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The Good Lives Model (GLM) in Theory and Practice

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Abstract

The Good Lives Model (GLM) is a strengths-based rehabilitation theory that augments the risk, need, and responsivity principles of effective correctional intervention through its focus on assisting clients to develop and implement meaningful life plans that are incompatible with future offending. During the decade of its existence, the GLM has seen advances in its underlying theory and application, as well as in its popularity, although empirical support for its application in practice remains in its infancy. This article briefly reviews the evolution of the application of the GLM, describes new and more accessible terminology for key GLM constructs, and offers ideas for situating traditional treatment programme components within the GLM framework. This brief article is intended to provide a summary of recent developments from existing texts on the application of the GLM.

Introduction

The Good Lives Model (GLM; Ward & Gannon, 2006; Ward & Stewart, 2003) has become increasingly popular in sexual offending treatment programmes (McGrath, Cumming, Burchard, Zeoli, & Ellerby, 2010) and is in use in diverse jurisdictions around the world. The GLM is a strengths-based approach to offender rehabilitation that augments the risk, need, and responsivity principles of effective correctional intervention (RNR; Andrews & Bonta, 2010) through its focus on assisting clients to develop and implement meaningful life plans that are incompatible with offending. Preliminary research suggests that the GLM can enhance client engagement in treatment and reduce dropouts from programmes (e.g., Simons, McCullar, & Tyler, 2006), a factor well-known to be associated with higher recidivism rates (Hanson, et al., 2002; Olver, Stockdale, & Wormith, 2011). This article reviews the evolution of the application of the GLM since its introduction, describes recently developed accessible terminology for key constructs, and offers suggestions for applying the GLM in traditional treatment programmes.

In brief, a central assumption of the GLM is that offending results from problems in the way an individual seeks to attain primary human goods, which reflect certain states of mind, outcomes, and experiences that are important for all humans to have in their lives. Examples include happiness, relationships/friendships, and experiencing mastery in work and leisure activities. Identifying the primary goods that are most important to clients, and those that are implicated in the offence process, constitutes a fundamental component of assessment because treatment explicitly aims to assist clients to attain these primary goods in personally meaningful, rewarding, and non-harmful ways in addition to addressing re-offence risk (Ward, Yates, & Long, 2006; Yates, Prescott, & Ward, 2010; Yates & Ward, 2008). Within the GLM, in addition to representing risk factors for recidivism, criminogenic needs are conceptualised as obstacles that block or otherwise frustrate pro-social attainment of primary human goods. They are therefore directly targeted in treatment as a crucial step towards assisting clients to attain primary goods in their lives. In this way, clients become invested in the treatment process because treatment explicitly aims to assist them to live a fulfilling life in addition to reducing and managing risk. As suggested by Ward, Mann, & Gannon (2007) "…offenders want better lives not simply the promise of less harmful ones" (pp. 106). It is beyond the scope of the current article to describe the GLM theory and its development in detail. However, Key developments in recent years include its alignment with desistance theory and research (Laws & Ward, 2011) and integration with the Self-Regulation Model – Revised (SRM-R; Yates, et al., 2010; Yates & Ward, 2008). Several journal articles, books, book chapters, and guides for implementation are available that provide comprehensive descriptions of the GLM theory, including these recent developments (Laws & Ward, 2011; Ward & Maruna, 2007; Ward, Yates, & Willis, 2012; Willis & Yates, in press; Yates, et al., 2010).

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Ward and colleagues first proposed the GLM over a decade ago (Ward, 2002; Ward & Stewart, 2003), however, its operationalisation in practice has been much more recent (Willis, Yates, Gannon, & Ward, in press; Yates & Prescott, 2011b; Yates, et al., 2010). Not surprisingly, as with any new model, technique, or approach, its application has not been without problems. Many professionals first learned about the GLM at professional conferences and in journal articles and book chapters in the absence of more comprehensive training and implementation packages (e.g., Ward, et al., 2006; Yates, Kingston, & Ward, 2009; Yates & Prescott, 2011b; Yates, et al., 2010). As a consequence, there was a tendency for programmes to adopt elements of the GLM without necessarily re-designing their philosophical underpinnings, mission statements, supervisory activities, or programme manuals and materials. For example, while some programmes may have replaced RP-based avoidant goals with more positive and forward-looking approach goals, others have not. Still others have attempted to apply avoidance-based approaches to achieving primary goods. Furthermore, programmes replacing avoidant goals with approach goals have done so typically without assessing primary human goods and developing intervention plans based on the GLM (Willis, Ward, & Levenson, in press). In the absence of concise, comprehensive resources for implementation, many programmes interested in the GLM have been challenged in their capacity to fully and comprehensively implement the GLM. The resulting well-intended but haphazard approaches have sometimes resulted in programmes claiming to follow the GLM that are each different in their understanding and implementation of the GLM. In the first years of its existence, there were few resources for clinicians for the GLM, such as structured methods for assessing and examining the role of primary goods in the life and offence process of each client. As a result, it was common to find that programmes attempting to implement aspects of the GLM were in fact implementing strategies that were not always in keeping with the tenets of the GLM; for example, simply adding a GLM module or component onto the end of a traditional risk-oriented treatment programme (Willis, Ward, et al., in press). Introducing the GLM at the end of a treatment programme is considered too late because the potential for enhancing client engagement in each stage of treatment has been lost, and because this approach does not allow for examination of the relationships between GLM constructs, such as primary goods, and offending and risk factors. More recently, an assessment protocol (Yates, et al., 2009), clinicians' guide (Yates, et al., 2010), client workbook (Yates & Prescott, 2011b), and overview for integrating the GLM into structured treatment programmes (Willis, Yates, et al., in press) have become available, in order to better aid clinicians to implement a fully informed GLM approach to treatment.

As trainers in the practical application of the GLM, the authors have identified specific obstacles which, once overcome, have the potential to improve its application in treatment. Specifically, some clinicians have acknowledged difficulties understanding and applying GLM terminology as a result of its initial theoretical presentation, as well as determining how the GLM can be effectively integrated with treatment modules targeting criminogenic needs. The GLM primary goods are abstract concepts that were not initially intended for direct use with clients; however, in the absence of more concrete terminology and application to practice, the theoretical terminology has been used in clinical practice, which has resulted in some confusion for practitioners and clients alike. In the following sections we introduce readers to more accessible terminology for each of the GLM primary goods – to which we refer as common life goals (Yates & Prescott, 2011a) – and outline how each of the common life goals and broader GLM concepts align with the typical module or phase-based structure of best-practice sexual offending treatment programmes (i.e., programmes that adhere to the RNR principles, use cognitive-behavioural methods, and employ therapists who demonstrate positive therapist characteristics; e.g., Hanson, et al., 2002; Lösel & Schmucker, 2005; Marshall, 2005; Yates, 2002). In doing so, it is our hope to make the GLM increasingly accessible to practitioners and to promote a positive approach to treatment and the change process itself. After all, treatment programmes for sexual aggression have historically been a challenging environment for all involved (Marshall, 2005; Prescott, 2013). Clinicians have often been expected to focus on full disclosure of past sexual aggression to the detriment of the client taking responsibility for future actions (Ware & Mann, 2012). Such a focus can preclude identification of strengths and goal pursuits that, together with risk management strategies, can help clients remain safe in the community.

Primary Human Goods/Common Life Goals

The GLM primary human goods were identified through an extensive review and synthesis of psychological, social, biological, and anthropological research (Ward & Stewart, 2003). Initial descriptions of the GLM proposed 10 primary human goods, while Purvis (2010) has suggested the separation of one of the initially proposed primary goods into two separate primary goods, suggesting the possibility of 11 primary human goods. In addition, the terminology associated with these goods has been explicitly revised (Yates & Prescott, 2011a) in order to be more accessible to

clinicians and clients than previous terminology, and to reflect common life goals in order to emphasise the importance of the goods to all individuals. Table 1 (derived from Ward & Gannon, 2006; Yates & Prescott, 2011a; Yates & Prescott, 2011b; Yates, et al., 2010) lists primary goods, common life goals, and their definitions. Examples of associated secondary or instrumental goods, which represent the concrete activities or means through which primary goods are attained, are also provided. Secondary goods can be pro-social or antisocial, and examples of each are provided.

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

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

Integrating Common Life Goals with Traditional Treatment Components

Critical to using the GLM and in keeping with the needs principle of effective correctional interventions (Andrews & Bonta, 2010) is the assessment of criminogenic needs. The key difference in using the GLM is how criminogenic needs are understood, included, and addressed within the overarching framework of a treatment programme and the emphasis on each client's GLP (for details see Willis, Yates, et al., in press; Yates & Prescott, 2011b; Yates, et al., 2010; Yates & Ward, 2008). The aims of each treatment component or module are framed using approach goals, as opposed to solely avoidant goals, and are linked to the fulfillment of common life goals. For example, a module addressing relationships would focus on how to seek out and establish satisfying relationships rather than a focus on overcoming intimacy deficits and avoiding problematic relationships. Most modules common to RNR-based programmes, and all modules targeting the reduction or management of criminogenic needs, can be linked to one or more common life goals. Table 2 details common components of RNR-based programmes and associated GLM constructs and common life goals.

To review, treatment from a GLM perspective aims to assist clients to attain common life goals in pro-social, non-offending ways, while simultaneously targeting risk reduction. Addressing criminogenic needs is a crucial step in working towards these dual aims. For example, consider a client who places high importance

Table 1

Primary Goods, Common Life Goals, Definitions, and Possible Secondary/Instrumental Goods[1]

Primary Good	Common Life Goal	Definition	Possible Secondary/Instrumental Goods
Life (healthy living and functioning)	Life: Living and Surviving	Looking after physical health, and/or staying alive and safe.	Pursuing a healthy diet, engaging in regular exercise, managing specific health problems, earning or stealing money to pay rent or to meet basic survival or safety needs.
Knowledge	Knowledge: Learning and Knowing	Seeking knowledge about oneself, other people, the environment, or specific subjects.	Attending school or training courses, self-study (e.g., reading), mentoring or coaching others, attending a treatment or rehabilitation programme.
Excellence in Work and Play[2]	Being Good at Work and Play	Striving for excellence and mastery in work, hobbies or leisure activities.	Being employed or volunteering in meaningful work, advancing in one's career; participating in a sport, playing a musical instrument, arts and crafts.
Excellence in Agency (autonomy and self-directedness)	Personal Choice and Independence	Seeking independence and autonomy, making one's own way in life.	Developing and following through with life plans, being assertive, having control over other people, abusing or manipulating others.
Inner Peace (freedom from emotional turmoil and stress)	Peace of Mind	The experience of emotional equilibrium; freedom from emotional turmoil and stress.	Exercise, meditation, use of alcohol or other drugs, sex, and any other activities that help manage emotions and reduce stress.
Relatedness (intimate, romantic, and family relationships)	Relationships and Friendships	Sharing close and mutual bonds with other people, including relationships with intimate partners, family, and friends.	Spending time with family and/or friends, having an intimate relationship with another person.
Community	Community: Being Part of a Group	Being part of, or belonging to, a group of people who share common interests, concerns of values.	Belonging to a service club, volunteer group, or sports team; being a member of a gang.
Spirituality (finding meaning and purpose in life)	Spirituality: Having Meaning in Life	Having meaning and purpose in life; being a part of a larger whole.	Participating in religious activities (e.g., going to church, prayer), participating in groups that share a common purpose (e.g., environmental groups).
Happiness	Happiness	The desire to experience happiness and pleasure.	Socialising with friends, watching movies, sex, thrill-seeking activities, drinking alcohol, taking drugs.
Creativity	Creativity	The desire to create something, do things differently, or try new things.	Painting, photography, and other types of artistic expression; participating in new or novel activities.

[1] Adapted from Yates and Prescott (2011a, 2011b), and Yates et al. (2010)

[2] The primary good that has been suggested as being separated into two primary goods (i.e., Excellence in Work and Excellence in Play; Purvis, 2010)

Table 2
RNR Treatment Components and Associated GLM Constructs/Common Life Goals

RNR Treatment Component	GLM Construct/Common Life Goals
Autobiography	Good Life Plan (past and present)
Offence Progression	Knowledge, Good Life Plan (past and present)
Cognition/Problem-Solving	Knowledge, Personal Choice and Independence, Peace of Mind, Relationships and Friendships
Relationships/Intimacy Deficits	Relationships and Friendships; Community
Sexual Self-Regulation	Happiness, Peace of Mind, Relationships and Friendships ++
General Self-Regulation	Peace of Mind, Personal Choice & Independence, ++
Emotion Regulation	Peace of Mind, Personal Choice & Independence, ++
Relapse Prevention Plan	Integrated Good Life/Self-Regulation/Risk Management Plan (present and future-oriented)

Note. The common life goals listed represent those conceptually linked to each RNR treatment component. For any given individual, additional common life goals will be relevant (especially for general/sexual/emotion regulation as indicated by ++).

Table 3
Good Lives Plan Template (Adapted from Yates, Prescott, & Ward, 2010)

Common life goals desired	**Ways to obtain goals**	**How I will know I am getting these**	**Problems I will need to manage**	**Risk factors**	**Risk management strategies**
Life: Living and Surviving					
Knowledge: Learning and Knowing					
Being Good at Play					
Being Good at Work					
Personal Choice and Independence					
Peace of Mind					
Relationships and Friendships					
Community: Being Part of a Group					
Spirituality: Having Meaning in Life					
Happiness					
Creativity					

developing and rehearsing strategies to simply cope with these states when they occur as a risk reduction strategy.

As illustrated in Table 2, using the GLM, construction of an integrated good life/self-regulation/risk management plan (including a future oriented GLP) replaces the traditional relapse prevention plan towards which clients work throughout treatment. Rather than a focus solely on risk factors, high risk situations, warning signs, and coping strategies, this plan centres on clients' valued common life goals and their relationships to offending, risk factors, and self-regulation failure. In addition to factors that are targeted in and of themselves, risk factors are also conceptualised as obstacles, barriers, or threats toward implementing the GLP, and strategies for addressing risk factors are included such that any potential threats to the GLP can be effectively managed. For example, the risk factor of emotional congruence with children may be seen as interfering with the common life goal of relationships and friendships with others, in addition to creating a risk to re-offend. Risk factors are incorporated into the GLP, but in a way that is meaningful to the client. Returning to the same example, using treatment as a means of solely or predominantly for avoiding all interactions with children will likely be less successful than developing skills in interpersonal competence in relationships with adults. "Risk factors" that signal that the GLP is not being implemented and that individuals are not actively pursuing valued goals, are also included (Yates et al., 2010). Table 3 provides a future-oriented GLP template, illustrating the integration of common life goals, risk factors, and risk management strategies.

Conclusion

The GLM is a theoretical and rehabilitation framework that augments accepted empirically derived principles of effective correctional programming and that supplements existing research-based practice. As illustrated in the current article, the GLM and its operationalisation and application have evolved considerably over the past decade. This brief article has described alternative terminology for key GLM concepts and outlined how treatment components based on established risk factors can be situated within a GLM framework. The developments presented in this article are designed to supplement existing GLM resources (see Willis, Yates, et al., in press; Yates, et al., 2009; Yates & Prescott, 2011b; Yates, et al., 2010) and to promote the GLM's application as intended – as a treatment approach and a framework informing treatment programmes in their entirety. Integrated appropriately, the GLM offers the potential to enhance outcomes of cognitive-behavioural, RNR-based treatment programmes through keeping offenders meaningfully engaged in treatment and in activities to attain life goals in ways that are incompatible with offending. However, misguided application could unintentionally increase the very risk practitioners work to prevent and manage.

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