches on all areas of life - ranking from employment over freedom to lasting marriages. Critical self-reflection and awareness of negative consequences of previous patterns gave inmates through all risk-groups a motivational push to introduce and work towards a shift.

5.6 Outcome Rating Scale (ORS)

Although the treatment was conducted over a fairly short period, a positive outcome was measurable. Over all risk groups, satisfaction increased in terms of

- Individual (personal wellbeing)
- Interpersonal (family, close relationships)
- Social (work, school, friendship)
- Overall (general sense of wellbeing)

Treatment Group: Risk group development over all ORS categories. All risk groups showed a positive trajectory, reaching higher satisfaction in all above mentioned categories, stating a major success of treatment.

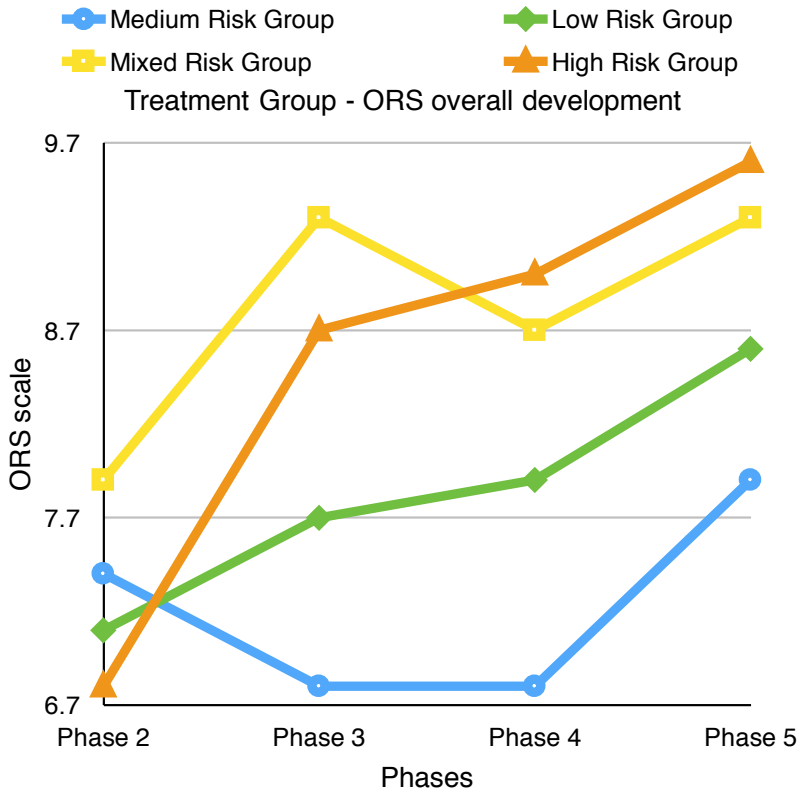


Chart 8 - Treatment Group. Development of all ORS categories.

Control Group: Risk group development over all ORS categories. Here such a clear picture cannot be drawn. Especially the wellbeing of high-risk group members without treatment is dramatically low. Medium group remains on a constant level, whereas mixed and low risk group do not show a clear trend.

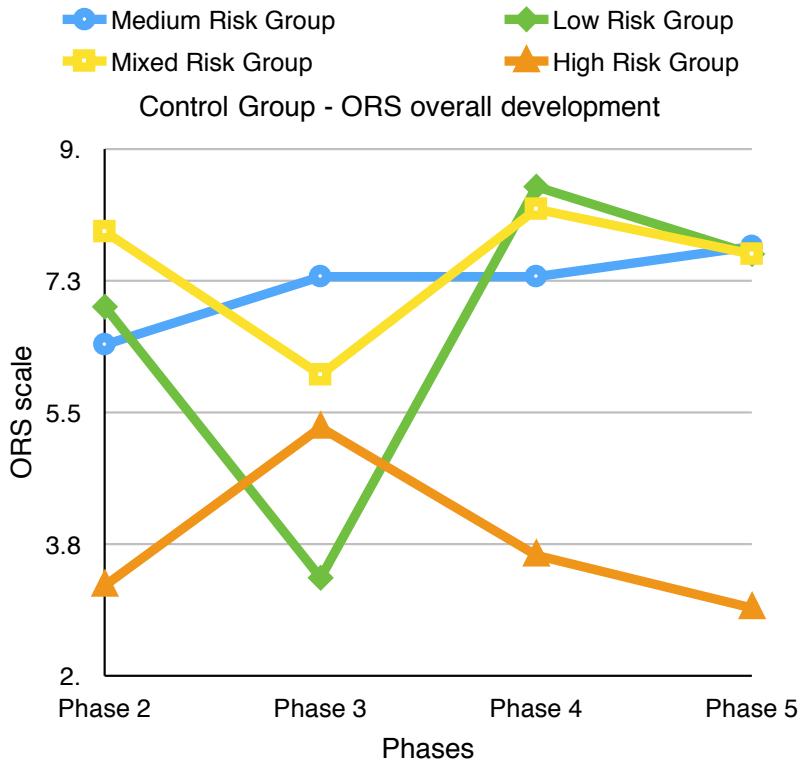


Chart 9 - Control Group. Development of all ORS categories.

Treatment Group - Development of individual ORS category. Examining the development of the individual ORS category, all areas showed improvement. Major progress was made in the area of social development (work, school, friendship). In all ORS categories, a clear positive achievement was possible.

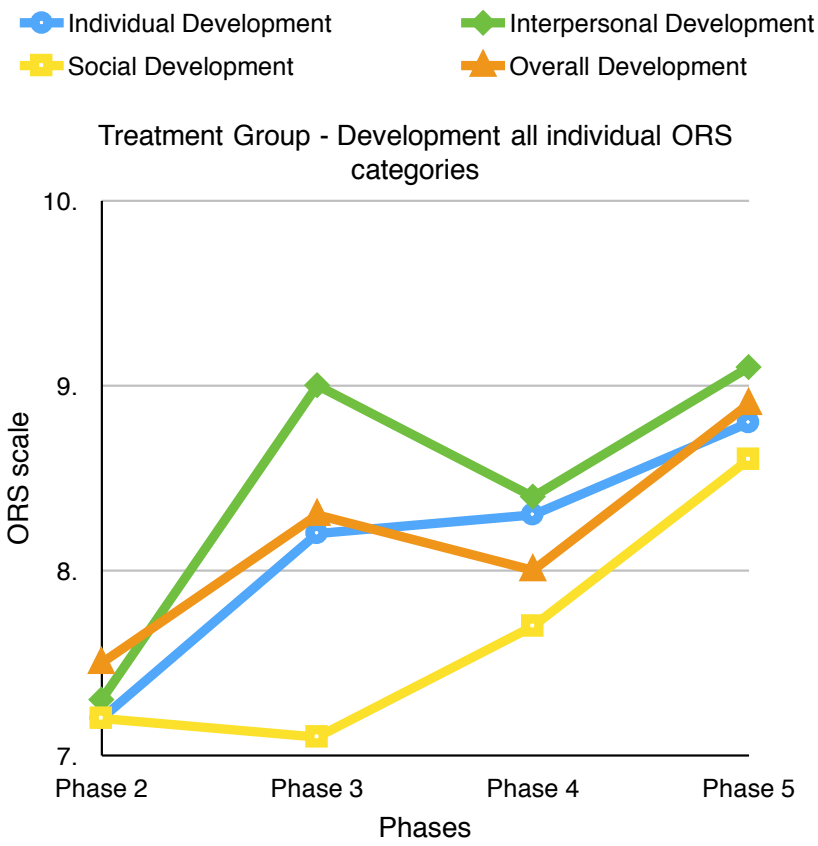


Chart 10 - Treatment Group. Development of all individual ORS categories.

Individual development (personal wellbeing). Especially the low and medium risk group achieved major improvements under that category. The low risk group grew over 4 full index points.

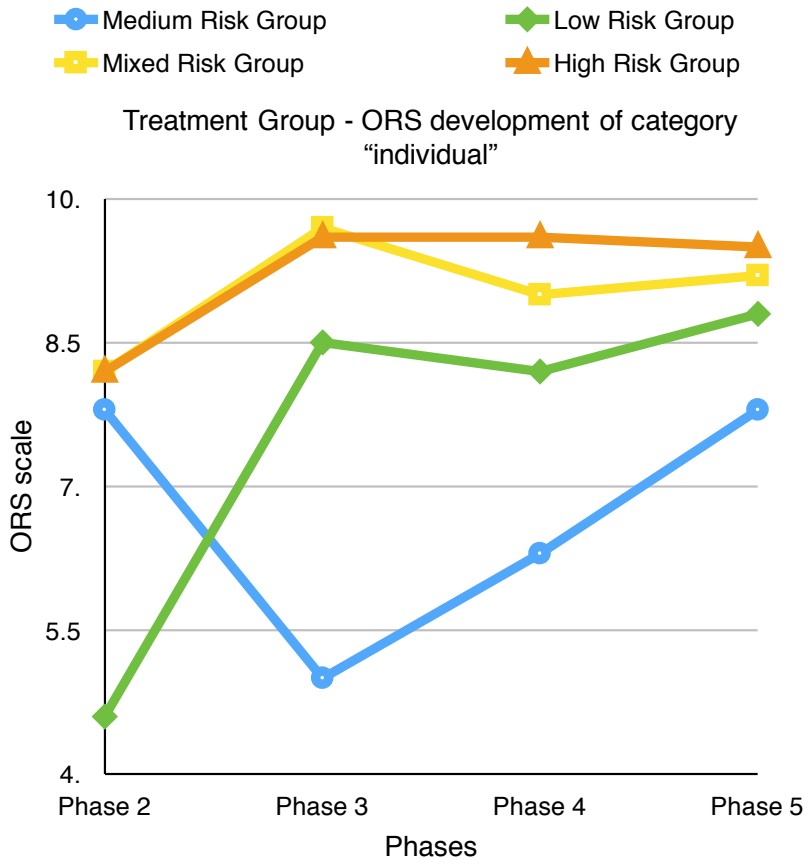


Chart 11 - Treatment Group. Development of category "individual".

Interpersonal development (family, close relationships). Also in the area of the interpersonal development all risk groups made progress. In particular, the high-risk group performed best, growing over seven full index points.

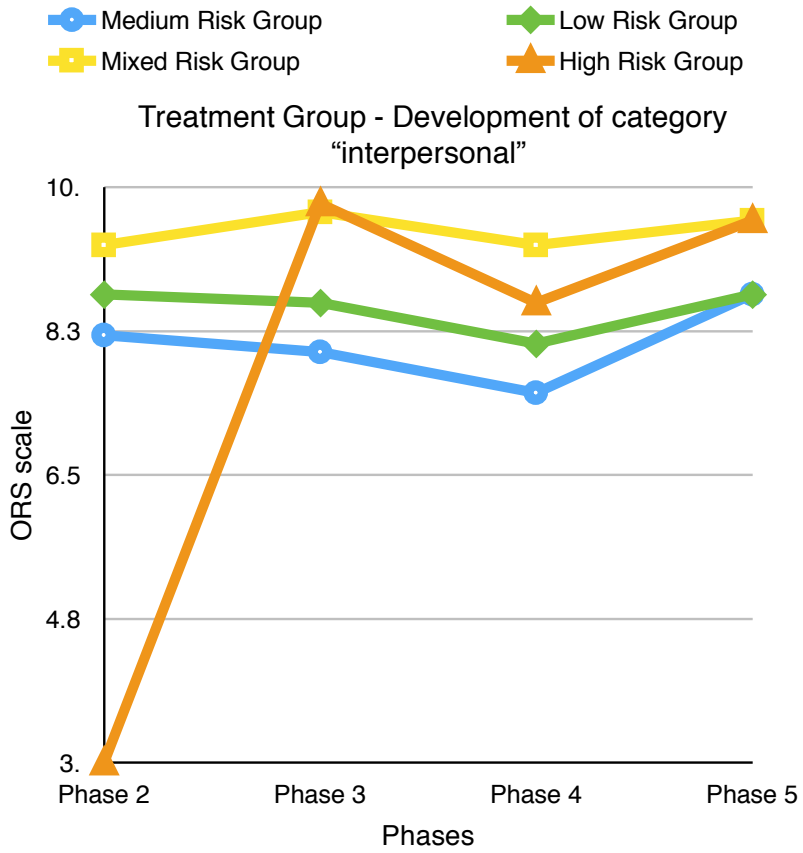


Chart 12 - Treatment Group. Development of category "interpersonal".

Social development (family, close relationships) and overall development (general sense of wellbeing). Development in both categories, social and overall, was positive. Again, the high-risk group's development was the best.

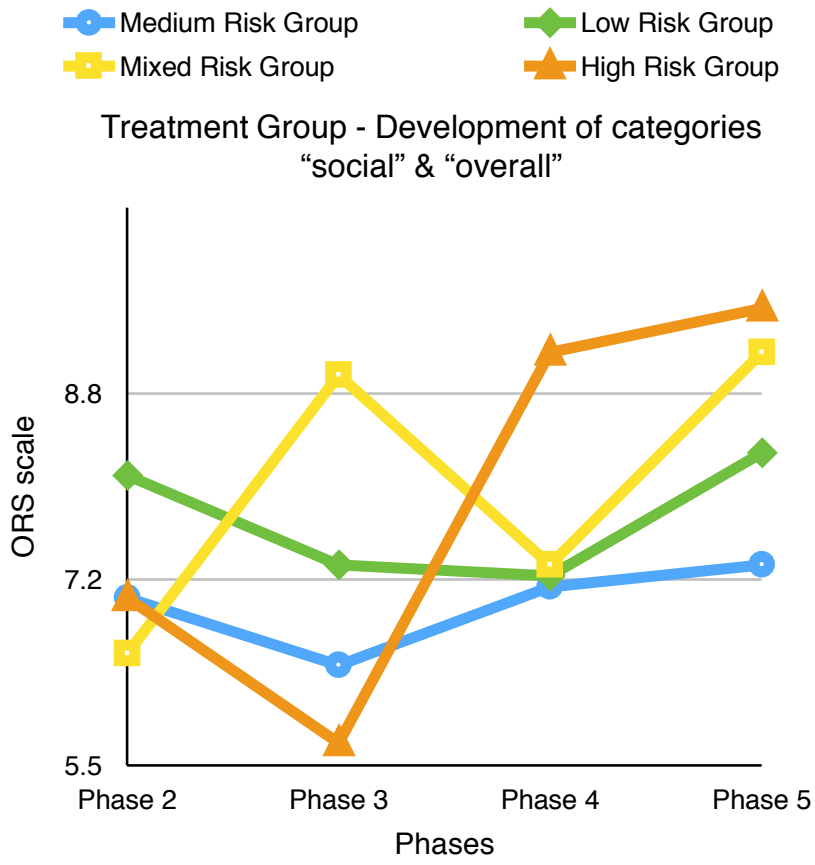


Chart 13 - Treatment Group. Development of categories "social" & "overall".

5.7 Group Session Rating Scale (GSRS)

Compared to the treatment Outcome Rating Scale (ORS), satisfaction with the Group Session Rating (GSRS) grew positively as well, but not to the same extent as the ORS. In particular, the group dynamic for the medium risk group fell after session one. Consequently, more and better team/trust building measures between group members have to be applied before and during treatment.

Treatment Group: Development of all GSRS categories.

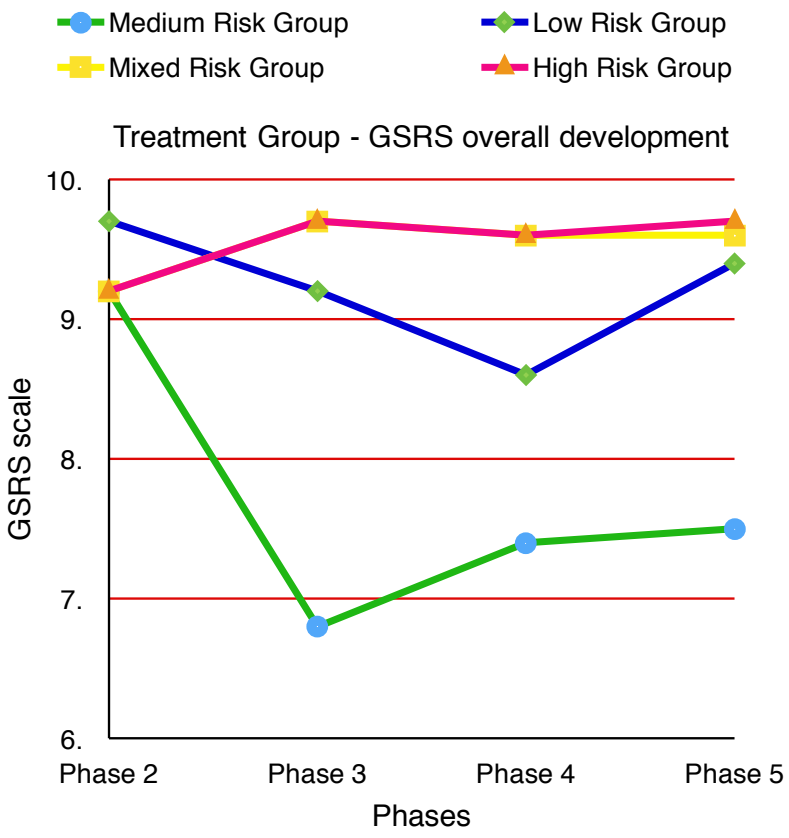


Chart 14 - Treatment Group. Development of all GSRS categories.

Treatment Group - Development of GSRS categories "Goals and Topics".

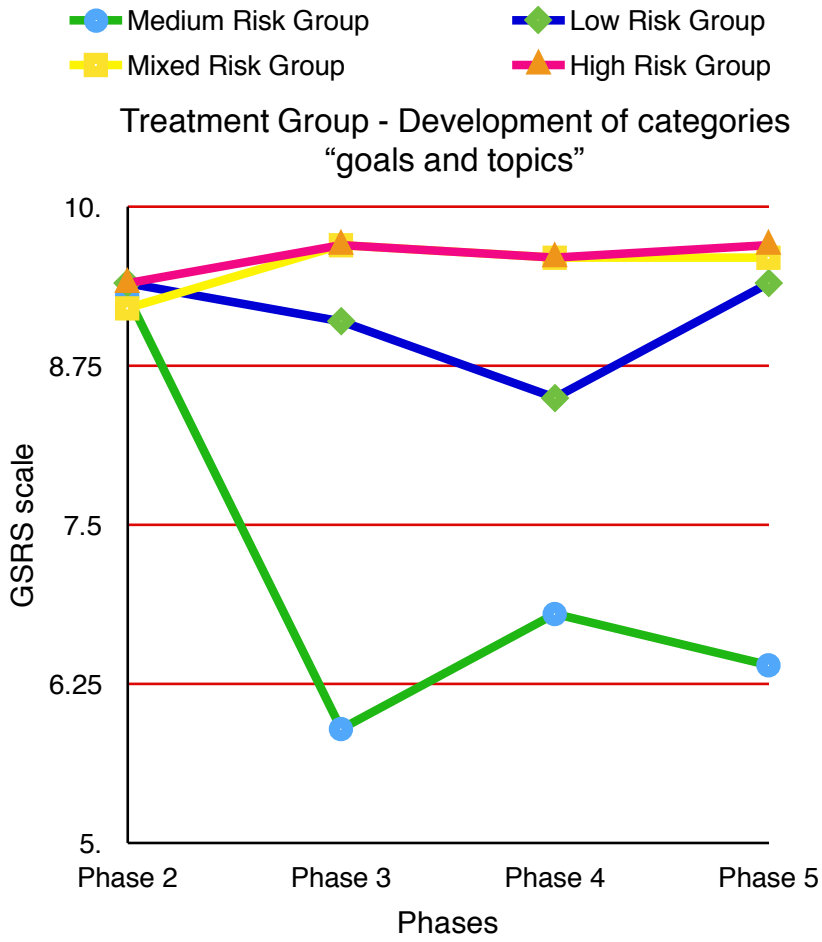


Chart 15 - Treatment Group. Development of categories "goals and topics".

Goals and Topics. Participants rated the group session's "goal and topic" achievement in the course of the treatment more as positive — "We worked on and talked about what I wanted to work on and talk about". Again, the medium risk group and mixed group had dynamic issues.

5.8 Treatment Session Rating

Next to ORS and GSRS an own measurement to rate treatment outcome of each individual phase was designed only for the program, called **Problem Solving Treatment (PST)** assessment.

Satisfaction over all Problem Solving Treatment (PST) categories. Three of four risk groups rated the treatment positively, achieved changes in behaviours patterns and felt more equipped for the next time they encounter a problem (e.g. jealousy, drug/alcohol abuse).

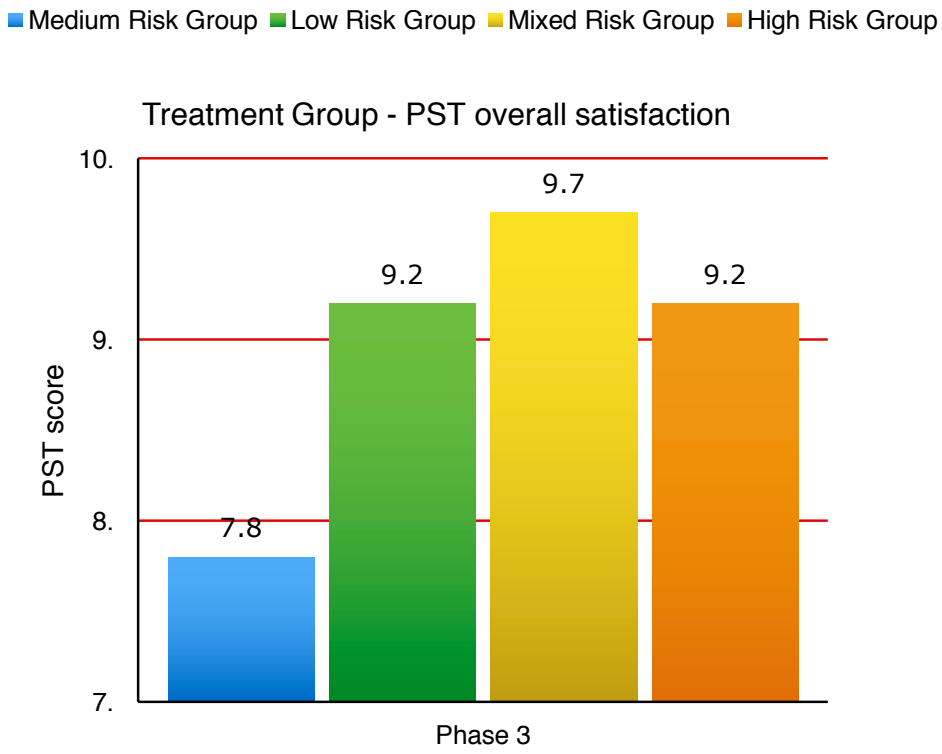
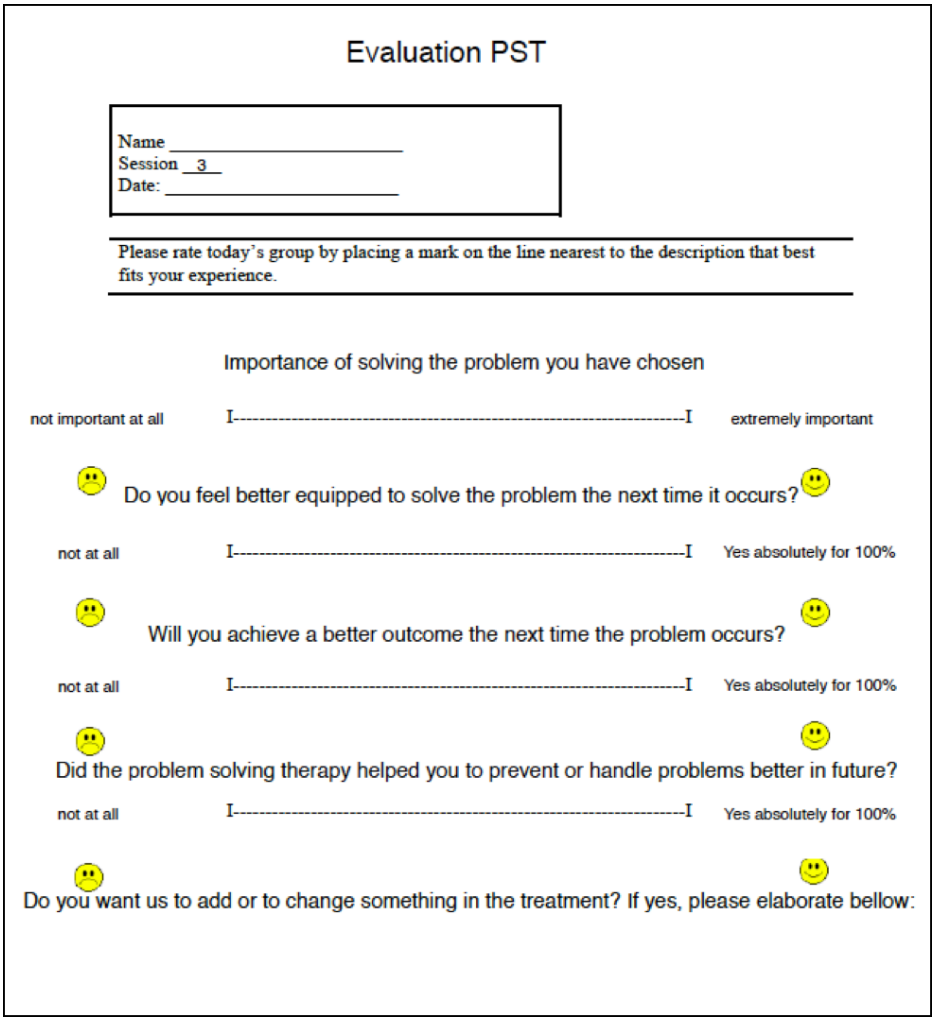


Chart 16 - Treatment Group. Development of all “PST” categories.

In the medium risk group, one offender could not be engaged (yet) through therapy; therefore, the satisfaction data are lower as compared to other groups. Overall offenders have been satisfied by the treatment and developed positively.

Note: The medium group has one offender denying credible facts of his index offence.

Questionnaire PST



Evaluation PST

Name _____
Session _3_
Date: _____

Please rate today's group by placing a mark on the line nearest to the description that best fits your experience.

Importance of solving the problem you have chosen

not important at all I---------- extremely important

Do you feel better equipped to solve the problem the next time it occurs?

not at all I---------- Yes absolutely for 100%

Will you achieve a better outcome the next time the problem occurs?

not at all I---------- Yes absolutely for 100%

Did the problem solving therapy helped you to prevent or handle problems better in future?

not at all I---------- Yes absolutely for 100%

Do you want us to add or to change something in the treatment? If yes, please elaborate bellow:

Picture 8 - Questionnaire PST.

The questionnaire was designed individually for each treatment phase to explore content's success.

Satisfaction with single Problem Solving Treatment (PST) category.

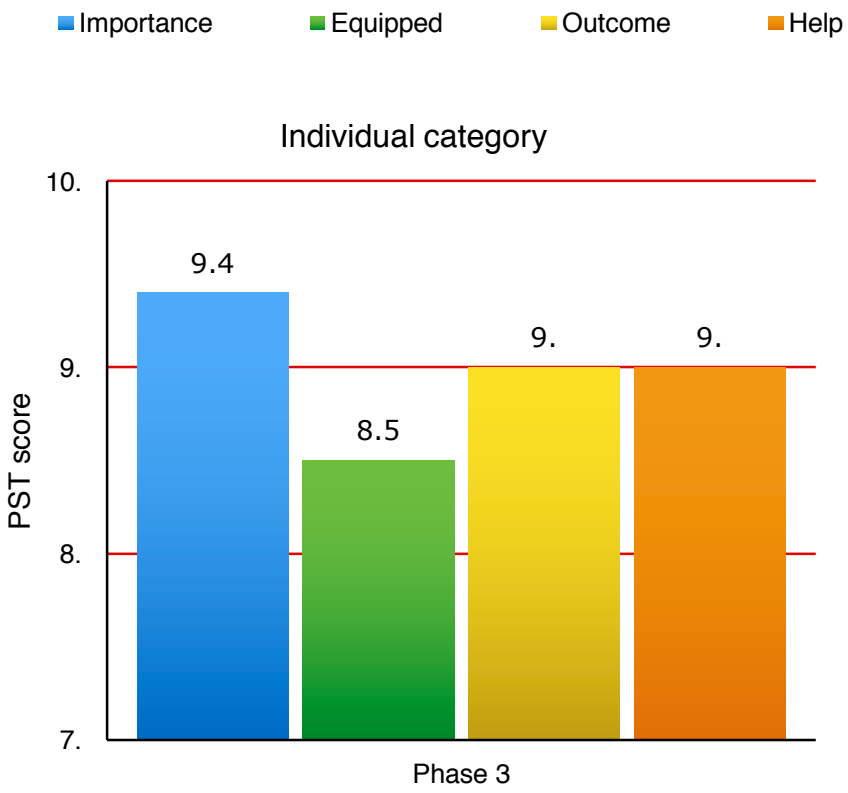


Chart 17 - Treatment Group. Single PST category.

Inmates stated an overall positive treatment satisfaction. They especially recognized the importance of solving their individual problems. All risk groups developed positive behaviour patterns regarding: “Will you achieve a better outcome the next time this problem occurs?” and “Did the problem solving therapy help you to avoid or handle problems better in future?”

Nevertheless, the need remains for longer and more intense training, so that inmates acquire more tools in order to “feel better equipped to solve the problem the next time it occurs.”

Relationship Capacity

Positive results were also achieved in the area of building relationship capacity. Inmates realized, especially, the importance of solving their defined problem in order to prevent reoffending. High ratings were also achieved in the category "outcome". Above 90% felt they would achieve a better outcome – in terms of handling the situation more adequately and within legal limits – if the problem occurs again. Nevertheless, ratings regarding "feeling equipped" to solve the problem the next time it occurs came in at a lower level. Again, a deeper, more extensive training is necessary.

Treatment Group - Satisfaction of category "Relationship Capacity"

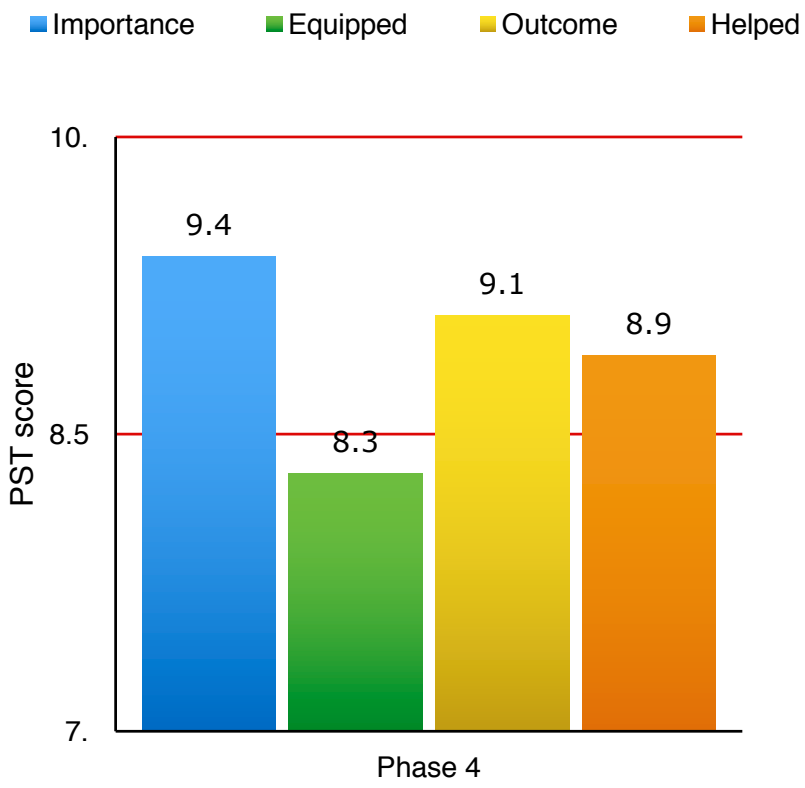


Chart 18 - Treatment Group. Single "Relationship Capacity" category.

Feedback. Despite the need of higher intensity for treatment, participants rated the program positively:

"It is clear and I understand very well." (S2)

"Information is clear and enough." (M5)

Sex Drive

Feedback. In the category “sex drive”, participant’s feedback was further positive.

“What I learnt is very important.” (S2)

“I wish for more treatment.” (S4)

Compared to the prior phases, individual rating also in the category “equipped” was higher. All categories achieved a high average value of 8.95.

Treatment Group - Satisfaction of category “Sex Drive”

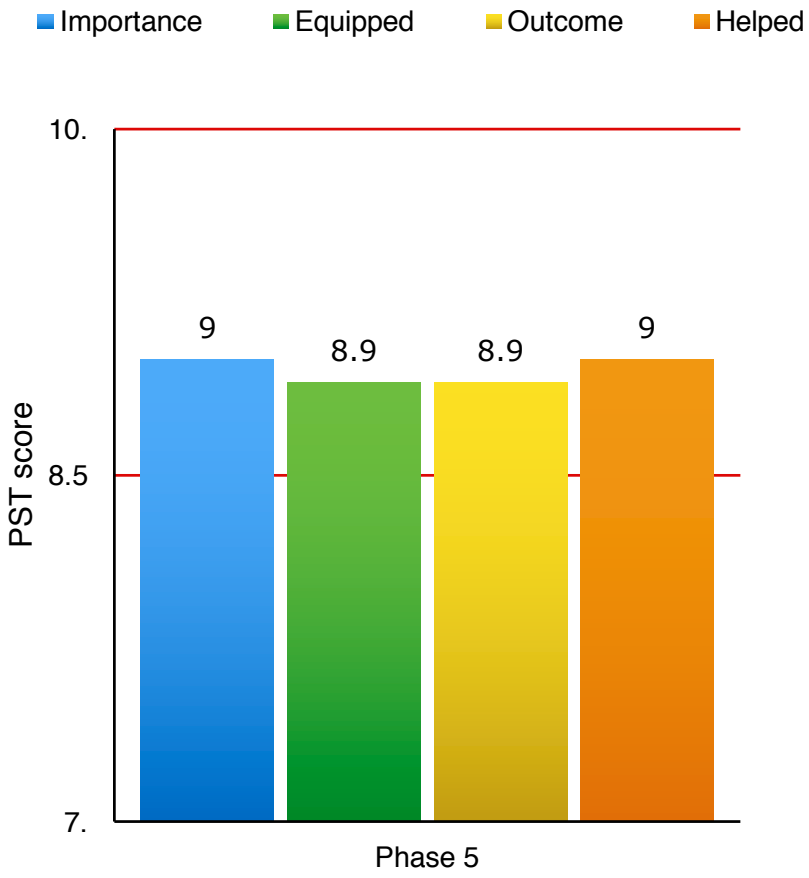


Chart 19 - Treatment Group. Single “Sex Drive” category.

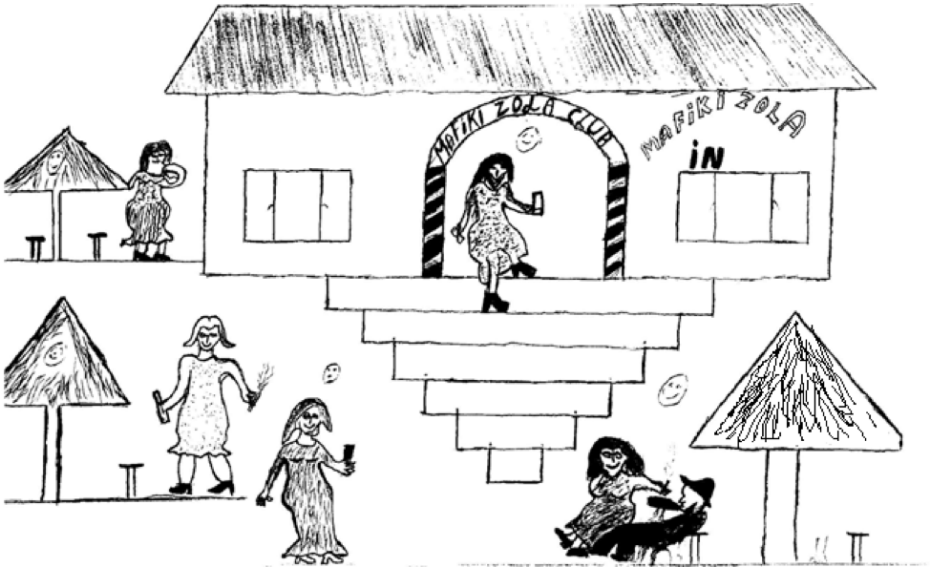
5.9 Problem Drawings

As evaluated during the preparation phase, inmates suffered from various challenges that influenced the treatment structure. The content of vivid material (e.g. pictures, videos) was enhanced, and exercises were reduced and adapted to meet linguistic skills.

In line with the problem solving structure, inmates were asked to draw the content of their individual problem to enhance understanding of treatment patterns.

Venue. In line with previous evaluations two primary locations where identified: the family home and bars. Here, problems leading to the index offence occurred most often or had its most common roots.

Picture 9 - Drawing of venue, family house.



Picture 10 - Drawing of venue, bar/shebeen.

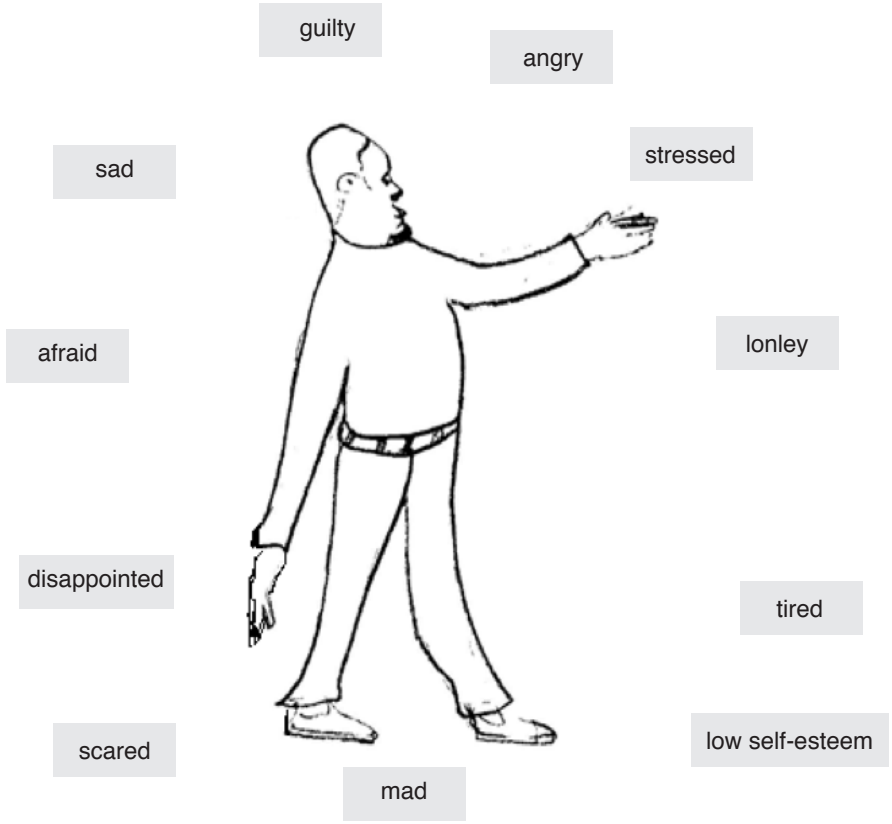
Feelings. To identify individual behaviour patterns leading to the index offence and to make the participants understand these contexts, they were asked to draw and describe feelings of all people involved. In line with previous findings the main categories of protagonists drawn were:

- Offender himself
- Offender's family
- Offender's friends

Offender himself. Inmates mainly express dissatisfaction and negative feelings about the individual problem and the consequences it produced. Combined with the high motivational results of the PACI-O, this dissatisfaction can be used to encourage faster and deeper change, since it drives the individual hope for an improved personal situation that comes with certain life goals.

Picture 11 - Drawing of offender's feelings.

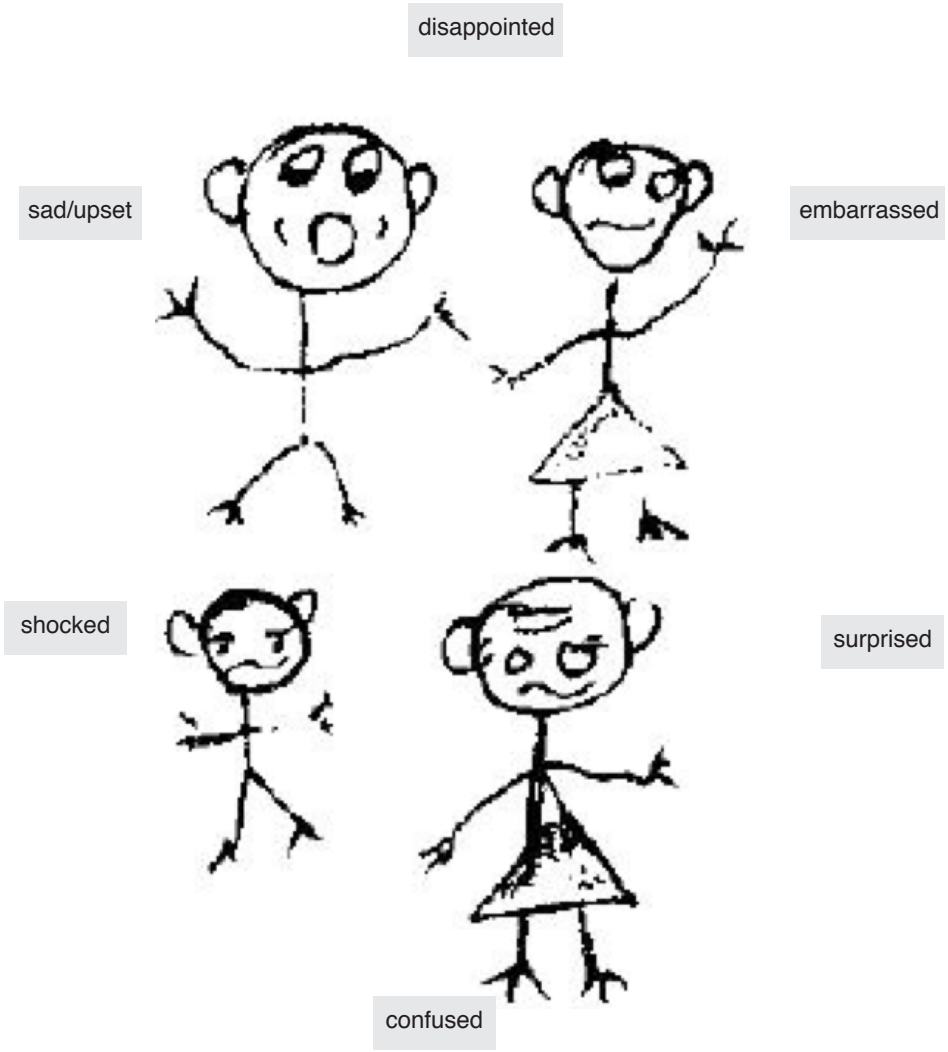
Offender's family and partner. Family feelings, according to offender's perception about the index offence or the root causes leading to the later one, are clustered in the chart below. Especially members having a positive social impact on the offenders' actions (see Stable-2007 data) expressed clear negative feelings about the offender's actions. This setting is a good foundation to enhance treatment's sustainability and outcome while on parole/after release.



Picture 12 - Drawing of offender's family and lover's feelings.

Picture 12.1 - Drawing of offender's family and lover's feelings.

Offender's friends. Neither the majority of close friends gave a positive feedback and are in support of the current offender's behaviour. This may serve again as a positive outer setting for sustainable change.



Picture 13 - Drawing of offender's friends' feelings.

5.10 Acute-2007

The Acute-2007 used to evaluate treatment success based on the general recidivism risk. High priority offenders are about four times more likely to reoffend than the low priority offenders as stated under chapter 3 (Hanson et al., 2007; Rettenberger et al., 2011).

General Recidivism. The general recidivism risk includes the areas and nominal categories below (Hanson, Harris, Scott, & Helmus, 2007).

Victim Access	Emotional Collapse
Hostility	Collapse of Social Sup-ports
Sexual Preoccupation	Substance Abuse
Rejection of Supervision	

General Recidivism Risk	
Score	**Nominal Categories**
0	Low
1-2	Moderate
3+	High

Table 19 - Acute-2007. General Recidivism.

Although the treatment period was short, in most categories inmates were more often rated the lowest risk score “0” after treatment, which stands for “low general recidivism risk.

Acute-2007 category	“Score 0” increase
Hostility Score	12 %
Rejection of Supervision Score	18 %
Emotional Collapse Score	27 %

Table 20 - Acute-2007. Risk Score “0”, overall development.

For instance in category “hostility”, 12% more inmates were rated the lowest risk score “0” after treatment. The same applies for the categories “Rejection of Supervision” or “Emotional Collapse”. In total the lowest risk score “0” was given in the above categories 19% more often after treatment through program officers. The graphic below shows the risk score development before and after treatment.

Treatment Group - General Recidivism risk group development.

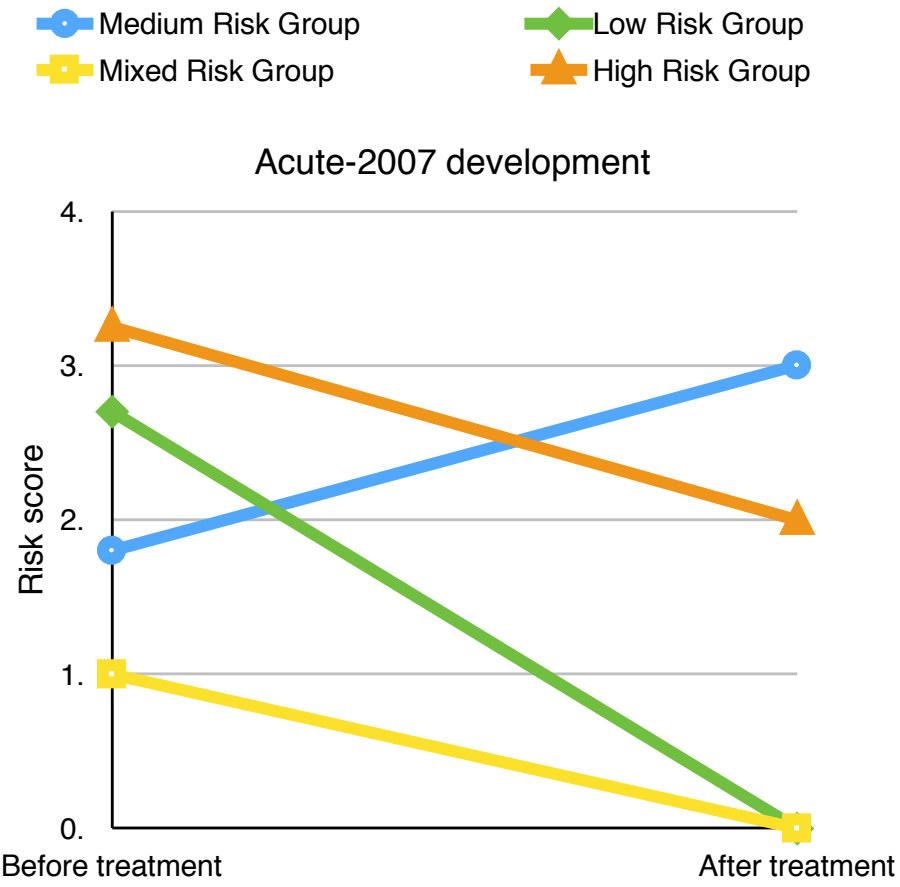


Chart 20 - Treatment Group. General Recidivism Risk development.

All risk groups were rated one risk category lower through treatment. (The low risk group became moderate to low, mixed risk group became moderate-low to low, and high-risk group became high to moderate). A positive development is visible in all participants of the medium risk group, apart from one offender (C3) with a clear negative development, which distorted the overall results of that risk group. C3 is an incest case (with a minor). He had problems integrating fully into overall group dynamic, which hindered him from speaking openly about his paedophilia in front of others. Again, to reach inmates like C3, longer and more extensive treatment is needed, but could not be covered thoroughly in the design of the pilot study.

Control Group - General Recidivism risk group development.

At the control group such positive development is not visible. The low risk group remains at a moderate (close to high) general recidivism risk factor. The mixed risk group has a very low general recidivism risk factor. The impact of the TLS treatment is clearly visible here. The high-risk group stays on a very high general recidivism risk factor, developing in the opposite direction to the treatment group, growing even 2 places higher during measurement period. The medium risk group remains on a moderate (close to high) general recidivism risk factor, with a slight decrease.

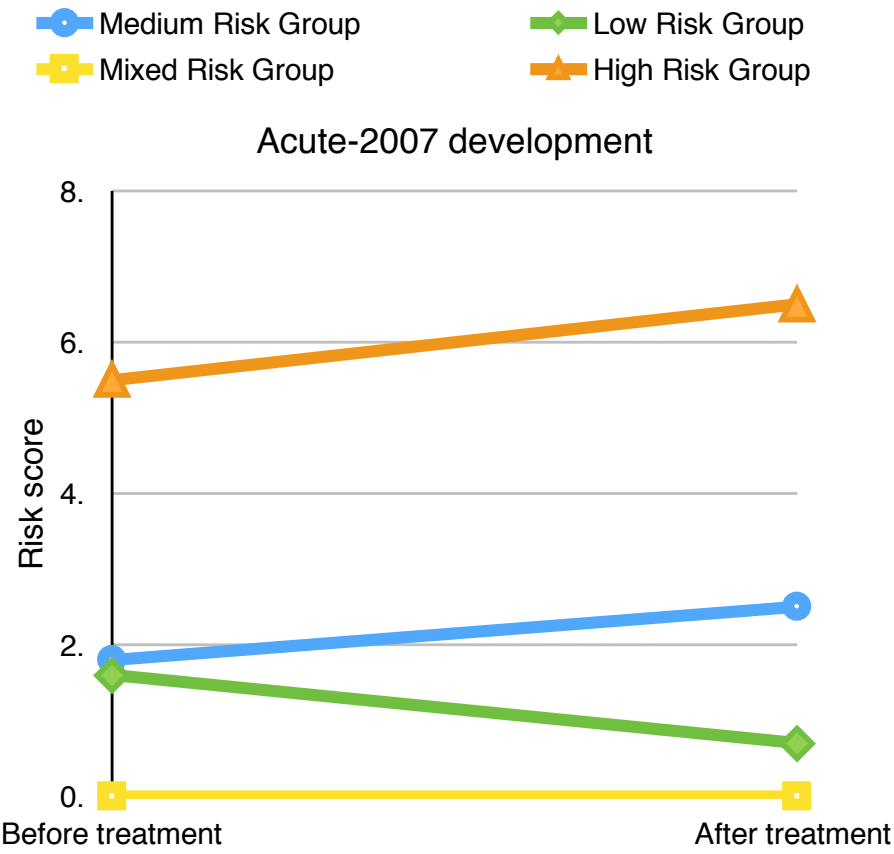


Chart 21 - Control Group. General Recidivism Risk development.

In summary there is a clear distinction visible between risk scores development of treatment and control group. Additional to general recidivism risk group development, sex/violence recidivism risk development was analysed as well to gain deeper insides on treatment's success (according to Hanson, Harris, Scott, & Helmus, 2007).

Treatment Group - Sex/violence recidivism risk group development

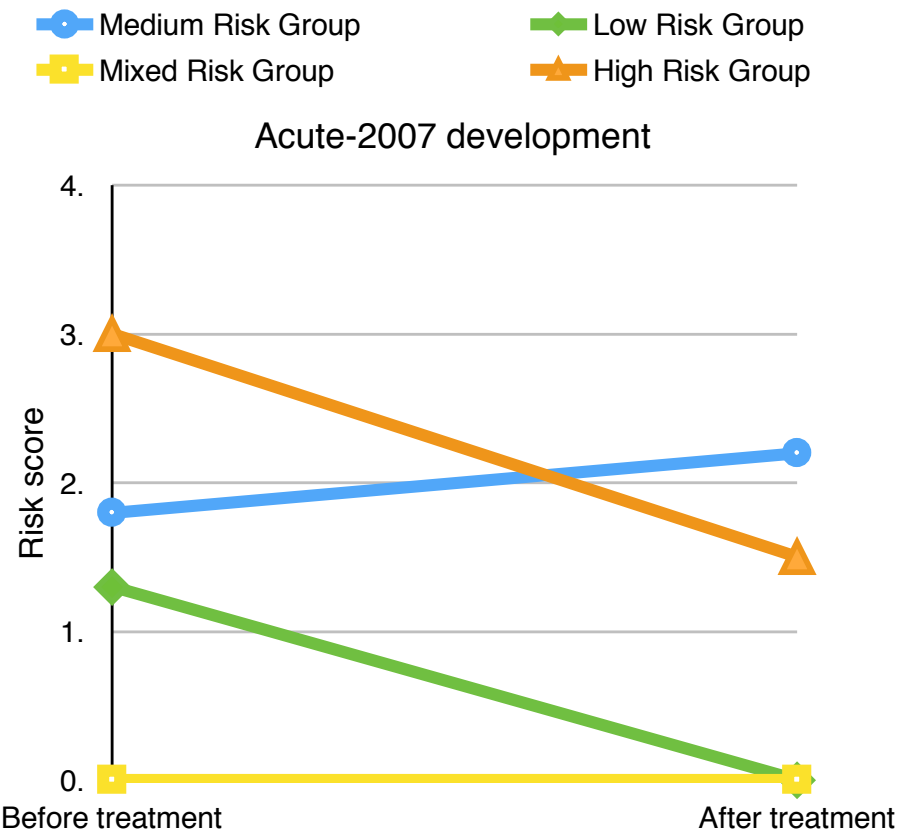


Chart 22 - Treatment Group. Sex/Violence Recidivism Risk development.

Similar to general recidivism, certain risk groups shifted one risk category lower through treatment. (The moderate to low risk group became low, high-risk group became high to moderate). There is no change in the mixed risk group, which may, in part, be due to the positive influence of TLS treatment. Again, the results of the medium risk group are distorted. Nevertheless, without offender C3, the same positive development as the risk groups (high and low) is visible here as well.

Control Group - Sex/violence recidivism risk group development.

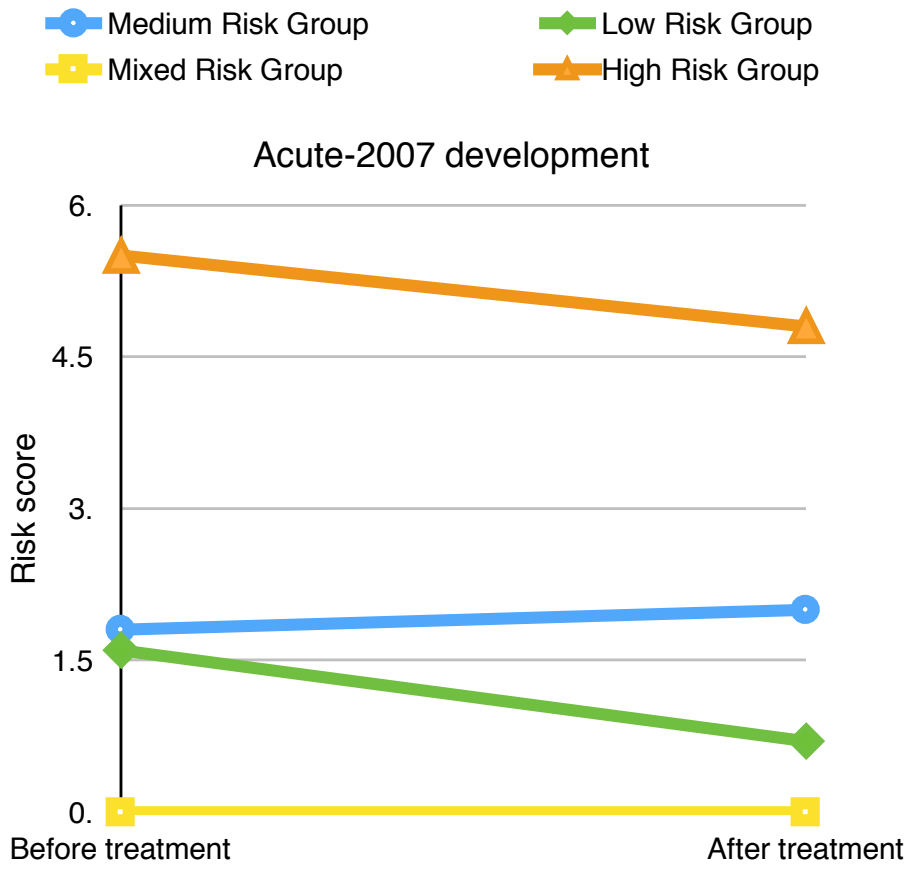


Chart 23 - Control Group. Sex/Violence Recidivism Risk development.

Similar development as compared to the general recidivism risk factor is visible. The low risk group stays in a moderate (close to high) risk factor, showing a slight decrease, but not comparable to the extent of the treatment group. The mixed risk group has a very low sex/violence recidivism risk factor. Again, influence of TLS treatment is recognizable. The high-risk group stays on a very high sex/violence recidivism risk factor, with a difference of plus 3 points from the control group at the end of the measurement period. The medium risk group remains on a moderate (close to high) sex/violence recidivism risk factor, with a slight decrease.

References

Hanson, R. K., Harris, A. J. R., Scott, T., & Helmus, L. (2007). Assessing the risk of sexual offenders on community supervision: The Dynamic Supervision Project. Ottawa: Public Safety Canada.

6. Summary

The Good Lives Model (GLM). The GLM views risk factors for continued sexual behaviour problems as obstacles that block or otherwise act as barriers to healthy and non-harmful attainment of primary human goods. Therapists using the GLM directly target these risk factors in treatment as a very important step towards assisting clients to attain primary goods in their lives. In this way, clients become invested in the treatment process because treatment explicitly aims to assist them live a fulfilling life – one that is satisfying to them – in addition to reducing and managing risk.

Treatment Approaches. Critical to using the GLM and in keeping with the needs principle of effective correctional interventions (Andrews & Bonta, 2010) is the assessment of criminogenic needs. The key difference in using the GLM is how criminogenic needs are understood, included and addressed within the overarching framework of a treatment program and the emphasis on each client's GLP (for details see Willis & Yates, in press; Yates & Prescott, 2011b; Yates & Ward, 2008). The aims of each treatment component or module are framed using approach goals, as opposed to solely avoidant goals, and are linked to the fulfilment of common life goals. For example, a module addressing relationships would focus on how to seek out and establish satisfying relationships rather than a focus on overcoming intimacy deficits and avoiding problematic relationships. For the Namibian experience, common areas of treatment focus included problem solving capacities, relationship capacities, and sex drive.

Program Design. The pilot treatment program was structured into five phases.

Phase	Instruments
Phase 1	Static-99 , PACI-O
Phase 2	Stable-2007, Tables of Goods, GSRS, ORS, Acute-2007 (Treatment Group)
Phase 3 Problem Solving Capacity	Acute-2007 (Control Group), Evaluation Treatment Phase (Assessor and participant), GSRS, ORS (Control and Treatment Group), Monthly Program Report, Problem Solving Report
Phase 4 Relationship Capacity	Evaluation Treatment Phase (Assessor and participant), GSRS, ORS (Control and Treatment Group), Monthly Program Report, Problem Solving Report, Drawing Exercise
Phase 5 Sex Drive	Evaluation Treatment Phase (Assessor and participant), GSRS, ORS (Control and Treatment Group), Monthly Program Report, Problem Solving Report, Letter to Victim

Table 21 - Program design.

In phase 1 and 2, the risk and motivational assessment for the treatment and control group clustering was done. Treatment was carried out in phases 3 to 5, based on the main problems evaluated in the earlier phases and focused on problem solving capacity, relationship capacity, and sex drive. The timeframe for each phase was calculated to be one month.

Lessons for treatment phases. The experiences from the prior preparation served to tailor the treatment's structure and content. The three major points that influenced the treatment's phase design were the following:

Illiteracy rate: The unexpected high illiteracy rate posed difficulties in teaching the program content adequately. The content was redesigned using:

- Less text work in classes and homework assignments
- More image material, such as videos and pictures
- Less content in the same timeframe

Limited receptiveness: The participants' limited capacity to absorb new content and limitations to memorize old topics led to:

- Shortened treatment sessions and less content during single sessions
- The use of role playing techniques to help visualize content and thereby to enhance memorization
- The use of fishbowl techniques to enhance participants engagement and participation in order to achieve higher treatment effect

The Namibian Correctional Service (NCS) settings: The structure of the Namibian Correctional Service altered the program's treatment in three areas.

- **Risk group composition.** Inmates allocated to different program risk groups did not necessarily meet the correctional facility's risk composition. For instance, inmates having a high-risk score under sex offending terms might have been in a lower correctional facility risk class. Inmates of the different correctional facility risk clusters are not allowed to mix or meet during treatment. In the group composition, both requirements had to be meet.
- **Language and literacy skills.** Only inmates with a certain level of literacy knowledge and sufficient English and Afrikaans language skills, due to the lack of program officers' language capacity, could enter the program.
- **Training of the program officer.** One program officer had not yet passed the full NCS's training, so higher risk groups were assigned to program officers with more experience and knowledge, while lower risk groups had to be assembled based on the officer's level of training.

Based on these findings, the final group structure and treatment content was evaluated and adjusted in order to enter the treatment phases.

Treatment phase: All treatment phases followed a similar pattern to achieve a certain level of participant's knowledge in structure and content of instruments and thereby to meet the shortages identified in the prior phases (e.g. limited receptiveness). All phases contained a:

- Problem solving worksheet
- Tailored evaluation of treatment phase for participants and assessors
- ORS
- GSRS
- Monthly program report

Findings

Role Models: The primary sources of positive influence were the subject's mother, followed by the/a sister.

- 85% of all participants named their mother as major source of influence. The influence of the mother was rated as 100% positive.
- Mainly female members in the family setting were identified as major sources of positive influence on the perpetrator.

The positive influence of the mother and other female siblings is crucial to consider in treatment and during treatment after release.

Motivation: Levels of motivation were very high. The low risk group had the highest level of motivation, whereas the high-risk group had the lowest motivational level. The data between the medium risk group and the low and medium mixed risk groups (receiving already treatment) did not differ much.

Motivational categories included family relations (to improve relationships, stay with, support family/family member), financial success (to be financially independent, /to have a job, further training), personal improvement (to be a better person, stay out of prison, be religious, control anger) and healthy lifestyle and were identified to be of major importance. In a holistic approach, treatment focused to meet in every chosen alternative (e.g. problem solving sheet) the identified four overall goals.

Obstacles to treatment: Clustered drug/alcohol abuse and polygamy were often identified as participants' primary concerns. In order to address the individual problems, both areas received extra attention during treatment.

Alcohol: Participant's assumptions regarding alcohol use were that they needed it to keep friends and women or to overcome problems.

Culture-Polygamy: Certain participants favoured polygamy as their preferred form of relationship. Reasoning included limited satisfaction, fun, or pleasure in monogamous relationships.

Whom does the problem involve? Apart from the perpetrator himself, again family members and certain friends were mainly identified to be a certain trigger. This knowledge is important for later treatment. Family and friends have to be also when on parole as far as possible involved and certain community/cultural beliefs tackled during treatment.

Data evaluation

ORS: Examining the results of the single Outcome Rating Scale, all areas showed improvement. Major progress was made in the area of social development (work, school, friendship).

GSRS: Compared to the treatment ORS, the satisfaction measured with the Group Session Rating grew positively as well, but not to the extent of the ORS results. In one exception, the group dynamic for the medium risk group fell after session one. Consequently more and better team/trust building measures between group members should be applied before treatment starts and during treatment.

Treatment Satisfaction Rating: Satisfaction over all problem solving treatment categories: Three of four risk groups rated the treatment positively, achieved changes in behaviour patterns, and felt more equipped for the next time they encounter the problem (e.g. jealousy, drug/alcohol abuse). Overall, positive treatment satisfaction and developmental progress were achieved. In particular, inmates recognized the importance of solving their specific problem. All risk groups developed positive behaviour patterns regarding: “Will you achieve a better outcome the next time the problem occurs?” and “Did the problem solving therapy helped you to prevent or handle problems better in future?” Nevertheless, there is a need for longer and more intense treatment, so that inmates acquire more tools in order to “feel better equipped to solve the problem the next time it occurs.”

Relationship Capacity: Equal results could be measured in the area of relationship capacity building. Inmates realized the importance of solving their problem in order to prevent reoffending. High ratings were also achieved in the outcome category. Over 90% of inmates feel they will achieve a better outcome – better in terms of more adequately and within legal limits – if their problem occurs again. Nevertheless, ratings of “feeling equipped” to solve the problem the next time it occurs are on lower. As mentioned more thorough training is needed.

Sex Drive: Compared to the prior phases, individual development in the feeling equipped category was higher. All categories achieved an average value of 8.95. Nevertheless, this has to be emphasized, and more extensive training is required.

Acute-2007. Comparing general recidivism risk factors from the beginning and end of treatment, most of risk groups reduced their level of risk through treatment. In virtually all categories, participants showed an improved outlook with less risk for future harm.

“Score 0” Development - of certain Acute-2007 categories.

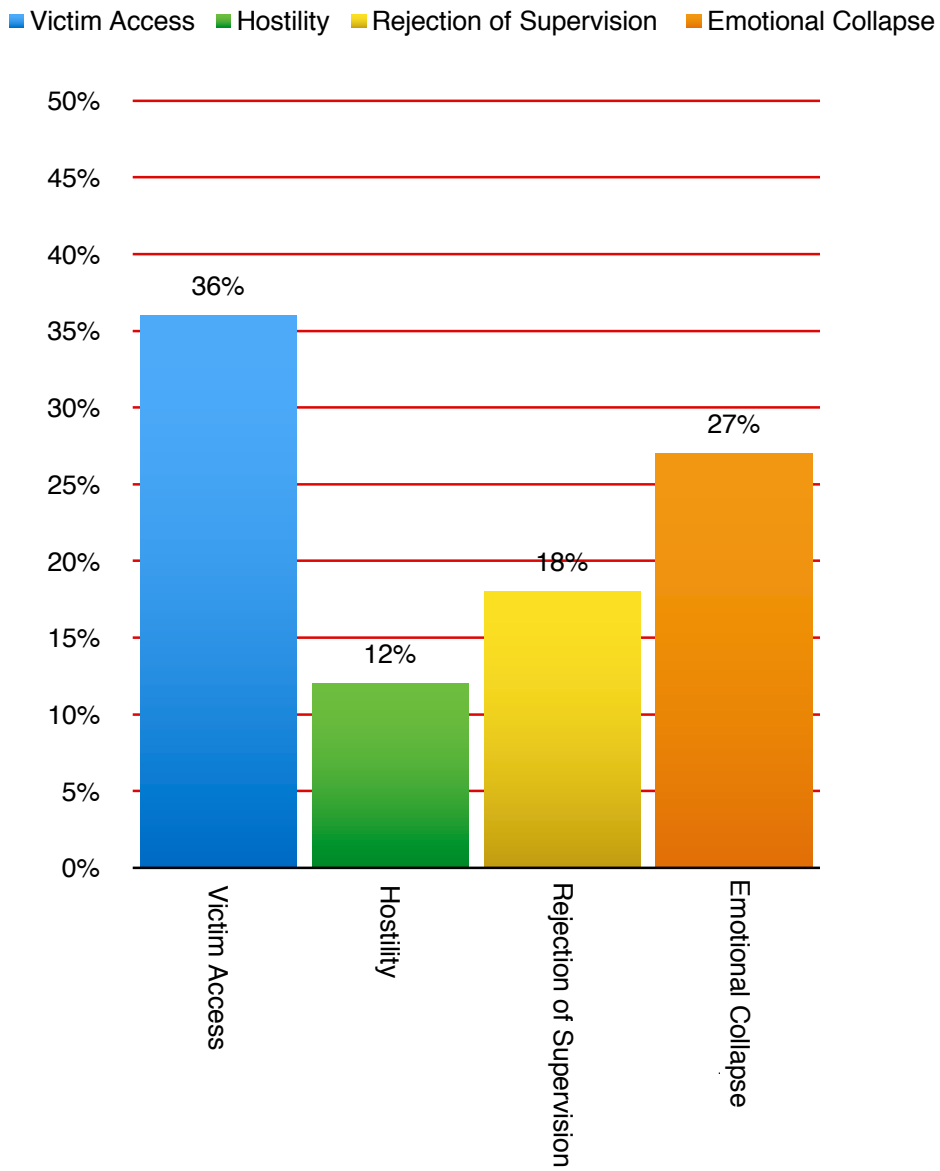


Chart 24 - Acute-2007. Overall category development.

References

Andrews, D. A., & Bonta, J. (2010). The psychology of criminal conduct (5th ed.). Cincinnati, OH: Anderson Publishing.

Willis, G. M., & Yates, P. M. (in press). Strengths-based theories and sexual offending. In T. Ward & T. Beech (Eds.), Theories of Sexual Offending. West Sussex, UK: Wiley-Blackwell.

Yates, P. M., & Prescott, D. S. (2011b). Building a better life: A good lives and self-regulation workbook. Brandon, VT: Safer Society Press.

Yates, P. M., & Ward, T. (2008). Good lives, self-regulation, and risk management: An integrated model of sexual offender assessment and treatment. Sexual Abuse in Australia and New Zealand: An Interdisciplinary Journal, 1, 3-20.