A Strengths-Based Treatment Program for Sexual Offenders
Liam E. Marshall, PhD
Research & Academics and Provincial Forensics

Introduction
• What is a Strengths-Based Approach and why use it?
  – Ethical considerations
• What does a Strengths-Based Approach look like?
  – Overview & Specifics
• Can it work?
  – Outcome from our use of SBA

Why a Strengths-Based Approach?
• Typically, treatment clients are volunteers
• Mentally ill and offender clients are typically coerced into treatment
  – Legal coercion vs Psychological coercion
• Universal Declaration of Ethical Principles for Psychologists, Clients have the right to:
  – Dignity; respect; self-determination; humane treatment, including a focus on strengths (Birgden, 2015)

Why a Strengths-Based Approach
• Recidivism studies are fraught with issues that make true recidivism unclear
• Recidivism studies are done on treatment as it was done 10 or more years ago
• Sometimes treatments are later found to be harmful
• A Strengths-Based Approach focused on improving well-being and life satisfaction will, at least, do no harm
• More enjoyable and less stressful for therapists

Adverse Childhood Experiences
• Significantly higher rates of ACEs in offenders, especially sex offenders, and mentally ill, than "norms"
• In particular, abuse (emotional, physical, sexual), neglect, parental separation or divorce
• Number of ACEs strongly related to poorer mental and physical health, including suicide attempts, depression, obesity, and victimization

Prisons are not rehabilitative
Separation from families and social networks
Stigma & labelling
Anti social subculture & norms
Lack of activity
Curtailment of autonomy

Courtesy of Dr. Ruth Mann, NOMS
Re-settle
Address attitudes and thinking
Address drug & Alcohol problems
Rehabilitative culture; Rehabilitative staff prisoner relationships
Safety & Decency

Hierarchical features of a rehabilitative prison

Courtesy of Dr. Ruth Mann, NOMS

Problems with “Problem-Focused” treatment

• Limits options
• Ignores unique capabilities & strengths
• Focus is on what “not to do” rather than “what to do”
• Leads to prescribed treatment instead of individualized treatment
• Looking for problems to explain behaviours
• Looking for cause and effect
• Typically takes control away from patient/client
• Leads to labeling

Reliability of labels

• >.60 = unacceptably low level of reliability
• .60-.70 = low reliability (projective measures)
• .70-.80 = moderate reliability (classroom multiple choice tests)
• .80-.90 = moderate-high reliability (achievement or intelligence tests)
• .91-1.00 = high reliability (measurement errors have virtually no effect)

Given the importance of the labels applied to sexual offenders in terms of their implications for the sexual offender and society, reliabilities of at least .90+ are needed

Reliability of Labels Applied to Sex Offenders

• Sadist: $kappa = .14$ (Marshall et al., 2002)
• Pedophile: $kappa = .65$ (Levenson, 2004); .55 (Perillo et al. 2014)
• Psychopath: $kappa = .39$ (Murrie et al., 2008)
  – Well trained raters: .95; versus State experts = .29; versus defendant experts = .14 (Rufino et al., 2012)

Strength-Based Approach (SBA)

• Empowers and motivates patients/clients
• Requires trusting and workable relationships
• Requires collaboration
• Instills a sense of hope
• Helps client build on existing strengths
• Does not catastrophize when things go wrong – part of the process
• Helps patient/client recognize that change is an ongoing process

What a Strengths-Based Approach is not

• Problem focused
• Inconsistent with a CBT, RNR, or RP approach
• Does not require therapists to be soft on clients
• Does not take the responsibility for change away from the client
• Is no more costly to run than other approaches
• Is not a cure
What a Strengths-Based Approach is

- A positive/motivational approach to change
- Focus is on strengths while also not ignoring with deficits
- Grounded in Risk/Needs/Responsivity, Motivational Interviewing, Desistance, and Positive Psychology Theory
- More enjoyable and safer for the therapist and client
- A positive approach to making positive changes

Examples of strengths not usually recognized

"in regione caecorum rex est luscus" Desiderius Erasmus (1500)

- Homeless patient telling other group members the best shelters for various things
- Colluding with other group members
- Not offending at every opportunity
- Reluctantly attending a treatment group
- Attention seeking
- Falling in love with the therapist
- Punching a wall
- Bragging/denying/manipulating/arguing

Components of a Strengths-Based Approach

Pre Treatment Issues
- Intake Assessments
- Interview

Treatment Program
- Approach, Targets,

Post-Treatment Issues
- Assessment
- Report

Other Considerations
- Non-treatment staff, Environment

A Strengths-Based Approach

Pre-Treatment Issues

SBA Intake Assessment

- RISK:
  - STATIC-99, STATIC-99R, VRS-SO, RRASOR, MnSOST-R, PPG, Polygraph, etc.
- NEEDS:
  - STABLE-2000, STABLE-2007, SONAR, PPG, Polygraph, SAPROF
- RESPONSIVITY:
  - URICA, Treatment Readiness Scale (Serin & Kennedy, 1997)

Conclusion: 1 Strengths-Based measure available.

SBA Pre-Treatment Interview

- Build rapport first: Offer to answer questions, talk about what they want
- Invite client to be part of treatment on their own terms
- Allow client to make decision on whether or not to enter treatment, empower them
- Do not push too hard, you are forcing client into a corner
- Express empathy and optimism
- Outline costs and benefits for client of entering treatment
- Overcome typical resistance issues:
  - Pressure to enter treatment, treatment efficacy (lack of), lack of trust in professionals, previous bad experiences/safety
A Strengths-Based Approach Treatment Program

Strengths-Based Approach Topics

- Self-Esteem
- Hope
- Guilt
- Empathy
- Coping
- Relationships
- Healthy sexuality
- Motivation
- Approach goals
- Knowledge
- Agency
- Autonomy
- Mastery
- Relatedness
- Creativity
- Mindfulness
- Relaxation

Behavioural Progression Model, Adapted From CSC

Immediate Factors
- Increased Stress
- Anxiety
- Depression
- Loneliness
- Emotional Arousability
- Anticipation
- Cognitive Struggle and Dissuasion
- Escalation in emotions
- Increased substance abuse

Offending

Immediate Factors
- Increased Stress
- Anxiety
- Depression
- Loneliness
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Offending

Post Offence

Fear
Shame
Self-Loving
Cover-Up Attempts
Cognitive Distortions
Increased Immediate Factors

Offending

Rockwood Offender Programs

Dosage matters
- Preparatory – typically 6 weeks
- Regular – typically 4 months
- Deniers - typically 4 months
- Maintenance - typically 3 months
- 2-3 sessions of max 2 1/2 hours per week

- Open-ended
- 8-10 offenders
- 1 therapist in each group
- Mix of all types of sex offenders in same group
- Entry to program as close to intake as possible
- No individual sessions unless special circumstance

WHAT IS EFFECTIVE?

MUST:
1. Address criminogenic targets
2. Employ empirically sound procedures
3. Deliver treatment in known effective ways

POSITIVE/MOTIVATIONAL PROGRAM

(ROCKWOOD PSYCHOLOGICAL SERVICES)

MOTIVATION & ENGAGEMENT
1. LEAD-UP
2. AUTOBIOGRAPHY

Goals and Optional Exercises
- Orientation to treatment
- Enhancing self-esteem
- Reducing shame
- Improving coping and mood management

PRIMARY TREATMENT
3. EMPATHY
- Letters/Diary entry
4. OFFENCE ANALYSIS
- Background Factors
- Immediate Factors
- Relationship Skills
- Nature and advantages of intimacy
- Problems of loneliness
- Attachment styles
- Communication
- Jealousy
- Sexuality
- Healthy sexual functioning
- Maximizing sexual satisfaction
- Reducing deviant interests
  - behavioural strategies
  - Pharmacological

FUTURE LIFE STRATEGIES
5. GOOD LIFE PLANS
6. SELF-MANAGEMENT
7. WARNING SIGNS FOR SELF AND OTHERS
8. SUPPORT GROUPS
- Professionals
- Family and friends
- Colleagues
9. FUTURE PLANS
- Accommodation
- Employment
- Leisure

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23
Criminogenic Issues in Sex Offenders
Based on Mann, Hanson, & Thornton, 2010

Sexual factors
- sexual interests in children
- Sexual interest in violence
Relationship problems
- lack of intimacy
- insecure attachment
- emotional loneliness
Low self-esteem/shame

Cognitive factors
- emotional congruence with children
- hostility towards women
- lack of concern for others
- offence supportive attitudes
Self-regulation issues
- emotional dysregulation
- behavioral dysregulation
- sexual (preoccupation)

Treatment Approaches
Traditional Approaches
• Psychoanalytic
• Behavioural
• Cognitive
• Relapse-Prevention
• Cognitive-Behavioral
New Directions
• Risk/Needs/Responsivity (Andrews et al.)
• Good Lives Model (Ward et al.)
• Motivational Interviewing (Miller & Rollnick)
• Positive Psychology (Seligman et al.)

Good lives model (Tony Ward et al.)

Primary goods:
1. Life: healthy/optimal functioning, sexual satisfaction
2. Knowledge
3. Mastery: in work and play
4. Agency: autonomy and self-directiveness
5. Inner peace: freedom from turmoil and stress
6. Relatedness: intimate, romantic, kinship, community
7. Spirituality: meaning and purpose in life
8. Happiness
9. Creativity

Good lives model cont.

Depends: internal conditions (skills and capacities) and external conditions (opportunities and supports)

Treatment:
1. Determine with each client personal goals and priorities in order to generate a specific good lives model suitable to him
2. Assist, if necessary, in acquiring the skills and attitudes necessary to work toward goals
3. Help identify ways to create opportunities to realize goals
4. Work with the client to identify support people who will assist in realizing goals

Positive Psychology Features

• What is good about life is as important as what is bad and therefore deserves equal attention
• Life is about more than avoiding or undoing problems
• Strength focus – not deficits
• Hope theory
  – Goals, Pathways, Agency
• Aim is for a more fulfilling life

DEGREE OF MANUALIZATION

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<th>Highly detailed manual</th>
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<tr>
<td>1) TARGETS</td>
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<tr>
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<td>Choice of targets</td>
<td>Fixed and specific targets</td>
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<td>2) PROCEDURES FOR EACH TARGET</td>
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<tr>
<td>None specified</td>
<td>Choice</td>
<td>Single and specified</td>
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<tr>
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<td>Unspecified</td>
<td>Dependent on each client's needs</td>
<td>Fixed number</td>
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<td>4) STRUCTURE</td>
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<tr>
<td>Fully unstructured</td>
<td>Treatment targets repeatedly addressed</td>
<td>Fully modularized</td>
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<td>5) TREATMENT STYLE</td>
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<tr>
<td>Idiosyncratic</td>
<td>Psychotherapeutic</td>
<td>Psychoeducational</td>
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<td>6) CLIENT INVOLVEMENT</td>
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<td>Client choice only</td>
<td>Collaboration</td>
<td>Therapist choice only</td>
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</table>
Features that Enhance Treatment Effectiveness
- Empathy
- Warmth
- Respect
- Genuineness
- Supportive
- Directive
- Flexible
- Encourages Participation
- Rewarding
- Attentive
- Trustworthy
- Use of humor
- Emotionally Responsive

Features that Reduce Treatment Effectiveness
- Aggressive Confrontation
- Rejection
- Manipulative/Lack of boundaries
- Lack of interest
- Critical
- Sarcastic
- Hostile/Angry/Rigid
- Cold/Unresponsive
- Dishonest
- Judgmental
- Authoritarian
- Defensive
- Nervous/Uncomfortable

Client’s perceptions of the therapist

Therapists are relatively poor at evaluating their own therapeutic characteristics and style.

- In 34 of 47 studies (72%) clients’ estimates of therapist features correlated with beneficial treatment effects.
- Therapist ratings were related to outcome in only 4 of 15 studies (26%).

(Free, Green, Grace, Chernus, & Whitman, 1985; Orlinsky et al., 1994)
# CLIENTS' PERSPECTIVES

(Drapeau, 2005)

1. See therapist as crucial but also value procedures
2. Quality of the program = the skills of the therapist
3. Good therapists are: honest, respectful, nonjudgmental, available, caring, confident, competent, and persuasive, encourage discussion, listen, display leadership and strength, and maintain order
4. Do not respond to therapists who are critical, devaluing, or confrontational
5. Clients want therapist to supportively challenging them in a caring manner
6. Clients desire to participate in decision making (work collaboratively) and they wish to attain mastery and feel competent

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# Group Climate

- Moos' Group Environment Scale (GES)
- 10 Subscales, has norms, well used
  - Expressiveness
  - Cohesion
  - Task Orientation
  - Self-Discovery
  - Leader control
  - Innovation
  - Anger & Aggression
  - Leader Support
  - Independence
  - Order & Organization

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# Therapist features related to significant treatment-induced changes

- Warmth
- Empathy
- Rewarding
- Directive

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# Treatment Strategies

Three approaches have typically been used:

a) Confrontational approach
b) Unchallenging approach
c) Motivational approach

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# Motivational Approach

- Motivate change through understanding and acceptance.
- Encourage clients to view themselves as a whole person with strengths who has engaged in an unacceptable behaviour.
- Be encouraging and supportive but set necessary limits, respond firmly, and challenge behaviours.
- A positive approach to treatment motivates clients to make positive changes.
- Therapists place responsibility for change in hands of clients but assist clients in finding ways to make changes.
### Resistance to change

- Not inherent part of our clients
- Observable behaviours
- Fluctuates
- Influenced by therapist’s behaviour (therapist confronts: resistance goes up!)
- Resistance is a signal to change strategy

### Some common traps that can cause resistance

- Confrontation-Denial
- Blaming
- Premature focus
- Labelling
- Question-Answer
- Expert

### Responding to resistance

- Back off
- Warmth, empathy, optimism & genuineness
- Listen, respect and reflect what you hear
- Emphasise personal control and choice - and mean it!
- Offer options

### Behavioural methods

**Positive reinforcement**

- Link to specific behaviour
- Give immediately after behaviour
- Tell clients exactly what they did that was appropriate and why it was appropriate.
- Make sure they understand exactly what behaviour should be repeated and why.
- Reinforcement needs to be proportional to the level of effort that the behaviour took to perform.
  - A major gain deserves strong reinforcement. A small gain deserves a little recognition.

### What to reinforce

- Statements of responsibility.
- Statements of motivation/intention to change.
- Self esteem, perspective taking, empathy, concern for others, etc.
- New skills or attitudes.
- Achievement of any other treatment goal

### Measuring Outcomes from our SBA groups
Predictors of Recidivism

Total N = 535; Recidivists N = 30

• Age: AUC = .37
• Sentence length: AUC = .43
• STATIC-99: AUC = .47
• PCL-R: AUC = .62

• Therapist post-treatment rating: AUC = .64*
  — Based on a rough scale: 5 points, post treatment is the sexual offender High, High-moderate, Moderate, Low-moderate, or Low risk for future sexual offending.
  — Only statistically significant predictor of recidivism in our study

• With more differentiation over topics and dimensions (Intellectual Understanding & Acceptance/Demonstration) perhaps predictive power would be even better

Rating Levels

• Level 4 = Optimal Functioning
  — Significantly better than average
  — Should rarely be given to offenders
  — Scale can be used without a level 4, if desired

• Level 3 = Normative (THIS IS THE GOAL OF TREATMENT)
  — Average functioning
  — Mostly achieves target of treatment
  — Might still have a little work to do, but no worse than non-offenders
  — This is the target of treatment

• Level 2 = Approaching Normative
  — Approaching average functioning
  — Starting to understand and see value in topic/category
  — May achieve level 3 post-treatment

• Level 1 = Unsatisfactory
  — Needs to redo treatment component

Information for Rating

• Levels should vary across topics
• Levels should vary between categories
• Avoid “halo” and opposite (“pitchfork”) effect
• When learning to use, have therapists complete separately and then discuss differences – aiming for inter-rater agreement 8-9 times out of 10 (i.e., does not have to be perfect agreement)

Procedural Issues

• When to score the TRS-2?
  — Halfway through treatment program. So as to guide the rest of time treatment to the most important issues.
  — At or near the end of treatment.
  • Using the TRS-2 prior to the end of treatment aids in determining whether the participant has satisfactorily completed treatment.
  • The TRS-2 forms the bases of our reports.

Instructions for Therapist Ratings

• 10 topics based on known criminogenic factors and treatment engagement issues.
• Rated on each of the two categories
  — intellectual understanding
  — acceptance/demonstration
• Ratings are based on your considered opinion of how well he is functioning on each topic
<table>
<thead>
<tr>
<th>Targets</th>
<th>Intellectual Understanding</th>
<th>Acceptance/Demonstration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sense of Agency</td>
<td>• Believes in ability to control own life</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Takes responsibility for making life changes</td>
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<tr>
<td></td>
<td>• Can identify steps to achieve goals</td>
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<tr>
<td>General Empathy</td>
<td>• Can perceive the emotions of others</td>
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</tr>
<tr>
<td></td>
<td>• Is able to put self in other’s shoes</td>
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<tr>
<td></td>
<td>• Responds with appropriate emotion to other’s emotions</td>
<td></td>
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<tr>
<td></td>
<td>• Attempts to comfort others - when possible and appropriate</td>
<td></td>
</tr>
<tr>
<td>Prosocial Attitudes</td>
<td>• Espouses pro-social attitudes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Cooperates with supervisor/supervision</td>
<td></td>
</tr>
<tr>
<td>Adequate Intimacy Skills</td>
<td>• Values others</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Appropriately self-discloses</td>
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</tr>
<tr>
<td></td>
<td>• Able to make friends with others</td>
<td></td>
</tr>
</tbody>
</table>

**TRS-2 Results - Inter-rater reliability**

- Two raters given TRS-2 information package with little consultation
- \( N = 32 \) offenders
- Scale Total – Intraclass Correlation Coefficient
  - Intellectual Understanding \( - .90 \)
  - Acceptance Demonstration \( - .96 \)
  - Total Scale \( - .95 \)
  - All significant \( @ p < .001 \)

**Predictive Validity**

- Retrospective study – TRS-2 scored from treatment reports by rater blind to results but aware of sexual offender issues
- Randomly selected 96 of 535 sexual offenders, including 21 sexual recidivists, released for a Mean of 5.84 years \( (SD = 3.60) \). \( M \) Age = 42.98, \( SD = 11.84 \)

<table>
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<tr>
<th>Type of Recidivism</th>
<th>N</th>
<th>This Study</th>
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<tr>
<td>Revocation</td>
<td>5</td>
<td>5.3%</td>
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<tr>
<td>Non-sexual non-violent</td>
<td>9</td>
<td>9.6%</td>
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<tr>
<td>Violent recidivism</td>
<td>3</td>
<td>3.2%</td>
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<tr>
<td>Sexual recidivism</td>
<td>21</td>
<td>22.3%</td>
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</table>

**Predictors of Recidivism from 2009 outcome evaluation**

Total \( n = 96 \); Recidivists \( n = 21 \)
- Age: AUC = \( .55 \), \( p = .53 \)
- Sentence length: AUC = \( .62 \), \( p = .10 \)
- STATIC-99: AUC = \( .53 \), \( p = .74 \)
- PCL-R: AUC = Unknown, only 29 Ss had PCL-R scores
Mean TRS-2 Scale Scores

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<th></th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
<th>Range</th>
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<tr>
<td>TRS-2 Total</td>
<td>94</td>
<td>49.68</td>
<td>6.11</td>
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<tr>
<td>TRS-2 Intellectual Understanding</td>
<td>94</td>
<td>26.52</td>
<td>3.22</td>
<td>18-31</td>
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<td>TRS-2 Acceptance /Demonstration</td>
<td>94</td>
<td>23.16</td>
<td>3.12</td>
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Predictive Validity - AUCs

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<tr>
<th></th>
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<th>Intellectual understanding</th>
<th>Acceptance/Demonstration</th>
<th>Total</th>
<th>95% CI – Total Score</th>
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<td>Upper Bound</td>
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<td>No Failure</td>
<td>57</td>
<td>.67**</td>
<td>.66**</td>
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<td>Non-sexual non-violent</td>
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<td>.89</td>
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* p < .05, ** p < .01, *** p < .001

NOTE: Except for "No Failure", all scales are reverse scored so that higher scores indicate greater probability of recidivism. For "No Failure", higher scores indicate greater probability of no failures.

TRS-2: Rater familiar with correctional program issues but blind to results

<table>
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<th>AUC</th>
<th>Sig.</th>
<th>95% Confidence Interval</th>
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<td>Lower Bound</td>
<td>Upper Bound</td>
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<td>TRS TOTAL</td>
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<td>&lt; .001</td>
<td>.65</td>
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<td>INTELLECTUAL UNDERSTANDING</td>
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<td>&lt; .01</td>
<td>.62</td>
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<tr>
<td>ACCEPTANCE /DEMONSTRATION</td>
<td>.78</td>
<td>&lt; .001</td>
<td>.66</td>
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Sexual Recidivists v Non-Recidivists

<table>
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<th></th>
<th>M</th>
<th>SD</th>
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<td>24.09</td>
<td>3.60</td>
</tr>
<tr>
<td></td>
<td>Non-Recidivist</td>
<td>27.17</td>
<td>2.74</td>
</tr>
<tr>
<td>ACCEPTANCE /DEMONSTRATION</td>
<td>Recidivist</td>
<td>20.47</td>
<td>3.47</td>
</tr>
<tr>
<td></td>
<td>Non-Recidivist</td>
<td>23.89</td>
<td>2.60</td>
</tr>
<tr>
<td>TRS TOTAL</td>
<td>Recidivist</td>
<td>44.57</td>
<td>6.85</td>
</tr>
<tr>
<td></td>
<td>Non-Recidivist</td>
<td>51.07</td>
<td>5.07</td>
</tr>
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</table>

Other Rockwood Programs

<table>
<thead>
<tr>
<th>Program</th>
<th>Recidivism</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Treated</td>
</tr>
<tr>
<td>Preparatory</td>
<td>1%</td>
</tr>
<tr>
<td>Deniers</td>
<td>2.5%</td>
</tr>
<tr>
<td>Anger Management</td>
<td>Reductions in State &amp; Trait anger, greater motivation for change</td>
</tr>
<tr>
<td>Domestic Violence</td>
<td>Improved dynamic risk factors &amp; improved responsibility taking</td>
</tr>
</tbody>
</table>

Rockwood Main SOTP

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Refusers</td>
<td>3.8%</td>
</tr>
<tr>
<td>Drop-outs</td>
<td>4.2%</td>
</tr>
<tr>
<td>Completions</td>
<td>95.8%</td>
</tr>
</tbody>
</table>
Outcome for Rockwood Program - 2005

<table>
<thead>
<tr>
<th>Reoffence</th>
<th>Treated* (N = 535)</th>
<th>Expected**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual</td>
<td>3.2%</td>
<td>16.8%</td>
</tr>
<tr>
<td>General</td>
<td>13.6%</td>
<td>40.0%</td>
</tr>
</tbody>
</table>

*Mean follow-up = 5.4 years
**Based on Static-99 and S.I.R.

Outcome for Rockwood Program - 2009

<table>
<thead>
<tr>
<th>Reoffence</th>
<th>Treated* (N = 535)</th>
<th>Expected**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual</td>
<td>5.6%</td>
<td>23.8%</td>
</tr>
<tr>
<td>Violent</td>
<td>8.4%</td>
<td>34.8%</td>
</tr>
</tbody>
</table>

*Mean follow-up = 8.4 years
**Based on Static-99 (revised 2003)

Example outcomes: Facility “A”

Pre
- Few programs running, no structure, no oversight, outdated approach, conflict between medical and allied health staff
- Low staff morale and difficulty recruiting

Strategy: provide training to interested staff members, implement one intervention, then expand

Post
- Every Allied Health team member running at least one criminogenic need-related group intervention with evaluation and reporting processes in place
- Medical staff (physicians & nurses) also running groups
- Clients’ perspectives canvassed
- Achievement of targets of treatment

Nursing run self-esteem program

Social Self-Esteem Inventory (Lawson, Marshall, & McGrath, 1979)

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-treatment</td>
<td>24</td>
<td>116.33</td>
<td>30.2</td>
</tr>
<tr>
<td>Post-treatment</td>
<td>24</td>
<td>128.33</td>
<td>28.7</td>
</tr>
</tbody>
</table>

\[ t (23) = 2.34, p < .03, \text{Norm Mean} = 132, \text{SD} = 21 \]

Emotional Self-Regulation Treatment Group

Helen Chagigiorgis, PhD (C.Psych)
Jeff Robinson, M.A.
Liam E. Marshall, PhD
Old Program Results: STAXI-II (N = 34)

<table>
<thead>
<tr>
<th>Scale</th>
<th>M</th>
<th>SD</th>
<th>%ile</th>
<th>M</th>
<th>SD</th>
<th>%ile</th>
<th>Diff</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Anger</td>
<td>22.1</td>
<td>9.7</td>
<td>80th</td>
<td>20.1</td>
<td>7.1</td>
<td>75th</td>
<td>2</td>
<td>1.3</td>
<td>.20</td>
</tr>
<tr>
<td>Trait Anger</td>
<td>21.8</td>
<td>7.7</td>
<td>90th</td>
<td>20.3</td>
<td>6.2</td>
<td>75th</td>
<td>1.5</td>
<td>1.8</td>
<td>.09</td>
</tr>
<tr>
<td>Anger Expression - Out</td>
<td>18.1</td>
<td>5.1</td>
<td>90th</td>
<td>17.5</td>
<td>4.2</td>
<td>90th</td>
<td>0.6</td>
<td>0.8</td>
<td>.46</td>
</tr>
<tr>
<td>Anger Expression - In</td>
<td>19.5</td>
<td>5.3</td>
<td>90th</td>
<td>17.8</td>
<td>3.7</td>
<td>75th</td>
<td>1.7</td>
<td>1.9</td>
<td>.06</td>
</tr>
<tr>
<td>Anger Control - Out</td>
<td>21.7</td>
<td>6.2</td>
<td>25th</td>
<td>20.4</td>
<td>5.4</td>
<td>20th</td>
<td>1.3</td>
<td>1.4</td>
<td>.18</td>
</tr>
<tr>
<td>Anger Control - In</td>
<td>21.3</td>
<td>6.7</td>
<td>40th</td>
<td>19.7</td>
<td>5.7</td>
<td>35th</td>
<td>1.6</td>
<td>1.7</td>
<td>.91</td>
</tr>
<tr>
<td>Anger Index</td>
<td>42.5</td>
<td>17.1</td>
<td>80th</td>
<td>43.2</td>
<td>14.0</td>
<td>80th</td>
<td>-0.7</td>
<td>-0.3</td>
<td>.78</td>
</tr>
</tbody>
</table>

Old Program versus New Program

<table>
<thead>
<tr>
<th>STAXI-II</th>
<th>Old</th>
<th>Mean</th>
<th>SD</th>
<th>%ile</th>
<th>M</th>
<th>SD</th>
<th>%ile</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Anger</td>
<td>22.1</td>
<td>9.7</td>
<td>80th</td>
<td>20.1</td>
<td>7.1</td>
<td>75th</td>
<td>2</td>
<td>1.3</td>
<td>.20</td>
</tr>
<tr>
<td>Trait Anger</td>
<td>21.8</td>
<td>7.7</td>
<td>90th</td>
<td>20.3</td>
<td>6.2</td>
<td>75th</td>
<td>1.5</td>
<td>1.8</td>
<td>.09</td>
</tr>
<tr>
<td>Anger Expression - Out</td>
<td>18.1</td>
<td>5.1</td>
<td>90th</td>
<td>17.5</td>
<td>4.2</td>
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<td>0.6</td>
<td>0.8</td>
<td>.46</td>
</tr>
<tr>
<td>Anger Expression - In</td>
<td>19.5</td>
<td>5.3</td>
<td>90th</td>
<td>17.8</td>
<td>3.7</td>
<td>75th</td>
<td>1.7</td>
<td>1.9</td>
<td>.06</td>
</tr>
<tr>
<td>Anger Control - Out</td>
<td>21.7</td>
<td>6.2</td>
<td>25th</td>
<td>20.4</td>
<td>5.4</td>
<td>20th</td>
<td>1.3</td>
<td>1.4</td>
<td>.18</td>
</tr>
<tr>
<td>Anger Control - In</td>
<td>21.3</td>
<td>6.7</td>
<td>40th</td>
<td>19.7</td>
<td>5.7</td>
<td>35th</td>
<td>1.6</td>
<td>1.7</td>
<td>.91</td>
</tr>
<tr>
<td>Anger Index</td>
<td>42.5</td>
<td>17.1</td>
<td>80th</td>
<td>43.2</td>
<td>14.0</td>
<td>80th</td>
<td>-0.7</td>
<td>-0.3</td>
<td>.78</td>
</tr>
</tbody>
</table>

Results: Stage of Change (URICA)

- Pre-Contemplation: 42.5
- Contemplation: 21.3
- Action: 19.0
- Old Program: 42.5
- New Program: 21.3

Clients’ Perspectives: Domestic Violence group

Would you recommend this group to others? = 97% said Yes.

Factor Analysis of whole scale: 1 factor accounting for 89% of variance

Therapist Post-Treatment Ratings

Domestic Violence Group

<table>
<thead>
<tr>
<th>TRS-2*</th>
<th>Mid Treatment</th>
<th>Post Treatment</th>
<th>t</th>
<th>Sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intellectual Understanding</td>
<td>21.62 (3.07)</td>
<td>27.44 (3.58)</td>
<td>7.11</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Acceptance / Demonstration</td>
<td>18.19 (2.86)</td>
<td>23.44 (3.78)</td>
<td>5.33</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Total Score</td>
<td>39.81 (5.59)</td>
<td>50.87 (7.15)</td>
<td>6.67</td>
<td>&lt;.001</td>
</tr>
</tbody>
</table>

### GROUP TRACKING DATA

- 255 individuals were referred to one or more of the core groups in the fiscal year
- 212 men became residents in the fiscal 2009-2010 year
- Average number of core groups each potential resident was referred to = 2.08
- Average number of core groups entered by each actual resident = 1.83.
  - Residents entered 88% of the core groups to which they were referred
- Average number of core groups completed by each actual resident = 1.45
  - Residents completed more than 79% of the core groups which they entered.

### GROUP SATISFACTION (all groups) – Assessed immediately post group completion or removal

<table>
<thead>
<tr>
<th>N</th>
<th>Mean</th>
<th>SD</th>
<th>Min</th>
<th>Max</th>
<th>Possible Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facilitator</td>
<td>727</td>
<td>13.42</td>
<td>2.13</td>
<td>4</td>
<td>15</td>
</tr>
<tr>
<td>Content</td>
<td>728</td>
<td>21.39</td>
<td>3.94</td>
<td>5</td>
<td>25</td>
</tr>
<tr>
<td>TOTAL</td>
<td>714</td>
<td>34.87</td>
<td>5.80</td>
<td>10</td>
<td>40</td>
</tr>
</tbody>
</table>