A Comparison of Two Manitoba Justice
Sexual Offender Programs

by

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ABSTRACT

The purpose of this study was to consider to what degree each of two sexual offender programs offered by Manitoba Justice adhere to the research based practice principles of risk, need, and responsivity and to assess the degree of therapeutic alliance that is created in each group. Based on the information gathered this research will attempt to determine, if possible, which program is better suited to Manitoba Corrections mandate to have the "lowest recidivism rates in Canada" and offer recommendations based on the data collected.

In-person interviews were conducted with employees who are connected to each of the programs. In-person interviews were also conducted with past-participants who took part in both programs. Current participants of the two programs were asked to complete a questionnaire about therapeutic alliance.

The findings indicated that neither of the programs adhere to the risk principle, both adhere to the responsivity principle, and only one adheres to the need principle. There was no difference on the clients' perception of therapeutic alliance within the groups.   Participants provided insight into the benefits and limitations of each of the groups.

Recommendations provided with regards to the sexual offender programming offered by Manitoba Justice include consistent programming, education/mentorship, utilizing a secondary risk assessment, and evaluation and research.

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<u>Introduction</u>

Currently Manitoba Corrections is running two sexual offender programs. The first is a closed relapse prevention cognitive behavioural based program which has been offered for the past twenty years. The second is an open, holistic, cognitive behavioural program which has been a "pilot" program since 2005.

Manitoba Corrections has a mandate to provide effective programming to individuals who have been convicted of an offence.   Sexual offences are especially damaging not only to the victim, but also to the offender, families, and society as a whole. The importance and need to offer effective programming for sexual offenders is great.   Not only is there a mandate to ensure that the programs being offered are best suited to reduce recidivism but there is also a strong ethical responsibility to ensure that programs being offered to sexual offenders addresses their criminogenic needs, reduces risk, and is delivered in a manner that is considered most effective.

I have worked for Manitoba Corrections for the past fifteen years. My first five years was at Headingley Correctional Center working in their sexual offender unit, three of those years I was a program facilitator delivering the Relapse Prevention Program. I moved into my position as a Probation Officer in the sexual offender unit ten years ago. Initially Probation Services also facilitated the Relapse Prevention program to our clients. Over a period of time the frustration experienced by Probation Officers with what we felt were limitations of the Relapse Prevention

Program became clear. It was at that time, in 2005, that Probation Services began to

pilot a different sexual offender program which was more process oriented and

focused on understanding the clients entire life experience and how that impacted

their offending behavior. It was this experience that sparked my interest in this

research project.   On a personal level I want to know that the programming we are

offering our clients has the best chance of creating an opportunity and environment

for clients who want to make change in their lives be successful.   Hearing the stories

our clients have to tell about their sexual offending as well as their own life

experiences can be emotionally draining and, from my experience, the best way to

balance that is to know that we are making a difference in clients' lives and in turn

reducing the number of potential future victims.

Research Problem

There are two main objectives to this research. The first objective is to

consider to what degree each of these programs adheres to the research based practice

principles of risk, need, and responsivity.   The second objective is to assess the

degree of therapeutic alliance that is created in each group. Based on the information

gathered this research will attempt to determine, if possible, which program is better

suited to Manitoba Corrections mandate to have the "lowest recidivism rates in

Canada" and offer recommendations based on the data collected.

It is also important to note that MB Corrections has not completed a formal

evaluation of the sexual offender program being offered. While the programs have

been offered to hundreds of clients over the years there has not been any consistent

pre and post testing completed that would allow any researcher to attempt to measure change in clients related to attitude, knowledge, and coping skills. As a result a future evaluation would be relying heavily on recidivism data to determine the success of the program.   The limitation in relying on recidivism data is that sexual offence recidivism rates are low, 10% to 15% after five years in the community (Hanson & Harris, 2000). This would create the need for a longitudinal study in order to capture a more accurate number of reconvictions.   These limitations have led the researcher to logically conclude that it is not likely a formal evaluation will be undertaken in the near future. Additionally, it is important for clients, the facilitators delivering the program, and for the safety of society to know if the current program is consistent with what works based on existing research.

Chapter Two

REVIEW OF LITERATURE

The literature on offender rehabilitation dates back to the 1950's. Andrews and Bonta (2006) provide a thorough review of the history of offender rehabilitation research. Highlighting key points in history, Andrews and Bonta (2006) described Kirby's (1954) review of four studies that he felt were methodologically sound, concluding that offender programming was based on hope and suggested further research be undertaken.   Walter Bailey in 1966 conducted a meta-analysis of 100 studies with 60% of the better controlled studies (22) showing improvement in treatment groups. This positive effect was tempered by Bailey's caution that it was the authors of the studies who wrote the reports and his conclusion was that the evidence to support correctional treatment was "slight, inconsistent, and of questionable reliability" (Bailey, 1966 in Andrews and Bonta, 2006). In 1972 Charles Logan was the first to develop a criterion for determining an adequate study of effectiveness. Of the 100 studies he reviewed he found that not a single study was adequate and concluded there was no evidence that allowed the conclusion that one form of programming is more effective than another.   In 1974 Martinson published his well known paper in which he sent the message that nothing works with respect to offender rehabilitation. His work was heavily critiqued and in 1979 Martinson published a paper in which he recanted his 'nothing works' statement and acknowledged his research showed that some programs did show a positive outcome even though others did not. Despite this acknowledgement by Martinson that some programming did show promise, the 'nothing works' perspective continued to

dominate until the 1980's when a number of papers began to present evidence that programming with offenders was effective (Gendreau & Ross, 1979; Ross & Gendreau, 1980) and researchers began to highlight the importance of programming being appropriately intense, matched to needs of clients, and multi-focused if necessary (Palmer, 1983 in Andrews & Bonta, 2006).

Risk, Need, Responsivity (RNR) and Evidence Based Practice

The Risk, Need, and Responsivity Model was first introduced by Andrews, Bonta, and Hoge in 1990 and then later by Bonta, Andrews, and Gendreau (Ward, Melser, & Yates, 2006). The model is based on what is known about the psychology of criminal behavior, specifically, that offending behavior can be predicted and that attention to level of treatment intensity and treatment targets can influence offending behavior (Ward, et al. 2006).

Bonta and Andrews (2007) have conducted significant research on the effectiveness of treatment of general offenders and how it is maximized by adhering to the Risk, Need, and Responsivity Principles (RNR). In general, treatment is most effective if we treat offenders who are most likely to reoffend (moderate or high risk), target characteristics related to offending (criminogenic needs), and match treatment to learning styles and abilities of offenders. In general, cognitive behavioral approaches have proven to be most effective (Hansen, Bourgon, Helmus, & Hodgson, 2009).

There is a significant body of research that has found evidence that adherence to the RNR principles provides the best human service intervention. It is now widely

accepted that following RNR principles is effective within the general forensic population (Andrews & Bonta, 2006; French & Gendreau, 2006; Landenberger & Lipsey, 2005).

There has been some question in the field of sexual offender treatment if the RNR principles can be equally applied to sexual offenders.   Hansen et al (2009) conducted a meta-analysis of twenty three sexual offender recidivism studies which met their criteria for being a quality study. They found that in the studies where none of the principles were adhered to, the treatment effect was consistently low. For studies in which all three principles were adhered to the treatment effects were consistently large and it was only in the studies that adhered to two principles that variability was evident. Their conclusion was that the RNR principles are relevant to sexual offender treatment and their results were consistent with the literature that suggests treatment effect increases as the principles are applied (Bonta & Andrews, 2007). In this same meta-analysis they found that the risk principle was not statistically significant which is consistent with other literature (Andrews & Dowden, 2006) that suggests the risk principle is the principle with the least amount of significance.

Hansen et al. (2009) suggest that based on the results of the meta-analysis treatment providers should take the RNR principles into consideration when designing and implementing their programs. They highlight that most programs offered currently are cognitive behavioral which generally adheres to the Responsivity principle. Where the most attention and change may be required is adherence to the Need principle. Treatment providers need to ensure that the

treatment targets emphasized in programs are those that are linked to sexual recidivism. McGrath, et al. (2003) who found that in 80% of the programs, offence responsibility, social skills training, and victim empathy were targets however, none of those have been linked to an increase in recidivism (Hansen & Morton-Bourgon, 2004, 2005). They do however acknowledge that attention needs to be paid to issues of denial, self-esteem, and self-efficacy in creating a climate for change.

The risk principles state that the highest risk offenders should receive the most intense treatment and that low risk offenders should receive little intervention.   The Risk principle is based on the premise that criminal behavior can be predicted and that intervention should be matched to risk level. Andrews and Bonta (2006) suggest that the risk principle is what bridges the gap between assessment and intervention. It is important to highlight that the risk principle does not mean that all low risk offenders should receive no treatment; rather that treatment intensity should be proportional to the offenders' level of risk (Andrews & Bonta, 2006, Bonta and Andrews, 2007).   This is also true for sexual offenders and Hansen et al. (2009) offer the Correctional Service of Canada (CSC) as an example of offering low, medium, and high intensity programming to their sexual offender population based on an assessment of their risk and needs. There is evidence that suggests if intensive correctional intervention is applied to low risk offenders it can actually increase their risk (Andrews, et al 1990, Lowenkamp & Latessa, 2002, Latessa & Holsinger, 2006). It is thought this may occur because exposing lower risk offenders to higher risk offenders may reinforce anti-social attitudes and placing low risk offenders in a program may disrupt their pro-social networks (Lowenkamp & Latessa, 2004).

Andrews and Bonta (2006) explain that the Need Principle is based on the idea that to reduce recidivism change must take place on the offenders' criminogenic factors, or those factors that influence criminal behavior.   They add that addressing non-criminogenic factors is not likely to change recidivism unless those factors are related to a criminogenic need. The criminogenic needs become the treatment targets. Andrews and Bonta (2006) further explain that because we can't directly observe a criminal's behavior we have to try to change the certain aspects of the person or the situation that we believe to be associated with criminal behavior.   Andrews and Bonta (2006) identify eight central criminogenic needs that were drawn from Dowden's (1995) work. These include: antisocial personality/negative emotionality, antisocial attitudes and cognitions, social supports for crime, substance abuse, inappropriate parental monitoring and discipline, problems in the school/work context, poor self control, and lack of pro-social activities. Hanson et al (2009) point out the criminogenic factors that are accepted for general recidivism are antisocial lifestyle, impulsivity, employment instability, negative peer association, aimless use of leisure time, substance abuse, poor problem solving, and hostility. Additionally for sexual offenders the following criminogenic factors have been identified: deviant sexual interest, sexual preoccupation, attitudes tolerant of sexual abuse, and intimacy deficits.   It is also important to note that characteristics that are considered non-criminogenic, meaning not having a direct relationship to recidivism, are internalizing psychological problems such as depression or anxiety, denial, low victim empathy, and social skills deficits (Hansen et al, 2009; Hanson & Morton-Bourgon, 2004, 2005).

Andrews and Bonta (2006) describe the Responsivity principle as delivering programs in a manner that matches the clients' learning style and ability.   They go on to say that cognitive behavioral approaches offer the best influence over behavior and that it does not matter what the actual problem is if a cognitive behavioral approach is utilized.   Cognitive Behavior strategies can include modeling, reinforcement, role playing, skill building, modification of thoughts and feelings through cognitive restructuring, and practicing new low-risk behavior over and over again. (Andrews & Bonta, 2006).

Responsivity Factors in the Group Format

Proeve (2003) reviewed factors thought in be both helpful and detrimental to the process of change in treatment.   It was presented that sexual offenders can spend almost 75% of their treatment time in the precontemplation or contemplation stage of change.   Stages of change is a model that describes how individuals proceed through stages of awareness and action towards change (Prochaska, J. O., Norcross, J. C., & DeClemente, C. C., 1994). In this regard a therapist who adopts a confrontational style will not only decrease a client's motivation for change but is also likely to negatively impact the client's self esteem, shame, and clients who have an insecure attachment style. Additionally a confrontational style will have a negative impact on group cohesion. Similarly, hostility displayed by the therapist will have a negative impact on client's self esteem, shame, and trust for the therapist. However, it is important for the therapist to continue to challenge the offenders distorted views in the context of supportive therapeutic relationship (Marshall & Burton, 2010).

Proeve (2003) presented a number of therapist characteristics that facilitate change in clients. These included the following; empathy, genuineness, warmth, respect, flexibility, rewardingness, use of humor, support, therapist confidence, self-disclosure, encouragement of emotional expressiveness, and using open ended questions.

Marshall et al. (1999) discussed the benefits of an open group format.   It was suggested that allowing new clients into the group as others graduate allows for accelerated progress of some offenders due to the more active participation of the existing members who have been in group longer. It was also suggested that the open format allows for treatment components to be customized to an individual's needs. Proeve (2003) suggested that general group format is best for the treatment of sexual offenders but in particular the open group format.

The responsivity issues that exist within a group can be paralleled to the conditions relevant in developing a therapeutic relationship with clients discussed next.

Therapeutic Relationship

Rothman (2007) summarizes in his dissertation that there is agreement in the research that psychotherapies are effective. As different types of therapies seem to be effective, researchers have begun to look for commonalities in the orientations. Over the past two decades it has been suggested that the therapeutic relationship is an essential part of the therapeutic process.   Rothman (2007) goes on to state that

contemporary theories of psychotherapy emphasize the importance of the alliance or relationship between the client and therapist. Rothman summarizes Carl Rogers (1957) view of the therapeutic relationship that the therapist's ability to be empathetic and congruent (genuine) in addition to offering unconditional positive regard (warmth, acceptance) toward the client is necessary to support client change.

Proeve (2003) identifies research that states the quality of the therapist client relationship is strongly related to treatment effectiveness and that there is reason to assume that the quality of the therapeutic relationship would be equally important for sexual offender treatment.   Dowden and Andrews (2004) conducted a meta-analysis to determine if Core Correction Practices (CCP) influenced treatment outcome. There are 5 CCP's identified including what they view as the most important, relationship factors, which they also define as therapeutic alliance.   Their research found appropriate treatment programs that also included CCP were more associated with increased effect sizes than those that did not include CCP.   Dowden and Andrews (2004) also highlight that CCP enhance the effect of human intervention programs that adhered to the risk, need, and responsivity principles. Marshall and Burton (2010) identified therapist features that facilitate change in clients. These include: empathy, genuineness, warmth, respect, supportiveness, emotional responsivity, directiveness, rewardingness, and use of humor. Additionally a therapist's ability to offer warmth, respect, and an ability to communicate acceptance of the client positively impacts motivation and decreases clients' shame (Proeve, 2003). The relationship characteristic that are being discussed are the same core conditions of warmth, empathy, positive regard, and genuineness that are primary in

the field of Social Work. Kirst-Ashman and Hull (1999) go on to state that these traits are the most basic and important when establishing a relationship with clients. Marshall and Burton (2010, pg 142) refer to the therapeutic alliance as "the degree to which the therapist and client work together".   They add that this is largely attributable to the style of the therapist. Marshall and Burton (2010) highlight that recent research has suggested that the quality of the relationship is more important than the implementation of a particular therapy.   They cite Norcross (2002) who reports it was found that the type of therapy accounted for about 15% of treatment effect where the therapeutic relationship accounted for 30% of the treatment benefit. The impact of the therapeutic relationship has not been the predominant focus of research and Buetler (1986) raised the concern that most of the research conducted has focused on the evaluation of techniques when technique only accounts for 15% of treatment effects.

Brief History and State of Current Practice

Relapse Prevention

        Prior to the 1970's there was little guidance and research informing work with sexual offenders. Relapse Prevention (RP) was one of the first models developed that offered a direct approach to intervention. RP was initially developed in the addictions field during the 1970's as a self-management model in that it taught users how to prevent a reoccurrence of the undesirable behaviour (Marlatt, 1982; Marlatt & Gordon, 1985). It was believed that RP could be equally applied to any impulse control behaviour, such as sexual offending (Laws, Hudson, & Ward, 2000). RP was

designed to be geared towards the maintenance phase of behavioural change.

Applying a cognitive behavioural approach to treating sexual offenders was also

emerging and gaining popularity around this time. Cognitive-Behavioural Therapy

(CBT) is based on the premise that all behaviours are preceded by thoughts and

feelings. By modifying thoughts or self talk we can change and control our thoughts

and behaviours.   These two approaches eventually began to be used in tandem and

over the years RP had become the treatment of choice for sexual offenders (Laws, et

al., 2000).

The RP model suggests there is a sequence of events both behavioural and

emotional, that one can assume, if left unchecked, will lead to a lapse of the undesired

behaviour. For sexual offenders this may include deviant fantasy. This lapse in

behaviour leads to a loss of control and subsequent loss of confidence in their ability

to remain abstinent. The negative thinking and affect that follows, if not dealt with

adequately, will eventually lead to a relapse of the undesired behaviour (Laws, et al.,

2000).   It is this assumption, that all offenders want to avoid offending, that brought

the model under review.

In recent years Relapse Prevention as the main stream approach has started to

be challenged. Clinicians and researchers have begun to question whether relapse

prevention works for sexual offenders. Laws et al. (2000) expressed the opinion that

RP, while providing a framework in which to understand sexual re-offending, falls

short in accounting for the complexities of offending and the differences between

offenders; as well not all offenders follow the same pathway towards a relapse.

Hansen (2000), Yates and Kingston (2006), Ward and Hudson (1998), and Marshall,

Anderson, and Fernandez (1999) all echoed the concerns of Laws et al. (2000) that

RP does not account for diversity and that there are offenders who do not match the

RP path to re-offending. Those offenders will not derive much benefit from the

intervention. There are offenders whose pathway to offending does not include

negative emotions and avoidance, but rather active planning and positive emotions

associated with sexual offending. Hudson, Ward, and McCormack (1999) found one-

third of offenders in their studies exhibited the active approach to offending.

Additionally, Ward and Hudson (2000) found 70% of offenders showed an approach

pathway to offending.

Yates and Kingston (2006) point out the model put forth by Pithers, Marques,

Gibat, and Marlatt (1983), which was adapted to fit sexual offending, was so widely

embraced by the community that the lack of empirical evidence to support the

effectiveness of the model has been overlooked.   One of the most comprehensive

evaluations of an RP program is the Sex Offender Evaluation and Treatment Project

(SOETP) in California. It began in 1985 and continued to 1995 and has continued to

follow its participants ever since.   In 1999 it was reported that no treatment effect

had yet emerged (Laws & Ward, 2006).   Yates & Kingston (2006) cite Rice & Harris

(2003) as describing this research project as the most well designed and executed

study the sex offender field has ever seen. The lack of treatment effect indicates that

the RP approach is not working, at least for the subjects in this study.

Over the past decade a number of different models have emerged in response

to the shortcomings of RP.   It is important to note that most of the programs over the

past two decades that used RP as their model of choice also used the Cognitive

Behavioral approach as their underlying theory.   The majority of these models

continue to be based in Cognitive Behavioral Theory (CBT) as the research has

demonstrated that programs including CBT are most effective in reducing recidivism.

As Yates and Kingston (2005) summarize, cognitive behavioral interventions are

based on the assumption that cognitions and behavior are linked and that thinking

influences behavior. The aim of CB interventions is to replace ineffective or deviant

responses with adaptive, pro-social beliefs.   This summary does not presume to

cover all of the existing approaches to sexual offender treatment. It does, however,

intend to offer a brief summary of the most widely accepted.

Self-Regulation/Pathways Model

The first of these is the Self-Regulation/Pathways Model offered by Ward and

Hudson (1998, 2000).   It includes nine stages and is based on the manner in which

behavior is regulated by the individual. It identifies three potential self-regulatory

problems and four pathways to offending. (Yates & Kingston, 2005, 2006).   Sexual

offending is explained in terms of the individual's goals, either inhibitory or

aquisitional, and behavioral strategies to achieve these goals.   The combination of the

goals and strategies reflects the four pathways to offending in the model.   The four

pathways are briefly summarized as follows (Laws & Ward, 2005; Yates & Kingston,

2005, 2006):

1) Avoidant-Passive Pathway which represents under-regulation of behavior.

    This pathway most closely represents the traditional relapse process in that the

    individual's goal is to refrain from offending but is unable to control his

behavior and use effective coping strategies. The individual experiences

negative emotional states, disinhibiting his behavior, and leading to feelings of

loss of control. These individuals are less likely to plan their offences.

2) Avoidant-Active Pathway represents a misregulation of behavior. Again, the

individual's goal is to refrain from offending, however he actively attempts to

suppress and control arousal or emotional states that threaten a loss of control,

however, these strategies are ineffective. The individual lacks the

understanding that the strategies do not work and this leads to a negative

emotional states that becomes a factor in the offending progression.

3) Approach-Automatic Pathway represents a disinhibition pathway as the

individual fails to control their behavior.   The individual does not desire to

avoid acting out sexually, however, the behavior is considered automatic

because it tends to be impulsive and based on entrenched cognitive and

behavioral scripts. The offence is planned on an unsophisticated level with

the goals activated by situational factors of which the individual may not even

be aware. This pathway is associated with positive emotional states such at

the anticipation of sexual gratification.

4) Approach-Explicit Pathway represents good self-regulation. The individual

has the ability to control his behavior; it is the goals that are problematic. The

individual has a belief system that supports sexual aggression. In this

pathway the individual intentionally plans the offence and may offend to

maintain positive mood states.

While there are benefits to this approach including that it can account for variability in behavior, it eliminates the reliance on the single pathway model (RP), and it can more closely adhere to principles of effective intervention (Yates & Kingston, 2005). It is a new model and has not been widely used in treatment programs and there are limited empirical studies on the model. However, there are a few studies that pertain to the validity of the model and suggest it shows promise for assessment and treatment (Yates & Kingston, 2005).

The Good Lives Model

The Good Lives Model (GLM) was developed by Tony Ward and his colleagues. This model aims to move the focus beyond just the risk factors of the individual. The individual is seen as an active, goal-seeking person looking to acquire primary human goods. These primary human goods include such things as relatedness, intimacy, autonomy, and emotional equilibrium. They are intrinsically beneficial to individual well being (Wilson & Yates, 2009). Sexual offenders' risk factors are seen as symptoms of ineffective strategies to achieve these goods or goals. It is not the goal (intimacy) that is problematic it is the individual's ineffective means of attaining that goal (sexual offence) that needs to be changed. In treatment the individual is assisted to identify the goals and develop the skill or ability to attain them in non-criminal means. The GLM is a good fit with the Responsivity Principle in that that it holds greater promise in motivating offenders towards change by attending to individual needs and creating a stronger therapeutic alliance (Ward & Stewart, 2003). A recent study found that the GLM was associated with higher rates

of motivation, engagement and completion, higher rates of within treatment change (coping skills) and lower rates of drop-out compared to the standard Relapse Prevention model (Simons, McCullar, & Tyler, 2008). This is significant as there is research that states an offender who drops out or quits a treatment program is at greater risk to reoffend than an individual who never took a program at all (Hanson & Bussiere, 1998)

Pathways Model

Ward and Seigert (2002) developed the Pathways Model which provides a model illustrating how adults commit child sexual abuse. The model draws on the three main theories of offending. These theories include David Finkelhor's Precondition Model (1984), Hall and Hirchman's Quadripartite Model (1992), and Marshall and Barbaree's Integrated Theory (1990). They took the best elements of these theories and incorporated Gagon's (1990) concept of sexual scripts and reinforced the significance in the context of adult offenders.

The Pathways model "suggests there are multiple pathways leading to the sexual abuse of a child, each involving developmental influences of one type or another, a core set of dysfunctional mechanisms, and an opportunity to commit the offence" (Ward & Siegert, 2002, pg320).   Ward and Siegert recognized that ecological factors exist that endorse the sexualization of children and increase a person's vulnerability to sexually abuse a child. They suggest that a person's vulnerability is further influenced by factors such as family environment, biological factors, developmental learning theory, and cultural models within the early

socialization process.   With sexual offenders these vulnerabilities are reinforced and interact with a set of common clusters taken from Marshall and Barbaree's (1990) work and include: problems with emotional regulation, social skill and intimacy deficits, deviant sexual arousal, and distorted thoughts. So an individual's vulnerability may be further influenced by the ecological factors. This vulnerable person who also experiences any one of the common clusters will be at higher risk to follow one of five pathways to offending.

The five pathways include the following (Ward & Siegert, 2002):

1) Intimacy Deficits – This involves an adult who has normal sexual scripts and may only offend at times when a preferred partner is not available. The child is viewed as a "pseudo-adult" and the primary cause of the abuse is the adult's loneliness and intimacy deficits leading to a need to engage in sexual contact with another person.

2) Deviant Sexual Scripts – This involves an adult who has subtle distortions in their sexual scripts that interact with dysfunctional relationship schema. These individuals may have been prematurely sexualized by being a victim of sexual abuse. The script flaw is in the context in which sex is viewed as desirable and interpersonal closeness is only achieved through sex. Children are chosen as sexual partners as a matter of opportunity and emotional/sexual needs.

3) Emotional Dysregulation – This involves an adult who has normal sexual scripts but has difficulties in some aspect of emotional regulation.   This may include inability to identify emotions, inability to manage negative emotions,

and an inability to use social supports in times of emotional distress.   The

mismanagement of negative emotions either acts as a disinhibitor or compels

the person to use sex as a soothing strategy.   The person links sex with

emotional well being.

4) Anti-social Cognitions – This involves an adult with normal sexual scripts but

who holds attitudes that support crime in general. They have lengthy criminal

records including all types of offences.   They may have received a diagnosis

of a conduct disorder at some point. The sexual abuse of a child is initiated by

their antisocial attitudes and beliefs in conjunction with sexual arousal and

opportunity.

5) Multiple Dysfunctional Mechanisms - This involves an adult who has

distorted sexual scripts and has pronounced flaws in all the other primary

psychological mechanisms. The ideal relationship is between and adult and

child. This group represents the true or pure pedophile. This individual may

be able to resist their sexual impulse to abuse a child but will always be at risk

to act on them.

The pathways described above explain how situational triggers interact with

various predispositions or vulnerabilities of individuals resulting in sexual abuse of

children. The model only describes how an individual may begin to abuse children

and not how the abuse continues, however, it is suggested that the abuse itself is

enough to distort an individual's sexual scripts to allow the abuse to continue.

At this time there is little empirical evidence to support the Pathways Model and

the authors acknowledge that it may need to be refined. However, there is some

evidence to support the idea that offenders follow multiple pathways to offending and

that intimacy deficits, self-regulation deficits, deviant sexual scripts, and preferences

influence offending (Ward & Siegert, 2002).

Chapter Three

METHODOLOGY

There are two main objectives to this research. The first objective is to consider the degree to which each of these programs offered by Manitoba Corrections adhere to the research based practice principles of risk, need, and responsivity.   The second objective is to assess the degree of therapeutic alliance that is created in each group. Based on the information gathered this research will attempt to determine, if possible, which program is better suited to Manitoba Corrections mandate to have the "lowest recidivism rates in Canada" and offer recommendations based on the data collected.

Description of the Programs

Program A – Traditional Relapse Prevention/Cognitive Behavioural

This program has been offered by Manitoba Corrections for approximately the past 20 years. It is based on the traditional Relapse Prevention (RP) approach first presented by Marlatt and Gordon (1985) which was originally designed as a maintenance program for abstinence with substance abusers.   One of its' main assumptions is that the subject wants to change and is motivated to maintain behavioral changes (Marlatt, 1982: Marlatt & Gordon, 1985). As previously mentioned, RP was adapted to sexual offenders and quickly became the treatment of choice (Laws et al., 2000).

This program, both institutionally and in the community involved a closed group of up to 10 adult men, with two facilitators, ideally one male and one female.

The length of the program in the community was approximately nine months, twice

per week. In the institution it ran approximately six months, twice per week.   The

expectation was that any offender who was taking a modicum of responsibility for his

sexual offending was placed in group. There was little attention paid to level of risk

or level of responsivity of the offender.   The reason for this was that it is the only

treatment model for sexual offenders available to Manitoba Corrections. The two

exceptions to this were very high risk offenders were contracted out to a private

psychologist and clients considered developmentally delayed are either contracted to

a private agency or worked individually with a case worker or Probation Officer.

The group's main activities included a "check in" (each group) aimed at

participants identifying their feelings and thoughts associated with their current life

situation and making the connection between thoughts, feelings, and actions (CBT).

The actual tasks of group include the autobiography, developing behaviour chain and

cognition chains, victim empathy exercises, identifying escapes and avoidances,

developing a changed cognition chain, and decision matrices.   The goal of having

participants complete these tasks revolves around identifying their precursors to

offending (both behaviourally and cognitively) and then developing a plan to avoid

future offending (escapes and avoidance and changed cognitions).   At the

completion of program the participants should be able to identify potential high risk

situations for themselves and make different choices or challenge their thinking to

guide themselves away from a re-offence.

A review was done of the traditional Relapse Prevention Manual (Group A)

(Pithers, et al.,1983) that is used provincially as the approved intervention program

for sexual offenders. This review was done to extract the treatments targets of the

program.   The program is broken down into the assignments mentioned above.   A

review of the description of the program and each of the assignments revealed the

following treatment targets: accountability, victim empathy awareness and training,

cognitive distortions towards offending, impulsivity, and identifying high risk

situations.

Program B – Open Ended, Holistic – Cognitive Behavioral

Prior to 2005 Probation Services in Winnipeg was offering the traditional

Relapse Prevention group to clients. However, group facilitators were experiencing

frustration in the delivery of sexual offender treatment due to the inherent limitations

using traditional RP and the closed group format.   A common observation was that

putting a heterogeneous group of offenders through a very structured, closed group

process was limiting the range of criminogenic factors that could be addressed.   It

was seen as a waste of resources to be placing all offenders, including low risk/need

offenders into a lengthy program.

In an effort to address some of the concerns a pilot Open sexual offender

group was implemented in the community in 2005 and in the institution in 2008 in an

effort to incorporate recent research into an open process group. Open groups have

utilized a cognitive behavioral approach with an emphasis on a holistic model of

intervention. Holistic approaches incorporate developmental issues, humanistic

approaches and include experiential therapies as part of the process in treatment

(Longo, 2002).   Longo (2002) goes on to explain that a holistic model incorporates

traditional RP and CBT but also moves beyond, incorporating models to improve

one's "overall mental and physical health and recovery".   A key principle is the

acceptance of the therapeutic relationship as a focal point and essential part of

treatment. There is a focus on wellness with the message that clients can heal, go

forward, and they are worthy of respect and dignity (Longo, 2002).   This approach

assists offenders to internalize the insights they develop in treatment by emphasizing

a more process versus a psycho-educational approach. As a result, the emphasis has

been placed on interventions that are dynamic and process oriented and grounded in

the offender's real life experiences and ongoing functioning and management of

criminogenic factors. Each intervention is focused on process oriented insight and

skill building.   The group consists of no more than eight men and two facilitators,

ideally one male and one female.   The community group is offered once per week

and the institutional group was offered twice per week.

A structured manual for Group B does not exist, however an outline exists of

what treatment targets may be addressed should it become relevant to any particular

client or the group as whole. This is consistent with a holistic model because the

premise of a holistic model is to have individual tailored treatment targets as opposed

to a step by step approach that a structured group or manual would prescribe.

Marshall (2009) also makes an argument that programs with a structured manual or

what he calls "over manualization" limits a therapist's ability to be responsive to the

needs of the clients.   He adds that the therapist's reduced ability to be flexible

reduces the benefits of treatment. Group B consists of three main assignments:

pathways, offence cycle, and a wellness plan. It is important to define how the work

being completed aligns with the current models.   The pathways assignment provides the opportunity for each client to identify significant events throughout their lives (historical risk factors) along with how they felt/thought and how they coped with those events. This process would align with Ward and Siegert's Pathways Model (2002) in that it identifies the key issues in one's development (ie. intimacy deficits, sexual scripts, ineffective coping, core emotional issues, and cognitive distortions). The offence cycle assignment in which men identify their motives and path towards their offence would align with Ward's Self-Regulation Pathways (1998) in that it helps to identify if the offending was approach or avoidance directed. And finally the Wellness plan fits with the Good Lives Model in that it focuses on the whole self and how the individual may attain their life goals as well as managing their risk.   Longo (2002) describes a wellness plan presented by Ellerby (1999) as using approach goals with focus on healing and self improvement. He highlights that wellness plans will include avoiding risky behavior but is also followed with what the client should do to change the behavior to a healthy one.   The wellness plan will encompass a plan for the individual's emotional, mental, spiritual, and physical health.   The treatment targets that consistently are revealed during the group process are accountability, deviant sexual interest, sexual pre-occupation, attitudes towards sexual offending, intimacy deficits, victim awareness, unhealthy or ineffective coping which can include substance abuse, hostility, suppression of emotions, and anti-social peers and behaviors, and impulsivity.

Design

A multiple Case Study design was used for this research. Case Studies are the preferred research strategies when questions such as "how" and "why" are being asked, when the researcher has little control over events and when the focus is on a real life phenomenon (Yin, 1994) Case studies maybe used for exploratory, descriptive, or explanatory studies.

The key stakeholders in this research are the Justice Department of Manitoba, specifically Probation Services and Headingley Correctional Center's Assiniboine Treatment Center, the program managers, the program facilitators, and the program participants.

The two units of analysis are the programs offered by MB corrections.   It was determined that each of the two programs being offered by Manitoba Justice will be a case study. The traditional Relapse Prevention program being 'Group A' and the open ended program being 'Group B'.   Within each of these groups units of analysis will be the groups manuals, program managers, past participants, current participants, and facilitators.

It is believed the program that adheres most closely to the principles of best practice and has the highest degree of therapeutic alliance will be the program that offers the best chance at reducing the sexual recidivism of its participants. A review of literature has shown that there are two factors that account for much of the treatment effect in a human service intervention in corrections.   The first of these factors is the level of adherence to the RNR principles. The second of these factors is

the therapeutic alliance between the client and therapist (or facilitator). If this

research can determine where each of the case studies (programs) adhere to these two

factors then it is reasonable to assume that some conclusions can be drawn about

which program would have the best chance at reducing recidivism.

The study included three sets of participants. 1) Eight past participants who had

taken part in both Group A and Group B, with their most recent experience being

Group B, 2) Seven staff members, all of whom had experience facilitating Group A,

four of whom had experience facilitating both Group A and Group B, and three

program managers, all who had experience facilitating Group A and who have

knowledge of Group B, 3) eight participants currently participating in Group A, and

thirteen participants currently participating in Group B.

Past participants were identified using a data base maintained by Manitoba

Probation Services.   There were eight identified as having participated in both

programs. Seven of the eight were contacted initially through their former Probation

Officer to let them know to expect communication from the researcher. One of the

eight had no current contact information and this writer was unable to locate him.

The seven remaining participants were sent a letter inviting them to contact the

researcher should they be interested in participating (Appendix A). Four of the seven

contacted the researcher and an interview time was scheduled. The four participants

attended for the interview and the consent form (Appendix B) was reviewed and

participants were provided with $25 remuneration for their time and expense.   The

participants were then introduced to the research assistant (Ms. Michelle Joubert) who

conducted the interview. The researcher is actively involved in facilitating Group B

and has supervised some of the participants on Probation. Therefore a research assistant was utilized to interview past participants to avoid any real or perceived coercion to participants.   The response rate for past participants was 50% (4 of 8).

The past participants ranged in age from 35 to 65.   Their static risk level for sexual recidivism, as calculated according to the guidelines of the Static 99 (Hansen & Thornton, 1999) ranged from 5 to 8 or Moderate-High to High.   The length of time participants had taken part in Group A was approximately 150 hours; the four participants completed Group A between 1994 and 2005. The length of time participants had taken part in Group B ranged from 95-170 hours; the four participants completed Group B between 2006 and 2010.   The client who received 95 hours was Moderate-High risk and the client who received 170 hours was High risk.

The current participants were easily identified as they were currently participating in the groups. There were eight participants taking part in Group A being offered at Headingley Correctional Center. Their static risk level for sexual recidivism, as calculated according to the coding rules of the Static 99 (Hansen & Thornton, 1999) ranged from 1 to 6 or Low to High.   At the time of the questionnaire they had all been in group for approximately 102 hours. There were thirteen participants taking part in one of two Group B's being offered at Manitoba Probation Services. Their static risk level for sexual recidivism, as calculated according to the coding rules of the Static 99 (Hansen & Thornton, 1999) ranged from 0 to 7 or Low to High.   At the time of the questionnaire participants had been in the group ranging from 35 to 120 hours.

The researcher and a research assistant (Ms. Karen Tuck) attended each of the groups at the beginning of a scheduled group session.   The research was explained and consent form (Appendix C) was reviewed with the participants.   Participants were asked to sign or not sign the form and return to the researcher. At that time it was explained that the research assistant would be reading out the Working Alliance Inventory and they could choose at that time to either answer or not answer the questions about their facilitators. The researcher left the room. Participants were asked to put their questionnaires in a sealed envelope, even if not completed, and hand back to the research assistant. Participants were not provided with remuneration for their participation.   The response rate for Group A was 75% (6 of 8) and the response rate for Group B was 92% (12 of 13).

The employee participants were identified easily through existing knowledge the researcher had regarding the programs. There were seven employee participants including three program managers.   All seven had experience facilitating Group A and four had experience facilitating Group B and one of the program managers had limited experience facilitating Group B.   Years of experience working directly with sexual offenders for employees ranged from 5 to 30 years and employees came from a variety of academic backgrounds representing undergraduate university-level to Masters-level education. Employee participants were first sent the consent form in letter format explaining the research and inviting them to contact the researcher should they be interested in participating (Appendix D). All of the employees contacted the researcher to indicate an interest. An agreed upon time and location was scheduled. The consent form was reviewed and signed. Employee participants

were not provided with remuneration.   The response rate for employee participants was 100% (7 of 7).

Sources of Information

Surveys

Two surveys were developed that consisted of open ended questions.   Some of the questions also included a five point Likert Scale to rate the participants' opinion followed by the opportunity to explain their selection.   A Likert Scale was used to allow participants the opportunity to focus on the questions and provide a framework for the participants to compare the two programs. All questions also included the opportunity for participants' to explain their answers and why they chose a particular number on the scale. The employee survey (Appendix E) consisted of seventeen questions organized around five areas of interest including risk, need, responsivity, therapeutic alliance, and personal satisfaction. The past participant (Appendix F) survey consisted of twenty questions organized in two categories including, responsivity/therapeutic alliance and treatment targets.

Questionnaire

The current participants were asked to complete the Working Alliance Inventory to determine the level of therapeutic alliance that they felt with respect to their facilitators. Copyright approval to use the WAI was granted by Dr. Adam Horvath on June 7, 2010. The Working Alliance Inventory (WAI, Horvath & Greenberg, 1989) is a 36 item self report instrument designed to measure three aspects of the working alliance between the client and the therapist. The three aspects

include Task, Bond, and Goal.   Task is described as both the clinician and clients

viewing in session actions or tasks as relevant. Bond is described as the mutual

personal attachment between the client and therapist and includes trust, acceptance,

and confidence. Goal is described as where both the client and therapist mutually

endorse and value the anticipated treatment outcome (Horvath & Greenberg, 1989,

Horvath, 2007).   Martin, Garske, and Davis (2000) reviewed a number of

therapeutic alliance scales and concluded the WAI is an appropriate tool for most

research projects and that it can be used for all types of therapy.

The WAI has good reliability in terms of internal consistency; the client form

of WAI had alphas of .87, .82, and .68 for the goals, tasks, and bonds subscales. The

WAI has very good validity. There is support for the construct validity of the WAI

and the goal subscale seems to have the best discriminant validity (Horvath, 2007).

Adherence to Risk, Need, and Responsivity

The Collaborative Data Outcome Committee (CODC) is a committee of 12

experts that was formed with the task of establishing guidelines to advance the quality

of sexual offender treatment outcome studies (Hansen, Bourgon, Helmus, &

Hodgson, 2009). The members of the committee were selected based on their level of

expertise in the field of sexual offender research. The committee developed a set of

guidelines to rate the quality of studies. (Beech, A., et al., 2007). The guidelines are

the consensus opinion of members of the committee. Included as part of the

guidelines, the CODC also outlined how they determined if sexual offender treatment

programs adhered to the risk, need, and responsivity principles.   They felt that

programs adhered to the risk principle when they provided intensive interventions to higher risk offenders and little or no intervention to low risk offenders. In practice, the CODC found sexual offender treatment programs did not offer differing intensities to different risk offenders.   Therefore, they determined that if a program was targeted at higher risk than average offenders it was deemed to adhere to the risk principle.   Adherence to the need principle was met if the sexual offender program treatment targets were related to sexual offender and general recidivism based on prior research. These targets, specific to sexual offender risk include, sexual deviancy, anti-social orientation, sexual attitudes, intimacy deficits. Sexual offender programs were determined to have met the responsivity principle if they provided treatment in a manner that matched the learning style of their participants. This typically means offering cognitive-behavioral programming facilitated by skilled therapists (Hansen et al., 2009).   For the purposes of this research I will use the CODC guidelines to determine if each of the two groups offered by Manitoba Justice adheres to the risk, need, and responsivity principles.

Methodological Concerns

The main methodological concern for this research is the low number of participants which does not allow for any statistically significant results to be provided. However, the purpose of this research was to compare the existing two programs which provided a limited pool of participants to choose from. Additionally, in the absence of any pre and post testing completed by Manitoba Justice and the high cost of collecting recidivism data for hundreds of participants [MB Justice is required

to pay a fee per criminal record check (CPIC)] it was strongly felt that utilizing the

small number of participants available and comparing their experience would still

provide valuable information when comparing the two programs.

Chapter Four

DATA ANALYSIS

This research utilized a qualitative analysis of the information collected from participants.   This process included starting with the stated categories of the research, those being Risk, Need, Responsivity, and Therapeutic Alliance.   The researcher next began the process of searching for themes within the responses of participants that fit into the categories for each of the case studies, Group A and Group B. Attention was paid to the possibility of any new categories emerging from the feedback. Royse, Thyer, Padgett, and Logan (2006) suggest that within case study research the data can be organized around individual cases as well as going between the cases to generate common themes and narratives.   Data was organized into themes common to both case studies, Group A and Group B.   It was discovered that there were five main categories, Risk, Need, Responsivity, Therapeutic Relationship, and Personal Satisfaction. The themes that emerged within each of these categories will be presented.

The participants for this study were drawn from Government of Manitoba employees who have facilitated both Group A and Group B and the respective program managers (n=7), past participants who took part in both Group A and Group B (n=4), and current participants of Group A and Group B (n=21).   The employee participants are currently working either with Probation Services in the community or at Headingley Correctional Center.   There were four facilitators who had the opportunity to facilitate both programs and there were three program managers all of whom had facilitated one program (group A) and one who had some limited

experience in facilitating the second program (group B). While all of the program

managers have knowledge of Group B they do not all have experience facilitating.

Therefore, in some cases, questions about Group B were answered and in other cases

questions were omitted on request of the interviewee based on lack of knowledge.

Due to the small number of participants efforts were made not to include any

potential identifying information about participants. This was done in an effort to

ensure the participants' confidentiality was maintained to best of my ability.

The Risk Principle

All participants were asked a series of questions pertaining to assessing risk and the Risk Principle. Questions 3 and 4 provided a five point Likert scale to select a rating and then allowed for an explanation as to why that was selected. The Likert scale ranged from a score of 1 "Very Poorly, 2 "Poorly, 3 "Somewhat", 4 "Fairly Well", and 5 "Excellent".   These questions included:

1. How do you determine your clients' risk?

2. Do you feel that you have all the tools you need available to allow you to accurately determine your clients' risk to sexual re-offend?

3. How well do you feel Group A addresses the Risk Principle?

4. How well do you feel Group B addresses the Risk Principle?

Three themes that were generated by employees were determining risk, lack of a secondary assessment, and adherence to the risk principle. The themes are presented and separated into responses for each group.

Determining Risk

The way in which participants determine risk is an important consideration in human intervention. As Bonta and Andrews (2006) research has shown providing our most intensive intervention to the highest risk clients is the most useful allocation of scarce resources. The sexual offender programs offered by Manitoba Justice are time consuming for clients and facilitators. Ensuring that we have an accurate determination of the clients risk is the important first step. All of the participants

identified the use of the Level of Service Case Management Inventory (LSCMI) and

the Static-99 as the main source of information in determining clients' risk levels.

The LSCMI is not specific to sexual offenders. It identifies general criminogenic

needs and provides a risk level to re-offend for any type of offending. The Static-99

is specific for sexual offenders and looks only at static (historical) factors and

provides a risk for re-offence both sexually and violently. Participants also identified

utilizing existing file information such as Pre-Sentence Reports, existing

psychological assessments, and clinical impressions as tools used to determine risk.

Lack of Secondary Assessment

All of the participants also identified that in determining their clients' risk

they are missing information that would be provided by a secondary or dynamic risk

tool. A secondary or dynamic risk tool would identify dynamic risk factors specific

to sexual offenders.   Dynamic factors can change and when they are changed it

results in a corresponding change in recidivism risk, either increased or decreased

(Hansen and Harris, 2000). There were seven employees interviewed and all of them

regardless of whether they worked in the community or the institution felt that not

having a secondary risk tool impeded employees ability to assess risk accurately as

detailed by the following response:

> While the current standard and availability of information is helpful towards
>
> assessing risk, there is a glaring weakness in this protocol. In reference to
>
> sexual offender specific risk, there is currently no dynamic risk assessment

measure that could assist in capturing and appropriately evaluating the elements of risk that fluctuate and change over time.

Another employee highlighted why a secondary risk tool is necessary in corrections work:

We need a dynamic tool as well. It would provide us with more accurate information with how our offenders are managing risk factors that are more specific to sex offending that are not included in the Static 99 or the LSCMI.

Many of the employees said that they gain knowledge about a client's risk not just through formal risk assessment but through additional sources as described by an employee:

We determine risk with a combination of the Static 99 and a clinical interview. The clinical interview includes things like basically the person's level of motivation, are they denying, their history and even the severity of the offence, so some of the static risk factors, was their offence against a stranger or how old was the person, the level of violence used. So that was the clinical part.

Some of the employees highlighted that in the absence of a dynamic tool they rely not only on their clinical impressions but are also informally assessing the dynamic factors based on prior knowledge in order to assess a clients' risk   One employee explained that prior training on a dynamic tool, the Stable 2000, was being utilized to help get a clearer picture of the client's sexual risk, "…on my own I look at dynamic risk factors and try to assess them on my own informally…I use the Stable, some of the risk factor in the Stable to assess on my own."

It is an important observation of the employees who are working daily with clients who have committed a sexual offence that they do not feel they have been equipped with the tools necessary to accurately determine their client's risk.

Adherence to the Risk Principle

The two questions which asked facilitators to rate how well they feel each program adheres to the risk principle provided a five point Likert scale. The scale ranged from a score of 1 "Very Poorly, 2 "Poorly, 3 "Somewhat", 4 "Fairly Well", and 5 "Excellent".   Collectively the participants provided Group A with an average rating of 2.7 and Group B with an average rating of 4. Employee feedback will be presented based on each of the two groups.

Group A

The one main theme that emerged from the comments provided is that in the past there has been little or no attention paid to the risk principle in deciding who should be placed into group.   One employee described the criterion for accepting a client into the group:

> It didn't really address it at all (the risk principle) because we just put everyone into the group if they were not in absolute denial and it didn't really matter what risk level they were at…we still put anybody in and we mixed people up and I don't think it was even designed to address any risk principle.

It was a common observation by the employees taking a client's risk into consideration was completely absent from the decision making process when choosing who should attend the group in the past:

> We put all the clients in there, we didn't specify, they were all low, medium,
> high risk clients that would go in. It had to do with their probation order not
> to do with where they were at or what their risk was…It wasn't looked at, that
> the low risk clients may not have needed the same intensity as the high risk
> clients.

One employee mentioned that it was only after a client had begun the group process
that attention began to be paid to what that client's needs might be, "In terms of
eligibility as long as you had a sexual offence and you were taking some
responsibility you were in the program and we would now address your needs and
your risk."

The employees who are still actively involved in facilitating Group A all
talked about how in recent years Manitoba Justice has been working towards
implementing a risk tool (LSCMI) that is based on the principles of risk, need, and
responsivity. In recent months, as this tool has become utilized departmentally there
has been direction given that interventions should be focused on and offered to the
higher risk clients. This direction has been applied to the sexual offender program as
well. This was described by one employee:

> One of the things that we have changed in the unit is there is a lot of emphasis
> on the RNR principles. I think now we are doing a fairly good job at looking
> at what is the risk of a particular individual we are looking at and taking into
> account that if this is a low risk individual and putting him into a long term
> group with high risk individual could potentially increase their risk. So we are

looking at having group for medium-high, high risk individual. So I think

there because we've made that shift we are doing not too bad.

Group B

One of the significant ways that Group B is different from Group A is that

Group B is open group format. An open group format is an ongoing group that sees

clients complete their assignments, "graduate" out of the program, and new clients

join the group. The group members who are lower risk or have fewer needs may

complete the program in fewer sessions than clients who are have higher risk and

needs. The open format allows for varying intensities of program to be offered to

different clients within the same group. In this regard Group B is attending to the risk

principle as described by one employee:

> As far as risk is concerned if you have a higher risk guy we will keep him in
>
> longer where as a low risk guy might only stay for nine months whereas a
>
> higher risk guy might stay for a year an half or two years. We tailor the group
>
> according to risk level, if they need more we keep them in longer.

Another employee described the same process of having less intense (or infrequent)

meetings for lower risk clients:

> Each client is aware that they are only expected to participate in group until
>
> they acquire appropriate risk management skills, they are more engaged and
>
> motivated to complete their core tasks and not remain in group for a pre-
>
> determined period of time.

Information provided by the employees described a similar situation to what Group A

experienced; that initially when the group began there was not a significant amount of

attention paid to filtering out low risk clients and focusing on the higher risk clients.

However, since Manitoba Justice has begun using the LSCMI and, as a policy, is

more actively attending to the risk, need, and responsivity principles efforts have been

made to focus on referring higher risk clients to group. One employee expressed an

opinion about that process saying "Now we are tailoring and putting more of the high

risk guys into group which I think is more appropriate".

The Need Principle

All participants were asked a series of three questions pertaining to assessing client's criminogenic needs and adherence to the Need Principle. Questions 2 and 3 provided a five point Likert scale to select a rating and then allowed for an explanation as to why that was selected. The Likert scale ranged from a score of 1 "Very Poorly, 2 "Poorly, 3 "Somewhat", 4 "Fairly Well", and 5 "Excellent". Collectively the participants provided Group A with an average rating of 2.3 and Group B with an average rating of 4.3. The questions included:

1. How do you determine what your client's Criminogenic Needs are?

2. How well do you feel Group A addresses the Need Principle in addressing criminogenic needs of participants?

3. How well do you feel Group B addresses the Need Principle in addressing criminogenic needs of participants?

Based on the feedback from employees four main themes emerged. The themes related to determining a client's needs, historical factors, treatment targets, and group structure.   The themes are presented and separated into responses for each of the groups.

Determining a Client's Criminogenic Needs

As already mentioned in the description of the risk category, staff felt the absence of a secondary or dynamic risk tool was leaving unable to accurately assess their clients' overall criminogenic needs.   This is an important consideration because there are dynamic factors such as intimacy deficits, sexual self-regulation, and attitudes

supportive of sexual assault (Hansen & Harris, 2000) sexual deviancy, anti-social orientation, sexual attitudes, and intimacy deficits (Hansen, Bourgon, Helmus, & Hodgson, 2009), that have been identified in the research specific to sexual offenders that are not wholly captured by a general risk tool such as the LSCMI. Specifically this is an important consideration in any discussion about criminogenic needs. Criminogenic needs are those needs that are specifically linked to a client's increased or decreased risk to reoffend and they tend to fluctuate over time. These are factors that are generally accepted as appropriate treatment targets for human service intervention (Andrews & Bonta, 2006). An employee highlighted the need for a secondary risk tool, "It would be really nice to have a dynamic risk assessment meant for sex offenders that looked at that. Really right now (we're) looking at the LSCMI which has benefits but also has shortfalls in this area". Another employee appropriately described why it would be important to have a risk tool to assist client in determining criminogenic needs, "There is currently no dynamic risk assessment measure that could assist in capturing and appropriately evaluating the elements of risk that fluctuate and change over time".

In the absence of a validated tool to help identify what client's criminogenic need specific to sexual offending are, employees identified a number of sources they use to gather information and make a determination about needs for their clients.   This is summarized by an employee as, "Criminogenic needs are assessed through the LSCMI test measure, client self report, collateral information from the client's partners, family members, community supports, as well as ongoing clinical impressions".

As was already briefly mentioned in the risk category in the absence of a risk tool to help identify the criminogenic needs specific to sexual offenders, employees are relying on knowledge gained from previous training on risk tools such as the Stable 2000 or previous experience from other agencies to help form a more accurate determination of their clients needs. This is described by an employee as:

With criminogenic needs we have the risk assessment tools like the LSCMI, it looks at a person's general criminogenic needs, like family, education, peers, drugs, attitudes, and then lifestyle issues. (I am) also using the Stable to identify criminogenic needs related to my clients sexual offending like stuff around sexual self regulation, deviant sexual interest, their attitudes, stuff about their sexual behaviors.

Historical Factors

Several of the employees who have facilitated the programs identified historical factors as relevant in the work they are doing with their clients. This was described as life events that occurred throughout the client's life and understanding how the client interpreted those events, specifically how they felt and how they coped with those events.   In allowing the client to talk about these historical events, patterns emerge in their coping that are relevant to their offending behavior.

Group A

In the traditional relapse prevention group the focus is on the current sexual offence that led that a client to be charged, convicted, and referred to the group process. One employee talked about that process, "It specifically focused on the current offence and doesn't look at all of their issues that led to the offence. It just

focused on behaviors tailored to that person's offence".   Another employee related the same opinion, "We didn't look at that (past issues and patterns), it was more the RP model of what lead up to that exact offence".

Group B

In Group B, the first assignment, the pathways, requires that clients look back at their life events and how they felt and coped with those events in their lives.   An employee talked about how in Group B there is time spent trying to understand what issues a client may have struggled with throughout their lives:

> You are looking at struggles they might have had, past abuse issues, or relationship with their wife or past offending behavior too. When we do an offence cycle we look at all of their offending behavior so we are able to address their needs better because it is looking at all their core emotional issues and life issues leading up the offence, not just what happened in the last couple of weeks.

Group B's approach to taking a broader look at a client's life may provide more insight into understanding how the client ended up sexually offending. As described by one employee, "It takes a broader look at someone's life and then it's able to identify what are those needs that are going on within that context and how do they all factor into the choice to start sexually offending".

Treatment Targets

Treatment targets are the risk factors addressed within the group process. Ideally the treatment targets addressed in the group are the same as the criminogenic

needs identified in the research that impacts a client's risk. Targets identified in the literature that are specific to sexual offender risk include sexual deviancy, anti-social orientation, sexual attitudes, and intimacy deficits. Targets of general recidivism have been identified as anti-social lifestyle, impulsivity, employment instability, negative peer associations, aimless use of leisure time, substance abuse, poor problem solving, and hostility (Hansen et al., 2009).

Group A

There was agreement in the majority of employees' responses suggesting that Group A generally does not do well in addressing the criminogenic needs of the participants.   Given that the program is Relapse Prevention there is a significant amount of time spent talking about the current offence and the lead up (thoughts and actions) directly preceding the offence.   One employee observed that while Group A does well on its focus of pro-criminal thinking it falls short on addressing the broad spectrum of factors that may be relevant for a client and even in some cases does not address issues that are raised.   The employee said:

> Traditional SOP (sexual offender program) does not address criminogenic needs terribly well because it very specifically focused on the pro-criminal thinking or pro-criminal attitudes and it focuses on that, specifically for sexual offending, so sexually deviant thinking fantasy. And where it acknowledges that there are all these other criminogenic factors that may be involved, it puts them to the side and it's like this isn't the program for that, it is for the sexual stuff.

It appears that while Group A's focus on the criminal thinking leading up to the offence is a strength that comes at the cost of understanding the complete picture for clients.   It was described in the following way by an employee:

> It is very strong at addressing the thinking, the intrinsic, pro-criminal attitude, and the thinking criminogenic needs, but there are often other factors that happen; offending doesn't happen in a vacuum. Group A doesn't particularly address substance abuse very well, it doesn't address family/marital, it doesn't really address those things, but it is very focused on pro-criminal attitude. So what it does address I think it addresses well, but overall the criminogenic needs, it is very narrow in its scope.

An important observation made by some employees is that while Group A is weak at addressing some of the criminogenic needs at Headingley Correctional Center group members are expected to attend weekly one-to-one sessions where facilitators are able to address some of the factors that may not have been captured in the group process.   The employee said, "The thing I really liked about Group A is you had a combination of in-group as well as one-to-one that allowed the flexibility to address specific needs".

The one-to-one to component of Group A is offered only in the institutional groups. While Group A was being offered in the community at Probation Services one-to-ones were not offered as part of the group process. The main reason for this was logistical; clients were already expected to attend two group sessions per week and it was not realistic to expect them to attend another hour long session with a probation officer to supplement the group process. The employees whose experience

it was facilitating the group in the community collectively had more negative

opinions about Group A's inability to address criminogenic needs.

Group B

All of the employees who had the opportunity to facilitate Group B had positive

comments about the ability to address a broad range of treatment targets within the

group process.   One employee suggested that Group B's practice of taking a look at a

client's entire life allowed for more criminogenic needs to emerge and to be

addressed.   This was described by the employee as:

> I think that it is one of the strengths of Group B, it takes a broader look at
>
> someone's life and then it's able to identify what are those needs that are
>
> going on within that context and how do they all factor into the choice to start
>
> sexually offending. So I think in terms of targeting criminogenic needs as a
>
> whole Group B is much more comprehensive.

The same opinion was expressed by another employee, specifically that Group B's

focus on the whole life of the client, not just prior to the offence, allows for more

treatment targets to emerge.

> In group 2 (B) we look at all the issues that they've struggled with throughout
>
> their life leading up to the offence, not just a behavior chain specifically
>
> looking at what went on in a client's life a month leading up to their offence.
>
> You are looking at struggles they might have had, past abuse issues or
>
> relationship with their wife or past offending behavior too. When we do an
>
> offence cycle we look at all their offending behavior so we are able to address
>
> their needs better because it is looking at all their core emotional issues and

life issues leading up to the offence not just what happened in the last couple of weeks.

<div align="center">Structure</div>

The structure of the group emerged as an important theme for employees that either inhibited or encouraged the ability to address the criminogenic needs of the clientele. The structure of the group A is a closed format, meaning that the same number of clients begin the group together and finish the group together. The closed format group is also time limited usually running for a period of about six months in the institution.   In Group B the group structure is an open format that allows for an ongoing intake of new clients as former clients finish their assignments and move out of the group.   The open format does not put any time limits on how long a client can be a member of the group. If a client demonstrates a need to continue in the group they are permitted to continue until their needs are met. The structure of the groups was highlighted by many of the employees.

Group A

Group A follows the closed group format and it closely adheres to the Relapse Prevention manual in what tasks are required to complete the group. The manual states that all of the group participants complete assignments in the same time frame before moving on to the next assignment.   This rigid structure sometimes limited the needs that could be addressed within the group context as described by one employee:

It is a closed group, we follow a script in what we cover in group so there is not a lot of leeway to have sessions on say a bunch of guys have problems with relationships or intimacy deficits. We don't have a couple of sessions to

talk about dating or what it's like to meet a woman or to focus on intimacy

deficits.

The same employee added:

Because it was scripted and certain assignments we had to get done, the

assignments were long, it was time limited, the only time we had a chance to

address criminogenic needs was in check in…it is time limited in what we

could address, we wouldn't spend a whole session on a certain topic related to

a certain need.

Another employee highlighted the limitations of the prescribed time frame of Group

A was in allowing the opportunity to not only discuss criminogenic needs but even

being able to allow them to emerge.

…it was ignored, it was just put them all through group, get them finished

regardless of any individual risk…it wasn't all that easy because of the length

of time that was allowed in these groups. They had to be done at a certain time

because another group was starting, it didn't really allow for any extra time to

be spent on that.

Group B

The open format of Group B reduced the need to adhere to a specific time line

in the group process. This flexibility seems to allow facilitators the luxury of

pursuing issues raised by clients that would be connected to their offending behavior.

Because it's an open group and if an issue comes up around how a person is

managing dating or their sexual behavior in the community we can spend a

couple of sessions talking about certain topics related to that client's criminogenic needs.

Employee participants were given a list of twelve treatment targets which were taken from the Collaborative Data Outcome Committee (Hansen, et al. 2009) which has used these treatment targets to determine whether or not a program is adhering to the need principle.   Participants were asked to firstly decide whether or not the treatment target was addressed in their program, and if so, to rate on a five point Likert scale the importance of that target based on focus in group and time spent discussing the target. A score of 1 meant "little importance", a score of 3 meant "somewhat important", and a score of 5 meant "very important".   Employees were encouraged to comment on why they chose a particular number.   If the participant felt the target was not addressed at all it was assigned a 0. All of the participants (n=7) provided feedback on Group A as they all had direct experience facilitating the program. The program managers did not provide feedback on Group B, leaving the facilitators to provide feedback (n=4). The following table shows the results of that series of questions.

Table 1 – Treatment Targets - Employee Participants

TREATMENT TARGET	GROUP A (N=7)	GROUP B (N=4)
Antisocial Lifestyle	2.5	3.7
Impulsivity	2.7	3.7
Employment Instability	1.3	3.2
Negative Peers	2.2	3.5
Aimless Use of Leisure Time	1.8	3.2
Substance Abuse	2.7	3.2
Poor Cognitive Problem Solving	3.6	4.5
Hostility	2.5	4.5
Deviant Sexual Interest	3.6	4.5
Sexual Pre-Occupation	2.7	4.5
Attitudes Tolerant of Sexual Crime	2.7	4.5
Intimacy Deficits	2.3	4.75

Employee comments on why they chose a particular number to represent the importance of a treatment target is presented for each group.

Group A

The highest rated of the general criminogenic factors based on facilitator ratings was poor cognitive problem solving (score of 3.6 out 5) and followed equally by impulsivity and substance abuse (scores of 2.7 out of 5).   The highest rated sexual offender specific treatment target was deviant sexual interest (score of 3.6 out 5)

followed equally by sexual pre-occupation and attitudes tolerant of sexual crime (score of 2.7 out of 5).   It appeared to be a recurring theme that for the treatment targets rated less than 3 or less than "somewhat important" the only manner in which that treatment target emerged in the group process was if the client brought up the issue during their check in.

Anti-social lifestyle

> …I don't think there was an opportunity except in check in to get an idea of what their lifestyle was like and you wouldn't get anything out of check in.
>
> …it may have come up depending on the client, if they disclosed in check in, but thinking of the assignment work, unless it was directly connected to their offending and was in their chain, otherwise it wouldn't have come up.
>
> …it was definitely addressed but how well it was dealt with…it just seemed very rushed and didn't address the larger issue of why this guy is drinking at four in the afternoon. So it definitely recognized the need for it but didn't spend a lot time addressing it...The program facilitators would really have to make a note to focus on that in one-to-one instead.

Impulsivity

> …it really focused on the relapse prevention, looking at the risk factors or Problem of Immediate Gratification.
>
> …some of it might be visible in a behavior chain or check in but I don't think it ever allowed you to get any real important information.
>
> …really trying to look at working with offenders to develop better coping skills.

Employment Instability

…it's a discussion but not a huge portion of the work

…I don't think it was ever viewed as a treatment target but something most

clients would share more readily in check than other aspects of their life.

Negative Peer Associations

…if they said anything it was in check in or maybe occasionally in a behavior

chain, and again I don't think you ever really get anywhere with that either.

…depending on the individual but I think that would tend to get discussed a

lot, it will vary depending on the specific person.

Aimless Use of Leisure Time

…even though it is recognized we should be talking about it there just isn't

time

…That one tends to come up a fair amount, and again if it fits within the work

it is not necessarily a focus you go in…but if it's an issue with someone in

their work then you address it and try to develop better habits.

Substance Abuse

…not an important treatment target but they were more apt to talk about it

…that one tends to come up a lot, becomes a big factor with a lot of people we

are working with.

…it touches on some of the drawbacks of drinking, but especially the

increased risk that substance abuse brings for that offender it addresses fairly

well but doesn't address why the offender is using the substance to begin with

Poor Cognitive Problem Solving

…it is relapse prevention, cognitive behavior therapy based it's really looking at developing better thinking responses.

…it was viewed as a treatment target…it was more when you were doing the cognition chain or changed behaviors and stuff and again, I think it was mostly the facilitators dragging it out or putting words in their mouth just to get the thing completed.

Hostility

…probably hit or miss; some it's not very important, some it's very important

…only brought up in check in

Deviant Sexual Interest

…very important and it's addressed, that is the core focus of the program

…somewhat important but didn't look at whole history

Sexual Pre-Occupation

…relied on check in but again we didn't have the detailed history, more relying on self-disclosure

…in terms of the day of the offence, quite high, in terms of the overall not as high

…particularly see that with child porn offenders or a lot of offenders will collect porn even if it's not their offence and it doesn't do much to address that.

Attitudes Tolerant of Sexual Crime

…those were the focus and we spent most of the time in group discussing that

kind of stuff specific to the offence.

Intimacy Deficits

…it's acknowledged but when I was training I was always told that is on the

side. We know the stuff is there and we can acknowledge it but we are not

spending group time talking about it.

…it doesn't teach an offender who is looking for intimacy with an eight year

old, it teaches the negative of that and why not to do that but it doesn't show

how to have a healthy relationship with another adult.

Group B

The highest rated of the general criminogenic factors based on facilitator

ratings were poor cognitive problem solving and hostility (score of 4.5 out 5)

followed by anti-social lifestyle and impulsivity (score of 3.7 out 5). The highest

rated of the sexual offender specific criminogenic factors based on employee ratings

was intimacy deficits (score of 4.7 out of 5) followed equally by deviant sexual

interest, sexual pre-occupation, and attitudes tolerant of sexual crime (4.5 out 5).

When answering the questions related to the importance of the treatment

targets in the group process it was raised by employees that in the open, flexible

structure of group B there are more opportunities for issues to be raised by the clients

and forum for meaningful discussion to take place.   Rather than providing a specific

explanation for each of the treatment targets some of the employees provided a

general answer for clusters of targets. One employee lumped all of the targets into one explanation about her/his views:

Everything has importance…there was importance placed and time given in group to talk about all of this. It was threaded throughout, not necessarily the structure saying today we are talking about this but responding to the needs that came up in the group within the group and let's talk about that in relation to how it's hitting these pieces here…not just acknowledging that they are there but talking about them and trying to understand where do they come from, where does it stem from, what is the underlying belief system that is going on there. I think that is one of the reasons some of the guys responded better to this.

Another employee suggested that the majority of general criminogenic targets were discussed in group due to the importance of check in, "Because there was more of a process in check in and someone may have been discussing that and then connections are made to their offending later".

In explaining the importance of the criminogenic needs specific to sexual offending an employee offered that the therapeutic relationship that is fostered in Group B may allow for criminogenic needs to be discussed openly:

When we do a pathways and cycle we look at all their deviant sexual behavior not just current offence and because we form such a strong therapeutic relationship they self disclose way more in Group B than in Group A and we are able to target that better to help manage their risk. They are more open to talk about issues and they have such a bond with their facilitators and other

group members that they tend to open up more about all their deviant behavior

not just their offence and it gets attended to in group.

The Responsivity Principle

In much of the literature the Responsivity Principle is described as delivering a program in a manner that meets the learning needs of the client by a skilled therapist. It has been widely accepted that cognitive behavioral programming is a good fit (Hansen et al., 2009). Discussed to a lesser extent in the literature is the "specific responsivity principle" which requires that a therapist adjust the delivery of treatment to a client's personality and cognitive style (Marshall and Burton, 2010).   The therapist characteristics identified by Dowden and Andrews (2004) of warmth, empathy, and genuineness are key in being able to adjust to clients when needed.   It was suggested that if a therapist does not possess these characteristics the effects of treatment may be lessened.

All participants were asked a series of three questions pertaining to assessing risk and the Responsivity Principle. Questions two and three provided a five point Likert Scale to select a rating and then allowed for an explanation as to why that was selected. A score of '1' being "very poorly", '3' being "Somewhat", and 5 being "excellent". Collectively the participants provided Group A with an overall rating of 2.3 and Group B with an overall rating of 4.3. These questions included:

1. How do you determine what your client's responsivity needs are (ie. learning style, level of intelligence)?

2. How well do you feel Group A addresses the responsivity Principle in meeting the learning needs of your participants?

3. How well do you feel Group B addresses the responsivity

Principle in meeting the learning needs or your participants?

The responses provided by employees were organized into five themes which included: know your client, structure of the groups, readiness, literacy, and one-to-ones.   It is an interesting observation that although employees are aware of the importance of cognitive behavioral programming their focus was on the specific responsivity principle as described above. The themes focused more on the individual responsive needs of clients and how that is addressed within each of the groups.

Know your client

All of the participants felt that the most effective way of assessing a client's responsivity issues was to get to know your clients well.   A number of methods were provided collectively as means of knowing who your client is. These included:

1. Pre-group interview
2. File review
3. Collateral interviews – spouse, family, friend
4. Existing Psychological/Psychiatric reports
5. Previous group experience
6. Mental Health consults

Structure of the Groups

The structure of the groups was raised in the Needs section of the data analysis. The same description of the two programs would apply for this section regarding open versus closed group format.

Group A

The structure of Group A did not lend itself well to fostering an environment where clients could address their offending issues. An employee pointed out because the bulk of the Group A focuses on completing assignments versus process it created a gap for some clients. It was described as:

In terms of how the group is set up, it is assignment heavy. I think it makes it difficult to deal with some of those responsivity issues because a lot of the work is happening outside of the program, outside of the group, and then guys are kind of left on their own to try to figure those things out.

Frustration with the group structure was also identified by an employee who said, "One of my frustrations with Group A often is we tend to spend a lot of time teaching how to do the assignments correctly with participants".

Group B

Employees who facilitated Group B identified the flexibility of the structure of the group as being a positive means of working with the clients, allowing for more attentiveness to the needs of the clients.   In part, this flexibility can occur because there is not a structured manual that the facilitator must follow. Marshall (2009) has suggested that programs with a very structured manual reduce the therapist's ability to be flexible and adjust to the clients' needs. An employee summarized the importance of the flexibility by saying:

There was more room to move around and do things differently with each of the individual guys based on how do they learn best and where are they at. So

that group based on the flexibility of that program gave us the opportunity to respond better.

An additional benefit of the structure of Group B that was highlighted is the importance of the larger group discussions which are characteristic of the group, "There are often larger group discussions and those larger group discussions I think you are able to pull everybody in and stress important points and have offenders stress important points".

<div align="center">Readiness</div>

Clients enter the group process at different levels of readiness and motivation to engage. As with any human intervention program, clients experience different levels of comfort and trust in discussing personal issues and take varying amounts of time to get to the point of being able to be open with others.   In particular with sexual offenders who are being asked to discuss very intimate issues in their lives, readiness can be particularly important.   This was an important theme to employees as they all recognized that if a client is not ready to discuss his personal issues that the group will not be an effective mode of intervention.

Group A

The importance of readiness and how it can prevent a client from being able to complete his work in a meaningful manner was discussed by an employee:

> Because is it scripted, you are in there for a certain period of time so if it's going to take you longer because you have issues with being in a group when it's time to go you have to go, so if you are not ready we aren't being responsive to a clients needs…I can remember doing a guy's behavior chain

and it would take us three or four sessions to get through it, it was like pulling

teeth because he wasn't ready but he had to do it because it was his turn. All

we could really do was put him last, this guy can go last out of eight guys in

group but eventually he has to do it.

A concern raised by an employee was the possibility of limiting the level of

meaningful information from clients when they are forced to complete an assignment

they may not be ready for, "For the most part they did it because they had to. I think

a lot of the information they provided was either, was almost like we were pulling

teeth forcing them to say something, so who knows if it was even all that accurate".

Group B

In Group B clients are not expected to begin doing their assignments until

they feel they are ready to disclose personal information about themselves to the other

members in group.   The benefits of allowing clients the opportunity to wait were a

common observation made by employees.   An employee highlighted how long it can

take for a client to feel he trusts the other group members, "A guy can wait six

months to do his pathways until he's comfortable speaking in the group and he trusts

the group, we respond to the client's needs better".   The importance of not pressuring

a client to disclose information about himself until he is ready reaped many more

benefits as described by an employee:

Group B is designed that you do your work when are ready, when you are

more comfortable, the comfort would be up at that point. There was more,

they engaged more, they disclosed more information, more supportive of each

other, more comfortable environment for them, so they were committed to

change because of that.

The importance of client readiness can go beyond whether or not an assignment can

be completed but also spills over into developing healthy, trusting relationships with

other group members.

<div align="center">Literacy</div>

The level of literacy in correctional clientele varies greatly from clients who

have had very minimal levels of education, to clients who have university level

educations.   Overcoming literacy issues can prove to be a difficult task when the

same program is being offered within a group of clients from very different

backgrounds.

Group A

Employees felt that while the structure of group A did not attend very well to

clients who may have literacy issues that the facilitators themselves helped to mediate

that gap.   An employee said, "As facilitators we address it fairly well. Gauging

where somebody is at if someone has literacy issues, we would make arrangements to

have somebody help write it out or we would write it out as they were talking".

While facilitators were able to help clients with literacy issues, one employee felt that

despite this, the level of literacy expected to complete the assignments in group A

was still problematic:

> Hopefully you do a good assessment and have information on file and know
>
> the client and we would have some information on any unique issues. We
>
> knew of clients who had specific issues like illiteracy, we would make some

accommodation for that, but you were stuck with the same structure to pull

them through in the same way.

An important observation was made by an employee about how despite trying to help

clients who struggle with literacy it can cause the client to disengage from the

process:

> The guys who are literate and have a better grasp of English, higher
>
> functioning are more engaged. The guys who are struggling just to do the
>
> homework or never did well in school they seem to be less engaged and it
>
> doesn't seem to be lack of interest or wanting to change sexual offending
>
> behavior it's just you can see there is a disconnect and the disconnect starts to
>
> grow when they see some guys are getting it and moving on very well and
>
> when they are falling behind they tend to detach themselves from the
>
> process…the ones who had trouble with the homework and didn't do their
>
> homework, weren't motivated to their homework were not engaged; just
>
> getting them to show up on time was a victory.

Group B

There are assignments that need to be completed in Group B however, the

assignments are always completed within the group process and never sent home to

be worked on individually by clients. It was expressed by employees that this was a

positive aspect of Group B:

> It is at the client's speed, if there are literacy issues there is processing in
>
> group so you are processing their pathways, you are processing their offence

cycle, so even if there are literacy issues it is the facilitator who is

documenting the information.

An employee pointed out that even though literacy issues can be overcome by the

facilitator processing the assignment for a client and not having an expectation of

being able to write, different cognitive levels within the group still may have an

impact:

> When you are looking at someone's actual work…you run into a similar issue
>
> if the person whose work it is, is more cognitively advanced than others. I
>
> think that the other people, not get left behind, but may have some issues and
>
> it's harder to be responsive to their needs.

One-to-Ones

The one-to-one sessions with clients was identified as an important factor in

being responsive to clients needs.

Group A

The one-to-one sessions are considered part of Group A being offered in the

institution. These one-to-one sessions appear to be a integral part of the success of

the group. Employees identified that gaps in the service provided by Group A are

addressed individually. This included responsivity issues such as literacy but also

gaps in addressing the criminogenic needs relevant to clients that were not addressed

in group. An employee talked about the importance of supplementing the group with

one-to-one sessions, "The success of this style of program really depends on the

facilitators and the one-to-one work that happens outside of group because the group

is so heavily focused on written assignments and presentation".

Therapeutic Alliance

The therapeutic alliance or relationship the facilitator has with their clients is a very important consideration when discussing the effectiveness of programming. Marshall and Burton (2009) highlighted the importance of the relationship specifically to working with sexual offenders.   They cite Norcross (2002) who said that therapeutic relationship created 30% of the treatments effects that clients gained from treatment.   Marshall and Burton (2009) also discuss that a positive relationship with clients reduces the number of dropouts and with respect to sexual offenders; offenders who drop out have a higher recidivism rate than those who refuse treatment all together.   They also go on to suggest that facilitator skill is what develops group cohesiveness and cite Braaten (1989) that group cohesiveness is a pre-condition for change.

All participants were asked a series of three questions pertaining to therapeutic alliance and the benefits and limitations of each of the groups

1. Having facilitated both groups did you feel you had equal ability to build a therapeutic relationship with your clients?

2. Please explain what the benefits and limitations of Group A were in developing a therapeutic alliance?

3. Please explain what the benefits and limitation of Group B were in developing a therapeutic alliance?

The three program managers provided limited information on Group B based on their knowledge. Four themes emerged from the feedback of participants, including group

structure, one-to-ones, starting where the clients is/building trust, and facilitator skill. The themes are presented and separated into responses for each of the groups.

Group Structure

Group structure has been a theme raised in the last two sections, need and responsivity, and it has been raised again with respect to the therapeutic relationship. A detailed description of the groups' structure can be found in those sections.

Group A

Employees focused on the rigid structure of Group A as being a deficit in building strong relationships with clients in the group. The structure, specifically around time lines and ensuring all participants have completed the required assignment before progressing to the next left one facilitator feeling like she/he had to focus on keeping clients on task rather than building relationships:

> I remember in Group A there would be times where there would be out and out struggles with clients, where you are having to remove someone for not doing their assignments. I've never seen that happen in Group B...In Group A because it is so scripted it was more difficult to develop a therapeutic alliance because you had to pressure them into getting the work done.

Another employee provided perspective on why the structure limits the ability to build a therapeutic relationship with the clients:

> The short duration and rigid structure of the group severely limits the ongoing opportunities to explore the specific issues (attachment, trust, intimacy, boundaries, communication, and learning style) that typically interfere or limit the development of a genuine therapeutic alliance. In addition, the elements

(discussions surrounding non-clinical issues, celebrations of milestones) that

tend to promote group cohesion and enhance therapeutic relationships are

practically non-existent due to time restraints.

A positive aspect of the structure that was highlighted by an employee was with

regards to the frequency at which the group meets:

> The twice weekly frequency of group appears to facilitate the development
>
> and maintenance of an intense and occasionally close relationship with clients.
>
> In addition to approximately six hours of weekly contact, the twice weekly
>
> structure of group permits clients and facilitators to address some of the
>
> immediate emotional impact of difficult issues. On these occasions, the
>
> emotional intensity can facilitate the development of therapeutic qualities
>
> based on reliance and consistency.

Group B

The more flexible structure of Group B in allowing time for clients to get to

know each other and build trust before having to share personal information appeared

to be an important factor for employees. One employee summarized this benefit:

> The format of this group provides ongoing opportunities to incorporate
>
> therapeutic alliance as a primary treatment target. In this regard, the initial
>
> two months of group is solely designed to build therapeutic relationships and
>
> during the ensuing groups, each member is provided the opportunity to
>
> develop a sense of rapport, trust, and safety with facilitators and other group
>
> members at their own pace. Without experiencing the pressure and/or fear of

moving forward with scheduled tasks, the treatment participants have an open

time frame to not only develop and maintain a therapeutic alliance, but

address any obstacles, such as fear and shame, to therapeutic safety that may

arise at any time throughout the treatment process.

The issue of not pressuring clients to share information before they are ready was also

raised as a factor that enhances the relationship between the facilitators and the

clients. An employee said, "The structure of Group B is you take people where they

are at and it helps to build that therapeutic alliance and people aren't feeling pushed

or pressured to move along, we are going at their pace". Another employee talked

about how not pressuring clients to disclose information before they are ready gives

the facilitator insight into what some of their underlying issues may be:

The benefit is that you take the time you need to start when the client is ready

there is no confrontation in Group B, it really fits with motivational

interviewing. When you do their pathways if you know for sure that

something significant happened in a guy's life, like you know the guy's dad

committed suicide and he refused to talk about it you don't make him talk

about it, but clinically you note that there is something blocking him from

talking about it...in Group B you don't pressure people to talk until they're

ready to and you assess why they aren't talking about it and you work on

those issues. So that is why in Group B it's a lot easier to develop a

therapeutic alliance because clients don't feel threatened or pressured.

One-to-Ones

One-to-ones has been discussed previously. There take place on a weekly basis in the institution along with Group A.

Group A

The one-to-one sessions that supplement Group A in the institution have been raised in the previous sections as a benefit and it appears to be a benefit with respect to building therapeutic alliance as well.   One employee discussed how the one-to-one sessions enhance the relationship with clients:

The nice thing we have set up with our group is the one-to-ones outside of the program where you have the opportunity to develop that therapeutic relationship and explore some of those criminogenic needs that perhaps the focus of in group is too narrow to allow for that but in one-to-one you have the opportunity to address the broader needs...I feel that one-to-one was perhaps 80% of the reason I was able to develop that rapport...the one-to-ones really supplements the group, without that it would be a much different scenario.

Group B

Group B does not have one-to-one sessions with group members as a requirement of the group process. However, meeting individually during the group process is occasionally offered to clients. Situations where this might occur would be if a client is going through an emotional crisis that is beyond the scope of what the group can provide (ie. ongoing suicidal thoughts) or a situation with a partner or family member that needs to be addressed.   None of the employees made reference

to individual sessions being necessary in Group B in order to effectively meet the needs of the clients.

<u>Starting Where the Client is/Building Trust</u>

The employees all shared the view that they felt building trust with their clients was an important factor in establishing a therapeutic relationship. The foundation of being able to build trust is starting where the client is. Individualizing the client is one of Social Work's guiding principles. It suggests that no two people are the same and that the uniqueness of each client should be recognized. It also suggests that the worker should be able to adapt to the needs of the client (Sheafor et al., 1997).

<u>Group A</u>

Once again, employees talked about how the expectations of Group A, the group structure and time lines prevented facilitators from starting at the same place the client is perceived to be. An employee talked about how following that structure created barriers for developing a trusting relationship:

> One of the limitations right off the top traditionally is the way it set is automatic, introductions and then jump into family of origin and that is a lot to put out there so that is a limitation because it is hard to develop trust in the atmosphere where people are feeling uncomfortable to share things at such a fast pace...In terms of structure we are not moving along according to where people are but where we are in the program. So sometimes the guys feel I'm not ready to talk about his piece yet, and it's like well we have to, so let's get going here. So that can create some barriers, some issues.

This opinion was common amongst the responses from employees. One employee simply stated, "It was scripted, that there were assignments that had to get done, we couldn't go where the clients were at".

Group B

 The employees who had the opportunity to facilitate Group B talked about assessing where the client is at and not pressuring him to move ahead in the group was beneficial to help build a strong relationship.   This was described by one employee, "You take people where they are at and it helps to build that therapeutic alliance and people aren't feeling pushed or pressured to move along, we are going at their pace". This was echoed by another facilitator, "Each group member is provided the opportunity to develop a sense of rapport, trust, and safety with facilitators and other group members at their own pace".

<center>Facilitator Skills/Qualities</center>

Dowden and Andrews (2004) discuss five dimensions of effective correctional treatment which they refer to as Core Correctional Practices. The one they argue as the most important is the "interpersonal influence exerted by the correctional staff member is maximized under conditions characterized by open, warm and enthusiastic communication" (Dowden & Andrews, 2004: 205).   This has also been called the ability to foster a therapeutic alliance.   They cite a study by Lambert and Barley (2001) who found up to 30% of the improvement in patients can be attributed to the therapeutic alliance and concluded that the application of the alliance is relevant in correctional treatment (Dowden & Andrews, 2004).

The skills that are referred to as core correctional practices are essentially basic social work skills. These skills include fostering relationships with genuineness, warmth, and empathy (Kirst-Ashman& Hull, 1999; Sheafor, Horejsi, & Horejsi, 1997).

The feedback offered by employees did not differentiate between the two groups so the comments have not been divided.

> Really, it comes down to facilitator skill and to develop the therapeutic alliance and if an offender believes that you are trying to work with them, to assist them as opposed to out to get them, I think you will develop that rapport. So regardless of the program, I think it's individual facilitator style that accomplishes that; so I think you can do that in both programs. I think one-to-ones again help that tremendously.

A similar comment was made by another employee:

> Showing and demonstrating you are working with them as opposed to against them, that you aren't passing judgement on them but really working with them to identify risk and identify better ways to cope with that risk I think are really beneficial.

Working Alliance Inventory

The Working Alliance Inventory is a questionnaire used to determine the level of therapeutic alliance that clients feel with respect to their facilitators. Current participants of the groups being offered at Probation Services in the community and at Headingley Correctional Center were asked to complete the questionnaire.   The Working Alliance Inventory (WAI, Horvath & Greenberg, 1989) is a 36 item self

report instrument designed to measure the three components of Bordin's

pantheoretical definition of the alliance between the client and the therapist. Bordin

views therapeutic alliance as a pantheoretical factor or the variable that may be

responsible for client improvement across many different types of therapies (Horvath

& Luborsky, 1993).   The pantheoretical definition consists of three components

including Task, Bond, and Goal.   Task is described as the in counseling activities that

form the core of the counseling process. In a strong client/therapist relationship not

only are these tasks viewed as relevant but both the client and therapist take

responsibility to perform the tasks. Bond is described as the mutual personal

attachment between the client and therapist and includes trust, acceptance, and

confidence. Goal is described as where both the client and therapist mutually endorse

and value the anticipated treatment outcome (Horvath & Greenberg, 1989, Horvath,

2007).   Martin, Garske, and Davis (2000) reviewed a number of therapeutic alliance

scales and concluded the WAI is an appropriate tool for most research projects and

that it can be used for all types of therapy.   The research on the WAI does not

indicate a cut off number to assess levels (low, medium, or high) of alliance but rather

the numbers allows for comparison between groups or during different phases of

treatment. The WAI provides an overall score as well a score for three categories,

Task, Bond, and Goal (Horvath, 2007).

     The clients currently participating in both Group A and Group B were asked

to complete the questionnaire during their regularly scheduled group sessions. The

purpose of using the WAI for current clients was to gather information about the

client's view of their relationship with facilitators to determine if there was any difference between the two groups.

For the purposes of this research a comparison of the average scores provided by current participants of the groups (Group A and Group B) were provided. It is felt that that comparing how the participants of each group felt about their facilitators provided valuable information as to the extent of therapeutic alliance in each of the two groups.

The WAI is a 36 item questionnaire with a maximum score of seven for each item for a total potential score of 252 points. Within each of the three categories there are 12 questions providing a maximum score of 84 for each category, task, bond, and goal.   While there is no cut off score provided that provides a measure such as "high, medium or low", the average overall scores provided by group members is on the higher end of the scoring suggesting that group members felt their relationship with facilitators was on the stronger side.

Group A clients scored their relationship with their facilitators higher than did the clients of group B.   However, the only subscale where there was a five point difference was on the task scale. The Bond and Goal scales had very close or the same scores for both of the groups. A further discussion of this difference will take place in the discussion section of the thesis.

Table 2 (below) gives the average scores on each of the 3 categories for each group, and the sum of the 3 average scores for Group A and Group B.

Table 2 – Working Alliance Inventory

GROUP	TASK	BOND	GOAL	SUM OF AVERAGES
GROUP A (n=6)	71.25	64.75	65.25	201.25
GROUP B (n=13)	66.66	64.83	64.16	195.66

Personal Satisfaction

Personal satisfaction in one's employment is an important consideration.   It can be viewed as a protective factor that reduces employee burnout. The number of hours of training and experience it takes for an employee to become an effective facilitator can be significant. It requires the investment of resources by Manitoba Justice for the required training but also of other employees who take on the role of mentoring a new facilitator.   Given the investment required and coupled with the reality that few employees are interested in working with sexual offenders personal satisfaction is an important consideration when discussing any program.

Employees were asked one question about personal satisfaction. The answers were mainly provided by the four participants who facilitated both groups. The program managers were asked to provide feedback about their group A experience.

1. Based on your personal experience which group, A or B, did you find more personally satisfying to facilitate and why?

The two main themes that emerged from the participant feedback were frustration and client value. Employee feedback are presented by theme and separated into the two groups.

Frustration

Frustration is an important component of job satisfaction for employees.   If employees are frustrated with the service they are providing it is not likely that they will continue with that employment long term, or if they do remain in their position,

the quality of the service provided will diminish over time. Employees talked about some of their frustrations of their experience in delivering the programs.

Group A

Employees discussed a number of reasons why they had feelings of frustration in facilitating Group A.   A major issue appeared to be feeling that the group structure did not allow for issues that facilitators know are relevant to be addressed. One employee described his/her experience in the following way:

My Group A experience was marked by chronic frustration in observing the group members being frustrated and confused throughout the treatment program. This was largely due to the inflexible and rigid structure that prevented the participants from opportunities to explore the core issues that are critical to their recovery and overall risk management and wellness. At times, this was a glaring problem as group members became agitated and occasionally hostile in relation to being directed to attend to tasks they were clearly not ready to address.

Another employee expressed frustration by saying, "It was frustrating. It felt like you were working harder than the client".

As means of coping with the frustration that was experienced from feeling that clients' needs were not being address some employees began to integrate components or modify assignments to better meet the needs of the clients. This was described by one employee:

Before I ever did an open group or had any experience with that I was already getting so frustrated with Group A that I was basterdizing the program. We

were supposed to do a behavior chain that just looked at the offence in the

couple of weeks leading up to the offence. I would almost do a pathways

which is what we do in Group B…I was getting so frustrated with it and

feeling like it wasn't working and it wasn't tailored to the needs of the client.

So I already had it with Group A before I even had the experience of doing a

different kind of group because it was limited and not meeting the needs of the

client. So I was getting really frustrated with it.

Another employee described how integrating factors he/she felt were important

increased the level of satisfaction:

My philosophy is sexual offending doesn't happen in a vacuum and there are

all kinds of other factors connected to it and I don't feel like the traditional

SOP (sexual offender program) has the structure to deal with that. I know

sometimes people talk about 'well it can', and sure you can kind of talk

around it but the structure doesn't lend itself well to that. Although I have to

say this is the second Group A I've done since Group B and I've taken a lot of

the principles I saw in Group B and using them for myself in one-to-ones. So

in terms of my personal satisfaction it has increased dramatically since

incorporating some of those things, it just feels like it is more 'a bigger

picture' look at things, but not ignoring the sexual offending.

There were some positive comments about Group A specifically around feeling

satisfied when clients were engaged and appeared to understand the program. An

employee said:

It (Group A) was pretty satisfying as a whole because there are certain light

bulb moments you can see happening. Even the guys who are resistant, you

can see when things click for them, that is satisfying.

Another employee said:

My experience with group A I did find it personally satisfying. I found it

difficult at times, and stressful, maybe that is a hard word but I guess stressful

at times, but working with people and seeing them get engaged and start to

make changes and get excited about that process and work through them with

issues of minimization and denial and see them make steps I found very

rewarding.

Group B

The comments about Group B were generally all positive and focused around

feeling like the clients were getting their needs met and the group was structured in a

manner that challenged facilitators to engage with the clients.   An employee

summarized his/her experience as follows:

In Group B it is a satisfying way to do group. I feel like I am making a

difference with clients and it isn't cookie cutter, it is tailored to every client's

needs and I could do this group until I retire. I could just keep doing this

group, I feel like I am still learning. In Group A I didn't feel like I was

learning anymore.

Another staff member commented on general observations about Group B:

If we are looking at staff satisfaction, I think that clearly Group B provides for

far more positive attitudes towards that part of the job. Clearly facilitators

really enjoy that and feel that you are doing something valuable, that clients

are taking away information that is helpful, the clients are happier and they

feel they've accomplished something, they are gaining insight, the whole

thing is just a far more positive environment.

Value to Client

The motivation driving why anyone chooses to facilitate a sexual offender

program is often the ideal that the work being done with clients is effecting change in

their lives. The hope that a client can take the insight and knowledge learned in a

group and not only stay offence free, but go beyond that as well to have a satisfying

life with healthy relationships is at the core of what we do.   This premise is again

strongly linked to the values and ethics of Social Work and working to make our

clients lives better.

Group A

There were some positive comments made about Group A and how it is

satisfying when a client makes connections and gains insight, "It was pretty satisfying

as a whole because there are certain light bulb moments you can see happening". The

majority of the comments related to Group A's ability to meet the needs of clients

were negative. The same employee added:

I feel that some of the issues surrounding sexual offending, some of the

peripheral issues weren't addressed and we often saw in the participants or

client they left feeling there was undealt with issues. Some of the issues of

their own victimization or family marital issues. Some of that stuff wasn't

addressed and that was my feeling too.

Another employee stated, "When guys left Group A I just thought they just scratched

the surface in terms of looking at basic beginner risk factors in terms of what their

offence cycle is...in Group A it is stay away from kids, don't drink, just basic and

superficial".

Another employee talked about witnessing clients getting frustrated and not being

able to understand and develop a plan to keep them from offending in the future:

>My group A experience was marked by chronic frustration in observing the
>
>group members being frustrated and confused throughout the treatment
>
>program. This was largely due to the inflexible and rigid structure that
>
>prevented the participants from opportunities to explore the core issues that
>
>are critical to their recovery and overall risk management and wellness.

Group B

Employees' views about how Group B helps clients and how that translated

into personal satisfaction were very positive. This was described by an employee:

>Group B was a far superior therapeutic experience for me primarily due to
>
>observing the meaningful changes that clients made throughout treatment and
>
>being aware that the identification and management of their risk factors would
>
>likely have an impact on risk and recidivism in the community. This was
>
>made evident by the measurable differences in the participants level of self
>
>disclosure and accountability, motivation and commitment to healing and risk

management, willingness to consider feedback, and their provision of ongoing

encouragement and support for other group members.

An employee talked about taking satisfaction in utilizing counselling skills:

> I feel that I am using my skills as a therapist more, it is more meaningful
>
> because the clients are engaged and committed, I feel like we are going where
>
> the client's needs are and just clinically more satisfying.

Finally an employee talked about finding satisfaction in seeing clients change:

> You see clients changing more, more interested in change, feeling better about
>
> themselves at the end of group, more motivation to live healthier lives. You
>
> see closer relationships between the group members and supporting each other
>
> more. It is a feeling in group when they do take and they do their work and
>
> more supported all around.

<u>Past Participants</u>

The past participants (former group members) were identified from a data base maintained by Probation Services. There were eight participants that had taken part in both Group A and Group B. Of the eight, four indicated an interest in participating in the interview.   Participants were asked a series of 20 questions that included a five point Likert Scale and then had the opportunity to elaborate on their selections.   In analyzing the interview transcripts of the participants it was found that, in some cases, the number the participants chose on the Likert Scale was not consistent with their verbal answer which followed.   However, all results are presented and further discussion about this issue will take place in the next section of the thesis.

<center>Responsivity</center>

Former group members were asked the following questions related to the responsivity issues in the groups:

1. How comfortable did you feel sharing your personal information in Group A?

2. How comfortable did you feel sharing your personal information in Group B?

Participants were offered a five point Likert scale with a score of 1 being meaning "Not at All", 3 meaning "Occasionally" and 5 meaning "All the time". Collectively the participants provided Group A with an average rating of 2.5 and Group B with an average rating of 3.5.   Past group member described their comfort level.

<u>Comfort Level</u>

A client's level of comfort in the group is influenced by their level of trust of facilitators and other group members. Their level of trust and comfort will have a direct impact on their level of engagement and self-disclosure within the group which in turn will impact the level of group cohesion which has been mentioned previously as a key factor in effective group process (Marshall & Burton, 2010).

Group A

The four group members described their experiences in varying ways but it seemed to be consistent that getting comfortable within a group process takes time and is influenced by different factors for each individual. One group member suggested that everyone was there for the same reason and as he got to know the other group members his level of comfort increased:

We always used a first name basis so obviously when the group finished we wouldn't see each other again. I saw no reason to not lay it on the table. None of us were there for helping old ladies cross the street. We are all in the same boat. I got comfortable after a while.

Another group member highlighted having a professional to hear his story increased his comfort:

I was tired of carrying this burden, to let go and open myself to someone who understood myself, someone who was professionally trained to understand what I am talking about, why I am and feel the way I do. So it made a big difference to talk to someone that could communicate with me at that level.

Yet another group member felt the atmosphere of the group impacted him greatly saying, "I felt uncomfortable, I think one reason was the atmosphere it was cold, a

cold atmosphere. I was scared to death, that was the main problem, it was

impersonal".

And finally another group member seemed to base his level of comfort on a desire to

hurt himself saying he felt comfortable, "The reason why I picked this answer has a

lot to do with remorse and regret and for me the harm that I've done on a person. I

think I should go through as much pain myself such as humiliation".

Group B

The responses for Group B and how comfortable the group members felt was

again quiet varied. One member compared the atmosphere between the two groups

saying he felt comfortable all the time, "It was the complete opposite of the other

group, it was warm, they made you feel comfortable. At first I was shy, but from

then on it worked up". Another group member highlighted that how open the other

group members impacted his level of trust in the group saying he occasionally felt

comfortable:

> There are certain people I didn't trust in terms of privacy. You know, there
>
> just um some people that weren't ready to be open and truthful with
>
> themselves, why should I open myself up to somebody who isn't being
>
> truthful to themselves or in denial for that matter.

Treatment Targets

Both programs identified accountability or increased accountability, insight, and

risk management as treatment targets so past group members were following

questions related to these factors in the groups:

1. How accountable for your offending behavior (past and present offences) did Group A hold you?

2. How accountable for your offending behavior (past and present offences) did Group B hold you?

They were given a five point Likert scale with an opportunity to explain their choice. A score of 1 meaning "not at all", a score of 3 meaning "only partially", and 5 meaning "all the time". Collectively the participants provided Group A with an overall rating of 4.5 and Group B with an overall rating of 3.5.

3. How well do you feel Group A helped you to develop a better understanding about why you offended?

4. How well do you feel Group B helped you to develop a better understanding about why you offended?

Again a five point Likert Scale was used with an opportunity to explain on why they chose that number. A score of 1 meaning "not at all", a score of 3 meaning "only partially" and 5 meaning "I completely understood why". Collectively the participants provided Group A with an overall rating of 3 and Group B with an overall rating of 4.

5. How well do you feel Group A helped you develop a plan to avoid offending in the future?

6. How well do you feel Group B helped you develop a plan to avoid offending in the future?

The five point Likert Scale was offered to participants and a score of 1 meaning "not at all", 3 meaning "only partially, and 5 meaning "I had a complete plan".

Collectively the participants provided Group A with an overall rating of 3 and Group B with an overall rating of 4.

Three themes emerged from the participants answers including personal accountability, insight, and managing future risk. The feedback is separated into the two groups

<u>Personal Accountability</u>

The responses from group members were varied on what they felt prompted them to be accountable for their behavior.   The issues of accountability seem to center around if they felt the groups were a safe place to disclose offences, and wanting to disclose their behavior in order to move on with their lives.

<u>Group A</u>

One group member who said he felt held accountable all the time attributed that to his own choice to disclose information. He did not associate it with his comfort level in the group saying, "You only go by what myself as an individual tell them, and me personally I always told the truth. They can only ask me questions pertaining to the truth I tell them. If I don't tell them anything they can't ask me anything right?" Another group member felt being in the two groups helped him to open up, saying he felt comfortable all the time, "My whole life I've learned to shut things down and shut everyone out. The two groups I've taken have taught me to express myself and out in the open and I do it and I had to tell what I did. I am very happy where I am right now".   The same group member later added:

I have pushed away so many people who love me and tried to help me. Group

A helped me to bring out all the crap I've held in. I was able to see it all on

the paper and on the board as well as talking to my peers I was taking the course with. There is no way to go around it. For me to bring it out, talk about it, it hurt, but it made me look at myself. I'm just glad I had the chance to take Group A, it helped me a lot.

Only one group member commented on how he felt treated by the facilitators saying, "They made you feel like you were guilty, that is all I can say about that". He did not elaborate on what specifically made him feel this way. However, it can be speculated that he may have had feelings of being judged and perhaps being confronted during the process which likely would not have enhanced his self-disclosure in the group.

<u>Group B</u>

Two group members discussed the importance for them to have facilitators be non-judgemental and caring: One said he felt Group B held him accountable all the time and explained, "But I felt more comfortable with it. There again, the way they treated everybody, it was more humane, should I say, more friendly and more personal".

The other said that he felt Group B didn't hold him accountable at all yet went on to explain how the atmosphere in the group helped him to hold himself accountable:

I held myself accountable. The group was designed to help me or talk me through my situation, past, present, you know, what I have to deal with in life. For me personally accountability is what I admit I've done, how I hold myself responsible, that is what I see accountable being. There weren't there to pass judgement on me or criticize me; they were there to listen to me. It's not about holding me accountable it's about myself.

Insight

Developing insight within group members is a common treatment target in groups. As their insight and understanding about their behavior increases it seems that their level of internalization also increases. Some of the group members during the interview seemed to not have a clear understanding about why they offended or what some of the contributing factors were.

Group A

One group member appeared to still be struggling with the shame of his behavior and searching for an external answer as to why he offended. He said he left Group A with a partial understanding of why he offended:

> I don't know why I offended the way I did, what made me do what I did...I have to say yes, I made a mistake but that is not who I am either. I truly believe that is not who I am today. Why I offended the way I did, that is still in my head, I don't know when I will find the answer to that, maybe I never will. Maybe that is what keeps me on edgy, keeps me aware, but to do such a thing like that in my life again, no way, I truly believe I never will.

Another group member talked about how he did not gain a lot of insight during his participation and related that to how he felt in the group, "Like I said before, every time I went there, I was apprehensive, I just wanted to get out of there as fast as possible, that group really didn't do anything for me".

Group B

A group member mentioned that his experience in Group B encouraged him to talk about all of his charges on a deeper level and that was helpful to him:

The advantage of taking Group B is I had already seen what I had done and to help share with the other group and for me to talk about what I had done. I went deeper into my charges and bring it out for me to see that and bring it all into perspective. It has helped me a great deal, I really appreciate that program, whatever Group A didn't cover, Group B picked up.

Another group member was still struggling to understand why he offended:

Because again, I don't really know why I offended the way I did, I don't think anyone knows. Maybe because I myself as a child was sexually abused, had some impact or effect on me growing up. It's something that never left my mind. Yes, I did wrong, but when it came time face up to what I did, I didn't hold anything back. I didn't try to deny it, I took responsibility.

Managing Future Risk

Risk management and having a plan to avoid reoffending in the future is an important part of the group process. Both groups see this has been a key factor in the group process.

Group A

As part of risk management Group A works on two assignments the "escapes and avoidances" and the "changed cognitions" whose purpose is for clients to develop a plan for if they are in a situation in the future where they may be at risk to reoffend. This includes what they can do differently and what changed thoughts they can utilize

to change their behavior.   The group members' comments on how they felt Group A

helped them to develop a plan was limited. One group member said, "Group A didn't

help me at all, Group B helped me. I liked the Group B".

Another group member talked about victim awareness and his own shame as

being factors for him that would help to avoid offending:

Like I said before, this is not what I am as a person, why I did what I did,

again, I don't know why. I developed an understanding, I am more mature

now, I guess you could say I was still a kid in my mind when I did those

things. Today I can understand and I can see when you hurt a person, I can

see, if someone did that to you, how would you feel, or my kid, or my

girlfriend, or my wife. So it just prepares me, not only that, the thought of

know what I did, disgusts me very much. Some people say you will forgive

yourself inside, I don't think so, I am still waiting for that day.

Group B

Group B's last assignment prior to group members leaving the group is the

wellness plan. This is designed to highlight what their core issues are (ie.

abandonment, fear, shame, helplessness) and how they have ineffectively coped with

those issues (including the offence) in the past, and develop a plan to how they can

cope in a healthier, more effective manner in the future to manage their risk.   One of

the group members talked about being able to recognize some of that unhealthy

coping and compared his experience in the two groups:

I had the experience of both groups really really helped me, one bring out my

charges and partially what happened in my past. When I did part (group) B

we went deeper into what really bothered me. I got to see it on paper and for

me to express all the crap that happened to me. Like I said running away was

one of the hardest things that I've done. I've used alcohol, I've drank for

weeks, drank, work, and for me that was an unhealthy way of living and it

helped me to see that overworking myself wasn't good at all, drinking instead

of resting.

Interestingly, another group member who has reoffended since completing both

groups did not blame his group experiences. He talked about his Group B experience

saying he felt he had a complete plan to avoid reoffending when he left the group:

I offended again after that. It helped me to avoid certain situations to think

before you do something, to not put yourself in a position where you will

offend or a situation where you will break the law at all…Group B helped me,

I just didn't help myself.

Past group members who had taken part in both Group A and Group B were

also asked to identify from the same list of treatment targets provided to facilitators

whether or not that target was a factor in their offending, and if so, how well did they

feel each of the groups helped them to address that risk factor. There were given a

five point Likert Scale, some of them chose to elaborate on their selection but most

did not. A score of '1' meaning 'not at all', 3 meaning 'only partially' and a score of

5 meaning 'I left with a good understanding'.   They were provided with definitions

(Appendix G) of the treatment targets for clarity purposes.   If the participant felt that

a treatment target was not a factor in their offending, no score was given. Their

feedback has been represented in the following table in the form of averages.

Table 3 – Treatment Targets - Past Group Members

TREATMENT TARGET	GROUP A (N=4)	GROUP B (N=4)
Antisocial Lifestyle (n=3)	3	5
Impulsivity(n=4)	3	5
Employment Instability (n=2)	2	5
Negative Peers (n=4)	3	5
Aimless Use of Leisure Time (n=4)	3	5
Substance Abuse(n=4)	2.5	5
Poor Cognitive Problem Solving (n=3)	3	5
Hostility (n=3)	2.3	5
Deviant Sexual Interest (n=3)	3	5
Sexual Pre-Occupation (n=3)	2.3	5
Attitudes Tolerant of Sexual Crime (n=4)	2.5	5
Intimacy Deficits (n=4)	3	5

In the questions that were asked of past group members their answers were

not always clear and it was hard to determine if they did understand what their

offending was about.   In asking past group members to identify if any of the twelve

treatment targets were a factor in their offending it was expected they would be more

likely to endorse the targets of general recidivism, and not endorse the targets of

sexual recidivism as easily.   This was not the case. The past group members seemed to have a realistic view of what played a role in their offending including the factors that have a negative stigma attached to them (deviant sexual interest, sexual pre-occupation, and attitudes tolerant of sexual abuse).

Chapter Five

DISCUSSION

As stated earlier in this paper there were two objectives to this research. The first objective of the research was to consider the degree to which each of the two programs offered by Manitoba Justice adheres to the research based practice principles of risk, need, and responsivity.   The second objective is to assess the degree of therapeutic alliance that is created in each group. Based on the information gathered, this research would attempt to assess, if possible, which program is better suited to Manitoba Corrections mandate to have the "lowest recidivism rates in Canada" and offer recommendations based on the data collected.

Adherence to Risk, Need, and Responsivity

The first task was to consider if Group A and Group B adhere to the risk, need, and responsivity principles. This was done by referring to the guidelines established by the Collaborative Data Outcome Committee (CODC).   The CODC (Hansen et al., 2009) felt that programs adhered to the risk principle when they provided intensive interventions to higher risk offenders, and little or no intervention to low risk offenders. The CODC found that in practice sexual offender treatment programs in the same locations did not offer differing intensities to different risk offenders.   Therefore, they determined that if a program was targeted at higher risk than average offenders it was deemed to adhere to the risk principle.   Adherence to the need principle was met if the sexual offender program treatment targets were related to sexual offender and general recidivism based on prior research. The

targets, specific to sexual offender risk include sexual deviancy, anti-social orientation, sexual attitudes, and intimacy deficits. Targets of general recidivism were anti-social lifestyle, impulsivity, employment instability, negative peer associations, aimless use of leisure time, substance abuse, poor problem solving, and hostility. Sexual offender programs were determined to have met the responsivity principle if they provided treatment in a manner that matched the learning style of their participants. This typically means offering cognitive-behavioral programming facilitated by skilled therapists (Hansen et al., 2009).

The Risk Principle

Group A

The information collected from employee participants clearly demonstrated that in the past, the accepted practice was to place offenders, regardless of risk level, into the same group. No attention was paid to their level of risk; rather, some admission of responsibility was enough to refer a client to group.   Given this historical lack of attention paid to clients' risk, Group A is not considered to be adhering to the risk principle. It is important to note that employee participants said that in recent months more attention is being paid to ensuring clients with a moderate to high risk level are being referred to the group and the low risk offenders are being offered alternate interventions. However, until this practice of referring lower risk clients to alternate interventions is well established, Group A cannot be considered to be adhering to the risk principle.

Group B

Group B has had much the same experience as Group A in that clients with varying risk levels have been accepted into the group.   Similar to Group A, in recent months more attention is being paid to ensuring clients' with a moderate to high risk level are being referred to the group. However, in the Group B's that were being offered during the data collection portion of this research there were low risk clients participating in the group. Based on the CODC guidelines, Group B can not be considered to be adhering to the risk principle.

It is very important to note that Group B is an open ended group. Open ended groups allow for participants to graduate when their work is completed and allows for new clients to enter. This permits clients of lower risk to receive less intense (or less frequent) intervention. Clients are permitted to progress through the group at their own pace, addressing the issues relevant to them. So although there may have been clients of lower risk included in Group B, the format of the open group which allows clients to progress at a quicker pace would still offer an option for lower risk clients without subjecting them to the expectation of longer or more intense programming. The CODC did not find, in practice, any groups that were offering differing intensities to clients within the same group. Whether or not the open group format of Group B and the practice of lower risk clients receiving less intense (less frequent) treatment would imply compliance with the risk principle needs to be investigated further.

Another important point of discussion about the two groups and their adherence to the risk principle is the explanation of why the current groups, both

Group A and Group B, included low risk clients. This relates back to employees'

concerns about the lack of a secondary risk assessment to assist in determining a

client's sexual risk to recidivate.   It is evident, based on information provided, that

in these cases employees are relying on collateral information and/or their existing

knowledge of dynamic risk factors not captured by Manitoba Justice's current risk

assessment tools to get a more accurate picture of risk. It may be that these lower risk

clients are in fact at a higher risk to reoffend.   Therefore, on the surface it appears

that allowing low risk clients into group is not adhering to the risk principle.

However, when one understands the rationale of why those clients have been referred

to the group, it is an honest attempt to adhere to the principle and ensure that higher

risk clients are being offered the appropriate level of intervention.   It can be argued

that while this practice is based on an informed decision, it still may be compromising

the risk principle because the decision are being based on judgment and/or an

outdated risk tool.

The Need Principle

Employee participant feedback related to treatment targets can be divided into

two categories, 8 criminogenic factors related to general criminality and 4 related

specifically to sexual offenders that have been identified by the Collaborative Data

Outcome Committee as acceptable treatment targets for sexual offender intervention

(Hansen et al., 2009).

The eight factors related to general criminality include antisocial lifestyle,

impulsivity, employment instability, negative peer associations, aimless use of leisure

time, substance abuse, poor cognitive problem solving, and hostility.   The four

factors that are specific criminogenic needs to sexual offenders include deviant sexual

interest, sexual pre-occupation, attitudes tolerant of sexual crime, and intimacy

deficits.

The CODC suggests that for a program to be adhering to the Need principle it

must be addressing these criminogenic factors at least 51% of the time.

Group A

The highest rated of the general criminogenic factors based on employee

ratings was poor cognitive problem solving (score of 3.6 out 5) and followed equally

by impulsivity and substance abuse (scores of 2.7 out of 5).

Poor cognitive problem solving and impulsivity are core concepts of Relapse

Prevention (Marlatt & Gordon, 1985) and the assignments required of participants

focus on identifying thinking just prior to the offence which often reveals poor

problem solving and impulsivity.   Employee participants felt that substance abuse

was a common issue identified by the clients in their check ins and their chain work,

thereby making it a topic of discussion on many occasions.

The employees' qualitative feedback supported their rating choices of the

treatment targets. The feedback suggested that the remaining factors were not

specific treatment targets within the group content or structure. It was expressed that

a factor only became a treatment target if the clients raised the issue during their

check ins and even then, discussion of the topic did not necessarily merit further in

depth discussion in relation to their offending or daily functioning. Employees

currently facilitating Group A mentioned that most often the criminogenic factors

were discussed individually during one-to-one sessions as opposed to an extensive group discussion.

The highest rated sexual offender specific treatment target was deviant sexual interest (score of 3.6 out 5) followed equally by sexual pre-occupation and attitudes tolerant of sexual crime (score of 2.7 out of 5). This is logical if one looks at the content (group manual) of Group A. All of the assignments are designed to focus almost solely on the immediate time frame leading up to the sexual offence and examining the thinking connected to those behaviors. The behaviour and cognitive chains are intended to look at the immediate time frame just prior to the offence (the day or hours just before the offence occurred). It is logical that given the intense focus on the behavior and thinking leading up to the offence, that the sexual thinking specific to the current offence would be revealed. It is important to note that while some of the sexual thinking is revealed through this process there may be a significant amount left unaddressed. This is because according to Group A structure only the most current offence is addressed. Any additional (for which the client may have not been charged) or previous offending is either not addressed or left for individual work during one-to-ones with the facilitator. This was supported by feedback provided by employees where they highlighted that Group A's structure and inflexibility impeded their ability to address a broader range of treatment targets within the group process.

The CODC created the guideline that programs were considered to adhere to the need principle if the majority (51%) of the treatment targets were criminogenic needs (Hansen, et al., 2009). It was determined earlier that the treatment targets for Group A based on the manual are accountability, victim empathy, cognitive

distortions, impulsivity, and identifying high risk situations.   The facilitators

provided insight into what, in practice, are the treatment targets addressed in group.

The two most significant of the targets were deviant sexual interest and poor

cognitive problem solving (3.6 out of 5). The next four highest targets were sexual

pre-occupation, attitudes tolerant of sexual abuse, substance abuse, and impulsivity

all scoring 2.7 out of 5 as rated by the facilitators. It is important to note that a score

of three was considered "somewhat important".   This means that facilitators felt that

only two treatment targets of the twelve identified by the CODC were considered

more than "somewhat important" in Group A. Given this information provided by

facilitators it is felt that Group A does not adhere to the need principle.

It is an important finding that employees repeatedly mentioned the importance

of one-to-one work with their clients.   The CODC does not discuss one-to-one versus

group work with sexual offenders. The one-to-one time allowed employees to

address some of the criminogenic factors that were not discussed during the group

process.   It would seem the one-to-one meetings are where a significant amount of

meaningful discussion and work took place between the client and the facilitator.

Without the one-to-one to supplement the Group A process, it would fall short of

meeting the needs of the clients.

Group B

The highest rated of the general criminogenic factors based on facilitator

ratings was poor cognitive problem solving and hostility (score of 4.5 out 5) followed

by anti-social lifestyle and impulsivity (score of 3.7 out 5).

The highest rated of the sexual offender specific criminogenic factors based on employee ratings was intimacy deficits (score of 4.7 out of 5) followed equally by deviant sexual interest, sexual pre-occupation, and attitudes tolerant of sexual crime (4.5 out 5).

The pathways and offence cycle assignments for Group B have clients identify significant events throughout their lives, how they felt and/or thought about the event, and how they coped with the event. This assignment demonstrates for clients their patterns of negative thinking and ineffective or unhealthy coping on which they have relied through their lives. The pathways assignment allows opportunity for many of the treatment targets to emerge including as anti-social pattern, substance abuse, intimacy deficits, hostility, impulsivity, and sexual pre-occupation.   The offence cycle assignment allows clients to address all of their sexual offending, including current and historical. It uses the information gained from the pathways and includes what was happening in the client's life in the more immediate time frame prior to their offences taking place (six months). Again, this further demonstrates for the clients their patterns of negative thinking and unhealthy coping.   The purpose of the offence cycle is on identifying the development of sexual thinking, distorted thinking, and planning that allowed for the offence to occur.   This assignment allows for even more of the criminogenic needs to emerge and become treatment targets such as sexual pre-occupation, attitudes tolerant of sexual abuse, intimacy deficits, and sexual deviance. Employee answers suggested they felt the open, flexible structure enhanced their ability to address treatment targets within the group.

The CODC created the guideline that programs were considered to adhere to the need principle if the majority (51%) of the treatment targets were criminogenic needs (Hansen, et al., 2009). It was determined earlier that the treatment targets for Group B based on the outline are accountability, deviant sexual interest, sexual-occupation, attitudes towards sexual offending, intimacy deficits, and unhealthy coping including substance abuse, hostility, suppression of emotions, anti-social peers and behaviour, and impulsivity.   The employees provided insight into what, in practice, are treatment targets addressed in group B. The most significant of the targets were intimacy deficits (4.7 out 5) followed equally by deviant sexual interest, sexual pre-occupation, attitudes tolerant of sexual crime, poor cognitive problem solving and hostility (4.5 out of 5).   Of the twelve treatment targets considered by employees 3.2 out of 5 was the lowest score attributed.   It is important to note that a score of three was considered "somewhat important".   This means that facilitators felt that all of the twelve treatment targets identified by the CODC were considered more than "somewhat important" in Group B. Given the information provided by employees it is felt that Group B does adhere to the need principle.

Past group members were asked to consider the same twelve treatment targets as employee participants. The were asked to determine firstly if they felt the treatment target was a factor in their offending and if so how well did each of the groups assist them to understand that factor on a scale of 1 to 5 ("Not at all" to "I left with a good understanding").   It is valuable to get feedback from the participants of the group and Garret, Oliver, Wilcox, and Middleton (2003) suggest that views of service users should be considered as part of any evaluation. Past participants

provided Group A with a rating ranging from 2 as the lowest to 3 as the highest. Past

participants provided Group B with a rating of 5 for all twelve treatment targets.

While the rating provided by past participants (n=4) are not statistically significant it

is important to consider the pattern demonstrated by their answers, specifically that

Group B provided them with a better understanding of the issues related to their

offending.

It is an important consideration when interpreting the information gathered

from past group members are that they were asked for retrospective opinions on their

experiences. There are two issues that may have influenced past participants

feedback about the two groups. The first issue is that Group A would have been the

first group completed by past participants and Group B would have been the second.

Past participants would have only been referred to Group B if it was felt they either

did not gain enough insight and understanding from Group A or if they reoffended

after completing Group A.   Being that Group B was their most recent experience,

past group members may have been biased to feel more positively towards Group B.

The other issue worth considering is past group members may have felt they

benefited more from Group B because of their own personal situation at the time.

They may have more willing to engage and were in a more positive place in their

lives allowing them to be more open to gaining insight and open to personal growth.

Responsivity Principle

The Responsivity Principle is described by Andrews and Bonta (2006) as delivering programs in a manner that matches clients' learning style and ability. They feel that cognitive behavioural approaches offer the best influence over behaviour.

Group A

Group A is a closed group offering the Relapse Prevention Model delivered within a cognitive behavioural framework.   The assignments of Group A (behaviour chain, cognitive changes, escapes and avoidances with supporting changed cognitions) are cognitive behavioural in nature, focusing on getting the client to determine what his behaviours and supporting thoughts were that preceded the offence.   A major component of the Relapse Prevention program is victim empathy training which includes watching videos and discussion about victim impact and then later writing a letter from the victim to self and a letter to the victim (which is not sent). While these tasks are not cognitive behavioural, the intent is for clients to later integrate that knowledge into their future thinking in hopes of managing their behaviour.   Based on the CODC guideline that states if a program is delivered in a cognitive behavioural manner it is meeting the responsivity principle (Hansen et al., 2009) Group A can be considered to be adhering to the principle.

Group B

Group B is an open ended group that provides a process oriented intervention that is grounded in the client's life experiences and ongoing functioning and management of risk factors. It is delivered within a cognitive behavioural framework.

The pathways and offence cycle assignment both have the client identify their thoughts and feelings associated with a particular behaviour and life event.   The final assignment is developing a risk management plan which includes new or healthy coping to address the ineffective, unhealthy, offending coping. The essence of this assignment is challenging the old coping (behaviour and thinking) and cognitive restructuring.   Based on the CODC guideline stating that a program delivered in a cognitive behavioural manner is meeting the responsivity principle (Hansen et al., 2009) Group B can be considered to be adhering to the principle.

Specific Responsivity Principle

Marshall and Burton (2010) highlighted that in addition to the responsivity principle there is the specific responsivity principle to consider when discussing group process. The specific responsivity principle is the therapist's ability to respond to the unique characteristics of their clients. Employee participants identified a number of these specific responsivity issues that they felt were important in delivering an effective program. These issues went beyond whether or not the program was delivered in a cognitive behavioural manner. The main concerns raised by employees included the structure of group, readiness of the clients, and literacy of the client.

Based on the feedback provided by the employee participants it seemed there was a clear preference for Group B in meeting the specific responsivity principle. The open, flowing structure of Group B allowed facilitators to feel that they could allow clients to build relationships and trust within the group before being asked to

share their personal information. There was no pressure to push them ahead to the next assignment if they were not demonstrating readiness to do so. Group B's assignments are all process oriented, meaning they form out of discussion with the client about his life and offending behaviour. The facilitator is responsible for recording the information and structuring the information into the format of the assignments.

Alternatively Group A was viewed collectively by facilitators as having a number of weaknesses that would impede addressing the other responsivity concerns. Most significant appeared to be the rigid structure of the group.   Each assignment in Group A must be completed by all participants before the next assignment can be initiated. This means that a client who may be struggling with readiness might only have ten sessions before he has to do his assignment. Even if he is not ready he is required to move forward potentially leaving him feeling pressured, which in turn may prevent him from providing full disclosure of his criminogenic needs.   The assignments in Group A are almost exclusively written in advance by the client and then brought back to group for processing. This clearly sets the stage for any clients with language barriers, literacy issues, or cultural barriers to feel alienated by the process.

Again, it is an important consideration that the Group A being offered at Headingley Correctional Center is supplemented with one-to-one work which allows facilitators to address some of these issues and assist clients in completing their assignments. However within the group itself the opportunity and flexibility for the facilitators to respond to the needs of their clients is limited.

Therapeutic Alliance

The specific responsivity principle is closely linked to the importance of the therapeutic relationship. Many of the responsivity concerns of clients are addressed within the context of having established a therapeutic alliance between the facilitator and the client.

Employees who facilitated Group B felt that the group provided an environment that naturally allowed for the therapeutic relationship to build between clients and facilitators. Again, employees cited the open structure and no specific time lines as factors that contributed to facilitators feeling that they could take the time to get to know the clients, allow clients time to build trust with each other and the facilitator prior to discussing their life and offending histories. Allowing client to wait until a level of trust was established helped clients to openly discuss and problem solve relevant every day struggles they are facing. This is not to say that a therapeutic relationship cannot be built within Group A; however all the participants acknowledged it would be more challenging given the structure and time limitations of Group A. The main challenges identified for Group A are the rigid structure and sticking to the timelines allotted to complete the assignments. Once again, facilitators expressed the opinion that it is within the one-to-ones outside of the group process where facilitators really have the opportunity build a relationship with their clients. It should be noted that while one-to-ones offer a benefit, it also creates a deficit in the group members' ability to build trusting relationships with the other facilitator and group members.

The feedback provided by the current participants in their scoring of the Working Alliance Inventory for both Group A and Group B showed no major difference in their perception of the alliance with their facilitators.   However, it is important to point out that Group A scores higher than Group B specifically in the Task aspect of the scale. This showed a 4.5 point difference in favour of Group A. This is not unexpected when one considers the structure of Group A.   The Task aspect refers to the clients' perception that in-session actions are relevant (Horvath & Greenberg, 1989).   Given that Group A is structured almost solely around assignments rather than process, it is logical that clients may perceive in-session tasks as relevant.

Given the employees' positive perception of how well the structure of Group B facilitates opportunities to build relationships with clients over the structure of Group A it was unexpected that that the scores would be so similar between the groups with Group A in fact scoring higher. It seems clear from employee comments that Group A's structure does in fact limit the opportunities to build strong relationships with clients. It was suggested by employees and one may speculate that the one-to-one sessions being offered to supplement the Group A process is where the relationship development is taking place rather than in the group process itself.

 It remains an important finding that the scores from the clients' perspective demonstrated a similar perception regarding the facilitators from both groups. This likely comes back to facilitator skill and the individual facilitator's ability to build and maintain relationships. The issue of individual skill was also raised by employees.   While none of the employees identified this skill as basic Social Work

skill it is easy to draw parallels between them.   Social Work skill is the ability to deliver a program in a warm, empathetic, genuine (Kirst-Ashman & Hull, 1999) manner with warmth, respect, supportiveness, emotional responsivity, directiveness, rewardingness, and use of humor (Marshall & Burton, 2010).

Personal Satisfaction

Employee participants' feedback demonstrated two main issues related to personal satisfaction in facilitating the programs. These were frustration and perceived value to the clients.   Participants expressed frustration in how the structure of Group A prevented them from addressing issues they felt were relevant to the client's offending or management of risk. This frustration led to facilitators deviating away from the prescribed program to include tasks or expand on tasks that they felt would better meet the needs of the clients.   Participants also felt that they were providing a better service to the clients with Group B. They felt they were in a better position to help clients develop insight and develop risk management strategies. Employees expressed they experienced greater personal satisfaction in delivering Group B.

Personal satisfaction of employees should be an important consideration for management. Frustration and growing feelings of one's inability to effect change in our clientele can lead to increased risk for burn out for employees.

It is important to discuss the influence of the real world demands on the employees and program managers who work with sexual offenders and who are facilitating the groups.   The employees presented as having a comprehensive

understanding of the principles of risk, need, and responsivity and an appreciation for their importance in offering effective programming.   It can be speculated that despite best intentions to ensure that these principles are being met there are barriers evident which limit their abilities. The barriers are often political or bureaucratic in nature. There is limited funding to adopt new risk tools and to provide the required training to staff. Depending on the political climate there may be pressure to ensure that all sexual offenders receive intervention.   Despite best efforts and intentions it is not always a clear decision to include or exclude clients from groups. Employees can be faced with ethical dilemmas. For example, if they strictly adhere to the risk principle and exclude a lower risk client from group despite their feelings that he may be higher risk and he reoffends will the employee feel responsible for the harm done to yet another victim?

Chapter Six

CONCLUSION AND RECOMMENDATIONS

Conclusion

A stated goal of this research was that a conclusion about which of the two

programs would be better suited to Manitoba Corrections mandate to "have the lowest

recidivism rates in Canada" would be drawn.   The literature has repeatedly invokes

adherence to the principles of risk, need, and responsivity in order to provide the best

opportunity to reduce recidivism (Andrews & Bonta, 2006; Hansen et al., 2009).   It

is felt that Group B, the open ended cognitive behavioral program would be the

program that has the best opportunity to effect change within clients, thereby

reducing their risk to reoffend.   It was determined that Group A adhered to one of the

three principles (responsivity) and that Group B adhered to two of the three principles

(need and responsivity).   The main area where group A was lacking was in meeting

the need principle and according to Hansen et al. (2009) this is the most important of

the three principles when considering programming for sexual offenders.   The

feedback from the current participants in the groups on therapeutic alliance appeared

to be relatively equal.   There was no significant difference in how the clients

perceived the facilitators suggesting that this would not be a determining issue in

deciding which program is better.

It is also important to highlight that while Group A does adhere to the

principle of responsivity based on the CODC guidelines (Hansen et al., 2009) there

were other responsivity concerns (specific responsivity principle) raised by all of the

employee participants. These responsivity issues (client readiness, building trust,

group cohesion) were difficult to address due to the structure and time limitations of

Group A.   It is also important to note that while Group A is delivered in a cognitive

behavioral framework the model of relapse prevention has received significant

criticism for failing to account for the complexities of the offenders who do not

follow the RP path to reoffending (Hudson et al., 1999, Laws et al, 2000, Yates &

Kingston, 2006, Ward & Hudson, 2000).

Group B is also delivered in a cognitive behavioral format and the

assignments are based on some of the more current research that is showing promise

with sexual offenders such as the Self-Regulation Pathways Model (Ward & Hudson,

1998, 2000), the Good Lives Model (Ward & Stewart, 2003), and the Pathways

Model put forth by Ward and Seigert (2002).   While all of these models are relatively

new in the field of sexual offender treatment there is some research to show that they

offer a more comprehensive understanding of how clients offend.   There is no doubt

that further research needs to be done on the long term effectiveness of these models.

Recommendations

There are five recommendations arising arose from this research with respect to

sexual offender programs being offered by Manitoba Justice.   It was apparent that

with a few exceptions there was consensus among employee participants about the

benefits and limitations between the two groups.

1. Consistent Programming

It is recommended that Manitoba Justice adopt Group B as the one program that can be run by both Probation Services and Headingley Correctional Center.   It is my personal opinion that is very important for groups to be continued to be offered in both locations. The benefits of offering the same program in both locations would be the ability to transfer clients easily between the two locations.   There are clients who complete program at Headingley that are later supervised by Probation Services in Winnipeg.   Attending a maintenance group following completion of the core sexual offender program is a common recommendation.   It would be beneficial for all of the clients to have completed the same program. More importantly there are occasions where clients are excluded from the group at Headingley due to lack of time. If both locations were running the same open program it would be feasible that clients could begin programming at Headingley and transition to the Probation program when their term of incarceration expires.   This could be potentially very significant for clients who live in the northern regions of Manitoba where there no sexual offender specific intervention provided. These clients could begin their group at Headingley and transition in the community group when their time expires and be supported by Employment and Income Assistance while completing program and then return to their home communities upon completion.   Many of the northern clients face additional obstacles related to cultural and societal issues that increase their risk for recidivism.   A model that would allow for them to complete treatment before returning to their home communities may significantly impact their risk to recidivate.

This was done for a brief period of time when there was a Group B offered at

Headingley and this proved to be a relatively smooth transition for clients.

2. Education and Mentorship

It has been established that an important part of the success of any

intervention is the skill of the facilitator. The ability to develop and maintain a

therapeutic relationship with the clients in the group is as important in effecting

change as the intervention being provided. The required skills and characteristic of

facilitators as identified by Dowden and Andrews (2004) and Marshall and Burton

(2010) are also key social work skills. When selecting who will be facilitating sexual

offender programs employees who have an educational background in social work or

other counseling education and/or experience should be given a preference.

Marshall and Burton (2010) also discuss the importance of providing training

to facilitators who are delivering group programs. Marshall has developed a training

program for therapists working with sexual offenders that emphasizes the therapeutic

process. Further investigation into this type of training program for existing

facilitators may be beneficial.

3. Ongoing Evaluation

It is recommended that Manitoba Justice begin planning for how a long term

evaluation of the sexual offender program can be undertaken.   It is recommended

that the department first establish a comprehensive data base in a statistical program.

Secondly, it is recommended that the department begin pre and post testing to

measure change for clients who are participating in the group programs. And lastly,

the department should develop a plan to track clients' recidivism over time. If these

recommendations were in place it would increase the likelihood that any future evaluation could be more easily conducted with available data and provide valuable information.

4.   Keep Current with Evidence Based Practice

It is recommended that current literature in the field of sexual offender intervention be attended to and integrated where appropriate into the group program. This should be an ongoing duty of program managers and facilitators of the group programs and time should be granted to employees to complete this task. It should not be considered a luxury or something that is undertaken by motivated staff on their personal time.

5.   Secondary Risk Tool

It is strongly recommended that the department look at adopting a secondary (dynamic) risk tool to assist staff in accurately identifying clients' risk to reoffend sexually.   This is clearly a deficit identified by all employees in the effective management of their clientele. If there was a validated secondary risk tool available for employees it would make adhering to the risk principle a much more realistic target. To suggest which secondary tool would be best is beyond the scope of this paper.

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Appendix A

[Letterhead]

December 21, 2010

Re: Invitation to Participate in a Comparison of MB Justice Programs

Dear Mr. X:

You are invited to participate in an interview regarding Manitoba Justice's Sexual Offender Programs. You are being chosen because you participated in two different programs offered by Manitoba Justice. Your experiences and opinions on the similarities and differences of the programs are a valuable part of evaluating the programs.

Your participation is completely voluntary and you are free to decline or withdraw at any point without negative consequence now or in the future.   Your participation will include an interview in which you will be asked to share your opinions about your experience while in group. Examples of questions that will be asked include:

- How well did the groups help you to develop a better understanding of why you offended?
- How comfortable did you feel sharing your personal information in the groups?
- How well did you feel the groups helped you to develop a plan to avoid offending in the future?
- A series of questions related to identifying what you think were contributing factors to your offending including alcohol and drugs, anti-social lifestyle, employment, impulsivity, and negative peers are examples.

All of your opinions are **<u>confidential</u>** and only the researcher and researcher's supervisor will have access the data collected for the study. The interview should take approximately 45 minutes of your time.

You will be given $25 at the beginning of the interview to compensate your time and expense for attending the interview.   The interview will be held at 225 Garry Street and the time will be arranged between yourself and the interviewer.

If you are interested in participating in this important study please contact Lisa Ginter directly at 945-8986.

Primary Researcher:
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lisa.ginter@gov.mb.ca

Research Supervisor and Committee Chair:
Denis Bracken, Ph.D.
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Lisa Ginter   Dr. Denis Bracken
Social Work Student   Student Advisor
Probation Officer   Faculty of Social Work
225 Garry Street   University of Manitoba
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Appendix B

[Letterhead]

Participant Name

February 2, 2011

Research Project Title: **A Comparison of Two Manitoba Justice Sexual Offender Programs.**

Primary Researcher:
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Research Supervisor and Committee Chair:
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bracken@cc.manitoba.ca

This research will be conducted for completion of the Masters Thesis and will be supervised by Dr. Denis Bracken.

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

Invitation: You are invited to participate in an interview regarding Manitoba Justice's Sexual Offender Programs. You are being chosen because you participated in two different programs offered by Manitoba Justice. Your experiences and opinions on the similarities and differences of the programs are a valuable part of evaluating the programs.

Purpose: There are two purposes to this research. The first is to examine the therapeutic alliance that exists in group therapy from the clients' perspective. The second purpose is to examine how each of the two programs offered by Manitoba Justice adheres to models of effective intervention.

Your Participation: Participants in this study will be interviewed using a prepared interview guide that uses open ended questions. Each participant will be interviewed in person by a researcher who has not been involved in the program. The interview should take approximately 45 minutes to one hour. The interviews will be tape recorded, while the researcher takes notes. If at any point a participant is uncomfortable with their answers being tape recorded, the researcher will take written notes only for the duration of the interview and stop the recording devise.

Reminder: Your participation is voluntary and you are free to decline or withdraw at any point during the interview. You have the right to withhold consent, or withdraw consent at any time without negative consequences now or in the future (legal, employment, or other).

Harm: Participants in this research will not be in any risk of harm that is greater than what one would experience in normal everyday life. Your participation is entirely voluntary.

Questions: The questions that will be asked are simple and based on your opinion and experience in the program offered by Manitoba Justice. The following are not all of the questions that will be asked by will give you an idea of what will be asked.
- How comfortable did you feel sharing your personal information in the groups?
- How accountable did you feel in each of the groups?
- Do you feel that your risk factors were addressed in the groups?
- Do you feel that you had a plan to manage your risk at the completion of the program?

Interview Space, Date, and Time: Interviews will be held in an empty office at 225 Garry Street. The date and time of the interviews is to be determined between your schedule and the researcher.

Confidentiality: Only the researcher and the researcher's supervisor will have access to the data collected for this study. Confidentiality will be maintained by keeping only an identification number on the data collection forms that will be kept in a locked cabinet off site. Names will not be attached to interview forms and completed interviews will be stored in a locked file cabinet. Interview tapes will be destroyed after the interviews have been transcribed.

Distribution of Findings: If you wish to receive the notes from your interview I will forward a copy of them within a week. Please leave your email address, address, or

another way of contacting you if you wish to receive a copy of the interview. A summary of the findings will be available to you should you be interested at the conclusion of this research (approximately May 2010). You may indicate your interest in receiving a summary at the end of this consent form.

Remuneration: You will be provided with $25 to cover the cost of transportation and your time for participating in the study. This money will be given to you prior to the interview.

Your signature on this form indicated that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researchers, sponsors or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation. You may contact the researcher, Lisa Ginter at 945-8986 or research supervisor, Dr. Denis Bracken at 474-8581 should you have any questions.

This research has been approved by the Psychology/Sociology Review Ethics Board. If you have any concerns or complaints about this project you may contact any of the above names persons or the Human Ethics Secretariat at 474-7122. A copy of this consent for has been given to you to keep for your records and reference.

Participant's Signature   Date

Researcher and/or Delegate's Signature   Date
___Yes, I would like a copy of the interview
___No, I do not want a copy of the interview

___Yes, I would like to receive a summary of the findings of the study
___No, I would not like to receive a summary of the findings of the study

If you chose to receive a copy of the interview or summary of findings please indicate what method of communication you prefer and your address.
Email_____
Mailing
Address_____
Other
method_____

Appendix C

[Letterhead]

Research Project Title: **A Comparison of Two Manitoba Justice Sexual Offender Programs**.

Primary Researcher:
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Research Supervisor and Committee Chair:
Denis Bracken, Ph.D.
Faculty of Social Work
University of Manitoba
(204)474-8581
bracken@cc.manitoba.ca

This research will be conducted for completion of the Masters Thesis and will be supervised by Dr. Denis Bracken.

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

Invitation: You are invited to participate in an interview regarding Manitoba Justice's Sexual Offender Programs. Your experience and opinions on your group experience are very important.

Purpose: There are two purposes to this research. The first is to examine the therapeutic alliance that exists in group therapy from the clients' perspective. The second purpose is to examine how each of the two programs offered by Manitoba Justice adheres to models of effective intervention.

Your Participation: Participants in this study will be given a questionnaire called the Working Alliance Inventory that has 36 questions. This should take about 45 minutes. The questions will be read to you out loud and then you can circle your response.
Reminder: Your participation is voluntary and you are free to decline or withdraw at any point during the questionnaire. You have the right to withhold consent, or withdraw consent at any time without negative consequences now or in the future (legal, employment, or other).

Harm: Participants in this research will not be in any risk of harm that is greater than what one would experience in normal everyday life. Your participation is entirely voluntary.

Questions: The questions you will be asked are on a questionnaire called the Working Alliance Inventory which has been widely used to determine clients' opinion on their group experience,

Interview Space, Date, and Time: You will be asked to complete the questionnaire during your regular group time.

Confidentiality: Only the researcher and the researcher's supervisor will have access to the data collected for this study. Confidentiality will be maintained by keeping only an identification number on the data collection forms that will be kept in a locked cabinet off site. Your name will not be attached to your questionnaire and completed questionnaires will be stored in a locked filing cabinet.

Distribution of Findings: A summary of the findings will be available to you should you be interested at the conclusion of this research (approximately December 2010). You may indicate your interest in receiving a summary at the end of this consent form.

Remuneration: You will not receive any credit or remuneration for participating in this research.

Your signature on this form indicated that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researchers, sponsors or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

You may contact the researcher, Lisa Ginter at 945-8986 or research supervisor, Dr. Denis Bracken at 474-8581 should you have any questions.

This research has been approved by the Psychology/Sociology Review Ethics Board. If you have any concerns or complaints about this project you may contact any of the above names persons or the Human Ethics Secretariat at 474-7122. A copy of this consent for has been given to you to keep for your records and reference.

_____

Participant's Signature   Date

_____

Researcher and/or Delegate's Signature   Date

___Yes, I would like to receive a summary of the findings of the study
___No, I would not like to receive a summary of the findings of the study

If you chose to receive a summary of findings please indicate what method of communication you prefer and your address.
Email_____
Mailing
Address_____
Other
method_____

Appendix D

[Letterhead]

December 1, 2010

Research Project Title: **A Comparison of Two Manitoba Justice Sexual Offender Programs**.

Primary Researcher:
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bracken@cc.manitoba.ca

This research will be conducted for completion of the Masters Thesis and will be supervised by Dr. Denis Bracken.

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

Invitation: You are invited to participate in an interview regarding Manitoba Justice's Sexual Offender Programs.

Purpose: There are two purposes to this research. The first is to examine the therapeutic alliance that exists in group therapy from the clients' perspective. The second purpose is to examine how each of the two programs offered by Manitoba Justice adhere to the Risk, Need, and Responsivity Principles that have been widely accepted as the model for effective intervention with criminal offenders.

If you are interested in participating in this research please contact the researcher, Lisa Ginter, directly at 945-8986

Your Participation: Participants in this study will be interviewed using a prepared interview guide that uses open ended questions as well as a Likert Scale questions. Each participant will be interviewed in person by the researcher. The interview should take approximately 45 minutes to one hour. The interviews will be tape recorded while the researcher takes notes. If at any point a participant is uncomfortable with their answers being tape recorded, the researcher will take written notes only for the duration of the interview and stop the recording devise.

Reminder: Your participation is voluntary and you are free to decline or withdraw at any point during the interview. You have the right to withhold consent, or withdraw consent at any time without negative consequences now or in the future (legal, employment, or other).

Harm: Participants in this research will not be in any risk of harm that is greater than what one would experience in normal everyday life. Your participation is entirely voluntary.

Questions: You will find an attached interview guide with the questions that will you will be asked. Please note that Group A refers to the Closed Relapse Prevention Program and Group B refers to the Open Cognitive Behavioral Program

Interview Space, Date, and Time: Interviews will be held in an empty office at either 225 Garry Street, at Assiniboine Treatment Center at Headingley Correctional Center, or another neutral location agreed upon by the researcher and yourself. The date and time of the interviews is to be determined between your schedule and the researcher.

Confidentiality: Only the researcher and the researcher's supervisor will have access to the data collected for this study. Confidentiality will be maintained by keeping only an identification number on the data collection forms that will be kept in a locked cabinet off site. Names will not be attached to interview forms and completed interviews will be stored in a locked file cabinet. Interview tapes will be destroyed after the interviews have been transcribed. It is important to be aware that an informed reader, such as another employee of Manitoba Justice, may be able to speculate which facilitator provided certain responses. However, please know that care will be taken to exclude any identifying responses. Only the researcher and the research supervisor will know who participated in the research. Manitoba Justice will not have access to this information.

Distribution of Findings: If you wish to receive the notes from your interview I will forward a copy of them within a week. You will be able to make changes at that time. Please leave your email address, address, or another way of contacting you if you wish to receive a copy of the interview. A summary of the findings will be

available to you should you be interested at the conclusion of this research (approximately May 2011). You may indicate your interest in receiving a summary at the end of this consent form. A summary of the findings will provided to you once all of the current participants in your program have completed. This measure is taken to assure there is no vulnerability to your current participants.

Remuneration: You will not receive any credit or remuneration for participating in this research.

Your signature on this form indicated that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researchers, sponsors or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

You may contact the researcher, Lisa Ginter at 945-8986 or research supervisor, Dr. Denis Bracken at 474-8581 should you have any questions.

This research has been approved by the Psychology/Sociology Review Ethics Board. If you have any concerns or complaints about this project you may contact any of the above names persons or the Human Ethics Secretariat at 474-7122. A copy of this consent for has been given to you to keep for your records and reference.

_____
Participant's Signature   Date

_____
Researcher and/or Delegate's Signature   Date
___Yes, I would like a copy of the interview
___No, I do not want a copy of the interview
___Yes, I would like to receive a summary of the findings of the study
___No, I would not like to receive a summary of the findings of the study
If you chose to receive a copy of the interview or summary of findings please indicate what method of communication you prefer and your address.
Email_____
Mailing
Address_____
Other
method_____

Appendix E

<u>Employee Participant Questions</u>

1. How do you determine your client's risk?

2. Do you feel that you have all the tools you need available to allow you to accurately determine your client's risk to sexually reoffend?

3. How well do you feel Group A addresses the Risk Principle?

1	2	3	4	5
Very Poorly	Poorly	Somewhat	Fairly Well	Excellent

4. How well do you feel Group B addresses the Risk Principle?

1	2	3	4	5
Very Poorly	Poorly	Somewhat	Fairly Well	Excellent

5. How do you determine what your client's Criminogenic needs are?

6. How well do you feel Group A addresses the Need Principle in addressing criminogenic needs of participants?

1	2	3	4	5
Very Poorly	Poorly	Somewhat	Fairly Well	Excellent

7. How well do you feel Group B addresses the Need Principle in addressing criminogenic needs of participants?

1	2	3	4	5
Very Poorly	Poorly	Somewhat	Fairly Well	Excellent

8. How do you determine what your client's responsivity needs are (i.e. learning style, level of intelligence)?

9. How well do you feel Group A addresses the Responsivity Principle in meeting the learning needs of your participants?

1	2	3	4	5
Very Poorly	Poorly	Somewhat	Fairly Well	Excellent

10. How well do you feel Group B addresses the Responsivity Principle in meeting the learning needs of your participants?

1	2	3	4	5
Very Poorly	Poorly	Somewhat	Fairly Well	Excellent

11. Having facilitated both groups did you feel you had equal ability to build a therapeutic relationship with your clients?

12. Please explain what the benefits and limitations of Group A were in developing a therapeutic alliance?

13. Please explain what the benefits and limitations of Group B were in developing a therapeutic alliance?

14. Based on your personal experience which group, A or B, did your clients present as more engaged and committed to the process and why?

15. Based on your personal experience which group, A or B, did you find more personally satisfying to facilitate and why?

Which of the following treatment targets do you feel Program A attends to? For those that are relevant please rate the importance (in terms of focus, duration, etc) of each within the group process.

RATE:

1	2	3	4	5
Little importance		Somewhat important		Very important

antisocial lifestyle

impulsivity

employment instability

negative peer associations

aimless use of leisure time

substance abuse

poor cognitive problem solving

hostility

deviant sexual interest

sexual pre-occupation

attitudes tolerant of sexual crime

intimacy deficits.

Which of the following treatment targets do you feel Program B attends to? For those that are relevant please rate the importance (in terms of focus, duration, etch) of each within the group process.

RATE:

1	2	3	4	5
Little importance		Somewhat important		Very important

antisocial lifestyle

impulsivity

employment instability

negative peer associations

aimless use of leisure time

substance abuse

poor cognitive problem solving

hostility

deviant sexual interest

sexual pre-occupation

attitudes tolerant of sexual crime

intimacy deficits.

Appendix F

Past Participant Questions

1. **How comfortable did you feel sharing your personal information and feelings in Group A?**

1   2   3   4   5
Not at all   Occasionally   All the time

Tell me why you picked that?

_____

2. **How comfortable did you feel sharing your personal information and feelings in Group B?**

1   2   3   4   5
Not at all   Occasionally   All the time

Tell me why you picked that?

_____

3. **How accountable for your offending behavior (present and past offences) did Group A hold you?**

1   2   3   4   5
Not at all   Only partially   All the time

Tell me why you picked that?

_____

4. **How accountable for your offending behavior (present and past offences) did Group B hold you?**

1   2   3   4   5
Not at all   Only partially   All the time

Tell me why you picked that?

_____

5. How well do you feel Group A helped you to develop a better understanding about why you offended?

1	2	3	4	5
Not at all why		Only partially		I completely understood

Tell me why you picked that?

_____

6. How well do you feel Group B helped you to develop a better understanding about why you offended?

1	2	3	4	5
Not at all why		Only partially		I completely understood

Tell me why you picked that?

_____

7. How well do you feel Group A helped you develop a plan to avoid offending in the future?

1	2	3	4	5
Not at all		Only partially		I had a complete plan

Tell me why you picked that?

_____

8. How well do you feel Group B helped you develop a plan to avoid offending in the future?

1	2	3	4	5
Not at all		Only partially		I had a complete plan

Tell me why you picked that?

_____

9. Do you feel that living an anti-social lifestyle was a contributing factor in your offence?

If yes, how well do you feel Group A helped you to address that risk factor?

1	2	3	4	5
Not at all		Only partially		I left with a good understanding

How well do you feel group B helped you to address that risk factor?

1	2	3	4	5
Not at all		Only partially		I left with a good understanding

---

10. Do you feel that employment instability was a contributing factor in your offending? If yes,

How well do you feel group A helped you to address that risk factor?

1	2	3	4	5
Not at all		Only partially		I left with a good understanding

How well do you feel group B helped you to address that risk factor?

1	2	3	4	5
Not at all		Only partially		I left with a good understanding

---

11. Do you feel that how you spent your leisure and recreational time was a contributing factor in your offending? If yes,

How well do you feel group A helped you to address that risk factor?

1	2	3	4	5
Not at all		Only partially		I left with a good understanding

How well do you feel group B helped you to address that risk factor?

1	2	3	4	5
Not at all		Only partially		I left with a good understanding

---

12. Do you feel that alcohol and/drug abuse was a contributing factor in your offending? If yes,

How well do you feel group A helped you to address that risk factor?

1	2	3	4	5
Not at all		Only partially		I left with a good understanding

How well do you feel group B helped you to address that risk factor?

1	2	3	4	5
Not at all		Only partially		I left with a good understanding

---

13. Do you feel that impulsivity was a contributing factor in your offending? If yes,

How well do you feel group A helped you to address that risk factor?

1	2	3	4	5
Not at all		Only partially		I left with a good understanding

How well do you feel group B helped you to address that risk factor?

1	2	3	4	5
Not at all		Only partially		I left with a good understanding

---

14. Do you feel that negative peer associations were a contributing factor in your offending? If yes,

How well do you feel group A helped you to address that risk factor?

1	2	3	4	5
Not at all		Only partially		I left with a good understanding

How well do you feel group B helped you to address that risk factor?

1	2	3	4	5
Not at all		Only partially		I left with a good understanding

---

15. Do you feel that poor problem solving was a contributing factor in your offending? If yes,

How well do you feel group A helped you to address that risk factor?

1	2	3	4	5
Not at all		Only partially		I left with a good understanding

How well do you feel group B helped you to address that risk factor?

1	2	3	4	5
Not at all		Only partially		I left with a good understanding

---

16. Do you feel that hostility was a contributing factor in your offending? If yes,

How well do you feel group A helped you to address that risk factor?

1	2	3	4	5
Not at all		Only partially		I left with a good understanding

How well do you feel group B helped you to address that risk factor?

1	2	3	4	5
Not at all		Only partially		I left with a good understanding

---

17. Do you feel that you experiencing sexual pre-occupation prior to your offence and was this a contributing factor in your offending? If yes,

How well do you feel group A helped you to address that risk factor?

1	2	3	4	5
Not at all		Only partially		I left with a good understanding

How well do you feel group B helped you to address that risk factor?

1	2	3	4	5
Not at all		Only partially		I left with a good understanding

---

18. Do you feel that relationship issues or intimacy deficits (such as not connecting with your partner, not expressing your own emotions) was a factor in your offending? If yes,

How well do you feel group A helped you to address that risk factor?

1	2	3	4	5
Not at all		Only partially		I left with a good understanding

How well do you feel group B helped you to address that risk factor?

1	2	3	4	5
Not at all		Only partially		I left with a good understanding

---

19. Do you feel that you held attitudes or beliefs that were tolerant of sexual abuse or crimes and do you feel it was a contributing factor in your offending? If yes,

How well do you feel group A helped you to address that risk factor?

1	2	3	4	5
Not at all		Only partially		I left with a good understanding

How well do you feel group B helped you to address that risk factor?

1	2	3	4	5
Not at all		Only partially		I left with a good understanding

---

20. Do you feel that you had a deviant sexual interest that was a contributing factor in your offending? If yes,

How well do you feel group A helped you to address that risk factor?

1	2	3	4	5
Not at all		Only partially		I left with a good understanding

How well do you feel group B helped you to address that risk factor?

1	2	3	4	5
Not at all		Only partially		I left with a good understanding

Appendix G

Definitions

Group A – this group is the first group that you took part it. You initially would have done an autobiography and then later developed a behavior and thought chain that led up to your offence. It also looked at developing escapes and avoidances to prevent any future offending. You would have started and finished this group with the same group of men.

Group B – this would have been the second group you took part in. In this group you completed a pathways, offence cycle, and wellness plan. As part of this group you would have had two or three men graduate and two or three new men would join the group as participants.

Anti Social Behavior – this can be defined as behavior that can often lead to trouble in your life such as not working or going to school, conflict or fights in your relationships with family and friends, substance abuse, generally not following the "rules, or paying your bills or being able to keep your residences

Employment Instability – lack of regular employment, either through lack of desire or getting let go for poor performance, changing your job frequently

Leisure and Recreational time – this is what you do with your time outside of work or school.

Alcohol and Drug Abuse – this refers to your use of alcohol or drugs.   This may include binge drinking or using drugs occasionally.

Impulsivity – this can include doing things that you know you shouldn't but do anyways (examples include reckless driving, substance abuse, partying, quitting jobs with no other job to go to, moving frequently). This includes behavior that has a likelihood of negative consequences (either legally or with your partner or family)

Negative Peer Associations – this refers to what type of friends you may have been spending time with. Were your friends the type you helped you avoid getting into trouble or were your friends the type you typically would get into trouble with (such as substance abuse, partying, any criminal activity, etc)

Poor Problem Solving – you may have trouble identifying what problems you have to work on and have difficulty coming up with good or reasonable solutions to your problems.   Sometimes this can also include not having a long term plan or recognizing consequences for your actions.

Hostility – this means feeling angry or resentful towards others a big part of the time, this can also include angry or negative feelings that might feel excessive for the situation (totally freaking out over getting cut off in traffic), or it might include being "explosive".

Sexual Pre-occupation – this involves the frequency of your sexual thoughts and Behaviors. Consider if your thoughts or behavior related to sex got in the way or employment, school, or relationship with others. This might include use of pornography, attending strip clubs, casual sex or impersonal sex, multiple sexual partners, trouble controlling your own sexual impulses, disturbing sexual thoughts or anything that you think was just plain excessive.

Intimacy Deficits – can include not connecting with your partner, not being able to express your own emotions, or simply not having a been able to establish a meaningful intimate relationship with another adult.

Attitudes Tolerant of Sexual Abuse - this can be defined as beliefs that sometimes justify abuse or assaults such as "men need sex more than women", "everybody is entitled to sex", "some children enjoy sex with adults", "not all children are harmed by having sex with adults" or "if children don't say no, they want the sexual activity to continue".

Deviant Sexual Interest – this can be defined as having an interest in inappropriate or illegal sexual activity.   This would show up in your life as having more of a preference for this type of sexual activity instead of an age appropriate, healthy sexual relationship.