Using the good lives model (GLM) in clinical practice: Lessons learned from international implementation projects☆,☆☆

David S. Prescott [a,*], Gwenda M. Willis [b]

[a] *PO Box 134, East Middlebury, VT 05740, USA*
[b] *University of Auckland, New Zealand*

A B S T R A C T

Efforts to implement the Good Lives Model (GLM) in offending treatment programs highlight common challenges across diverse settings. Long described as an overarching framework for rehabilitation, the GLM has recently been reconstructed as a *practice framework*. In this paper, the authors explore how the reconstruction of the GLM as a practice framework can help address challenges to GLM implementation observed internationally. Challenges to effective implementation of the GLM in a variety of settings and across cultures are described, based upon the authors' experiences helping programs and practitioners use the GLM to their fullest potential. Drawing on the theoretical resources of practice frameworks, it offers ideas for how programs and practitioners can respond to these challenges as implementation efforts unfold. Specifically, the paper focuses on how core values and principles of the GLM (Level 1 of practice frameworks) can inform intervention guidelines (Level 3 of practice frameworks). Research has been clear that proper implementation of any treatment approach can take considerable time to conduct properly; it is the authors' hope to equip programs and practitioners with ideas for moving forward thoughtfully with the GLM.

1. Introduction

Originally created as a rehabilitation theory (Ward, 2002), GLM proponents have often referred to the model as a strengths-based *overarching framework for rehabilitation*. This conceptualization, and the words that describe it, can be confusing to those who are newer to GLM implementation (and to therapeutic services in general). In our experience, much of an implementation's success can depend on the mindset of the practitioner or program and how they understand the context of treatment and the lives of their clients. Ward and Durrant (2021) recently reconstructed the GLM as a *practice framework*. Practice frameworks offer a more explicit and nuanced way of organizing interventions in the criminal justice system than what might be achieved by reference to overarching frameworks. Practice frameworks comprise of three interconnected levels: core values and principles, knowledge related assumptions (including etiological assumptions for offending behavior) and intervention guidelines. Applied to the GLM, core values include ethical values of human dignity, human rights and agency, prudential values of *primary human goods* (PHGs; experiences or states of being sought for their own sake; for example, relationships, happiness,

mastery), and the dual focus on risk reduction alongside enhancing wellbeing. Knowledge related assumptions center on the goal-directed nature of human behavior, specifically that human actions (including offending behavior) reflect attempts to secure one or more primary human goods. In the context of limited internal capacity and/or environmental opportunities and resources to seek out primary goods in prosocial ways, people may turn to offending behavior. Intervention guidelines focus on the construction of a Good Life Plan that centers on the client's most heavily weighted primary human goods and strengthening both internal and external capacity for their meaningful, adaptive, prosocial pursuit. Such a focus necessarily includes addressing causal processes associated with offending, which are commonly reduced to lists of dynamic risk factors (Heffernan et al., 2019). Core features of the GLM practice framework are summarized in Table 1.

Although the conceptualization the GLM as a practice framework is new, the central features and philosophy have not changed substantively in the past 20 years (Ward & Stewart, 2003). The GLM was developed to address limitations of risk-oriented approaches to offending treatment programs, and in particular, difficulties engaging clients when treatment aims don't necessarily cohere with client goals and aspirations. -

---

Table 1
The good lives model practice framework.

Level 1 Core values and principles	Level 2 Knowledge related assumptions	Level 3 Intervention guidelines
Ethical values: • Universal human rights; everyone is entitled to wellbeing, and expected to respect others' rights to wellbeing. Dual practice aims of wellbeing enhancement and reducing/managing risk to others • Human agency; enhancing capacity to formulate goals and construct plans to realize goals Prudential values/primary human goods (PHGs): • Life (including physical survival and healthy functioning) • Knowledge • Mastery (excellence in work and/or play) • Autonomy and self-directedness • Inner peace (i.e., freedom from emotional turmoil or stress) • Relatedness (including intimate, family, and friend relationships) • Community (i.e., a sense of belonging) • Spirituality (i.e., meaning and purpose in life) • Happiness • Creativity	• Humans are goal directed, behavior is purposeful and related to prudential values; everyone lives according to an implicit or explicit Good Lives Plan centred on prioritised PHGs • Sense of identity is understood by how different PHGs are prioritised and sought • Offending behavior results from internal and/or external obstacles blocking the pursuit of PHGs in prosocial ways; obstacles include criminogenic needs • Overcoming obstacles and attaining PHGs in prosocial ways will enhance wellbeing and reduce risk	• People who have offended are ascribed the same moral status as everyone else; they are treated with respect (incl. Freely consenting to treatment and spoken to and about using respectful language) and collaborate in all aspects of intervention planning • An individual's Good Lives Plan provides a template for intervention planning, monitoring treatment progress, and future-oriented Good Lives/Risk Management plans • Treatment focuses on strengthening internal and external resources to overcome obstacles and implement a prosocial Good Lives Plan • Evidence-Based Practice guides selection of treatment models and techniques for overcoming specific obstacles

Numerous publications describe its underlying values, etiological assumptions, and practice implications (e.g., Ward & Maruna, 2007; Willis, Yates, et al., 2013; Yates & Prescott, 2011).

GLM implementation efforts around the world have encompassed common experiences, opportunities, and challenges across diverse settings. This article draws upon these experiences and presents observations made across offending treatment programs in Europe, North and South America, Asia, and Australasia. It reviews elements of the GLM in practice that have commonly presented challenges to practitioners and administrators and draws on the conceptualization of the GLM as a practice framework to help address implementation challenges. Together and individually, the authors have helped to implement the GLM in regions as diverse as the US, Canada, Ireland, Czechia, Singapore, Japan, Hong Kong, Australia, New Zealand, Norway, and Namibia. For the purposes of this article, we have anonymized all examples to protect the confidentiality of practitioners and the agencies they work for. We note that most of our examples originate from sexual offending treatment programs, but illustrate common experiences across offending treatment programs. These challenges are organized according to relevant levels and their constituents of the GLM practice framework. Challenges upholding ethical values are described first, which are illustrated with statements made by professionals who

support the GLM but have struggled with its implementation.

2. Challenges upholding ethical values

"I find the term 'treatment' is confusing to many outside stakeholders; maybe we should call it 'sex offender management.'" This statement was made by an expert in abuse prevention who was seeking to convince outside stakeholders that providing treatment to individuals who had sexually abused others could result in safer communities. On the surface, it may seem like an acceptable reframe of treatment provision to policymakers who care little about the wellbeing of those who have broken the law; in their minds, managing lawbreakers is the highest value. Hence, referring to it as "management" may actually increase the likelihood of securing funding for treatment or building bridges with agencies that serve those who have been abused and who take a dim view towards those who have caused harm. Paradoxically, the most likely way to build safer communities often lies in helping those who have abused develop balanced and self-determined lifestyles that are incompatible with offending (Purvis et al., 2015; Wilson et al., 2009). In this way, the words "treatment" and "management" only speak to lesser parts of the overall rehabilitative experience. Treatment often connotes something that professionals provide to clients, whereas rehabilitation refers more to a person becoming better and more fulfilled than they have been before. Management often suggests forces exerted onto someone who would otherwise behave undesirably; within the GLM, management is not imposed, but rather cultivated within the client so that they can more easily manage their own lives. Such a stance reflects the core ethical value within the GLM practice framework of human agency (Ward & Durrant, 2021). To this end, it is vital that practitioners think of the GLM as a framework for helping clients rebuild their lives, or – in some cases – build them for the first time.

"These people don't deserve to have a good life." In one instance, when a program in the UK decided to adopt the GLM and name their program after it, local officials successfully pressured the program to keep its original name. This instance reflects the extent to which many in the public believe neither in rehabilitation nor that opportunities should be provided for clients in treatment to build a better life for themselves. In other words, the core values at the heart of the GLM practice framework – including human dignity and universal human rights – do not always resonate with the public or key stakeholders. In a similar vein, across the US, practitioners often work in legislative contexts that seriously undermine individuals' pursuit of PHGs in personally meaningful, prosocial ways. Indeed, in a U.S. sample of men previously imprisoned for sexual offenses, Harris et al. (2019) found that although many PHGs were desired, very few were attained, with probation conditions, registration, and residence restrictions blocking common sources of primary human goods (e.g., working to attain the PHGs of life and mastery, going to church to attain PHGs of community/belonging and spirituality). Consistent with Harris et al.'s research, many practitioners in the US purport that individuals with sexual offense convictions cannot live a good life, given traditional and seemingly obvious avenues to goods attainment – including employment and spending time with friends and family – may be frustrated by registration, probation, and other legal requirements. It is this context – often extreme difficulty attempting to reintegrate into the community after conviction (and often incarceration) – that arguably separates the US from other countries in terms of the challenges these individuals face as they implement a good life plan. However, even in the US, many programs are able to operate in the spirit of the GLM and help clients find ways of assessing and working to attain PHGs in the contexts in which they find themselves. Indeed, Harris et al. (2019) found that group treatment programs provided one of the few sources of PHGs (and in particular community and knowledge) for men in their sample, underpinning the inherent value that treatment programs can provide.

"All this theory and background information isn't helping me. I need bullet points. Just tell me what to do." As constructs, offending and

rehabilitation are complex; there is no one explanation for offending and no one-size-fits-all treatment program. In our experiences implementing GLM, practitioners often work in environments where resources are scant, funding is minimal, time is tight, and stress is high. Further, a large number of treatment methods in the field are highly scripted and manualized, such as the Cognitive Behavioral Intervention for Sexual Offending (CBI-SO; University of Cincinnati, n.d.). Manualized treatment programs are inconsistent with the GLM's focus on human agency, and supporting individual clients to formulate their own goals and construct plans to realize goals (Marshall, 2009). Practitioners at the front lines of treatment sometimes experience the temptation to reduce their thinking about clients to checklists of treatment tasks that address an array of dynamic risk factors (Ward et al., 2007). These checklists too often exist without a comprehensive case formulation or understanding of underlying vulnerabilities and processes underlying risk factors (Heffernan et al., 2019). In our experience, clients are often viewed through the lens of a list of risk factors with little regard for how these factors have developed and how they may interact. Proper GLM implementation lies in the practitioner's ability to develop a comprehensive understanding of the client's valued primary human goods and desired means for pursuing these, and approaching treatment holistically, with a focus on strengthening client capacity to attain primary human goods across each domain of the client's life (Prescott & Willis, 2021).

A client assessed as having "deviant sexual preferences," "intimacy deficits," and "poor sexual self-regulation" may be treated for each of these risk factors, separately. Some programs may target each of these risk factors in turn, one directly after another. The GLM emphasizes understanding and appreciating how adverse life events such as sexual victimization may have caused the person to experience the loneliness and heartache that can result in intimacy deficits as well developing sexual scripts that result in "deviant sexual preferences" identified in an assessment (Levenson et al., 2017; Prescott & Willis, 2021). A GLM approach would work to help the client develop other means for self-regulation that bring about a sense of inner peace and build skills for a broader range of interpersonal relationships. This is not to say that the GLM is the only approach that includes a comprehensive understanding of the client; rather, this understanding (nestled in the knowledge related assumptions of the GLM practice framework; Ward & Durrant, 2021) is a core component of the GLM that is less emphasized in programs to which the authors have consulted.

Finally, clinicians claiming to use the GLM sometimes talk about their clients in other ways that depart from the core values of the GLM; most notably, that clients are fellow human beings worthy of respect (Ward et al., 2007). In many cases, this can involve labeling language, such as referring to clients as "sex offenders" or "abusers" with little regard to how this might undermine treatment efforts (Willis, 2018). The circumstances in which forensic and correctional practitioners often find themselves means that their workday can include shifting how they think from a holistic understanding of their clients in one moment to documenting sessions in a way that outside stakeholders such as evaluators or accrediting agencies will understand and find helpful. It is therefore no surprise that many practitioners would prefer to reduce the GLM to its most basic elements in an easy-to-implement fashion that requires only as much understanding of the client as is absolutely necessary.

3. Challenges upholding prudential values

Central to the GLM is the idea that all human beings are predisposed to seek out certain circumstances, actions, experiences, and states of being for their own sake. These are referred to as *primary human goods* (PHGs) and reflect the prudential values of the GLM practice framework. Like other elements of the GLM, these PHGs have been explored in depth and do not need a deep exploration here (Purvis et al., 2015; Yates et al., 2010). On paper, these PHGs can appear quite simple. In practice, the

picture becomes less clear. Yates and Prescott (2011) re-cast these "goods" as "common life goals", meaning that they are goals that all human beings have in common in one form or another. In our experience implementing the GLM, framing goods as goals can make the basic concepts of the PHGs easier to understand at the front lines of treatment and is typically more palatable to clients who often simply want to work towards concrete goals that will lead to a better life.

Nonetheless, re-casting the PHGs as goals can result in conceptual drift away from the original idea of the PHGs. While clients and practitioners alike often try to understand and cast goals as specific, measurable, and achievable, within a predetermined time frame, it is often the case that life does not comport with lists of goals. In our experience consulting to practitioners, it often seems that treatment programs drift into considering life to involve series of problems to be solved and goals to achieve rather than experiences to be lived and states of being to aspire to. While treatment programs work towards a goal of an offense-free future, human beings often have their sights set higher: "I want to be a better father, partner, man, Christian or Muslim," etc. A focus on "Good Life goals" can help reconcile noted challenges to upholding prudential values. Good Life goals are client-generated goals that provide a prosocial, meaningful source of one or more PHGs – in other words, they represent adaptive secondary/instrumental goods. Good Life goals provide a foundation from which to identify specific, measurable, attainable, and relevant treatment/intervention goals which focus on building client capacity to pursue their Good Life goals. Fundamental to the process of exploring client Good Life goals is an intimate understanding of each of the PHGs and the various way in which they might be realized.

What follows are some tips for considering each of the PHGs in practice, reflecting on common challenges observed across GLM implementation projects. The full list of PHGs have been explored in a variety of publications (e.g., Purvis et al., 2015; Yates et al., 2010) and are synopsized below, in no particular order:

3.1. Life (survival and healthy functioning)

This PHG involves basic survival needs and healthy living and surviving. Common means by which people ensure living and surviving are through healthy nutrition, exercising, health care, and acquiring income for food and shelter. Important to remember, however, is that while this good may be in the background of consciousness for practitioners, it is often perceived as extremely important to clients in treatment, especially those who have recently re-entered the community following incarceration (Harris et al., 2019). One implication for practitioners is that although they may want to stay focused on more psychologically oriented goals in treatment, it may be necessary to help clients achieve more immediate goals in order to be truly helpful to clients.

3.2. Knowledge

It is only natural to have a fundamental desire for knowledge about oneself and the world. People often work to achieve this PHG through various forms of education and self-study or therapy and other self-help activities. In the authors' experience, this PHG is often overlooked. Across settings, we have found that knowledge is also implicated in any number of problematic behaviors. For example, one client noted that knowledge played a role in their viewing child sexual exploitation materials (CSEM) simply because they wanted to know what sex with children would be like. After several months in treatment, they came to view knowledge as conspicuously absent in their earlier life; had they truly understood the harm of sexual abuse, they would never actually have viewed CSEM. Practitioners using the GLM are therefore encouraged to look beyond the more traditional means by which people acquire knowledge, such as in academic settings. One way to do this is to investigate how curiosity has appeared (or not appeared) in the functioning of the client across their lifespan.

3.3. Mastery (excellence in work and/or play)

As originally defined, being good at anything involves a sense of mastery. Although it may seem obvious, human beings commonly want to be good at something, and find the process of doing something well to be intrinsically rewarding (Ryan & Deci, 2000). Treatment programs and practitioners often focus on this PHG by promoting sports, leisure hobbies, or other activities that align with client interests and strengths. One place where those implementing the GLM might also wish to focus is on those more subtle, day-to-day activities where clients experience even minor success (e.g., waking up on time, submitting job applications, treating others respectfully).

3.4. Autonomy and self-directedness

In one way or another, all human beings want self-directedness and desire the ability to make decisions for themselves (Ryan & Deci, 2000). Entire wars have been fought in order for people to achieve independence from one another. In practical applications, the authors have often found that this PHG can actually be difficult for practitioners and clients to grasp. In the authors' experience within the criminal justice world, programs and clients alike can often view autonomy in all-or-nothing terms (e.g., having freedom as an ultimate goal). It is also common for programs to focus on this PHG primarily in terms of how it was implicated in offending; many sex crimes have occurred because the person wanted to have their way without regard or concern for the other(s) involved. Often, programs and practitioners focus less on how passing moments of personal choice and independence may manifest throughout one's day or intersect with other PHGs (e.g., maintaining personal choice and independence within relationships).

3.5. Inner peace

Everyone needs some kind of emotional regulation and equilibrium. Like autonomy, it can be easy to focus on how clients have met this PHG via harmful means (e.g., substance abuse, sexual assault). In the authors' experience, there has been considerable focus in many quarters on importing meditation, mindfulness, and movement therapies such as yoga and tai chi into programming as adjunctive methods for helping clients to achieve a sense of inner peace (Jennings et al., 2013). One advantage to using these methods and focusing on inner peace more broadly is that it enables clients to develop the self-observation skills needed to address other areas of their lives. All too often, clients who have sexually abused have had histories of trauma and adversity that have led them to spend their lives focusing on their environment and scanning it for evidence of threats (Levenson et al., 2016; Levenson et al., 2017). By explicitly focusing on methods for achieving a sense of inner peace, programs and practitioners can better prepare their clients to engage in self-regulation by helping them to observe their internal (as opposed to external) experience. Ultimately, in order to use cognitive-behavioral interventions, clients must first be able to observe their thoughts and behaviors (Prescott, 2020).

A note of caution is warranted, however: it can be very difficult for clients to develop skills for achieving a sense of inner peace (Prescott, 2020). Many clients who have experienced trauma often find periods of quiet reflection to be exactly those times when memories of past adversity return with deep impact and emotional flooding (Levenson et al., 2017). For these reasons, practitioners may wish to help clients find ways to achieve inner peace that occur in small doses, at least through the beginning phases of treatment.

3.6. Relatedness

It takes some effort to establish healthy bonds with others, including intimate, romantic, and family relationships. In the authors' experience, treatment programs understandably focus on how clients misused or otherwise violated their relationships with others through abuse. Programs commonly focus on the basics of building relationships and practicing social skills (Stinson & Becker, 2013). The authors urge practitioners to consider also how they might help clients to experience themselves as more effective in a wider range of interpersonal relationships and able to relate to others empathically. In other words, where programs can often be skills-based with regard to empathy and relationships, it can be useful to focus on the overarching PHG in order to address the intersection of empathy, compassion, and daily interactions with others, with an eye to the client's experience of competency in each.

3.7. Community/belonging

Reintegrating people who have sexually abused others into the community has long been a focus of research and practice efforts (Wilson et al., 2009). It has been well established that these efforts can be challenging (McCartan et al., 2019). As with the PHG of *Life,* truly addressing this PHG can mean that treatment providers supplement their role as therapist with a measure of case management (for example, helping to research resources within the community to which the client can contribute and from which they can benefit). Although programs and practitioners are well-versed in the challenges of adjusting to life in the community after conviction for a sex crime, the unfortunate reality is that many are returning to communities that are themselves in chaos and often dangerous. It is vexedly paradoxical that people who have completed treatment for abuse and violence often return to communities where the threat of violence against them is very high.

3.8. Spirituality

Central to this good is the idea that all humans desire to have a sense of meaning and purpose in their lives (Emmons, 2003). Indeed, having a sense of meaning and purpose is among the most important aspects of a coherent good life plan, one that is often directly linked to the most heavily weighted PHGs (Harris et al., 2019). Often, this is the sense that one is part of a larger whole. For many clients, spirituality and religion are intertwined. In the authors' experience of implementing the GLM, we have often found that as much as programs may pay lip service to this good, practitioners are often reluctant to discuss spiritual matters with clients. In some cases, this has been because they are not religious and find discussions of others' religious experiences unappealing, irrelevant to offending, or otherwise problematic. Some may fear that they open themselves to various liabilities if they discuss religion and spirituality. Often, practitioners find themselves in a kind of trap in which they feel they must respond to their clients' spiritual experiences when it may be simpler and more effective to simply listen with interest and discover what they learn about their client along the way.

Of course, of all the PHGs, spirituality may be the most easily misunderstood. In one case, the first author was called upon for an opinion in a legal challenge to a treatment program; the client alleged that the GLM "imposes" religion on its clients rather than eliciting how spirituality has played a role in one's life and behavior in the past and how it might change in the present and future. The matter was easily resolved but points to why many practitioners might be concerned about these discussions. In fact, one cogent concern expressed about the GLM is that, misapplied, it may become overly paternalistic by suggesting to clients what is and isn't important to them (Glaser, 2011).

3.9. Creativity

This good involves the desire for creativity or novelty in one's life. While it is a common experience among practitioners that clients can be surprisingly creative in the arts, this good also captures the need for people to find their own solutions, try new things, and have fresh, different experiences. This good, along with Autonomy and Relatedness,

is among the first to be severely limited when one is arrested for a sex crime (McCartan et al., 2019). Practitioners implementing the GLM will therefore wish to be aware that this most innate motivation is itself in need of care and protection. On their face, creative endeavors can serve the PHG of Mastery. However, they can also serve as vital coping skills for those who are experiencing the stress of rebuilding their lives. The authors therefore urge that this good not be forgotten in the pursuit of other, more immediate treatment goals.

3.10. Happiness

All human beings need to have these states at one time or another. Certainly, this good is frequently implicated in offending with clients who abuse others, in whole or in part, because they believe it will feel good. In the authors' experience with implementing the GLM, however, this good is often associated with anguish, anxiety, and depression. Many clients in programs have actually become highly reluctant to seeking anything resembling happiness or pleasure because, as one client observed, "That's what got me into all this trouble." Others have expressed that experiencing happiness and pleasure could pose an unacceptably high risk to others in that any experience of pleasure may serve as a gateway to offending in much the same way that many who have been dependent on alcohol need less than a drink to return to old habits. For these individuals, it was as if the presence of depressive symptoms actually served a protective function. Treatment therefore required a re-assessment of what happiness and pleasure could be for these clients. Finally, it is important to remember that many clients with backgrounds of trauma and adversity can have difficulty recalling any past states of happiness or pleasure. One client asked aloud whether beating a bully who attacked their sister on the school bus counted as happiness or pleasure.

4. Challenges upholding knowledge related assumptions

In earlier texts (e.g., Yates et al., 2010), the GLM proposed a number of "flaws" to one's good life plan. In essence these flaws in one's plans serve a destabilizing function and act as obstacles to living a good life. They include:

- Maladaptive or harmful means are used to achieve or acquire goods.
- A narrow scope: pursuing a small number of goods at the expense of others, thereby risking a good life plan going awry or badly out of balance.
- Conflict between goods, often with the result being that the pursuit of one good interferes with attaining another.
- Lack of internal capacity to attain goods in prosocial ways (such as having medical or mental situations that preclude one's living up to their full potential).
- Lack of external capacity to attain goods in prosocial ways, such as not having the resources to attain goods to the best of one's abilities.

A few points with respect to implementation are worthwhile to make. The first is that in the authors' experiences with implementation, the word "flaw" is often misunderstood. Although the word was originally intended in a moderately positive light (for example, even the most beautiful diamonds have flaws), many practitioners understood it as potentially pejorative (for example, that their clients were flawed individuals). After much discussion, in the authors' trainings we have replaced the word "flaws" with "obstacles" due to its less pejorative tone. The word "challenge" also entered these discussions but was also ruled out due to its potential for misunderstanding (for example, one can "challenge" someone to a fight, engage in adversarial legal challenges, etc.).

Second, while these obstacles appear as a list of bullet points on a page, or a series of exercises in a workbook, they can be highly interactive in practice. In other words, clients rarely face one obstacle;

instead, the obstacles can be part of a broader narrative. For example, a client may lack the internal capacity to build relationship skills and have trouble attaining this good. Absent these relationship skills, they may then focus on relationships to the detriment of other goods, such as inner peace or Autonomy (the obstacle of narrow scope, above). The client may then have difficulty effectively asserting themselves within their relationships, with the effect that there is then a conflict between the goods of Relatedness and Autonomy.

In order to disentangle these obstacles, practitioners can use clinical sessions to sort through how obstacles in one area can lead to another. One way to think about this can be to observe the sometimes glaring conflicts between goals (for example, the momentary pursuit of inner peace through violence against a loved one) or the obviously narrow scope (for example, the client who works two or three jobs to make ends meet only to revert to substance abuse to cope with the demands) and work backwards to establish skills to learn or capacities to develop.

5. General challenges to implementation

A practice framework for rehabilitation involving 10 primary human goods alongside five obstacles to attaining these goods: How hard could this be to implement? Although this question is posed with lighthearted sarcasm, it speaks to even greater challenges. First, implementation science finds that the time required to implement a program with fidelity can be in the area of two years (Fixsen et al., 2005). This means that programs and practitioners must have considerable patience – even compassion – with themselves and others as they learn the nuances of GLM implementation. It is also noteworthy that one study recently found that it took upwards of two years to see improvements in psychotherapy outcomes at the individual level following the implementation of an evidence-based treatment methodology (Brattland et al., 2018).

What are the implications of the above research? For starters, while professionals treating harmful waited for a broader literature showing that treatment of people who have abused effectively reduces their risk, the application of treatment models is more complicated than it seems. First, implementing a treatment model requires much more time and patience than some of implementation approaches allow. The traditional methods of bringing in a trainer and (sometimes) having follow-up consultation is only the beginning of full implementation (Moss & Mousavizadeh, 2017). Beyond that, research by Brattland's group has shown that even with successful implementation it can take longer to observe improvements in client outcomes and practitioner effectiveness. Added to this is the fact that application of a model in one area does not ensure its success in another. In the authors' experience, a critical factor is the people in leadership positions in programs who set the culture in which successful implementation can happen. In the authors' experience, successful leadership and treatment culture are not always guaranteed for any number of reasons (in one case, the Executive Director of an institution left their position, creating a leadership vacuum and change of culture in terms of treatment provision) (Willis et al., 2018).

Against this backdrop, this section reviews real-life challenges to successful implementation of the GLM that programs and practitioners may wish to anticipate. As a list, these challenges are by no means exhaustive. They are provided in the hope that others can benefit from the wisdom, and mistakes, of their colleagues around the world.

5.1. Cultural considerations

Practitioners and clients from Central and South America as well as Asia and various indigenous cultures (e.g., the First Nations of Canada, Native Americans, Australian Aboriginals, and New Zealand Māori) have often questioned how the GLM applies across cultures. More often than not, the GLM is recognized to more closely align with indigenous models of health and wellbeing compared to risk-oriented treatment approaches (e.g., Leaming & Willis, 2016). By far the most common

question the authors have received has been, "We are a more collectivistic culture than the cultures where you come from. For us, our family is central to our existence. The GLM has a focus on autonomy, but I don't see how that applies to us."

Ultimately, the answer to this question (and related concerns) has to do not so much with the GLM itself as to how it is applied. Clearly, in the example above, the weight that one places on autonomy will be less than it is for people in other more traditionally "western" cultures. However, the collectivistic nature of one's culture does not mean that one does not also desire personal choice and independence. Instead, it may simply need to be understood differently. Even the most family-oriented people on Earth will sometimes need moments of solitude or desire to decide what the family meal will be that evening. Also, the meaning of behaviors may also be different. A colleague who spent time with a First Nations tribe in Canada described how, in their view, "a criminal is someone who behaves as if he has no family." In a larger city in the USA, the same person might be described as doing what he wants no matter the consequences to others. The real question in GLM implementation is how a given good is attained by a given individual, in their community, and with respect to their culture. The GLM can never be applied in accordance with what the practitioner thinks is correct with the client, but instead in accordance with the client's cultural values and preferences.

5.2. The belief that, "We already do this."

Unfortunately, in the authors' experience, many people who receive introductory information about the GLM form premature judgments about it. In particular, they take note of the elements that seem most familiar (for example, the idea that people generally want relationships) and arrive at the conclusion that they are already proficient at implementing the GLM. Sadly, it is sometimes difficult for people to dissuade themselves of this notion. It can come in the form of, "I've already gotten training on strengths-based approaches" or "This is a lot like motivational interviewing." In the authors' experience, making these premature judgments is a sign that the practitioner is also not practicing in adherence to other areas of the GLM practice framework, such as its core values and principles, knowledge related assumptions. Important to keep in mind are questions such as:

- Is the practitioner attending to the actual PHGs?
- Is the practitioner attending to the PHGs as they are defined? These first two points are not merely academic. Contrary to what some practitioners have imagined, the PHGs as constructed have an empirical foundation described in the foundational writings (e.g., Ward & Maruna, 2007; Ward & Stewart, 2003; Yates et al., 2010)
- Can the practitioner identify the PHGs that are important to this client?
- Can the practitioner describe how the PHGs were implicated (or not implicated) in the client's problematic behaviors?
- Does the practitioner have a solid understanding of how PHGs interact with causal processes implicated in the client's offending?
- Has the practitioner conducted a solid assessment of the client's strengths (as they relate to prosocial acquisition of PHGs) and accounted for how the client can apply them to treatment and to their life beyond treatment more effectively?
- Can the practitioner identify the obstacles in the client's good life plan?
- Can the practitioner identify how the client has sought to implement a good life plan in the past? In the present, and how they plan to implement in the future?
- Have the practitioner and client arrived at the answers to questions such as how the client and others around them will know that they are attaining a good effectively or ineffectively?

This is by no means an exhaustive list and is intended to illustrate the point that the GLM, much like many other collaborative and strengths-based approaches, can seem familiar at first but take much longer to implement effectively and with fidelity (Prescott & Willis, 2021).

5.3. "This is easy."

It is indeed easy to read a paper or even a book and assume one can quickly develop expertise in a given method, model, or approach. In order to prevent this, training is most effective with the trainer reminds trainees to suspend their beliefs or disbeliefs until they understand the entire model and how its components interrelate. Further, the most effective way to learn the GLM is with guidance, supervision, and coaching. Receiving feedback on one's practice is one of the most effective ways to improve one's performance (Prescott et al., 2017).

5.4. "We've made a simplified GLM."

In some cases, practitioners using other practice frameworks (or perhaps lacking a practice framework) have integrated selected components of the GLM into existing practice. In other cases, practitioners have simply left out some of the goods or attempted to subsume them under other goods. This becomes problematic for many reasons, including that decisions regarding which goods to abandon are often made by practitioners or program administrators and not through dialogue with the developers or the clients themselves. What may be a convenience to a practitioner (for example, leaving out spirituality) can come with the cost of neglecting significant portions of the clients' lived experiences. In many cases within the authors' experiences, attempting to subsume seemingly less important goods such as creativity has meant that the subsumed good gets lost or are considered to be an afterthought in treatment. In the authors' experience, it is vital to avoid simplification. Ultimately, while some goods may be less important to us, they may hold particular importance to our clients. Accordingly, attention to such goods may help enhance client engagement in the rehabilitation process.

5.5. "We have a unit on the GLM; it's part of our broader program."

Several years ago, observed that many agencies claiming to use the GLM had simply added a final treatment module (or revised an existing module) for consistency with the GLM. To be clear, treating the GLM as an "add-on" is inconsistent with the intent of the GLM as an overarching practice framework. The authors' more recent experience suggest that many agencies continue to treat the GLM as an add-on, with psychoeducation regarding the GLM often included in a discreet module or therapy task. Of course, learning about something and discussing it is not the same thing as meaningful application making changes to one's life. Ultimately, integration is not the same thing as implementation.

Ultimately, a fundamental aspect of GLM implementation is careful attention to maintaining and upholding it as a practice framework for rehabilitation, rather than rejecting it as idealistic or as a vague, aspirational, out-of-reach framework with little relevance to everyday practice. As a practice framework, the GLM offers flexibility and rehabilitation does not take the same shape for each client. It is not simply a means by which to manage people and the risks they may pose. Ultimately, the GLM requires a twin focus of the client enhancing wellbeing as well as helping them to develop the skills necessary for managing risk across diverse settings (Purvis et al., 2015; Willis, Prescott, & Yates, 2013).

6. Conclusion

It can be tempting for programs to attend a training or study the GLM literature and then seek to implement it. In the authors' experience, agencies that do not pursue the GLM as a practice framework, embracing its core values and principles, knowledge-related assumptions, and

intervention guidelines are often most likely to have difficulty with proper and effective GLM implementation. Indeed, we have found that programs and practitioners have often underestimated the breadth and depth of the GLM's core values and principles in the rush to pursue specific intervention guidelines. To this end, we encourage programs and practitioners to develop strategic plans for considering full GLM implementation rather than attempt to implement it in a convenient but piecemeal fashion.

Declaration of competing interest

The authors have no conflicts of interest to report.

References

Brattland, H., Koksvik, J. M., Burkeland, O., Gråwe, R. W., Klöckner, C., Linaker, O. M., Ryum, T., Wampold, B., Lara-Cabrera, M. L., & Iversen, V. C. (2018). The effects of routine outcome monitoring (ROM) on therapy outcomes in the course of an implementation process: A randomized clinical trial. *Journal of Counseling Psychology, 65*(5), 641–652. https://doi.org/10.1037/cou0000286

Emmons, R. A. (2003). *The psychology of ultimate concerns: Motivation and spirituality in personality*. New York: Guilford.Emmons.

Fixsen, D. L., Naoom, S. F., Blase, K. A., Friedman, R. M., & Wallace, F. (2005). Implementation research: A synthesis of the literature. In *FMHI Publication #231*. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network.

Glaser, W. (2011). Paternalism and the good lives model of sex offender rehabilitation. *Sexual Abuse: Journal of Research and Treatment, 23*, 329–345.

Harris, D. A., Pedneault, A., & Willis, G. M. (2019). The pursuit of primary human goods in men desisting from sexual offending. *Sexual Abuse, 31*, 197–219. https://doi.org/10.1177/1079063217729155

Heffernan, R., Ward, T., Vandevelde, S., & Van Damme, L. (2019). Dynamic risk factors and constructing explanations of offending: The risk-causality method. *Aggression and Violent Behavior, 44*, 47–56. https://doi.org/10.1016/j.avb.2018.11.009

Jennings, J. L., Apsche, J. A., Blossom, P., & Bayles, C. (2013). Using mindfulness in the treatment of adolescent sexual abusers: Contributing common factor or a primary modality? *International Journal of Behavioral Consultation and Therapy, 8*, 17–22.

Leaming, N., & Willis, G. M. (2016). The good lives model: New avenues for Māori rehabilitation? *Sexual Abuse in Australia and New Zealand: An Interdisciplinary Journal, 7*, 59–69.

Levenson, J., Willis, G., & Prescott, D. (2017). *Trauma-informed care: Transforming treatment for people who have sexually abused*. Brandon, VT: Safer Society Press.

Levenson, J. S., Willis, G. M., & Prescott, D. (2016). Adverse childhood experiences in the lives of male sex offenders and implications for trauma-informed care. *Sexual Abuse: A Journal of Research & Treatment, 28*(4), 340–359. https://doi.org/10.1177/1079063214535819

Marshall, W. L. (2009). Manualisation: A blessing or a curse? *Journal of Sexual Aggression, 15*, 109–120.

McCartan, K. F., Harris, D. A., & Prescott, D. S. (2019). Seen and not heard: The service user's experience through the justice system of individuals convicted of sexual offenses. *International Journal of Offender Therapy and Comparative Criminology*. https://doi.org/10.1177/0306624X19851671

Moss, R. K., & Mousavizadeh, V. (2017). Implementing feedback-informed treatment: Challenges and solutions. In D. S. Prescott, C. L. Maeschalck, & S. D. Miller (Eds.),

Feedback-informed treatment in clinical practice: Reaching for excellence (pp. 101–121). Washington, DC: American Psychological Association Press.

Prescott, D. S. (2020). Trauma-informed care in secure settings: The whys, hows and challenges associated. In H. Swaby, B. Winder, R. Lievesley, K. Hocken, N. Blagden, & P. Banyard (Eds.), *Sexual crime and trauma* (pp. 33–56). Cham, Switzerland: Palgrave Macmillan.

Prescott, D. S., Maeschalck, C., & Miller, S. D. (2017). *Feedback-informed treatment in clinical practice: Reaching for excellence*. Washington, DC: American Psychological Association Press.

Prescott, D. S., & Willis, G. M. (2021). Evaluation de la fidélité des professionnels au Good Lives Model (GLM). In E. Dieu, E. Zinsstag, & T. Ward (Eds.), *Special Issue« Criminologie de la confiance et Good Lives Model (GLM)»*. Revue Internationale de Criminologie et de Police Technique et Scientifique. in press.

Purvis, M., Ward, T., & Willis, G. (2015). Applying the good lives model of offender rehabilitation to sex offenders. In M. Carich, & S. Mussack (Eds.), *The Safer Society handbook of adult sexual offense assessment and treatment*. Safer Society Press.

Ryan, R. M., & Deci, E. L. (2000). Self-determination and the facilitation of intrinsic motivation, social development, and well-being. *American Psychologist, 55*, 68–78.

Stinson, J. D., & Becker, J. V. (2013). *Treating sex offenders: An evidence-based manual*. New York: Guilford.

University of Cincinnati, n.d.University of Cincinnati (n.d.). Group interventions. Retrieved from https://cech.uc.edu/about/centers/ucci/products/interventions/group-interventions.html.

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

Ward, T., & Durrant, R. (2021). Practice frameworks in correctional psychology: Translating causal theories and normative assumptions into practice. *Aggression and Violent Behavior, 58*, 1–9. https://doi.org/10.1016/j.avb.2021.101612

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

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

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

Willis, G. M. (2018). Why call someone by what we don't want them to be? The ethics of labelling in forensic/correctional psychology. *Psychology, Crime & Law, 24*, 727–743. https://doi.org/10.1080/1068316X.2017.1421640

Willis, G. M., Prescott, D. S., & Levenson, J. S. (2018). Promoting therapist longevity: Exploring sexual offending treatment providers' experiences of workplace support. *Journal of Sexual Aggression, 24*(3), 311–325.

Willis, G. M., Prescott, D. S., & Yates, P. M. (2013). The good lives model (GLM) in theory and practice. *Sexual Abuse in Australia and New Zealand, 5*, 3–9.

Willis, G. M., Yates, P. M., Gannon, T. A., & Ward, T. (2013). How to integrate the good lives model into treatment programs for sexual offending: An introduction and overview. *Sexual Abuse, 25*, 123–142. https://doi.org/10.1177/1079063212452618

Wilson, R. J., Cortoni, F., Picheca, J. E., Stirpe, T. S., & Nunes, K. (2009). Community-based sexual offender maintenance treatment programming: An evaluation. In *Research Report R-188*. Ottawa, ON: Correctional Service of Canada.

Yates, P., Prescott, D., & Ward, T. (2010). *Applying the good lives and self regulation models to sex offender treatment: A practical guide for clinicians*. Brandon, VT: Safer Society Press.

Yates, P. M., & Prescott, D. S. (2011). Review: Redefining primary human goods: Applying the good lives model to clinical practice. In , *68. NOTA News*. December 2011.