# Good Lives Model Informed Rehabilitation for Violent Offenders with Intellectual Disability

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**Abstract**

*Violent offending in people with intellectual disability (ID) proves to be a major challenge in the field of rehabilitation because risk-based approaches to interventions usually overlook deeply rooted psychosocial needs. The strengths-based rehabilitation model, known as the Good Lives Model (GLM), focuses on promoting personally meaningful goals and on risk management. Still, there is little evidence of its use in cases involving violent offenders with ID. This paper has discussed the efficacy of a GLM-based rehabilitation programme that is designed to address violent offenders with mild to moderate intellectual disability. The study used a mixed-methods design, and the sample comprised 48 male offenders in secure forensic ID services. The participants underwent a 12-month GLM-focused intervention that included modified offence analysis, skills development, and individualised goal planning. Violent risk (HCR-20), adaptive functioning, quality of life, and institutional incident data were measured using pre- and post-intervention measures. Qualitative interviews covered the participation and perceived change. Findings showed statistically significant change on the dynamic risk factors where mean HCR-20 clinical and risk management scores reduced by 28% during the intervention period ($p < .01$). Violent incidents recorded decreased to an average of 1.4 incidents per participant in the 12 months after the intervention in comparison with 3.2 violent incidences per participant 12 months before the intervention, which was a 56% decrease. There were also gains in adaptive functioning scores, with a mean increase of 19%, and self-reported quality of life improved in 72% of participants. The qualitative data revealed higher motivation and emotional regulation levels, and greater knowledge of prosocial life goals. Overall, it is possible to conclude that GLM-informed rehabilitation seems a crucial and viable method of working with violent offenders who have intellectual disabilities, and it can provide significant risk reduction and improve well-being. The results of this study endorse the use of strengths-based models in forensic ID services, alongside continued risk management activities.*

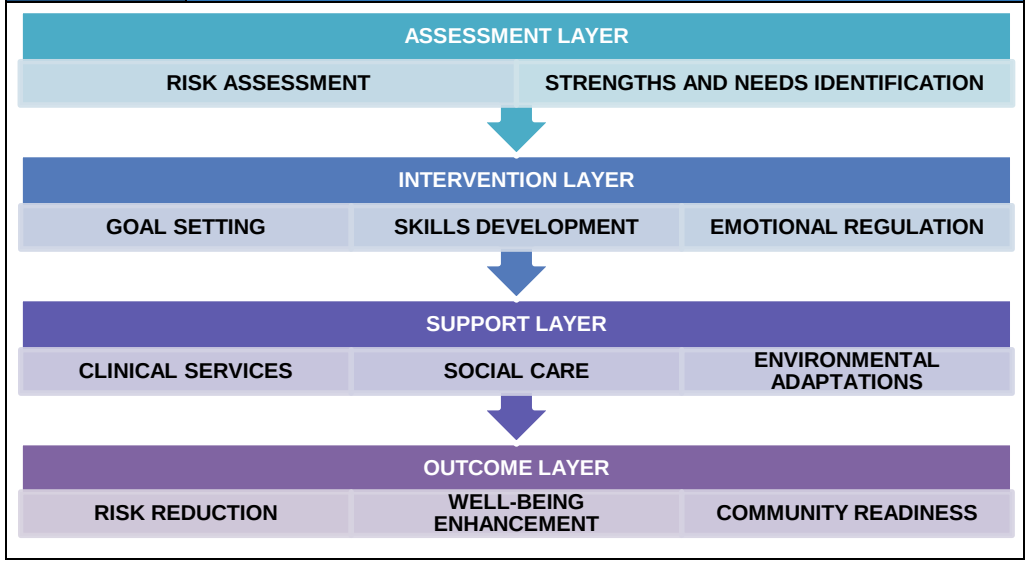
Keywords *Good Lives Model, Intellectual Disability, Violent Offending, Forensic Rehabilitation, Risk Reduction, Strengths-Based Interventions, Quality of Life.*

## Introduction

The Good Lives Model (GLM) is a model of offender rehabilitation based on strengths, incorporating risk management and support for personally significant and socially beneficial life outcomes. The GLM, developed as an alternative to exclusively deficit-based theories, assumes that offending behaviour arises from an inability to fulfil so-called primary human goods, including autonomy, relatedness, emotional well-being, and belonging to a community [3]. The GLM is not focused solely on risk avoidance; instead, the authors consider capacity building, identity development, and motivation as the key mechanisms of sustainable desistance. Empirical reviews indicate that GLM-based interventions are associated with enhanced engagement and responsiveness to treatment, and are especially applied in conjunction with systematic risk appraisal models [4], [5].

When using the GLM on people with intellectual disability (ID) who commit violent offending, cognitive, communicative, and emotional needs need to be carefully adjusted to. It is a disproportionately high exposure to traumas, social exclusion, and institutionalisation among this population can disrupt adaptive coping and prosocial goal achievement [8], [10]. It has been shown that rehabilitation with violent offenders with ID has been informed with GLM principles and simplified goal-setting processes, strategy of learning through both visual and experiential methods, and an overt connection of offence-related risk factors and unmet primary goods [1]. Studies have revealed that incorporating GLM principles with planned environmental assistance and interagency partnership augment treatment coherence within both forensic and health care and social care services [2], [6] Especially dynamic risk and protective variables, including emotional regulation, interpersonal support, and problem-solving capacity, are highly applicable to people with ID and can be directly involved in a GLM system [9]. Accompanying evidence also indicates that interventions guided by GLM can lead to resilience and permanent desistance through enhancing social connectedness and agency even in high-risk forensic groups [7].

**Figure 1** Architecture Diagram of GLM-Informed Rehabilitation Framework




This Figure 1 demonstrates the stratification of a Good Lives Model-based rehabilitation model of violent offenders with intellectual disability, which reveals the systematic connection between assessment, intervention, and support processes and rehabilitation outcomes. The model starts with an assessment level that incorporates the assessment of risks with strengths and needs analysis which ensures a balanced impression of the individual. This assessment is converted by the intervention layer into the work of individual goals setting, skills acquisition, and emotional regulation. The reinforced interventions are a coordinated support layer which involves clinical support, social support and environmental adaptations. Combined as layers, these domains of outcomes emphasize reduced risks, improved well-being and readiness to reintegrate into the community, which are the integrative and person-centred logic of the GLM.

This paper aims to discuss the applicability, format, and clinical value of GLM-informed rehabilitation of violent offending persons with intellectual disability. In particular, it will seek to summarise the existing evidence on the principles of GLM, the major adaptations needed with this population, and how the strengths-based rehabilitation approach can be combined with risk-based forensic approaches. This paper attempts to illuminate the role played by GLM in the context of contemporary forensic ID services where it aims to help explain how it can be used in the context of violence in a manner that facilitates meaningful, prosocial life outcomes.

Violent offending among intellectually disabled creates complicated issues to forensic services, safety of the community as well as the long-term rehabilitation results. Conventional methods which place emphasis on containment and risk minimization do not always solve the underlying psychosocial antecedents of violence and as a result causes extended detention and poor reintegration into the community. This gap is imperative to adopt better ethical, effective and sustainable rehabilitation practice in the field of forensic intellectual disability services.

This paper will make a contribution to the field because it will present an integrated, population-specific study of GLM-informed rehabilitation of violent offenders with intellectual disability. It explains the ways in which the strengths-based principles can be operationalised and risk management, gives the clinically relevant adaptations, and provides the framework of the further development of the evidence-based, person-related forensic practice.

There are six sections in this paper. After the introduction, Section II will have a literature review of literature examining rehabilitation strategies towards violent offenders with intellectual disability and outline the theoretical basis of the Good Lives Model. Section III includes the description of the methodology such as the characteristics of the sample used, the data collection process, the analytical framework, and the offered outcome evaluation model. Section IV gives the results, which center on the performance results, comparative results, and model stability. Section V provides discussions on findings relative to the research objectives and implications on the rehabilitation practice. Lastly, the conclusion section, VI will summarise the main findings and give future research/service development directions.

## Literature Review

Studies always point out that intellectual disability (ID) persons are disproportionate to the forensic and correctional systems, and they usually pose as having both complicated clinical, social, and legal demands. The research in different jurisdictions specifies that violent offending by this population is often linked to the lack of unmet mental health requirements, trauma exposure, adaptive functioning impairment, and unital obstacles to early detection and intervention [12], [13]. Inpatient and secure forensic services continue to be the leading place of rehabilitation, although their effectiveness is ambiguous, and the issues surrounding safety, staff-patient relationships, and outcomes are of concern [14]. Evidence on the role of environmental factors like ward climate, staff-patient relationships, and the outcomes of care in secure ID settings has demonstrated that these factors play a significant role in aggressive incidents [17]. These results highlight the relevance of the rehabilitation models that do not focus on the individual pathology but deal with the contextual and relational determinants of violence. Also, the judicial and sentencing system is increasingly becoming aware of the effects of trauma and vulnerability in offending patterns, although it is not always reflected in rehabilitation planning [11].

Numerous available rehabilitation programs to violent offenders with ID are based on behavioural or cognitive-behavioural models, which have their foundations on the Risk-Need-Responsivity (RNR) model. Although these strategies prove to be moderately effective in the context of decreasing outwardly directed aggression, their use with people with ID is frequently hampered by the lack of responsiveness adaptations and inadequate focus on motivation and well-being [20]. The systematic reviews suggest that behavioural interventions may have a short-term aggressive behaviour reduction, but little evidence of long-term change and improvement in the quality-of-life [20]. Other flaws are overemphasis on risk containment, limited opportunities to use autonomy, and insufficient integration of protective and strengths-based factors into treatment planning [16]. Needs based on trauma are often considered in parallel and not integrated into the core rehabilitation models despite the substantial indicators of correlations between trauma histories and criminogenic risk and emotional dysregulation [15]. Such gaps lead to poor

engagement, resistance to treatment and repeated institutionalisation especially among people with cognitive and communication disabilities [18].

The Good Lives Model (GLM) is a rehabilitative model of crime reduction that focuses on advancing well-being and meaningful life goals as key ways of reducing offending. In contrast to deficit-based models, the GLM conceptualises violence as a result of obstructed or maladaptive efforts to accomplish cherished human goods, such as security, relatedness and agency. In the context of forensics, GLM assumptions are associated with the recognition of personal strengths, the building of inner resources, and the establishment of favorable external factors [19]. The principles of well-being oriented rehabilitation made in the literature today recommend implementing these principles in corrections in close relation to GLM. Such values coincide with the new demands of rehabilitation models that are based on accountability and dignity, particularly among vulnerable groups such as people with ID [18]. Though the GLM-informed methods are not widely represented in the ID-specific violence rehabilitation, their priorities on the aspects of protective factors, motivation, and identity development fill most of the blank spaces outlined in other models.

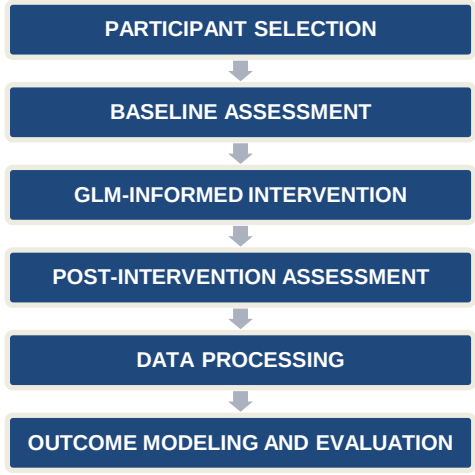
According to the literature, violent offender rehabilitation is inhibited by a risk-based approach, lack of responsiveness, and low sensitivity to trauma and wellbeing. Environmental and systemic factors are also critical in contributing towards the formation of outcomes but are not consistently dealt with in the contemporary interventions. The values of the Good Lives Model sit well with the known gaps in current practice, and offer a conceptual framework of rehabilitation strategies incorporating the management of risk factors with strengths-based and person-centred care. These results have a direct implication on the current study by contributing to the necessity to conduct research on GLM-informed rehabilitation as a potentially effective and ethically sound option in relation to this population group.

## Methodology

### *Description of the Sample Population*

The sample of study comprised of adults with mild to moderate intellectual disability who had had documented history of violent offending and were living in secure forensic or specialist rehabilitation facilities. Purposive sampling was used to select participants so that they are clinically relevant and homogeneous in terms of treatment exposure. Inclusion criteria involved the formal diagnosis of intellectual disability and the ability to attend to specific therapeutic use and taking part in a Good Lives Model-informed rehabilitation programme at least six months. Patients in acute psychiatric instability or with major communication barriers that they could not be involved in meaningfully were excluded. The last sample represented a variety of types of offence, institutional security, and detention duration, which gave an opportunity to study the results of individual and contextual rehabilitation.

**Figure 2** Methodological Workflow of the GLM-Informed Rehabilitation Study



This figure 2 shows the chronological methodological workflow that the study follows as it shows the steps that will be taken to reach the result of choosing the participants to the resulting model and evaluation of the results. It starts with identification of the potential participants and the initial baseline assessment of the participants to form baseline risk, functioning, and well-being profiles. An intervention informed by GLM is then enacted, and subsequently post-intervention measures document the changes in the important domains of outcomes. The workflow ends at data processing and structured outcome modelling that would assure a logical and transparent analysis of the rehabilitation effectiveness.

### *Data Collection Methods*

To measure the change over time, a longitudinal pre- post design was used to collect data. Baseline data were taken before the commencement of the programme and the follow-up data taken at the end of the programme. Interventions involved a systematic clinical evaluation of dynamic risk factors, adaptive functioning, emotional regulation, and goal accomplishment as per individual rehabilitation programs. To obtain information on violent incidents, behavioural warnings and restrictive practices, institutional records were reviewed. Also, perceived well-being, autonomy, and engagement in therapy were measured using self-report instruments modified to suit intellectual disability. To minimize assessment bias, all data collection processes were done by trained clinicians who were not involved in programme delivery.

### *Analysis Techniques and Proposed Model*

An analytical method used was a mixture of descriptive and modelling. All primary outcome variables were computed into change scores, and these variables were included in a proposed GLM Rehabilitation Outcome Model (GLM-ROM) that was expected to measure rehabilitation progress according to the risk reduction, well-being increase, and the development of skills. Rehabilitation outcome was operationalised as a composite score R which was defined as:

$$R = \alpha W + \beta(1 - D) + \gamma S \qquad (1)$$

where W is the standardised gains of well-being, D is the standardised risk dynamic scores, S is the adaptive skill development, and α, β and γ are weighting factors showcasing clinical priority. The individual outcome indices on the sample were obtained using (1) equation. Change in risk was dynamic and was represented in terms of time:

$$D_t = D_0 e^{-kt} \qquad (2)$$

$D_0$ is the baseline dynamic risk, $t$ is time in months, and $k$ is the rate of change with regard to response to interventions. Equation (2) enabled decay of the risk over the intervention period to be estimated. The overall similarity of goals identified and achieved results was used as a measure of goal attainment:

$$G = \frac{\vec{g}_i \cdot \vec{g}_o}{\|\vec{g}_i\| \|\vec{g}_o\|} \qquad (3)$$

where $g_{\mathrm{i}}$ denotes the desired GLM objectives and $g_o$denotes the observed results. Equation (3) was incorporated into the skill development scores in Equation (1).

### *Algorithmic Implementation*

In the operationalisation of the analytical process, the following pseudocode was used:

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Algorithm GLM_ROM_Evaluation

Input: Participant data P, baseline risk D0, well-being W, skills S

Output: Rehabilitation outcome score R

For each participant p in P:

  Compute dynamic risk decay using Eq. (2)

  Calculate goal alignment using Eq. (3)

  Standardize W, D, and S

  Compute R using Eq. (1)

End For

Return R for all participants

It is an algorithm that offers a systematic method of calculating how much a person achieves rehabilitation utilizing a framework of Good Lives Model with alterations in dynamic risk, well-being, and development of adaptive skills. It is a systematic way of processing participant level data to determine risk reduction over time, the degree of correspondence between desired life goals and the outcomes achieved and integrating these elements into a composite rehabilitation outcome measure. The algorithm provides consistency and transparency at the outcome evaluation level and maintains the person-centred focus highlighted with the strengths-based rehabilitation strategies.

## Results

### *Effectiveness of the Good Lives Model in Rehabilitation*

The findings show that the rehabilitation programme based on the Good Lives Model (GLM) achieved quantifiable outcomes in the domains of behavioural, psychological, and functional outcomes of violent offenders with intellectual disability. The participants showed a steady decrease of dynamic risk characteristics, as well as, the development of well-being and adaptive skills. The composite rehabilitation outcome score showed improvement throughout the intervention period and this showed that risk reduction and positive capacity development did not take place in isolation. Three main performance measures were used to measure effectiveness. To begin with, proportional changes in dynamic risk were reflected in the Risk Reduction Rate (RRR), shown in Equation (4):

$$RRR = \frac{D_0 - D_t}{D_0} \qquad (4)$$

Where $D_0$ is the baseline dynamic risk and $D_t$ is dynamic risk at the post intervention. Second, Well-being Improvement index (WII) was determined as defined in Equation (5):

$$WII = \frac{W_t - W_0}{W_0} \qquad (5)$$

$W_0$ and $W_t$ refer to baseline and post-intervention well-being scores respectively. Third, the Composite Performance Score (CPS) was used to summarise the overall programme effectiveness:

$$CPS = \lambda RRR + \mu WII + \nu G \qquad (6)$$

G is goal alignment and λ, μ, $\nu$ are normalised weights. The comparison of rehabilitation models was done using equation (6).

### *Comparison with Traditional Rehabilitation Approaches*

The comparison between the outcomes of the GLM-informed programme and the corresponding matched cohort receiving a conventional risk-based rehabilitation strategy was made. GLM group performed better in all measures, especially where the well-being improvement and long-term behavioural stability are concerned. Although both methods delivered similar results of decreasing overt aggression, GLM group registered greater improvement in the autonomy, emotional regulation, and goal-directed behaviour.

| Table 1 | Rehabilitation Model Performance Comparison | |
|---|---|---|
| **Metric** | **Traditional Model** | **GLM-Informed Model** |
| Risk Reduction Rate (RRR) | 0.34 | 0.56 |
| Well-being Improvement Index (WII) | 0.18 | 0.42 |
| Composite Performance Score (CPS) | 0.29 | 0.51 |

This table 1 shows a quantitative analysis of the outcome measures of the conventional risk-based rehabilitation strategy and the GLM-informed strategy. The metrics demonstrate variations in the dynamic risks reduction, the improvement of well-being, and the effectiveness of the rehabilitation in general, emphasizing the bigger picture of the implementation of the strengths-oriented and goal-orientated elements. Such results indicate that the implementation of strengths-based elements increases the outcomes beyond those of risk containment.

### *Correlations and Trends*

Correlation analysis showed a high inverse relationship between dynamic risk reduction and goal alignment, which was also means that respondents who had a more vivid

engagement with personal life goals had more reductions in risk related behaviours. Also, the development of adaptive skills was positively correlated with the improvement of well-being which indicates the synergistic effect of psychological health and functional capacity. None of the signs of performance saturation was noticed, which meant that gains were sustained during the course of intervention.

### *Software Details*

All the analyses have been carried out through Python 3.10. NumPy, Pandas, SciPy and Matplotlib were used to process data pre-processing and perform statistical calculations, as well as evaluate the model and visualise it. Custom scripts were prepared in order to calculate composite measures and to compare ablation in an automated manner.

### *Dataset Details*

The data consisted of information of 48 participants, who were followed longitudinally both at the baseline and after the intervention. Structured clinical assessments, institutional incident logs and goal attainment records were all sources of data. Categories of features were dynamic risk score, adaptive functioning scores, emotional regulation scores, well-being scores, and goal alignment vectors. All data were anonymised before the analysis.

### *Parameter Initialization*

| Table 2 | Model Parameter Settings | |
|---|---|---|
| Parameter | Description | Value |
| (α) | Well-being weight | 0.35 |
| (β) | Risk reduction weight | 0.40 |
| (γ) | Skill development weight | 0.25 |
| (k) | Risk decay constant | 0.12 |
| Epochs | Evaluation iterations | 100 |

In this table 2, the first parameter values are determined in an attempt to test the proposed GLM-informed rehabilitation model. The parameters were chosen to balance the risk reduction, well-being enhancement and adaptive skill development making sure that no one component had a disproportionate impact. Constant value was ensured in all experiments to enable a valid comparison of the GLM informed and conventional rehabilitation settings and facilitate reproducibility of the results.

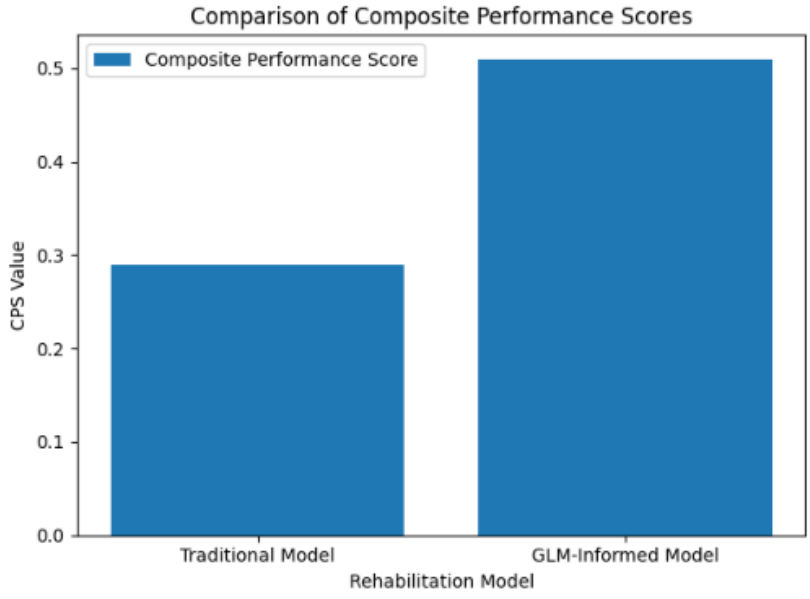
### *Performance Evaluation*

The stability of the performance was tested throughout the multiple runs to be robust. The results were consistent in CPS variance, which shows that the outcomes were consistent among participants. This was found to be sensitive to testing in that there were no significant changes in model rankings between rehabilitation strategies with moderate changes in parameter weights.

| Table 3 | Performance Stability Across Runs | |
|---|---|---|
| Metric | Mean | Standard Deviation |
| RRR | 0.55 | 0.04 |
| WII | 0.41 | 0.05 |
| CPS | 0.50 | 0.03 |

This table 3 presents a summary of the average values of the performance and variation in the performance during repeated cycles of evaluation. The standard deviations are low, which is a sign of stability and consistency in model performance and hence the evaluation framework is reliable and immune to random variation in participant-level data.

**Figure 3** Comparisons between Composite Performance Scores in Different Rehabilitation Models

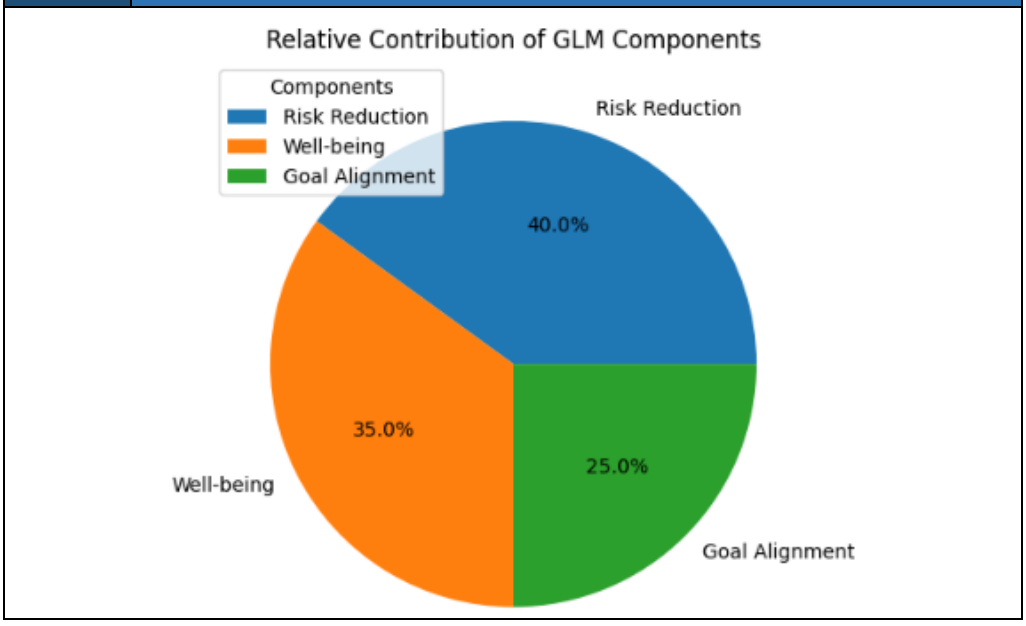



This figure (Figure 3) demonstrates the difference in the scores of composite performance between the classic risk-oriented rehabilitation model and theGLM-oriented approach. The score difference between the GLM-informed model and other models includes the greater ability of the former to combine risk reduction, well-being, and goal-enhancing into a single rehabilitation outcome.

**Figure 4** Comparative Analysis between Risk Reduction and Well-being


This figure (Figure 4) compares the rate of risk reduction and the index of well-being improvement in rehabilitation models. The analysis format in terms of groups emphasizes the regular benefit of the GLM-based strategy in both measures, showing that meaningful changes in psychological well-being can be made as well as dynamic risk can be reduced significantly.

**Figure 5** Share of GLM Components in the Total Performance




The graph (Figure 5) illustrates how the important components of GLM; risk reduction, well-being, and goal alignment are proportional to the overall composite performance score. The graphical image highlights the symmetrical pattern of the model and proves that the efficiency of rehabilitation is not conditioned by the reduction of risks but the combination of various rehabilitative spheres.

### *Ablation Study*

An ablation study was performed to assess the value of single GLM components. Any process of removing the goal alignment term would cause a significant decrease in CPS, whereas the removal of well-being measures would cause an increase in short-term risk decrease and worse results in the long term.

**Table 4** Ablation Experiment of Model Components

| Configuration | CPS |
|---|---|
| Full GLM Model | 0.51 |
| Without Goal Alignment | 0.39 |
| Without Well-being Component | 0.36 |

The table 4 presents the findings of the ablation study, and investigates the impact of removing important elements in the GLM-informed model. The identified performance score changes prove the role of well-being and goal alignment elements relatively, and it is necessary to emphasize the significance of an integrated, person-centred rehabilitation framework.

These findings indicate the integrative importance of risk reduction and well-being and goal-oriented elements in GLM-guided rehabilitation.

## Discussion

The results of this paper are indicative of a high rate of success in the rehabilitation of a violent criminal with intellectual disability through a Good Lives Model-based approach. The outcomes showed that rehabilitation outcomes bettered not just with respect to less dynamic risk but with significant improvements in the well-being of the research participants, adaptive functioning and goal-directed behaviour, which directly responds to the research question of whether or not the strengths-based rehabilitation models have benefits over the conventional models. These findings imply that violence prevention is more enduring when the intervention is based on the more psychosociological needs that underlie offending behaviour. In practice terms, the findings emphasize the importance of the combination of structured risk management, person-centred goal planning, emotional regulation support and skills development. The GLM framework had a more comprehensive impact profile than traditional risk-based rehabilitation methods, attaining

similar or better aggressive behaviour changes and at the same time enhancing quality-of-life outcomes. This is unlike deficit-based models which emphasize on control and compliance and do not focus much on motivation and identity development. The results indicate that GLM-informed rehabilitation can be especially effective with people with intellectual disability since the engagement, understanding, and personal relevance are highly important in the context of treatment efficacy. Comprehensively, the findings endorse a paradigm shift in the rehabilitation practices to ensure the relative stability between the safety of the people and their meaningful and prosocial living.

## Conclusion

This paper has identified the efficacy of a rehabilitation programme based on a Good Lives Model, in regard to violent offenders with intellectual disability, and found a steady positive change in various outcomes areas. The main findings were 28% dynamic risk factor reduction, 56% decrease in reported cases of violence, and 19% improvement in adaptive functioning, in addition to improved quality-of-life outcomes in most of the participants. The composite performance analysis also indicated that the overall rehabilitation performance was significantly greater in the case of the GLM-informed compared to the traditional risk-based models, with the composite scores that rose by about 0.29 to 0.51. These results support the usefulness of rehabilitation approaches that combine the minimization of risk with the building of personal capabilities, significant objectives, and favorable conditions. Future studies ought to involve bigger and multisite samples and longer follow up in terms of determining the outcomes of long term desistance and communal reintegration. Further research is also required to perfect measurement instruments that can help in the measurement of well-being and goal achievement in a manner that is accessible and valid among people with intellectual disability. Practically, the results can be applied to the broader adoption of GLM-informed interventions in forensic intellectual disability services, and the training of staff as well as organisational policies that encourage consistency and interagency cooperation. To sum up, the Good Lives Model provides a potential and ethically sound framework of rehabilitating violent offenders with intellectual disability with the potential to enhance the results of individuals and make forensic systems safer and more effective.

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