Illinois Association for the Treatment of Sexual Abusers

July 2014 *Membership Newsletter*

President's Message

~ Guy Groot

For the "President's message" in this newsletter, I would like to touch on two topics. Those topics are: looking at the confluence of goals for our association and talking a little a bit about the focus of this newsletter.

Several contacts over the last few months have led me to think more about the role of Illinois ATSA in several contexts. One situation involved receiving correspondence from an individual advocating taking a strong position about registration and residency restrictions. The second involved the release of the report by the *Illinois Juvenile Justice Commission* on "Improving Illinois Response to Sexual Offenses Committed by Youth." Both jarred my thoughts in different ways. The first led me to discuss the topic with the Illinois ATSA board members. Our immediate conclusion was to look to the mission of the organization. This led us to rededicate our focus on creating an informed network that can communicate and follow the mission of ATSA. The following words from the ATSA website speak volumes.

The Association for the Treatment of Sexual Abusers is an international, multi-disciplinary organization dedicated to preventing sexual abuse. Through research, education, and shared learning ATSA promotes evidence based practice, public policy and community strategies that lead to the effective assessment, treatment and management of individuals who have sexually abused or are at risk to abuse. ATSA is an association of individuals from around the world committed to achieving a high level of professional excellence. ATSA promotes the philosophy that empirically based assessment, practice, management, and policy strategies will: enhance community safety, reduce sexual recidivism, protect victims and vulnerable populations, transform the lives of those caught in the web of sexual violence, and illuminate paths to prevent sexual abuse." ***Continued page 4***

In this issue:

The Evolution of a Treatment Program

~Liza Simon-Roper, ACSW, LCSW & Michelle Progar, Psy.D

Since the early 1980's the field of sexual abuse has struggled with the treatment of children and adolescents who engage in sexually inappropriate behavior, and who were identified by either the juvenile justice system or the child welfare system as "sex offenders." This designation, which was inherited from the adult justice system, seemed to dictate the form of intervention that these youth and children received. Thus, as the adult system evolved into using a relapse prevention model focused on cycles of offending, these concepts were also applied to youth. (Prescott and Longo, 2010) As the field continued to grow, and as new knowledge about this heterogynous population was acquired, treating professionals and treatment programs also began to shift their focus. Most recently, in the state of Illinois, the Illinois Juvenile Justice Commission released a policy paper, *Improving Illinois' Response to Sexual Offenses Committed by Youth: Recommendations for Law, Policy, and Practice (March 2014);* the need for programs that are community based and family focused was emphasized.

The purpose of this article is to discuss the evolution of one such program offered at One Hope United (OHU), and to discuss the influence of *The Good Lives Model* (Ward 2006) and evidence based trauma informed treatments on this evolution. ***Continued page 2***

The Evolution of a treatment program...continued from page 1

~Liza Simon-Roper & Michelle Progar

This paper will also present preliminary findings regarding efficacy of the OHU program based on retrospective file reviews. These findings will also be used in an additional paper looking at the population OHU has served and how the program has evolved to meet the needs of the clients and their families. This data will also assist in informing what aspects of the program contributed to the clients' success in achieving their treatment goals.

One Hope United is a private, non-profit human service agency founded in 1895 that has grown into a multi-functional agency servicing children and their families regardless of race, ethnic heritage, religion, or creed. One Hope United provides a wide range of services to children and families in Illinois, Wisconsin, Missouri, and Florida. Since the 1980's the agency has provided community based "sex offender" treatment to adults in Kane County, Illinois. In approximately 2000, these services were expanded to include adolescents in Lake County, Illinois and Kenosha County, WI who were referred following adjudication on a sexual offense charge. Originally, this program utilized a cognitive behavioral approach that emphasized relapse prevention, and focused on implementing group treatment for the majority of the youth that were served. The program used Timothy Kahn's Pathways series of workbooks as its primary curriculum and strove to encourage youth to provide "clarification" to their victim(s) in order to repair the hurt that their behavior had caused as well as develop an understanding of their "cycle of offending" and developing a plan to prevent relapse. Since its inception the program strove to adhere to standards set forth by the Association for the Treatment of Sexual Abusers, and later, those promoted by the Illinois Sex Offender Management Board. Thus, youth and their parent(s)/guardian(s) were provided with informed consent for both the psychosexual assessment process and treatment should the client return for services. Neither the assessment nor treatment was provided pre-adjudication unless the client was admitting to engaging in inappropriate sexual behavior, and the family had consulted with their attorney. The questions that were addressed in the early "psychosexual evaluation" reports concerned level of deviant sexual interest; the client's understanding of their "cycle" of offending, and other forms of acting out that the client may have engaged in. In addition, the use of risk assessment tools as part of that assessment and periodically through the treatment process was also instituted early in the program's development. Thus, the program began as a specific treatment focusing on sexual acting out issues, which utilized primarily individual and group therapy. The program was based on the completion of tasks, with the final task being clarification/apology work to the victim(s) whenever possible. Initially, there were no outcome measures for the success of the program other than the client/family's verbal statements regarding the services. In 2003, the agency developed two outcome goals for the program. These goals were:

1. 90 % Clients who completed the treatment program would achieve 90% of their treatment goals and
2. 90% of the clients who completed treatment would have a reduced level of risk.

For the first and second year (fy 2004 and 2005) combined, the program demonstrated 83% of clients achieved at least 90% of their treatment goals, and 86% of the clients who completed treatment had an estimated reduced level of risk.

This data was gathered on 63 clients during this two year period. While these results were generally positive, it was during this period that the Good Lives Model was being developed by Dr. Tony Ward (2006) in New Zealand, and becoming better known in the US. This model, which was developed with an adult population, is a strength based approach to offender rehabilitation. The model emphasizes the importance of building capabilities in clients to improve the quality of their lives. This is a holistic approach that also recognizes the importance of the therapeutic relationship and encouraged a shift from shame to a more positive, supportive therapeutic process. It was also during this period that Dr. James Worling first published the ERASOR (2001) and began to discuss the SAFE-T program in Toronto, Canada as a model for working with youth. Both of these approaches influenced the further development of the program at One Hope United. A major contribution that both of these models had on the program were their increasing emphasis on the system that the client was involved in, the focus on strengths, the holistic approach, and the recognition that adolescents are developmentally quite different ***continued page 3***

The Evolution of a Treatment Program...continued from page 2

~ Liza Simon-Roper & Michelle Progar

from the adult population. Up to this point, many programs, One Hope United's included, emphasized addressing the behavior and "preventing" the behavior rather than attempting to understand the behavior in the context of the client's life experiences, supports, family environment, skill level, relationships, and strengths. This "new" focus also paralleled changes in the treatment of trauma with the establishment of the National Childhood Traumatic Stress Network (2001) and subsequent research and improved understanding of the impact of trauma as well as treatments that were effective in promoting healing from trauma. By 2006, these changes and ideas were relatively widespread, and the agency refocused their treatment program as a result. The following changes in the program structure were instituted:

1. Increased family involvement in the treatment process with the incorporation of family therapy whenever possible.
2. The incorporation of family groups to be held periodically to facilitate family involvement in the treatment process. These groups were held in conjunction with the adolescent groups, and scheduled approximately every 8 weeks.
3. Focus on strengths of the family and client in the assessment and treatment planning processes.
4. The increased focus on psycho-education and skill building in the groups, with less emphasis on clients needing to detail their behavior.

As a result of these changes, there were changes made in the outcome data that was gathered by the program. The agency became more interested in the idea of client well-being as well as safety. Thus the following outcomes were used, and continue to be used by the program:

1. 80% of clients will achieve at least 90% of their goals at discharge.
2. 75% of clients discharged will have a reduction in their estimated level of risk as assessed with the ERASOR,
3. 80% of clients discharged will demonstrate improvement on the Child and Adolescent Needs and Strengths Scale (CANS).
4. 90% of clients who were living in their family homes will remain in the home at discharge.

For the period of fy 2011 and fy 2012, clients did appear to meet some of these outcomes:

1. 80% of clients did achieve at least 90% of their treatment goals.
2. 75% were estimated to be at lower risk at discharge.

However, the outcomes related to the CANS and to children remaining in their homes, were not at the expected level, with 75% demonstrating improvement on the CANS and 82% remaining in their homes. These results were somewhat unexpected; however, they are based on a smaller number of clients in the program, 35 discharged during this two year period, and the use of the CANS was not routine with some staff particularly during fy 2011. As work with this population evolved, the complexity of these children and their families became clearer. While many youth did not demonstrate histories of delinquent behavior, these youth also appeared to have struggles in other areas of their lives including trauma histories, difficulty with peer relationships, and family conflicts. In addition, social media and technology were continuing to advance making pornography more readily available, and seeming to erode the skills of many of these youth to engage in healthy relationships outside of social media. In addition to these changes, changes in the stress level of families also appeared to increase for many of the youth referred.

As was noted in the Commission's policy paper, the passage of Sex Offender Registration and Notification Acts were likely a part of this stress. Children who are adjudicated in Illinois are frequently required to register, which can have a significant impact on their lives both as an adolescent and an adult. These complicating factors prompted ongoing evaluation of the program and the belief that there is a need for approaches that are not only family focused, but evidence based.

The current treatment protocol begins with a psychosexual assessment to assess for potential deviant sexual arousal, family history, trauma history, strengths, and amenability to community-based treatment. Clients in the program are typically expected to follow a safety plan designed to provide external structure and guidance for supervision, particularly early in the treatment process.

The program at One Hope United has a structure that utilizes a "phase of treatment" system. At the onset of treatment, clients and their caregivers are provided with a program overview which contains descriptions and examples of related assignments for each phase of the program.

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Illinois Association for the Treatment of Sexual Abusers

President's Message...continued from page 1

~ Guy Groot

The second, the release of the report from the Illinois Juvenile Justice Commission, led to a sad awareness of the lag time in the process of data collection and its eventual movement to the stakeholders who make legislative decisions. That report will possibly stimulate some change in the awareness and approach to juveniles. The information in the report has been available in other forms, and has been shared during prior publication and conferences in the past. From my perspective, nothing new, but it was importantly brought together in a form that may engender good discussion and possible movement.

Overall, both of these situations led to looking at that phrase in the ATSA mission, "shared learning." We must do what we can to share in the effort to inform ways to prevent sexual abuse. Treatment can often follow the paradigm of the Goldilocks and the Three Bears story. Some stakeholders around us in our work sometimes push from a perspective of *overdoing* in the form of treatment and management. Sometimes our clients push from a perspective of *doing less* in the form of treatment and management. Our daily search can often be finding the *right fit*.

The second topic I would like to address is the content of this newsletter. The articles focus on some perspectives on, and one agency's (One Hope United) application of treatment associated with the Good Lives Model.

It's a road like any other in a profession. It starts out a little bumpy. There may be roadblocks or detours along the way, requiring additional research. It's an approach that will require research along the way. The question will have to be explored, is what appears promising in the Good Lives Model, effective? Experience has shown that the model offers a promising increase in engagement and self efficacy. Does this translate into treatment effectiveness? The strength of evaluating, selecting and putting into practice more balanced and effective ways to meet primary needs, versus the reliance on previously utilized maladaptive methods makes common and clinical sense. Again, does this translate into effectiveness? These are questions that we sit in the midst of exploring.

It's also the time of the year that we as members look toward making our plans to attend this year's National ATSA conference in San Diego. As you do so, take the opportunity to reach out to those professionals you work with and give them a nudge to join you at the conference. I'd also like to give you a nudge to look at volunteering for your organization, Illinois ATSA. There are many ways to assist. These include joining the board, writing items for the newsletter, sharing resources, assisting in developing our training platform through webinars and other methods. It's a good thing. Take care, and enjoy your summer.

Applying the Good Lives Model When Working With High Risk Offenders

~ Rhonda Meacham

I find myself in a unique position of working almost exclusively with high risk offenders, specifically individuals that are in the process of reintegrating into the community after multiple years of incarceration and/or commitment as Sexually Violent Persons (SVP). One of the struggles I have had in honing my therapeutic skills relates to attending trainings and consistently hearing the disclaimer that the information being shared *DOES NOT* apply to the SVP population. Similarly, there are challenges associated with implementation of the Good Lives model with this group of individuals. If close attention is not given to the Risk-Need-Responsivity principles as outlined in Chapter 6 of *Applying the Good Lives and Self-Regulation Models to Sex Offender Treatment: a Practical Guide for Clinicians*, authored by Pamela M. Yates, David Prescott, and Tony Ward, creation of goals and objectives within this model could ultimately set our clients that are identified as high risk up for failure. The issue that will be addressed within this article references the clients that are deemed "high risk" on static and dynamic risk assessment tools, who have also been diagnosed with a personality disorder.

Individuals tend to have the ability to recognize the Goods that are most important to them and can articulate specific things they would like to do to aid in achieving fulfillment of the Good(s). Where the conundrum exists is in the lack of insight the individuals I have referenced above (high risk; personality disorder) have regarding the presence of maladaptive personality traits and how these traits interfere with their overall life satisfaction. In general, these clients have a tendency to believe their responses are externally driven, resulting from the actions of others, rather than inherent;

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Applying the Good Lives Model With High Risk Offenders...continued from page 4

~ Rhonda Meacham

thus they tend to perceive the only barrier to success as being the lack of change exhibited by those around them. The first course of action I take when implementing the Good Lives approach is to review dynamic risk factors that have been assessed as present for the individual, engaging them in discussion regarding their level of agreement with the assessment. This discussion has to go beyond the simple agree/disagree line of questioning. The discussion should include ways the individual believes they have progressed in the specific area of risk either through previous intervention or independent change, while identifying ongoing challenges. For this to be effective, the client should be provided the opportunity to offer concrete examples of when they demonstrated progress, while also identifying specific recent examples of the presence of ongoing issues related to the risk factor. This can then evolve into a discussion related to the negative impact the ongoing issues have in relation to fulfillment of specific Goods that are important to the individual. Again, a dual approach is best. How has the progress that has been demonstrated resulted in fulfillment of this Good, while increasing insight into how the ongoing struggles are interfering with consistent fulfillment? In reality, implementation of this step in the treatment planning process can take several weeks to several months, depending on the level of defensiveness presented by the client or the difficulty the individual has either internalizing the discussion or having the capacity to generalize the insights. Although it can be tempting for clinicians to move through this step without adequately completing the process, it is critical to persevere through this with patience and consistency to avoid ultimately joining in the creation of objectives that are unrealistic for the current skill level exhibited by the client, ultimately resulting in failure. The ultimate goal is to include objectives that address dynamic risk factors, recognized and accepted as present by the client, in the treatment planning process. When considering how to approach treatment, it is critical to ensure that our techniques are implemented in a way that is suitable to the risk level of the client. Often times, it will not be effective to use the same clinical approach with a high risk client, who has a diagnosed personality disorder as used with a low to moderate risk offender with a relatively adaptive personality structure. Clinicians working with individuals that are high risk/high need have a responsibility to commit to the therapeutic process of these individuals, which is likely to be more lengthy and trying. To fail to do so will result in the creation of goals and objectives that the individual is likely to pursue, only to ultimately discover the personality structure necessary to sustain the various Goods has not been adequately developed.

Good Lives Model with Adolescents: A Review of the Book (Edited by Bobbie Print)

~ Glen Ensinger

The Good Lives Model is perceived as a positive psychology model. Ward, Polaschek and Beech (2006) believed it is better to "promote human welfare by concentrating on strengths rather than focus on deficits." Linley and Joseph (2004) saw positive psychology is the "optimization of human functioning." James Haaven's work made a distinction between [bad] "old me" and the better "new me". Bobbie Print was motivated to edit the book in order to assist others with using the Good Lives Model with adolescents who sexually harm. Prior to this, the available book was written by Yates, Prescott and Ward (2010).

There have been numerous articles written about the Good Lives Approach. Clients are more likely to pursue more effective ways of meeting their needs if they understand the ineffective choices they made before. The real issue is how the therapist reaches a client who is unwilling or unable to identify what were ineffective or poor choices.

In the book, Anthony Beech identifies routes of offending which include;

1) An individual might use inappropriate strategies (secondary goods) to achieve primary goods.
2) An individual's Good Lives plan might suffer from a lack of scope, in that a number of goods are omitted from his/her plan.
3) There may be conflict in pursuit of goods that might result in acute psychological stress and unhappiness.
4) An individual might lack internal and external capabilities to satisfy primary goods in the environment he or she lives.

According to Beech, another important aspect is promoting self-efficacy. This is done by:

1) Mastery experiences
2) Vicarious experiences

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~ Glen Ensinger

3) Social persuasion
4) Reduction in stress levels

Beech also went on to state the "major aim of interventions with those who sexually harm should be to equip the offenders with the skills, values, attitudes and resources necessary to lead a different kind of life: one that is personally meaningful and satisfying and does not involve inflicting harm on children or adults."

G-Map, a program out of the UK, developed an adaption of the Good Lives primary needs to more appropriately address needs of an adolescent *(seen in the table at the bottom of this page).*

The primary differences include the *safety*, *status and meaning* and *purpose*. The differences meet the developmental needs of adolescents. As you can see, it addresses safety which seems to be an issue for adolescents. The adolescent may not understand the permanence of a car accident or a behavior that may do permanent harm to themselves or others. The difference with the meaning and purpose is that an adolescent is not necessarily interested in being successful at school and work. The other distinction that I see is status. Young people measure themselves differently than adults (and often measure themselves against peers); this can be an issue if the adolescent feels inadequate or if they are more immature.

Print, Fisher and Beech also addressed attachment and trauma theories which influence the understanding of juveniles who have harmful sexual behavior. They cited Creedon (2004), Smallbone (2006) and Burton (2013).

Attachment has been addressed from the time of Bowlby and Ainsworth. The importance of understanding youth who offend sexually and their attachment issues is important to the success of treatment.

Understanding the development needs of adolescents is vital with this model, since it is was initially designed for adults and later adapted for adolescents. There is a dearth of literature that points to the problem of using adult models for adolescents. Adolescent development is incomplete. Adults, although at times delayed in their maturity, are physically mature and thus there is a difference in how treatment should be designed and used. When working with adolescents it is important to understand the development issues. Helen Griffin and Laura Wylie identified this in the third chapter as they talked of the journey from the adult model to adapting it for adolescents.

On the other hand, one of the things I like about this model is that it addresses denial. In chapter 4, Elleen Okotie and Paul Quest address denial. They report denial is a reason for some programs to exclude clients from intervention programs. Okotie and Quest identify that fear of child protection systems or court systems, and the systems' response to the offense and/or family and community response leads to young people attempting to deny the offense. "The aim is for the practitioner and the individual to explore change together by looking at the person's past and current concerns, and goals." This is using Good Lives along side motivational interviewing (Miller and Rollnick 1991, 2002). "Davidson, Rollnick and MacEwan (1991) suggest that motivation is influenced by dynamic environmental and situational factors." As an avid user of motivational interviewing, I believe that directing the client to address what behaviors are effective and ineffective helps them identify that their sexual behavior has caused problems, and there is a more effective way to meet their needs.

Chapter 5 is on assessments and I will leave that section out as our last newsletter was on assessments.

Moving on to chapter 6, it is made clear the Good Lives plan is "An important element of the Good Lives model… a blueprint that includes those goals and activities that are important in achieving the type of life the individual would like to attain and reflect the kind of person they wish to become" (Langlands, Ward and Gilchrist 2009, 119). This is achieved by working with the Good Lives team or the people in the client's life. The plan takes account of "capacity, obstacles, means conflict and scope (Ward and Stewart 2003b).

The authors identify what that might be in a care plan such as;

1) What strengths do I have to help myself?
2) What things/people are around me to help me?

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Adult Primary Goods	Adolescent Primary Goods
Life	Healthy Living
Knowledge	Knowledge
Excellence in Play and Work	Status
Excellence in Agency	Independence and self-management
Inner Peace	Safety
Relatedness and Community	Relationships
Spirituality	Emotional Satisfaction
Happiness	Meaning and Purpose
Creativity	

Evolution of a Treatment Program...continued from page 3

~Liza Simon-Roper & Michelle Progar

We emphasize to the client and family that treatment is a process, and that movement through the program is not necessarily linear.

Our treatment program consists of individual, family, and group therapy modalities in providing sexual behavior problem treatment for adolescents. All clients are seen individually, and recommendations for participation in family and/or group therapy are made on a case by case basis, depending on its appropriateness for each client. Treatment is delivered utilizing psychoeducational workbooks and supplemental materials to deliver sexual behavior problem specific treatment concepts. However, one cannot overlook the atmosphere of safety and acceptance that is present in a therapeutic alliance, and it is our experience that this contributes to the clients' processing of their decision-making regarding their inappropriate sexual behavior. We have found an increase in clients presenting with significant trauma histories, thus our program has evolved to provide trauma-informed services, and treatment often incorporates addressing our clients' trauma histories. In 2012, the agency developed a category III NCTSN trauma treatment program utilizing an evidence based framework called Attachment, Self-Regulation, and Competency (Blaustein and Kinniburgh, 2010) and this framework is used in the treatment program for adolescents with sexual behavior problems as well. Group therapy is psychoeducational in nature and focuses on skill development in all areas of our clients' lives, such as relationships, affect identification and regulation, communication, and goals, much in alignment with the Good Lives model. As the program has evolved the importance of providing a non-shaming environment that addressed the developmental concerns of adolescence as well as the problematic behavior has become clear. Family groups are offered approximately every eight weeks in which parents/caregivers attend group, alternating between adolescents being present and meeting solely with parents/caregivers. This has allowed parents/caregivers to be more active participants in treatment and also provide them with opportunities to receive support from other parents/caregivers as well as group therapists. In Spring 2014, the program for the first time offered an eight week psychoeducational group for parents/caregivers of the adolescents in our program in an effort to provide parents/caregivers with an opportunity to learn more about the treatment concepts that the adolescents learn in treatment, as well as present them with information regarding attachment and self-care. It was our hope that by arming these parents/caregivers with this information, they would be better able to support their adolescent in treatment and gain a better understanding of sexual behavior problem treatment. The program received positive feedback from all participants and anticipates that the group will continue to be offered in the future.

The OHU program offers services that are not only community based, but also family focused and based on using client strengths whenever possible. As is noted in the Commission's report, there are no evidence based approaches for this population outside of Multi Systemic Therapy (MST). There is however, the SAFE-T program in Toronto Canada, which has been validated by several studies and is considered to be evidence informed. This is a program that the agency has found to fit well with our trauma informed approach practice, and one that this treatment program seeks to emulate. The program is now in the process of looking at over 100 closed client files to answer questions about which elements of the program appeared to have the greatest impact and how has this population changed in terms of presenting problems and needs. It is our belief that the focus on improving family functioning, assessing the whole child, and providing a safe, supportive environment for the client to address his or her inappropriate behavior and develop skills for engaging in positive, healthy relationships have all contributed to the success of this program. While this program has had limited formal assessment, the retrospective study of cases dating from 2003 suggest that treatment has been effective for the majority of clients served. Research indicates that for this population in general, recidivism is fairly low (Caldwell 2007). This program seeks to provide these young people with positive outcomes in a variety of areas such as in their ability to develop positive relationships, healthy boundaries, pro social skills in communication and affect regulation, an integrated sense of self and decision making skills. As we strive to provide this service, we look forward to continuing to align this program with evidence based programs such as the SAFE-T program, and conduct more formal assessment over the next several years.

(*See bibliography-page 9*).

Good Lives Model with Adolescents...continued from page 6

~ Glen Ensinger

3) What do I have to change about me to help me manage my harmful sexual behavior? (Internal and external)
4) How do I meet my most important needs now? How else can I meet these needs?
5) Which of my needs fight against each other?
6) Which of my needs do I neglect?

It is important, as always, that the goals/plans be realistic. Can the plan be applied as it is set out realistically, and can the client be successful using this plan? The authors also point out that the plans are to be revised as needed and this can show that progress is being made.

Chapter 7 focuses on therapeutic practice. This is where I believe I fit as a therapist; I am more focused on the assessment process to determine the particular needs of the client. I am not a research person and so my focus is on assessment and then treatment. Sex offender treatment is different from other forms of treatment as there is such an emphasis on recidivism. It has to be balanced, on the one hand, but directive in the approach at times (no therapist wants another victim). I believe The Good Lives model identifies this as: the therapist approaches the client with an understanding of what has been effective and what has not. The model approaches the client where they are. It seeks to identify what methods have been employed by the client to meet their needs and then addresses means to make changes so the client is meeting their needs more appropriately. The model is a holistic model in that it addresses the whole adolescent. The approach meets with important players in the client's life and assists these players in making necessary changes as well. This helps the client overcome obstacles as they arise.

Two other areas that the model addresses are trauma and attachment. These two areas impact the adolescent's life. Using a holistic model is necessary to address adolescent behavior. This model adapts to the needs of the client and focuses its energy on specific needs of the client versus a generalized approach. There is a great deal of research that shows the importance of identifying and treating trauma and attachment related issues.

What I found interesting is the treatment model adapted to the needs of the client. This included the length of an appointment, to the number of sessions a month, to the length of time the client was in the program. I believe this is very necessary and important in outpatient settings and I am sure that if we approached inpatient settings with what was necessary for the client, length of stay might change. The Illinois 9th Judicial Sexual Conduct Program generally keeps people in services from several months to generally a maximum of 18 months. But this has been changed based on the needs of clients. The program has had one client in outpatient services for over two years. While I am well aware this is nothing new, I believe there is still room for providers to learn to adapt the program to the specific needs of the client. The Good Lives model exemplifies this.

The 8th Chapter discusses transitions. The authors stated Willis et al. 2013 "plans need to be pragmatic, achievable and relevant to the young person's future living environment". As therapists, we are well aware that it is difficult enough to provide a safe environment for our clients while they are in treatment. It is just as important for the client to have a plan in place for being successful in the community after discharge from the program. The success depends on the team to establish protective factors and set up an environment that is proactive to protect the community and the client.

The 9th Chapter also includes responses from adolescents and practitioners. Practitioners saw the GLM as motivational, user friendly, easy to understand, complements other models and theories, assists in problem formulation, identifies and utilizes a young person's strengths and is rehabilitative.

The 10th and final chapter is a review of using GLM. I will leave you to read it at your convenience.

Young people interviewed found they were able to understand and retain GLM elements, understand their harmful behaviors and how to change them, identify needs and goals and meet these in appropriate ways, and matching workers to young people was important.

The GLM is positive and effective in helping youth live better lives. It has a method of assessment and treatment. Identifying youth's needs and the way they meet those needs will assist the therapist with tools to aid their clients in becoming productive citizens.

As you can see, I have taken you through the book chapter by chapter just highlighting important aspects of the model. The greatest fault I see with using this model is it was adapted from an adult program.

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Good Lives Model with Adolescents...continued from page 8

~ Glen Ensinger

I believe the model is somewhat simplistic in its approach, but this can also be seen as a positive. We as humans have needs and we meet them effectively or ineffectively daily. The issue with the clients we work with is they meet their needs in a way that is detrimental for them and creates victims. Our primary role is to protect the community. I believe if we apply the GLM model to help youth who have sexually harmful behavior we can reduce recidivism and increase the potential for our clients in being successful individuals.

If you are interested, I developed a survey and evaluation from Good Lives books. You can email me at gensinger@9thjudicial.org to request a copy of the surveys.

Evolution of a Treatment Program: Bibliography

~Liza Simon-Roper & Michelle Prograr

Bibliography

Blaustein, Margaret and Kristine Kinniburgh (2010). Treating Traumatic Stress in Children and Adolescents: How to Foster Resilience Through Attachment, Self-Regulation and Competency. The Guildford Press, New York.

Caldwell, Michael. *Sexual Offense Adjudication and Sexual Recidivism Among Juvenile Offenders.* Sex Abuse (2007) 19:107-113.

Illinois Juvenile Justice Commission (2014). *Improving Illinois' Response to Sexual Offenses Committed By Youth: Recommendations for Law, Policy, and Practice.* Illinois Department of Human Services

Kahn, Timothy K. (2011). Pathways: A Guided Workbook for Yuth Beginning Treatment. The Safer Society Press, Brandon, Vermont.

Willis, G.M., War, T., & Levenson, J.S. *The Good Lives Model (GLM): An Evaluation of GLM Operationalization in North American Treatment Programs.* Sex Abuse (2014) 26(1), 58-81.

Willis, Gwenda M., Yates, Pamela M., Gannon, Theresa A., & Ward, Tony. *How to Integrate the Good Lives Model into Treatment Programs for Sexual Offending: An Introduction and Overview.*Sex Abuse (2012), 2(2), 123-142.

Worling, James R. *The Estimate of Risk of Adolescent Sexual Offense Recidivism (ERASOR): Preliminary Psychometric Data.* Sex Abuse (2004)16, 235-254.

Worling, James (2011). *The Assessment and Treatment of Deviant Sexual Arousal with Adolescents Who Have Offended Sexually.* Journal of Sexual Aggression, DOI: 10.1080/13552600.2011.630152

THANK YOU TO ALL THE CONTRIBUTORS TO THE JULY IL-ATSA NEWSLETTER:

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